

**A PRECARIOUS BALANCE: MANAGING STIGMA,
CONFIDENTIALITY, AND COMMAND AWARENESS IN THE
MENTAL HEALTH ARENA**

MAJOR CARA-ANN M. HAMAGUCHI*

I. Introduction

A. The Secret that Killed Major (Maj) Ruocco

On February 7, 2005, Marine Corps Maj John Ruocco hung himself in a hotel room near Camp Pendleton, California. By all outward appearances, Maj Ruocco lived a charmed life. He was a devoted family man who loved his wife and two young boys. As a pilot in the Marines, he was a respected leader who dedicated his life to serving for the good of others. He was the life of every party, a pillar in his community, and a die-hard Boston sports fan. But Maj Ruocco had a terrible secret—he suffered in silence from untreated depression and post-traumatic stress.¹

After returning home from a deployment to Iraq where he flew more than seventy-five combat missions, Maj Ruocco was a different man. Once fun and joyful, he became withdrawn, easily agitated, and sullen. He was plagued with nightmares and insomnia, and struggled to

* Judge Advocate, U.S. Army. Presently assigned as Executive Officer, The Judge Advocate General's Legal Center and School, Charlottesville, Virginia. L.L.M., 2014, The Judge Advocate Gen.'s Sch., U.S. Army, Charlottesville, Virginia; J.D., 2009, University of North Carolina at Chapel Hill; B.A., 2001, Washington University in Saint Louis. Previous assignments include Complex Litigation Attorney, I Corps, Joint Base Lewis-McChord, Washington, 2012–2013; Trial Counsel and Operational Law Attorney, 3d Stryker Brigade Combat Team, Joint Base Lewis-McChord and Afghanistan, 2011–2012; Brigade Judge Advocate, 3d Stryker Brigade Combat Team, Joint Base Lewis-McChord, Washington, 2010–2011; Administrative Law Attorney, I Corps, Joint Base Lewis-McChord Washington, 2010; S-4, 112th Signal Battalion (Special Operations) (Airborne), Fort Bragg, North Carolina, 2005–2006; Executive Officer and Company Commander, B Company, 3d Psychological Operations Battalion, Fort Bragg, North Carolina, 2003–2005; Platoon Leader, 304th Signal Battalion, Camp Humphreys, Korea, 2001–2003. Member of the bars of North Carolina, the U.S. Court of Appeals for the Armed Forces, and the Supreme Court of the United States. This article was submitted in partial completion of the Master of Laws requirements of the 62d Judge Advocate Officer Graduate Course.

¹ See Kim Ruocco, *Finding Hope Amid Devastating Loss: A Military Widow Who Lost Her Marine to Suicide Shares Her Story*, HUFFINGTON POST, http://www.huffingtonpost.com/kim-ruocco/finding-hope-amid-devasta_b_4004046.html (last visited Dec. 10, 2014) (sharing the story of Major Ruocco's suicide and the circumstances leading up to it).

reconnect with his family. Eventually, his performance at work deteriorated. He had difficulty concentrating while flying his helicopter and failed a routine flight test. And then one night, when he could no longer bear the weight of his secret, he took his own life.²

According to his wife, Maj Ruocco was unable to bring himself to seek help despite her pleading:

He thought that people would think he was weak, that people would think he was just trying to get out of [deploying again] or trying to get out of service, or that he just couldn't hack it—when, in reality, he was sick. He had . . . suffered from depression and let it go untreated for years. And because of that, he's dead today.³

B. An Inherent Tension

Sadly, Maj Ruocco's reluctance to seek help and his fear of being judged is a common attitude among servicemembers suffering from mental-health issues. In today's military, the stigma of mental-health treatment is a "pervasive barrier to care."⁴ According to a study published in 2009 by the Office of the Army Surgeon General's Mental Health Advisory Team (MHAT), more than half of the servicemembers surveyed in Afghanistan felt that they would be seen as weak if they sought psychological health services.⁵ As such, rather than admitting their perceived "weaknesses," many Soldiers choose to forgo professional help.⁶ There is also a stigma built upon skepticism

² *Id.*

³ Associated Press, *Suicides Among U.S. Troops Averaging One a Day in 2012*, USA TODAY (Jun. 7, 2012), <http://usatoday30.usatoday.com/news/military/story/2012-06-07/military-troops-suicide/55453990/1>.

⁴ Crosby Hipes, *The Stigma of Mental Health Treatment in the Military: An Experimental Approach*, CURRENT RES. IN SOC. PSYCH. (Dec. 20, 2011), <http://www.uiowa.edu/~grpproc/crisp/crisp.html>.

⁵ U.S. ARMY MED. COMMAND, JOINT MENTAL HEALTH ADVISORY TEAM (MHAT) 6, OPERATION ENDURING FREEDOM AFGHANISTAN 35 (2009) [hereinafter MHAT 6] (reporting that 52.9% of the more than 1,580 respondents felt they would be seen as weak if they asked for help).

⁶ Hipes, *supra* note 4, at 1 ("Seeking treatment is stigmatized as a 'weak' act in the military, violating the norm of individual strength in coping with the demands of military service. Due in large part to fear of stigma from fellow soldiers, some personnel

regarding the use of mental-health records. The same MHAT study found that over a third of servicemember respondents avoided seeking help because they believed that doing so would harm their careers.⁷

While stigmas associated with mental-health treatment are not limited to the military,⁸ the military's culture presents unique challenges.⁹ After more than a decade of persistent combat, there has been an alarming trend of increased suicides and rising rates of mental-health issues among servicemembers.¹⁰ In light of these trends, access to quality care is critical, and reliable assurances of privacy and confidentiality are necessary, especially when stigma is a barrier to care.¹¹ A Soldier is more likely to seek help if he knows that he can do

returning from deployments with mental illness symptoms may forgo professional help.” (citing Charles Hoge et al., *Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care*, 351 NEW ENG. J. MED. 13 (2004); McFarling et al., *Stigma as a Barrier to Substance Abuse and Mental Health Treatment*, 23 MIL. PSYCHOL. 1 (2011); Deborah A. Gibbs et al., *Dynamics of Stigma for Alcohol and Mental Health Treatment among Army Soldiers*, 23 MIL. PSYCHOL. 224 (2011)).

⁷ MHAT 6, *supra* note 5, at 35 (reporting that 33.6% of respondent feared that seeking psychological health services would harm their careers).

⁸ See Patrick W. Corrigan & David L. Penn, *Lessons from Social Psychology on Discrediting Psychiatric Stigma*, 54 AM. PSYCHOL. 765, 765 (1999) for a discussion of the impact of stigma on the general civilian population.

⁹ See Def. Ctrs. of Excellence for Psych. Health and Traumatic Brain Injury (DCoE), *Background*, REAL WARRIORS, http://realwarriors.net/campaignmedia/factsheets/RW_Background.pdf [hereinafter *Background*, REAL WARRIORS] (“Asking for help can be challenging for anyone, but there are particular concerns that may prevent servicemembers and veterans from seeking support or care for invisible wounds.”); Lieutenant Colonel Anderson B. Rowan et al., *A Multisite Study of Air Force Outpatient Behavior Health Treatment-Seeking Patterns and Career Impact*, 171 MIL. MED. 1123, 1123 (2006) (“[T]he lower rates of treatment-seeking in the military, despite equivalent levels of psychological distress, suggest the presence of additional barriers or greater intensity of barriers in the military population.”).

¹⁰ See generally KATHERINE BLAKELY & DON J. JANSON, CONG. RESEARCH SERV., POST TRAUMATIC STRESS DISORDER AND OTHER MENTAL HEALTH PROBLEMS IN THE MILITARY: OVERSIGHT ISSUES FOR CONGRESS I (2013), *available at* <http://www.fas.org/sgp/crs/natsec/R43175.pdf> (last visited Dec. 10, 2014) [hereinafter CRS Report] (providing statistics regarding the rising rate of mental health diagnoses in the military). In particular, the Army has consistently led the other services in instances of mental disorder diagnosis and suicide rates. *Id.* at 4, 50 (reporting incidence rates of mental disorder diagnosis among the different services from 2007 through 2010 and rates of suicide by service between 1998 through 2011).

¹¹ RAND CORP., *INVISIBLE WOUNDS: PSYCHOLOGICAL AND COGNITIVE INJURIES, THEIR CONSEQUENCES, AND SERVICES TO ASSIST RECOVERY* 282 (Terri Tanielian & Lisa H. Jaycox eds., 2008) [hereinafter *INVISIBLE WOUNDS*] (“[F]ears of negative career

so privately without repercussions to his career or judgment from others.

However, absolute confidentiality in a military context is not possible. Commanders and leaders are responsible for ensuring readiness. They are also ultimately responsible for the health and well-being of their Soldiers and are expected to know the issues of the Soldiers within their formations. To this end, it is critical for commanders to have broad access to information, including information regarding their Soldiers' mental health. This presents a conundrum that is unique to the military: A commander's interest in having information is seemingly at odds with an individual Soldier's interest in seeking confidential mental-health services.¹²

The recent Washington Naval Yard shooting illustrates this conflict. In September 2013, Aaron Alexis—a contractor with a secret clearance working at the Washington Naval Yard—stalked and executed twelve unarmed employees.¹³ Following the incident, investigators learned that Alexis had been discharged from the Navy Reserves under honorable conditions despite several instances of minor misconduct on his record.¹⁴ They also found indications of mental-health issues in his record.¹⁵

consequences could be alleviated by allowing servicemembers with less-severe mental health issues to easily and confidentially receive mental health services.”)

¹² See *id.* (“Encouraging use of confidential mental health services runs counter to prevailing views that command should have access to information about all mental health service use to evaluate individual readiness.”).

¹³ See *Rampage at the Navy Yard: What Happened in Building 197?*, WASH. POST, Sept. 25, 2013, <http://www.washingtonpost.com/wp-srv/special/local/navy-yard-shooting/scene-at-building-197/> (detailing the events of the shooting); Michael D. Shear & Michael S. Schmid, *Gunman and 12 Victims Killed in Shooting at D.C. Navy Yard*, N.Y. TIMES (Sept. 16, 2013), <http://www.nytimes.com/2013/09/17/us/shooting-reported-at-washington-navy-yard.html?page-wanted%3Dall> (recounting the details of the shooting and describing the injuries of the victims).

¹⁴ See Trip Gabriel, Joseph Goldstein & Michael S. Schmidt, *Suspect's Past Fell Just Short of Raining Alarm*, N.Y. TIMES (Sept. 17, 2013), http://www.nytimes.com/2013/09/18/us/washington-navy-yard-shootings.html?pagewanted=all&_r=0 (providing a detailed account of Aaron Alexis's “history of infractions as a Navy reservist, mental health problems and run-ins with the police over gun violence”).

¹⁵ *Id.* (noting that just a month before he opened fire at the Washington Navy Yard, Alexis had complained to police about “hear[ing] voices speaking to him” and on a separate occasion, he had also confided to a friend that he suffered from “post-traumatic stress disorder,” which caused him to be withdrawn and made it difficult for him to sleep). Approximately a month before the shooting, on August 7, 2013, Aaron Alexis

The fact that Alexis maintained a secret clearance in the face of his misconduct and mental-health issues sent a wave of concern throughout Washington.¹⁶ During a post-incident press briefing on September 18, 2013, reporters peppered Secretary of Defense Chuck Hagel and Joint Chiefs of Staff Chairman General Martin Dempsey with questions about the security-clearance process. In particular, one such question scrutinized a change made to security-clearance applications in 2008:

[A] few years back, they took off mental health questions on security clearance reviews in order to de-stigmatize PTSD. Do you think that mental health questions should be returned to the security reviews because they are relevant? Do you think you're in a difficult position, having tried to de-stigmatize mental health reviews on the one hand and remove these questions from security clearance forms?¹⁷

In response to this question, General Dempsey zealously defended the change to the security-clearance forms: "I actually was one of those with [former Army Vice Chief of Staff] [General] Peter Chiarelli and others who believed that men and women should have the opportunity to overcome their—their mental disorders or their mental challenges or their—clinical health challenges and shouldn't be stigmatized."¹⁸ This dialogue highlights the inherent tension between two equally important interests—that of the individual Soldier and that of his commander.

C. Roadmap

The Army is currently looking at effecting a culture shift to dispel

called the police in Newport, Rhode Island, because he was convinced that he was being followed and harassed by a "microwave machine." *Id.*

¹⁶ *See id.* (reporting that Senator Susan Collins, a Republican from Maine, declared that the incident suggested "a very flawed system for granting security clearances," and called for a "Congressional investigation into the granting of security clearances to government contractors" and that "President Obama ordered the White House budget office to conduct a governmentwide [sic] review of policies for security clearances for contractors and employees in federal agencies").

¹⁷ *News Transcript: Defense Department Press Briefing by Secretary Hagel and General Dempsey in the Pentagon Briefing Room*, U.S. DEP'T OF DEFENSE (Sept. 18, 2013), <http://www.defense.gov/transcripts/transcript.aspx?transcriptid=5305>.

¹⁸ *Id.*

the stigma regarding mental health and to remove barriers to care.¹⁹ However, until then, the privacy needs of individual Soldiers must be balanced with the rights and duties of commanders and leaders. The key to achieving this balance is two-fold: (1) ensuring that commanders understand and respect a Soldier's interest in receiving confidential mental-health treatment; and (2) promoting transparency regarding the use of mental-health records so that Soldiers can seek help without fear of negative repercussions on their careers. Put simply, Soldiers would be more likely to seek mental-health treatment if they had assurances that their privacy would be protected and if the stigma was largely dispelled.

This article examines the conflict between privacy and the military mission, and advocates for a better balance between the two by centralizing information for commanders and establishing specific administrative consequences for commanders and leaders who fail to respect established privacy standards. This article also examines the current uses of mental-health information for mission and readiness requirements, and calls for more transparency for Soldiers. While parts of this article apply to the entire spectrum of mental conditions and disorders, this article focuses specifically on combat-stress and Post Traumatic Stress Disorder (PTSD).²⁰

To facilitate this discussion, Part II provides background information on the history of mental-health treatment in the Army and the current state of mental-health issues in today's Army. Part III addresses the

¹⁹ See Def. Ctrs. of Excellence for Psych. Health and Traumatic Brain Injury (DCoE), REAL WARRIORS, <http://realwarriors.net/> (last visited Dec. 10, 2014) (promoting resilience amongst servicemembers and awareness "to encourage help-seeking behavior among servicemembers . . . coping with invisible wounds"); see also George W. Casey, Jr., *Comprehensive Soldier Fitness: A Vision for Psychological Resilience in the U.S. Army*, 66 AM. PSYCHOLOGIST 2 (2011) ("My vision is that [Comprehensive Soldier Fitness] becomes a part of our culture over time, with our Soldiers understanding the positive dimension of psychological fitness much like professional athletes do."); U.S. DEP'T OF DEF., DEFENSE SUICIDE PREVENTION OFFICE ANNUAL REPORT—FY 2012, at 15 (2012) [hereinafter SUICIDE PREVENTION OFFICE ANNUAL REPORT 2012] (outlining efforts to Improve Strategic Messaging and Stigma).

²⁰ In 2011, Department of Defense (DoD) officials dropped the word "disorder" from PTSD in order to de-stigmatize the term. Within the DoD, the condition is now known as simply Post-Traumatic Stress (PTS) or Post-Traumatic Stress Injury (PTS "I"). See *infra* notes 54–55 and accompanying text. This article will continue to use the term PTSD for the sake of consistency, as the American Psychiatric Association's current *Diagnostic and Statistical Manual of Mental Disorders* still uses the term "PTSD." See *infra* note 66. The author intends no disrespect or disparagement by the use of "PTSD" over "PTS" or "PTS 'I'."

stigma associated with receiving mental-health treatment in the military that stems from the military's culture and from beliefs regarding negative career impact. Then, Part IV discusses why confidentiality is critical to overcoming stigma-related barriers to care, and discusses privacy policies and regulations at the federal-government wide, Department of Defense (DoD), and Army levels. Part V shifts focus to the military mission and discusses the rights and responsibilities of commanders in ensuring readiness and in knowing their Soldiers, and the duty of commanders to protect confidential information. To this end, Part VI discusses tools that allow commanders to access protected information. Part VII discusses the delicate balance between privacy and readiness, and proposes administrative consequences for commanders who perpetuate stigma or disrespect privacy. Finally, Part VIII of this article looks at the impact that mental-health issues can have on a Soldier's career and argues for more transparency regarding the use of mental-health information to reduce that impact.

II. Background

A. History of PTSD: From Shell Shock to Dropping the "Disorder"²¹

The history of PTSD reveals an early misunderstanding of combat stress, and even disdain, toward Soldiers who were suffering from combat-related psychiatric symptoms.²² In an austere military culture where courage and unflinching resolve were prized virtues, there was little sympathy for Soldiers who could "no longer cope and who [broke] down."²³ Many military officials considered these Soldiers to be cowards and weaklings, and they sought to punish afflicted Soldiers rather than help them.²⁴ Thus, "military morality was the first hurdle that had to be cleared before a beginning could be made in giving

²¹ This article focuses on the history of PTS beginning with the concept of "shell shock" in World War I. For a pre-World War I history of PTS, see Major Timothy P. Hayes, Jr., *Post-Traumatic Stress Disorder on Trial*, 191 MIL. L. REV. 67 (2007); F. Don Nidiffer & Spencer Leach, *To Hell and Back: Evolution of Combat-Related Post Traumatic Stress Disorder*, 29 MENTAL HEALTH L. 1 (2010).

²² See Major Tiffany Chapman, *Leave No Soldier Behind: Ensuring Access to Health Care for PTSD-Afflicted Veterans*, 204 MIL. L. REV. 1, 6 (2010) (citing Hans Pols & Stephanie Oak, *War and Military Mental Health: The U.S. Psychiatric Response in the 20th Century*, 97 AM. J. PUB. HEALTH 2132, 2132-33 (2007)).

²³ HANS BINNEVELD, FROM SHELL SHOCK TO COMBAT STRESS: A COMPARATIVE HISTORY OF MILITARY PSYCHIATRY 84 (1997).

²⁴ *Id.*

assistance.”²⁵

During World War I, many of the Soldiers who were constantly exposed to exploding artillery shells while fighting in trenches exhibited PTSD symptoms, such as memory loss, speech disorders, exhaustion, and irritability.²⁶ At the time, mental illness was thought to be a result of actual physical damage to the brain, which manifested in behavioral disorders.²⁷ Given these beliefs, “the underlying assumption was that the senses and brain could be injured by the explosion of artillery shells.”²⁸ As such, medical providers used the term “shell shock” to describe the afflicted Soldier’s condition. In many cases, Soldiers suffering from shell shock had to be taken out of the fight.²⁹ Military authorities who had little understanding and “appreciation of the magnitude of wartime psychiatric disorders” believed that these individuals were weaker than others and were thus “predisposed to situational stress.”³⁰ Some officials even believed that suffering Soldiers were cowards who were malingering to shirk their duties.³¹ As a result, rather than developing treatment and prevention methods, the Army focused on weeding shell-shocked Soldiers out of the ranks and tightening initial entry screening to “exclude vulnerable Soldiers from entering military service.”³²

Many of the early assumptions and beliefs regarding shell shock that were established in World War I were challenged during World War II. As World War II progressed, the Army Medical Department observed that psychiatric breakdowns were not exclusive to Soldiers exposed to

²⁵ *Id.*

²⁶ *Id.* at 85 (noting that other symptoms included blindness, paralysis, and hearing and speech disorders).

²⁷ *See id.* at 84. Prior to the war, venereal disease and excessive alcohol use were believed to be the leading causes of the brain damage that led to mental illness. *Id.*

²⁸ *Id.* at 86.

²⁹ 1 U.S. ARMY, MED. DEP’T, NEUROPSYCHOLOGY IN WORLD WAR II: ZONE OF THE INTERIOR, at xiii (Colonel Robert S. Anderson et. al. eds., 1966) [hereinafter NEUROPSYCHOLOGY IN WWII] (claiming that these Soldiers were unable to tolerate stress or make any “useful contribution to the military effort”).

³⁰ *Id.*

³¹ Chapman, *supra* note 22, at 6 (noting that commanders were further convinced that some Soldiers were shirking their duties because not all Soldiers were affected).

³² NEUROPSYCHOLOGY IN WWII, *supra* note 29, at xiii; Pol & Oaks, *supra* note 22, at 2133 (reporting that one psychoanalyst who consulted for the Armed Forces claimed that “individuals who had been unable to adjust to the demands of American society would never adjust to the demands of army life”).

exploding artillery shells.³³ By this time, the somatic³⁴ theory that connected mental illness to physical brain injuries had lost support within the psychiatric community.³⁵ Rather, the prevailing theory was that experiences, suggestions, and unresolved psychic conflicts could cause mental disorders within Soldiers.³⁶ Over time, the term “wartime neurosis” replaced the term “shell shock.”³⁷

During World War II, Army officials also learned that combat psychiatric breakdowns “could originate from normal or previously stable personnel as well as from those of weaker predisposition.”³⁸ In light of these observations, some medical professionals came to believe that grueling physical demands of combat coupled with chronic sleep deprivation could stress and fatigue even stable Soldiers to the point of nervous breakdown.³⁹ Around this time, the term “combat exhaustion” gained popularity. Many Soldiers endorsed this term because it offered them the possibility of treatment without being stigmatized and labeled with disparaging terms such as “psycho.” Unfortunately, the “combat exhaustion” concept wrongly created a belief that rest was the only treatment that Soldiers needed before returning to combat.⁴⁰

Despite the breakthroughs in psychiatry that World War II brought, there was huge disparity among medical professionals in diagnosing and treating Soldiers who presented psychiatric symptoms.⁴¹ Due to the lack

³³ BINNEVELD, *supra* note 23, at 87 (noting that even Soldiers on leave were known to suffer from the symptoms previously associated with shell shock).

³⁴ Defined as “of, or relating to, or affecting the body especially as distinguished from the . . . psyche.” MERRIAM WEBSTER’S COLLEGIATE DICTIONARY 1188 (11th ed. 2004).

³⁵ BINNEVELD, *supra* note 23, at 87 (reporting that at the end of WWI, “the need for explanations other than the physical effects of shelling became even greater”).

³⁶ *See id.* at 88–89. There were three prevailing points of view that replaced the original concept of shell shock. The first point of view was that traumatic experiences could shape emotions and cause behavioral disorders. The second point of view was that behavioral disorders were the result of suggestion and conscious or unconscious desires. Finally, the third point of view, influenced by Sigmund Freud, was that functional disorders were the result of unresolved psychic disorders within Soldiers’ minds. *Id.*

³⁷ *Id.* at 94 (discussing the shift away from the term “shell shock”).

³⁸ NEUROPSYCHOLOGY IN WWII, *supra* note 29, at xiii.

³⁹ *See* BINNEVELD, *supra* note 23, at 95 (explaining that infantry Soldiers fought the war on foot and were required to walk long distances loaded down with supplies, weapons, and ammunition, which led to exhaustion by the end of the war).

⁴⁰ Hayes, *supra* note 21, at 72 (“[T]he introduction and widespread use of such terms as ‘battle fatigue’ and ‘mental exhaustion’ reinforced the belief that a little rest would be all that was required to return the Soldier to the front.”).

⁴¹ BINNEVELD, *supra* note 23, at 95–96.

of psychiatric experience among many military doctors, Soldiers who exhibited psychiatric symptoms often received purely somatic diagnoses.⁴² Unfortunately, misdiagnoses were sometimes driven by commanders because “[p]sychiatric cases were bad for the reputation of the [unit] as well as for the career of the [commander] involved.”⁴³ The Army often used the number of psychological breakdowns in a unit as a gauge for the unit’s morale, and it was in the best interest of commanders to find alternate explanations for Soldiers leaving the fight.⁴⁴ As a result, many Soldiers did not receive proper care and mental-health issues became further stigmatized.

Nevertheless, the Army made serious efforts to handle the vast number of Soldiers afflicted by psychological issues. And as a result, the field of military psychiatry grew quickly during World War II and became a major component of the Army Medical Service.⁴⁵

Even with the large increase in Army mental-health professionals, rates of “psychiatric casualties” during the Korean War were extremely high.⁴⁶ In response, the Army attempted to “implement early intervention and treatment procedures for combat stress during the Vietnam War.”⁴⁷ Facially, these new procedures seemed to be effective. The number of Soldiers treated for combat stress during Vietnam was

⁴² See *id.* (explaining different reasons for the disparities in diagnoses). In addition, “[s]ometimes these doctors did not know how to deal with a [S]oldier who had suffered a breakdown and they simply reported that he had a back complaint or that he wet his bed.” *Id.* See also NEUROPSYCHOLOGY IN WWII, *supra* note 29, at 736 (“A frequent comment by frustrated and harassed psychiatrists during World War II was that responsible authorities failed to heed the lessons learned by psychiatry in World War I.”); OFFICE OF THE SURGEON GEN., OFFICE OF MED. HISTORY, REHABILITATING THE WOUNDED: HISTORICAL PERSPECTIVE ON ARMY POLICY 57 (2008) [hereinafter REHABILITATING THE WOUNDED] (“The Army started the war with only 35 physicians in psychiatric positions; of those only 20 had psychiatric training, and only 4 were board-certified.”).

⁴³ BINNEVELD, *supra* note 23, at 96.

⁴⁴ See *id.*

⁴⁵ See NEUROPSYCHOLOGY IN WWII, *supra* note 29, at xiii; GARY GREENBERG, THE BOOK OF WOE: THE DSM AND THE UNMAKING OF PSYCHIATRY 31 (2013) (discussing how the influx of Soldiers suffering from “war neuroses” grew the ranks of military psychiatry exponentially, and contributed to the growth of civilian psychiatry as well); REHABILITATING THE WOUNDED, *supra* note 42, at 57 (discussing the Army’s efforts to gain new psychiatrists by bringing in civilian psychiatrists and training “ordinary physicians into semi-psychiatrists”).

⁴⁶ Pol & Oaks, *supra* note 22, at 2136 (“Because of the nature of the conflict, characterized by quickly shifting front lines and widely dispersed battle fields, it was difficult to implement programs of forward psychiatry.”).

⁴⁷ Chapman, *supra* note 22, at 7.

quite low.⁴⁸ However, these numbers are deceiving because they only addressed rates of combat stress that manifested during the actual fighting of the Vietnam War. Due to the enduring belief that combat stress had no adverse long-term effects, military psychiatrists did not focus on combat stress once the war ended.⁴⁹ It was not until fifteen years later, when a survey revealed that hundreds of thousands of Vietnam veterans were suffering from service-related mental-health issues, that psychiatrists realized “prolonged exposure to combat experiences had adverse long-term consequences.”⁵⁰

This post-Vietnam revelation marked a paradigm shift in how combat stress was viewed by both military and civilian psychiatrists. In 1980, the American Psychiatric Association included PTSD in the third edition of its Diagnostic and Statistical Manual of Mental Disorders (DSM III).⁵¹ The establishment of a PTSD diagnosis was met with controversy. Mental-health professionals could not agree on a definition of PTSD or on specific metrics to evaluate and diagnose PTSD.⁵² As such, despite its recognition in the DSM III, PTSD was not widely diagnosed or studied in the 1980s. This lack of focus on PTSD continued through the Gulf War. During the Gulf War, PTSD received very little attention because the media primarily focused on Soldiers returning from combat with unexplainable chronic symptoms that were colloquially labeled “Gulf War Syndrome.”⁵³

⁴⁸ Pol & Oaks, *supra* note 22, at 2136 (reporting that the instances of combat stress made up less than 5% of all medical cases). See also BINNEVELD, *supra* note 23, at 87 (attributing the lower instances of combat stress in Vietnam to the availability of psychiatric drugs, shorter tours, and the availability of recreational activities). Another reason for the relatively low number of reported cases is that the discontent and reluctance to fight the War made treating Soldiers for psychiatric conditions less of a priority. *Id.*

⁴⁹ See Pol & Oaks, *supra* note 22, at 2136. Psychiatric disabilities that occurred post-war were “believed to be related to preexisting conditions” rather than related to the war itself. *Id.*

⁵⁰ Chapman, *supra* note 22, at 7; Pol & Oaks, *supra* note 22, at 2138.

⁵¹ AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 247–51 (3d ed. 1980). This new disorder included the concept of “delayed onset” in its diagnostic categories. Pol & Oaks, *supra* note 22, at 2138.

⁵² Pol & Oaks, *supra* note 22, at 2138. Some people went as far as to complain that the establishment of PTSD provided a diagnostic label to veterans who were largely “poor Americans . . . recruited in unusually large numbers” and given entitlements to a pension and medical care. *Id.*

⁵³ *Id.* For a comprehensive overview of Gulf Illnesses, see U.S. DEP’T OF VETERANS AFF., RES. ADVISORY COMM. ON GULF WAR VETERANS’ ILLNESSES, GULF WAR ILLNESS AND THE HEALTH OF GULF WAR VETERANS (2008), available at

With the advent of Operation Enduring Freedom (OEF) in 2001 and Operation Iraqi Freedom (OIF) in 2003, PTSD received renewed interest as thousands of Soldiers returned home from combat with invisible wounds. However, with a history marred by misjudgment, misunderstanding, and stigma, many Soldiers were skeptical of the PTSD label. In 2011, due to the negative connotation associated with the term “disorder,” and in an effort to de-stigmatize PTSD, top military officials dropped the “disorder”⁵⁴ in favor of calling the condition Post-Traumatic Stress (PTS) or Post-Traumatic Stress Injury (PTS “I”).⁵⁵

B. Mental Health in Today’s Military

Today, the U.S. military is operating in an era characterized by “persistent conflict.”⁵⁶ While combat-related stress has been present throughout the history of warfare and is by no means unique to combat in Iraq and Afghanistan, these modern conflicts have novel factors that play a role in influencing mental health.⁵⁷ First, current military operations require frequent and extended deployments. For over a decade, Soldiers have rotated in and out of combat and endured protracted separations

http://www.va.gov/RACGWVI/docs/Committee_Documents/GWlandHealthofGWVeterans_RAC-GWVIRport_2008.pdf.

⁵⁴ See Mark Thompson, *The Disappearing “Disorder”*: Why PTSD Is Becoming PTS, TIME (June 5, 2011), <http://nation.time.com/2011/06/05/the-disappearing-disorder-why-ptsd-is-becoming-pts/>.

⁵⁵ See U.S. DEP’T OF THE ARMY, ARMY 2020: GENERATING HEALTH & DISCIPLINE IN THE FORCE AHEAD OF THE STRATEGIC RESET 25 (2012) [hereinafter ARMY GOLD BOOK] (“GEN Chiarelli (among others) has advocated to change the ‘D’ from ‘Disorder’ in PTSD to ‘I’ for injury to dispel the perception that the word ‘disorder’ reflects an individual weakness.”). This report does note that the “change will require close collaboration with national medical organizations (e.g., American Psychiatric Association) to assess the impact of diagnoses of mental illnesses on help-seeking behavior, treatment, and care. *Id.* The *Gold Book* is an expansion of the *Red Book*, which was published in 2010. *Infra* note 82. Both reports are nicknamed according to the color of their respective covers.

⁵⁶ Casey, *supra* note 19, at 1 (“Persistent conflict is defined as protracted confrontation among state, nonstate, and individual actors who are increasingly willing to use violence to accomplish their political and ideological objectives.”).

⁵⁷ See ARMY GOLD BOOK, *supra* note 55, at 3 (“The wars in Iraq and Afghanistan are unique in many ways. They represent not only the longest wars fought by our Army, but also the longest fought by an all-volunteer force. Today’s wars have placed tremendous and unique burdens on our Soldiers and Families as compared to previous conflicts.”); INVISIBLE WOUNDS, *supra* note 11, at 5 (discussing “unique features of current deployments”).

from their families while operating for months-on-end in high-stress situations.⁵⁸ These deployments are more frequent, longer in duration, and have shorter rest periods in between than in other post-World War II conflicts.⁵⁹ Next, there are higher rates of survivability from wounds.⁶⁰ Due to advances in medical treatment and protective gear, “[w]ounded Soldiers who likely would have died in previous conflicts are instead saved.”⁶¹ However, these surviving Soldiers are frequently left with “significant physical, emotional, and cognitive injuries” long after their physical wounds have healed.⁶² Finally, mission requirements in the current conflicts are often complex and extremely stressful. In the modern counterinsurgency, Soldiers are often expected to perform various functions simultaneously under intense conditions. For example “[i]t is not uncommon to find a junior officer or enlisted [S]oldier who serves as a war fighter, counter insurgency expert, public works official, intelligence gatherer, and peacekeeper—all in the same day.”⁶³

This unique operating environment—marked by extended deployments, higher survivability rates, and complex missions—has taken a toll on the mental health of servicemembers. Since 2001, the overall rate of mental-health diagnoses among active-duty servicemembers has increased dramatically,⁶⁴ along with the rates of specific mental disorders, such as depression and anxiety.⁶⁵ The most

⁵⁸ Casey, *supra* note 19, at 2.

⁵⁹ See INVISIBLE WOUNDS, *supra* note 11, at 5 (“Troops are seeing more-frequent deployments, of greater lengths, with shorter rest periods in between—factors thought to create a more stressful environment for servicemembers.”); ARMY GOLD BOOK, *supra* note 55, at 4 (“[T]he [operational tempo] in Iraq and Afghanistan over the past decade has remained persistently high, providing very few opportunities for individuals to rest, either physically or mentally.”).

⁶⁰ INVISIBLE WOUNDS, *supra* note 11, at 6.

⁶¹ *Id.*

⁶² *Id.* Combat in Iraq and Afghanistan has led to the “highest ratio of wounded to killed in action in U.S. history.” *Id.* Soldiers are surviving serious injuries in the current conflicts, including amputations, severe burns, spinal cord injuries, blindness, and traumatic brain injuries. *Id.*

⁶³ Casey, *supra* note 19, at 2.

⁶⁴ BLAKELY & JANSON, *supra* note 10, at 7 (“Between 2001 and 2011, the rate of mental health diagnoses among active duty servicemembers increased approximately 65%.”). These diagnoses included adjustment disorders (26%), depression (17%), anxiety (10%), PTSD (6%), alcohol abuse and dependence disorders (13%) and substance abuse and dependence disorders (4%). *Id.* at 2.

⁶⁵ *Id.* at 3 (reporting changes in incidence rates of mental disorder diagnoses from 2001 to 2011). The incidence of some specific diagnoses including schizophrenia, personality disorders, and alcohol abuse and dependence have decreased, but the overall trend is one of increase. *Id.*

significant increase is with the reported incidence of PTSD,⁶⁶ which has increased approximately 650 percent since 2000.⁶⁷

The stress of modern combat has also led to other disturbing trends. Several studies have linked combat stress to increased alcohol and drug abuse among servicemembers.⁶⁸ In addition, suicides among active-duty servicemembers have risen dramatically in the last decade, and are at an all-time high.⁶⁹ In fact, “beginning in 2010, suicide has been the second-leading cause of death for active duty servicemembers, behind only war injuries.”⁷⁰

Despite these staggering statistics, experts suggest that these numbers are just the tip of the iceberg; they do not account for the estimated thousands of Soldiers who require, but do not seek, mental-

⁶⁶ The DSM-V still includes PTSD as the official diagnosis, rather than PTS. See Am. Psychiatric Ass’n, *Posttraumatic Stress Disorder*, DSM-5 DEVELOPMENT, [http://www.dsm5.org/Documents/PTSD %20Fact%20Sheet.pdf](http://www.dsm5.org/Documents/PTSD%20Fact%20Sheet.pdf) (last visited Dec. 10, 2014) (acknowledging the urging of military leaders to rename the disorder to reduce stigma but concluding that “[i]n DSM-5, PTSD will continue to be identified as a disorder”).

⁶⁷ BLAKELY & JANSON, *supra* note 10, at 3 (“The reported incidence of PTSD has increased approximately 650%, from about 170 diagnoses per 100,000 person years in 2000, to approximately 1,110 diagnoses per 100,000 person years in 2011.”).

⁶⁸ See e.g., Joshua E. Wilk et al., *Relationship of Combat Experiences to Alcohol Misuse Among U.S. Soldiers Returning from the Iraq War*, 108 DRUG & ALCOHOL DEPENDENCE 115 (2010) (finding a correlation between combat experiences and alcohol misuse); Karen H. Seal et al., *Substance Use Disorders in Iraq and Afghanistan Veterans in VA Healthcare, 2001–2010: Implications for Screening, Diagnosis, and Treatment*, 116 DRUG & ALCOHOL DEPENDENCE 93 (2011) (finding that alcohol use disorder and drug use disorder diagnoses were “highly comorbid with PTSD and depression”); INVISIBLE WOUNDS, *supra* note 11, at 129. But see BLAKELY & JANSON, *supra* note 10, at 3 (finding that the rates of diagnoses of alcohol abuse and dependence have decreased).

⁶⁹ Casey, *supra* note 19, at 2 (“The suicide rate among our [S]oldiers is at an all time high.”); see generally Robert H. Pietrzak et al., *Risk and Protective Factors Associated with Suicidal Ideation in Veterans of Operations Enduring Freedom and Iraqi Freedom*, 123 J. OF AFFECTIVE DISORDERS 102 (finding that PTSD, depression, and psychosocial difficulties are strong indicators of suicidal ideation).

⁷⁰ BLAKELY & JANSON, *supra* note 10, at 48. There is also some evidence that suggests that as the military reduces its footprint in combat, suicides may overtake war injuries as the leading cause of death among active duty servicemembers. See Greg Zoroya, *Suicides in the Army Declined Sharply in 2013*, USA TODAY (Jan. 31, 2014), <http://www.usatoday.com/story/news/nation/2014/01/31/suicide----military----army----numbers----decline/5057337/> (“During periods of weeks or months, more troops were dying by their own hand than were killed in combat.”).

health treatment.⁷¹ According to the Walter Reed Army Institute of Research, “[r]oughly half of the [S]oldiers who return from war with post-traumatic stress disorder don’t seek treatment.”⁷² These findings are paralleled in a 2012 *Military Family Lifestyle Survey Report* conducted by Blue Star Families.⁷³ This survey found that twenty-six percent of the spouse respondents reported that their servicemember “displayed symptoms of PTS.”⁷⁴ Of these respondents, sixty-two percent reported that their servicemember had not sought medical help or treatment.⁷⁵

The biggest barrier to seeking mental health care services is not due to a shortage of available services.⁷⁶ In fact, over the past decade, the

⁷¹ BLAKELY & JANSON, *supra* note 10, at 24 (“[T]hese data likely underestimate the true incidence and prevalence numbers and rates among active duty servicemembers of the U.S. Armed Forces.”). Another explanation for the lower numbers is that the data does not include “servicemembers who may experience mental health problems but who do not seek treatment for them at a fixed military medical or reimbursable civilian location.” *Id.*

⁷² See Seth Robinson, *Soldiers Fail to Seek PTSD Treatment or Drop Out of Therapy Early, Research Finds*, STARS & STRIPES (May 5, 2012), <http://www.stripes.com/news/special-reports/post-traumatic-stress-disorder-ptsd/soldiers-fail-to-seek-ptsd-treatment-or-drop-out-of-therapy-early-research-finds-1.177275> (reporting the findings of Major Gary H. Wynn during an American Psychiatric Association annual meeting).

⁷³ BLUE STAR FAMILIES, OFFICE OF RESEARCH AND POLICY, 2012 MILITARY FAMILY LIFESTYLE SURVEY (2012) [hereinafter Blue Star Families]. This survey was administered online to family members representing “a diverse cross section of military family members from all branches of services, ranks and regions, both within the United States and overseas military installations.” *Id.* at 6. “Of the 4,234 military family members that started the survey, seventy-nine percent (2,891) completed the entire questionnaire.” *Id.*

⁷⁴ *Id.* at 22–23. Notably, the respondent’s observations of their servicemembers are from a laypersons’ perspective; not all the servicemembers necessarily have PTSD. However, the survey still illustrates the prevalence of servicemembers who do not seek treatment.

⁷⁵ *Id.* at 23.

⁷⁶ *E.g.*, MHAT 6, *supra* note 5, at 56 (reporting that in a survey of 1,580 Soldiers in Afghanistan, only 6.5% of respondents cited lack of mental-health services, difficulty getting an appointment, availability of appointments, or not knowing where to go as factors affecting their decision to receive medical care, whereas more than 25% of surveyed Soldiers cited a stigma-based factor that affected their decision to receive medical care); INVISIBLE WOUNDS, *supra* note 11, at 104 (reporting that “logistical” barriers to care were cited less frequently when compared with “institutional and cultural” barriers to care). *But see* BLUE STAR FAMILIES, *supra* note 73, at 23 (citing “lack of confidentiality” as the biggest reason for seeking treatment, but ranking “good services were not conveniently available” as a larger factor than “negative image of seeking treatment” and “fear negative impact to career”). Significantly, the Blue Star Families Respondents were Family members rather than the servicemembers themselves.

DoD and the mental-health community at large have taken steps to improve access to mental health services.⁷⁷ Rather, the biggest barrier preventing Soldiers from seeking mental health care is the perceived stigma associated with receiving mental health treatment.⁷⁸

III. Stigma Regarding Mental Health Treatment

In social science literature, stigma is defined as “a negative and erroneous attitude about a person, a prejudice, or a negative stereotype.”⁷⁹ The Army Suicide Prevention Task Force specifically defines stigma from a military perspective: “the perception among Leaders and Soldiers that help-seeking behavior will either be detrimental to their career (e.g., prejudicial to promotion or selection to leadership positions) or that it will reduce their social status among their peers.”⁸⁰ Due to stigma, individuals with mental illnesses are often doubly challenged. In addition to struggling with the symptoms and disabilities resulting from their mental conditions, they are also “challenged by the stereotypes and prejudice that result from misconceptions about mental illness.”⁸¹ The fear of judgment and prejudice often prevents individuals with mental-health concerns from seeking professional help.⁸²

The military culture presents unique challenges with regards to stigma as a barrier to care. Strengths and attributes that are central to the military culture often conflict with the notion of seeking help or admitting struggles with invisible wounds. This section will discuss both

In addition, these Family members were affiliated with veterans and National Guard and Reserve Soldiers rather than just active-duty Soldiers. *Id.* at 6.

⁷⁷ See, e.g., ARMY GOLD BOOK, *supra* note 55, at 14–15 (detailing the efforts of the Army’s Medical Command in responding to the increase in behavioral health issues).

⁷⁸ See *supra* note 71.

⁷⁹ INVISIBLE WOUNDS, *supra* note 11, at 275 (citing Patrick W. Corrigan & David L. Penn, *Lessons from Social Psychology on Discrediting Psychiatric Stigma*, 54 AM. PSYCHOL. 765, 765 (1999)).

⁸⁰ U.S. ARMY SUICIDE PREVENTION TASK FORCE, ARMY HEALTH PROMOTION RISK REDUCTION SUICIDE PREVENTION REPORT A-13 (2010) [hereinafter ARMY RED BOOK].

⁸¹ Patrick W. Corrigan & Amy C. Watson, *Understanding the Impact of Stigma on People with Mental Illness*, 1 WORLD PSYCHIATRY 16 (2002).

⁸² Nicola Fear et al., *Does Anonymity Increase the Reporting of Mental Health Symptoms?*, BMC PUBLIC HEALTH (2012), <http://www.biomedcentrl.com/1471-2458/12/797> (“There is no doubt that the perceived stigma of having a mental disorder acts as a barrier to help seeking.”).

aspects of stigma according to the military-specific definition: the “warrior culture” of the Army, where Soldiers sometimes equate mental-health issues with weakness, and the common belief amongst Soldiers that seeking help or receiving treatment will adversely impact their careers.

A. Stigma Bred in the Warrior Culture

The Army’s warrior culture “is one that values strength, resilience, courage, and personal sacrifice.”⁸³ Soldiers are groomed to embody the Army Values and the Warrior Ethos, which champion attributes such as duty and selfless service.⁸⁴ These values are instilled in Soldiers from their first day in the Army,⁸⁵ and they are essential to “develop[ing] and maintain[ing] an effective fighting force.”⁸⁶ However, this culture can sometimes prove detrimental to the mental-health needs of individual Soldiers.⁸⁷ Soldiers often feel an obligation to master their problems and shake off ailments; “[t]he prevailing view within [the] ranks is that

⁸³ Craig J. Brian & Chad E. Morrow, *Circumventing Mental Health Stigma by Embracing the Warrior Culture: Lessons Learned from the Defender’s Edge Program*, 42 PROF. PSYCHOL. RES. & PRAC. 16, 16 (2011).

⁸⁴ *Warrior Ethos*, U.S. DEP’T OF ARMY, <http://www.army.mil/values/warrior.html> (last visited Feb., 22, 2015) (“I will always place the mission first. I will never accept defeat. I will never quit. I will never leave a fallen comrade.”); *Army Values*, U.S. DEP’T OF ARMY, <http://www.army.mil/values> (last visited Feb. 22, 2015) [hereinafter ARMY VALUES] (listing the seven Army Values: Loyalty, Duty, Respect, Selfless Service, Honor, Integrity, and Personal Courage); see Casey, *supra* note 19, at 2 (“Our Army Values and Warrior Ethos play a significant role in how we see ourselves, and therefore, in how we chose to behave.”).

⁸⁵ ARMY VALUES, *supra* note 84 (“Soldiers learn these values in detail during Basic Combat Training (BCT) from then on they live them every day in everything they do—whether they’re on the job or off. In short, the Seven Core Army Values . . . are what being a Soldier is all about.”).

⁸⁶ INVISIBLE WOUNDS, *supra* note 11, at 276.

⁸⁷ See *id.* at 276; Hipes, *supra* note 4, at 1 (“While these norms help to maintain a unified fighting force, their enforcement may foster divisions between individuals seen as fit for duty and individuals seen as too weak to handle the stressors of military service.”); see also Shaun M. Burns & James R. Mahalik, *Suicide and Dominant Masculinity Norms Among Current and Former United States Military Servicemen*, 42 PROF. PSYCHOL. RES. & PRAC. 347 (2011) (discussing how masculine norms such as self-reliance an emotional control or stoicism are barriers to seeking help and can ultimately lead a servicemember to suicide).

having problems with stress or seeking help is not only inconsistent with being a warrior but also a sign of weakness.”⁸⁸

Studies of deployed active-duty Soldiers have consistently found that beliefs rooted in the Army culture often prevent Soldiers from seeking mental-health care. For example, in the 2009 MHAT survey of 1,580 Soldiers in Afghanistan, many of the respondents believed that if they sought mental-health treatment they would be seen as weak (29.0%), members of their unit would have less confidence in them (29.5%), they would be embarrassed (25.8%), or their leaders would treat them differently (29%).⁸⁹ These beliefs regarding stigma were equally prevalent in maneuver units and in support-and-sustainment units.⁹⁰ The fear of judgment and embarrassment is common in many Soldiers throughout the Army—from infantrymen to mechanics to cooks.

B. Fear of Career Impacts

The second stigma-based barrier prevalent in the military is the fear that seeking help will have adverse career impacts. Specifically, Soldiers believe that admitting their mental-health struggles will negatively impact their security clearances, potential for career progression, or even their ability to continue to serve in the Army altogether.⁹¹ In an open-

⁸⁸ Casey, *supra* note 19, at 2; *see also* INVISIBLE WOUNDS, *supra* note 11 at 276; *Invisible Casualties: The Incidence and Treatment of Mental Health Problems by the U.S. Military: Hearing Before the H. Comm on Oversight and Gov't Reform*, 110th Congress 43 (2007) (statement of Army Specialist Michael Bloodworth) (agreeing with the notion that coming forth with a mental illness in the military is seen as a sign of weakness).

⁸⁹ *See* MHAT 6, *supra* note 5, at 56. Earlier MHAT studies conducted between 2003 and 2006 parallel these results—“[a]pproximately half of the servicemembers who screened positive for mental disorders cited concerns about appearing weak, being treated differently by leadership, and losing confidence of members of the unit as barriers to receiving behavioral health care.” INVISIBLE WOUNDS, *supra* note 11, at 277 (compiling the data from various Mental Health Advisory Team surveys).

⁹⁰ MHAT 6, *supra* note 5, at 5 (“No differences in stigma rates were found between maneuver and support and sustainment units.”).

⁹¹ *See* Invisible Wounds, *supra* note 11, at 280 (“Receiving a mental health diagnosis may also have significant career implications, particularly in some career tracks that require higher fitness standards. . . . Evidence of a mental health problem may also result in questioning of a military servicemember’s security clearance and hinder promotion.”); *Invisible Casualties: The Incidence and Treatment of Mental Health Problems by the U.S. Military: Hearing Before the H. Comm on Oversight and Gov't Reform*, 110th Congress 43 (2007) (statement of Army Specialist Thomas Smith) (“I believe that there are a lot of people that are afraid it is going to hurt their career to step forward.”).

ended survey that asked spouses to explain reasons why their servicemembers did not seek help, some of the responses included: “My husband did not want to be labeled or somehow ‘excused’ from the military after 16 years with no retirement”; “If our soldier were to be actually diagnosed with PTSD, we know it could affect his career”; and “It affects job evaluation.”⁹² Similarly, in the 2009 MHAT study, nearly a quarter (24.2%) of the respondents indicated that the belief that doing so would be detrimental to their careers in some fashion was a factor that affected their decision not to seek mental-health care.⁹³ As one officer summed up in sharing his struggle with PTSD, he feared that “Big Army” would find out about his condition and tag him as “broken” and that the “very act of seeking help from a mental health professional could be information that could be used against [him] to target [him].”⁹⁴

C. Stigma as a Barrier to Care

In light of the prevalent stigma associated with seeking mental-health treatment, many Soldiers are reluctant to seek help.⁹⁵ Rather than face real or perceived judgment for their conditions, they choose instead to suffer in silence. Without treatment, these Soldiers often turn to drugs or alcohol in an attempt to self-medicate.⁹⁶ Their work performance and family life often deteriorates, and in the most tragic cases, when all hope is lost, they turn to suicide.⁹⁷ Major Ruocco’s tragic story illustrates this destructive pattern. As a proud Marine Officer, his fears of judgment

⁹² BLUE STAR FAMILIES, *supra* note 73, at 24.

⁹³ MHAT 6, *supra* note 5, at 56. Notably, the percentage of Soldiers who believed that seeking treatment would harm their careers has gone down significantly since the MHAT study in 2004 of Soldiers in Iraq. *Background*, REAL WARRIORS, *supra* note 9, at 1 (reporting that in 2004, 50 percent of the Soldier-respondents from Operation Iraqi Freedom held the belief that seeking help would harm their careers (citing Hoge et al., *supra* note 6, at 13–22)).

⁹⁴ Chaplain (Major) Carlos Huerta, *Leaving the Battlefield: Soldier Shares Story of PTSD*, U.S. DEP’T OF ARMY, http://www.army.mil/article/78562/Leaving_the_battlefield_Soldier_shares_story_of_PTSD.

⁹⁵ SUICIDE PREVENTION OFFICE ANNUAL REPORT 2012, *supra* note 19, at 15 (“Some servicemembers do not access behavioral health care because of such perceptions [of being viewed as weak], along with concerns that seeking care will ruin their career.”); *see also* ARMY GOLD BOOK, *supra* note 55, at 69 (“[T]he biggest barrier to progress in the diagnosis and treatment of behavioral health conditions is the long-standing stigma associated with seeking and receiving treatment.”).

⁹⁶ *See supra* text accompanying note 68.

⁹⁷ *See* SUICIDE PREVENTION OFFICE ANNUAL REPORT 2012, *supra* note 19, at 15 (citing stigma reduction as a major goal of the Suicide Prevention Office).

and career repercussions made him unwilling to reach out for help.⁹⁸

To compound the problem, the very individuals who need the most help are the ones more likely to hold stigmatizing beliefs.⁹⁹ Servicemembers who meet screening criteria for a psychological health concern are approximately two times more likely to express anxiety about reaching out for care than servicemembers who did not meet screening criteria for a psychological health concern.¹⁰⁰

IV. Overcoming Stigma-Related Barriers to Care with Confidentiality

Confidentiality is critical to overcoming barriers to care associated with stigma.¹⁰¹ Soldiers who are otherwise too embarrassed or scared to seek treatment are more likely to do so with strict assurances of privacy.¹⁰² Many of them seek out mental-health providers and chaplains “off the record,”¹⁰³ and they are often wary of even being seen talking to these professionals.¹⁰⁴ As such, over the past decade, several professional organizations have recommended that the government and military support confidential reporting of mental-health issues to overcome to the stigma-based barrier to care.¹⁰⁵ In response, the DoD

⁹⁸ See *supra* text accompanying notes 1–3.

⁹⁹ Fear et al., *supra* note 81, at 1 (“[I]ndividuals who have a mental problem are more likely to experience barriers to care and hold stigmatizing beliefs.”).

¹⁰⁰ Hoge et al., *supra* note 6.

¹⁰¹ See INVISIBLE WOUNDS, *supra* note 11, at 282 (“Such fears of negative career consequences could be alleviated by allowing servicemembers with less-severe mental health issues to easily and confidentially receive services.”).

¹⁰² See generally Fear et al., *supra* note 81 (discussing the impact of anonymity on mental-health reporting).

¹⁰³ See Sadie F. Dingfelder, *The Military’s War on Stigma*, 40 MONITOR ON PSYCHOL. 52 (2009) (presenting the experience of Navy Lieutenant Justin D’Arienzo, PsyD, who was often approached in the lunchroom of the U.S.S. Kitty Hawk aircraft carrier “off the record” about issues).

¹⁰⁴ Interview with Major (Chaplain) David Beavers, Chaplain, The Judge Advocate Gen.’s Legal Ctr. & Sch., in Charlottesville, Va. (Jan. 9, 2014) (sharing that he has sometimes been asked to meet off-duty hours away from the office to preserve confidentiality).

¹⁰⁵ See, e.g., INVISIBLE WOUNDS, *supra* note 11, at xxviii (recommending that the military implement policies that “will require creating new ways for servicemembers . . . to obtain treatments that are confidential”); *APA’s Advice to the Military*, AMERICAN PSYCHIATRIC ASS’N, <http://www.apa.org/monitor/2009/06/stigma-war.aspx> (last visited Jan. 9, 2014) (recommending “[i]ncreased confidentiality concerning mental health treatment). See also BLUE STAR FAMILIES, *supra* note 73, at 24 (advocating for confidential avenues for spouses to express their concerns about their servicemembers

and the Army have enacted programs and policies to protect confidentiality.

A. Department of Defense Initiatives to Protect Confidentiality

Looking first at the efforts made by the DoD, the most significant change came in May of 2008, when former Secretary of Defense Robert Gates announced a change to the security-clearance application-and-renewal process that eliminated “the requirement for individuals to report if they have sought out counseling related to service in combat.”¹⁰⁶ In particular, Question 21 of the Standard Form 86 (SF-86) now reads:

Mental health counseling in and of itself is not a reason to revoke or deny a clearance. 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: 1) strictly marital, family, or grief not related to violence by you; or 2) strictly related to adjustments from service in a military combat environment.¹⁰⁷

Additionally, resources such as the Defense Centers of Excellence for Psychological Health and Traumatic Injury’s Real Warrior Program,¹⁰⁸

who are exhibiting symptoms of PTS). In the Blue Star Families *Lifestyle Survey Report*, an astounding eighty-six percent of the spouse respondents who reported that their servicemembers suffered from symptoms of PTSD cited “lack of confidentiality” as the primary reason for not seeking medical help. *Id.*

¹⁰⁶ ARMY GOLD BOOK, *supra* note 55, at 25. See Memorandum from Sec’t of Def. to Sec’ys of the Military Dep’ts et al., subject: Policy Implementation—Mental Health Question, Standard Form (SF) 86, Questionnaire for National Security Positions (18 Apr. 2008) [hereinafter SF 86 Policy Implementation Memo].

¹⁰⁷ SF 86 Policy Implementation Memo, *supra* note 106 (publishing the revised question). By way of comparison, the previous SF-86 question read: “In the last 7 years, have you consulted with a mental health professional (psychiatrist, psychologist, counselor, etc.) or have you consulted with another health care provider about a mental health related condition?”

¹⁰⁸ See *Background*, REAL WARRIORS, *supra* note 9, at 2 (promoting a toll-free Military Crisis Line, which is a confidential resource “that connects servicemembers in crisis and their families and friends with qualified, caring responders”); ARMY GOLD BOOK, *supra* note 55, at 71 (reporting that the Real Warriors Campaign’s DCoE Outreach Center

Military One Source (MOS), and the Military and Family Life Consultant Program (MFLC) offer confidential services to military personnel and their family members.¹⁰⁹ These resources were specifically created to “implement privacy and confidentiality policies to promote participation and reduce stigma.”¹¹⁰ Notably, while the programs handle issues including “stress and anger management, grief and loss, the deployment cycle, parent-child relationships, couples communication, marital issues, relationships, and relocations,” they are explicitly “non-medical” in nature and are not meant to be a substitute for medically-based mental health diagnoses and treatment.¹¹¹ Nevertheless, the confidential approach to counseling and stress management has been attractive to many servicemembers; the MFLC program saw an increase in use of about twenty-five percent between 2003 and 2010.¹¹² Finally, the DoD provides explicit direction to protect Soldier information and confidentiality.¹¹³

“provides access to psychological health information and resources 24 hours a day, seven days a week”).

¹⁰⁹ See generally U.S. DEP’T OF DEF., INSTR. 6490.06, COUNSELING SERVICES FOR DOD MILITARY, GUARD AND RESERVE, CERTAIN AFFILIATED PERSONNEL, AND THEIR FAMILY MEMBERS (21 Apr. 2009) (C1, 21 July 2011) [hereinafter DoDI 6490.06] (discussing Military One Source and Military and Family Life Consultant (MFLC) Program).

¹¹⁰ *Id.* encl. 3, para. 1.a. To further protect confidentiality, MFLCs are not military personnel, do not keep military records, and are available to meet with Soldiers and their Family members off post and after duty hours if desired. See MIL. CMTY. & FAMILY POL’Y (MC&FP), MC&FP FACT SHEET: MILITARY AND FAMILY COUNSELOR PROGRAM, [hereinafter MFLC FACT SHEET], available at http://www.militaryonesource.mil/12038/MOS/Factsheets/Factsheet_MFLC.pdf.

¹¹¹ See DoDI 6490.06, *supra* note 109, encl. 3, para. 1 (discussing the parameters of the MFLC and MOS programs).

¹¹² MFLC FACT SHEET, *supra* note 110, at 1. The rate of satisfaction for the MFLC services appears to be very high. In a survey of the program, “98% of [the 2,791] respondents rated the MFLC services they received as good or excellent, 99% would recommend MFLC to a friend, and 96% said MFLC services met most or almost all of their needs.” *Id.*; Kaytrina Curtis, *Military, Family Life Consultants Offer Coping Skills at Stewart-Hunter*, U.S. DEP’T OF ARMY (Apr. 19, 2012), http://www.army.mil/article/78142/Military_Family_Life_Consultants_offer_coping_skills_at_Stewart_Hunter/. Another testament to the success of the MFLC program is its growing popularity: “35% of active duty servicemembers reported using non-medical counseling services in 2010 compared to 10% in 2003.” MFLC FACT SHEET, *supra* note 110, at 1.

¹¹³ See U.S. DEP’T OF DEF., INSTR. 6490.08, COMMAND NOTIFICATION REQUIREMENTS TO DISPEL STIGMA IN PROVIDING MENTAL HEALTH CARE TO SERVICE MEMBERS (17 Aug. 2011) [hereinafter DoDI 6490.08] (establishing a presumption that healthcare providers “are not to notify a [servicemember’s] commander when the [servicemember] obtains mental health care or substance abuse education services”).

B. Army Initiatives to Protect Confidentiality

The Army has also made significant progress toward fostering confidentiality in recent years. In 2009, the Army initiated an experimental program to allow Soldiers to seek treatment for drug and alcohol abuse without their commander's knowledge. This program, called the Confidential Alcohol Treatment and Education Pilot (CATEP), was initially implemented at three Army posts, with the goal of allowing Soldiers to receive treatment for substance abuse without any subsequent damage to their military careers.¹¹⁴ Although CATEP is limited to Soldiers seeking treatment for substance-abuse disorders, it is significant in the mental-health arena because of the comorbidity¹¹⁵ between substance abuse and other mental-health issues.¹¹⁶ It also shows the Army's recognition of the importance of confidential treatment.¹¹⁷ After all, "[a]ll of the Army's healthcare services and resources will be ineffective as long as Soldiers suffer from stigma-associated with help-seeking behavior."¹¹⁸

V. Duties of Commanders and Leaders

A. Concerns with Confidentiality

The increased push for confidentiality is not without concern. In fact, "feedback from commanders indicates growing concern that they are left out of the loop on critical information pertaining to Soldier

¹¹⁴ See Dr. Charles S. Milliken, *Access to SUD Care: Confidentiality and Stigma Issues*, WALTER REED ARMY INST. OF RESEARCH 18 (May 3, 2011), <http://www.iom.edu/~media/Files/Activity%20Files/MentalHealth/MilitarySubstanceDisorders/5-3-11ppt2.pdf> (describing the CATEP program and its purposes). The CATEP program was initially started at: Joint-Base Lewis McChord, Washington, Fort Richardson, Alaska, and Schofield Barracks, Hawaii. *Id.* See also ARMY GOLD BOOK, *supra* note 55, at 33–34 (discussing the CATEP program and how the Army plans to expand "confidential treatment access and delivery").

¹¹⁵ "Comorbidity of conditions refers to two or more conditions co-occurring simultaneously." INVISIBLE WOUNDS, *supra* note 11, at 125.

¹¹⁶ See Milliken, *supra* note 114, at 7 (reporting that about half of the Soldiers who screen for PTSD, depression, suicidal ideations or risky behavior (such as driving too fast) also have a drinking problem); INVISIBLE WOUNDS, *supra* note 11, at 134 ("Substance use disorders often co-occur with other mental disorders.").

¹¹⁷ See ARMY GOLD BOOK, *supra* note 55, at 72.

¹¹⁸ *Id.* at 72.

performance and readiness.”¹¹⁹ In a 2011 survey of the Army’s CATEP program, leaders at the first-line supervisor level through commanders indicated that while they supported Soldiers getting treatment, they opposed not being informed of their Soldiers’ participation in the treatment.¹²⁰ Many specifically felt that not knowing what was going on with their Soldiers hindered their ability to effectively lead and help those Soldiers. They also felt that the absolute confidentiality detracted from overall unit readiness.¹²¹

In the Army, “commanders [and leaders] have a duty to ensure the safety and well-being of their Soldiers while also making sure their units are trained and ready to conduct the missions assigned to them on behalf of the Nation.”¹²² In this decade of persistent combat and increasing demands on Soldiers, this dual responsibility has become especially challenging.¹²³ To accomplish their duties and make critical decisions concerning well-being and readiness, commanders and leaders require information about their Soldiers, including certain mental-health information. Total confidentiality is not feasible.

B. Safety and Well-Being of Soldiers

Soldiers are the single most important asset in the Army.¹²⁴ As General Creighton W. Abrams Jr. articulated, “Soldiers are not in the Army, Soldiers are the Army.”¹²⁵ A commander’s primary duty,

¹¹⁹ *Id.* at 34.

¹²⁰ *See id.* (discussing the commander’s concerns). Notably, this survey also “posed a contrary view.” Many commanders who initially opposed the CATEP program’s confidential nature admitted that they would rather Soldiers receive treatment without command notification than for the Soldier not to receive any treatment at all. *Id.*

¹²¹ *Id.* at 345 (“[L]eaders support Soldier getting treatment, however, they oppose not being informed of Soldiers’ participation in treatment; many feel that confidentiality detracts from their ability to effectively help and lead Soldiers and diminishes overall readiness.”).

¹²² *Id.* at 64–65.

¹²³ *Id.* at 11 (quoting the Honorable John M. McHugh, Secretary of the Army, as saying “The most important thing we do is take care of our Soldiers, Civilians, and Families. However, the obvious stress of ten years of war in two theaters, inadequate dwell time at home to recover . . . and a rising number of non-deployable Soldiers have real implications for the Army today and in the future”).

¹²⁴ U.S. DEP’T OF ARMY, TRADOC PAM. 525-97, SOLDIER AS A SYSTEM foreword (24 Feb. 2006) [hereinafter TRADOC PAM. 525-97].

¹²⁵ ARMY GOLD BOOK, *supra* note 55, at 4 (quoting General Creighton W. Abrams Jr., 26th Chief of Staff of the Army).

therefore, is to take care of his Soldiers. In a mental-health context, this includes being vigilant for high-risk behavior and ensuring their Soldiers receive proper care and treatment.

With the troubling suicide rate over the past decade, the Army has put special emphasis on the importance of leaders knowing their Soldiers.¹²⁶ Commanders are expected to monitor the psychological health of their troops and recognize symptoms or unusual behavior that could be considered warning signs of self-injurious behavior.¹²⁷ For example, a commander should watch for a “disturbance or change in behavior, such as a [S]oldier being late to formation when previously the [S]oldier was on time for formation, or a [S]oldier becoming belligerent toward their chain of command.”¹²⁸ This responsibility extends to all leaders, including non-commissioned officers (NCOs). In a video message aimed at preventing suicide, now-retired Sergeant Major of the Army (SMA) Raymond F. Chandler III called on leaders and NCOs to remain vigilant: “I am calling on each of our leaders, but specifically our NCOs to make a difference. As the backbone of our Army, you are in the best position to be our first line of defense. It is vital that you know your Soldiers.”¹²⁹

Commanders also need to be aware of the “complexity of comorbidity and its impact on Soldier populations.”¹³⁰ Mental-health conditions are often associated with a myriad of other conditions that affect Soldier wellness.¹³¹ For example, Soldiers with PTSD often simultaneously suffer from chronic physical pain and other somatic

¹²⁶ *Id.* at 26 (“Leaders at all level must increase awareness of changes in behavior that may indicate a general decline in mental and physical health.”).

¹²⁷ See Ellen Nakashima, *Q&A: How the Army Handles Behavior Health Issues*, WASH. POST (May 8, 2011), http://www.washingtonpost.com/lifestyle/magazine/qanda-how-the-army-handles-behavioral-health-issues/2011/05/02/AF5f6lrF_story.html (reporting an interview with Army Colonel Rebecca I. Porter, Chief of Behavior Health Division of the Office of the Army’s Surgeon General) (“Ultimately the command is responsible for monitoring the health and well-being of its soldiers.”).

¹²⁸ *Id.* (adding that “[o]ther indicators [may include] a drunken driving accident [or] getting into arguments and fights”).

¹²⁹ *Video Profile: SMA Raymond Chandler*, REAL WARRIORS, <http://www.realwarriors.net/multimedia/profiles/chandler.php>.

¹³⁰ ARMY GOLD BOOK, *supra* note 55, at 45.

¹³¹ *Id.* at 42–43 (discussing comorbidity and describing comorbidity as “unquestionably the most complex health issue confronting a post-war force”).

symptoms, such as shortness of breath, fever, nausea, and dizziness.¹³² Poor mental health may also “contribute to poor physical health through altered biological functions (e.g., increased immune function) or by influencing individual health risk behavior (e.g., smoking, poor diet).”¹³³ In fact, mental-health conditions have been associated with health-compromising behaviors, such as alcohol dependence, risky sexual behaviors, and illicit drug use.¹³⁴ In a related matter, commanders must also be aware of the correlation between disciplinary issues and untreated mental-health issues.¹³⁵ Each of these issues has the potential to affect the safety and well-being of individual Soldiers and the unit as a whole.

Commanders are often held personally responsible for their Soldiers’ actions.¹³⁶ This is because the Army expects them to “have an active role in the care and well-being of their Soldiers.”¹³⁷ When a Soldier acts out or deviates from acceptable behavior, leaders at higher levels often want to know if that Soldier’s chain of command was aware of any warning signs and if the incident could have been prevented. Two high-profile cases demonstrate this point. After an investigation revealed that Private First Class Bradley Manning—the Soldier convicted in July of 2013 of various charges relating to the leaking of classified material to *WikiLeaks*—was possibly “experiencing an intense personal crisis and deteriorating mental health in the months he was leaking large amounts of classified data,”¹³⁸ there was an inquiry into whether his supervisors

¹³² See INVISIBLE WOUNDS, *supra* note 11, at 132 (noting some of the somatic complaints associated with Soldiers who screen positive for PTSD).

¹³³ *Id.* at 131.

¹³⁴ *Id.* at 133–35 (describing various studies relating to mental-health issues and associated consequences).

¹³⁵ ARMY GOLD BOOK, *supra* note 55, at 4 (“[T]he Army—from senior leaders to frontline supervisors—must foster a culture that facilitates a 360 degree awareness of the interactions of health and disciplinary issues on individual Soldiers, units and Army communities.”).

¹³⁶ Nakashima, *supra* note 127, at 2 (“In general, those who are in a soldier’s chain of command are considered to be responsible for what the soldiers do or don’t do . . .”).

¹³⁷ ARMY GOLD BOOK, *supra* note 55, at 69.

¹³⁸ Julie Tate, *Army Ignored Manning’s Deteriorating Mental Health*, *Defense Attorney Says*, WASH. POST (Aug. 13, 2013), http://www.washingtonpost.com/world/national-security/army-ignored-mannings-deteriorating-mental-health-defense-attorney-says/2013/08/13/56dd9e70-0451-11e3-a07f-49ddc7417125_story.html (citing the sentencing argument of Manning’s defense attorney). According to his defense counsel, Manning sent an e-mail to his NCO supervisor with the subject line of “My Problem.” In the email, Manning told his NCO that he was “suffering from a gender-identity disorder” that was causing problems with his family. He also attached a photograph of himself wearing a blonde wig and makeup. In a separate incident that

properly handled his case.¹³⁹ Similarly, there was also an investigation after Staff Sergeant Robert Bales walked off his post in southern Afghanistan in March of 2012 and murdered sixteen Afghan civilians. Among the questions that the investigating officer was tasked with answering was whether Sergeant Bales's chain of command recognized any warning signs or mental-health issues.¹⁴⁰ These inquiries stemmed from the expectation that commanders and leaders know their Soldiers.

Finally, and perhaps most significantly, Soldiers are likely to get the best possible care if commanders are aware of their mental-health issues and can collaborate with the Soldier and the Soldier's mental-health providers.¹⁴¹ The combination of the healthcare provider, the Soldier, and the commander is called the "health triad," and it has been effective in properly diagnosing and treating mental-health issues.¹⁴² When they are aware of a Soldier's issues, commanders and supervisors can support treatment by ensuring the Soldier gets to appointments, checking in with the Soldier, and even assisting the Soldier's family. After all, despite seemingly opposing interests, commanders and individual Soldiers do have a common goal: healthy and resilient Soldiers.

C. Soldier Readiness and Fitness

Commanders also have a duty to ensure readiness within their

occurred the month after sending this e-mail, "Manning was found in the fetal position in a storeroom with a knife at his feet." *Id.*

¹³⁹ Nakashima, *supra* note 127, at 1 ("Pfc. Bradley Manning's mental and emotional health was an issue for his supervisors. Whether they properly handled his case was the subject of an investigation . . .").

¹⁴⁰ This is based on the author's personal experience as a trial counsel for the case of *United States v. SSG Robert Bales*. Just a few days after the crime occurred, the Commanding General of U.S. Forces-Afghanistan initiated an investigation that included several lines of inquiry, including whether there were any early indications or warning signs prior to the crime.

¹⁴¹ See *Release of Protected Health Information to Commanders, Stand-To!*, U.S. DEP'T OF ARMY (Oct. 8, 2010), <http://www.army.mil/standto/archive/2010/10/08/print.html> ("Collaborative communication between commanders and healthcare providers is essential for Army readiness and the health and wellness of Soldiers.").

¹⁴² See, e.g., *id.* at 21 (crediting the collaboration of the health triad with the successful diagnosis and treatment of over 126,000 cases of traumatic brain injury (TBI) since the beginning of the war); Interview with Chaplain (Major) Beavers, *supra* note 104 (agreeing that collaboration is extremely effective in treatment for Soldiers).

units.¹⁴³ The Army measures the readiness level of a unit in “three key areas: manning, training, and equipping.”¹⁴⁴ Manning or personnel readiness “reflects not only the number of individuals assigned, but more importantly, their level of physical and mental fitness.”¹⁴⁵ When Soldiers suffer from untreated mental-health issues, including cumulative stress from multiple and prolonged deployments, there are often consequences to their performance and readiness.¹⁴⁶

Just as a physical injury such as a broken leg can affect a Soldier’s ability to accomplish a mission, invisible wounds can also hinder mission accomplishment. In 2011, “mental disorders accounted for more hospitalizations for servicemembers than any other illness.”¹⁴⁷ In particular, PTSD has been associated with “lower ratings of general health, more sick call visits, [and] more missed work days.”¹⁴⁸ These prolonged treatments and hospitalizations result in lost duty time that commanders must account and to which they must adjust.¹⁴⁹ In some cases, mental-health issues like PTSD may even affect a Soldier’s ability to deploy.¹⁵⁰

Even if a Soldier’s mental-health issues do not rise to the level of hospitalization, mental issues and high levels of stress can affect his work performance and quality.¹⁵¹ Anecdotally, Soldiers with PTSD

¹⁴³ See, e.g., Casey, *supra* note 19, at 2 (noting that readiness is an operational issue, and thus in the purview of commanders).

¹⁴⁴ ARMY GOLD BOOK, *supra* note 55, at 64.

¹⁴⁵ *Id.*

¹⁴⁶ See Casey, *supra* note 19, at 1 (“American soldiers have rotated between combat and home for more than nine years, incurring cumulative levels of stress that are impacting their performance, their readiness, and—in many cases—their personal relationships.”).

¹⁴⁷ BLAKELY & JANSON, *supra* note 10, at 1 (citing *Mental Disorders and Mental Health Problems, Active Component, U.S. Armed Forces, 2000–2011*, MED. SURVEILLANCE MONTHLY REP., June 2012, at 11–17).

¹⁴⁸ ARMY GOLD BOOK, *supra* note 55, at 24.

¹⁴⁹ See BLAKELY & JANSON, *supra* note 10, at 5 (“Calculated by lost duty time, the Army has been the service most affected by hospitalizations of active duty servicemembers for mental disorders.”). Between 2006 and 2009, the rate of hospitalizations increased by more than fifty percent as a result of increased instances of PTSD, depression, and substance abuse. *Id.*

¹⁵⁰ See ARMY GOLD BOOK, *supra* note 55, at 24 (“Soldiers with PTSD may continue to be more susceptible to episodic recurrences of severe symptoms based on stressful events associated with military life (e.g. deployments, extended family separations, and continued high OPTEMPO).”).

¹⁵¹ See INVISIBLE WOUNDS, *supra* note 11, at 138 (discussing the impact of poor mental health on employment).

often admit that they are unable to concentrate on their daily duties.¹⁵² This is because some of the hallmark symptoms of PTSD, such as hyper-arousal and avoidance,¹⁵³ can cause poor social functioning in an individual, and adversely affect the individual's performance and ability to work on a team.¹⁵⁴ This is especially true in "the high stress occupation and environment associated with military service."¹⁵⁵ Alcohol dependence and illicit drug use, which are frequently associated with mental-health issues, are also linked to productivity losses.¹⁵⁶

D. Critical Information for Commanders

A commander's task of measuring mental fitness and readiness is particularly challenging because the psychological wounds that affect behavior and cognitive function are invisible.¹⁵⁷ As such, to care for Soldiers and maintain readiness, commanders must have broad access to relevant Soldier information, which may include information regarding a Soldier's mental health in some specific circumstances.¹⁵⁸ First, a commander needs to know if a Soldier is prescribed medication that could impair duty performance. For example, if a Soldier's medication hinders his ability to operate a vehicle, the commander should not compromise safety by assigning that Soldier as a driver in a convoy, but the commander cannot take that step if the commander does not know of the medication. Next, commanders should also be aware of mental-health conditions that impair duty performance, such as hallucinations, significant impulsivity, or delusions. This is especially true for deployment-limiting conditions. Finally, commanders need to know if a

¹⁵² See, e.g., *Video Profile: Staff Sgt. Megan Krause*, REAL WARRIORS, <http://www.realwarriors.net/multimedia/profiles/krause.php> (explaining that as a result of PTSD, SSG Krause began to sleep during duty hours, was often late to work, became irritable with coworkers, and was not a team player).

¹⁵³ See AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS code 309.81 (5th ed. 2013).

¹⁵⁴ ARMY GOLD BOOK, *supra* note 55, at 24.

¹⁵⁵ *Id.*

¹⁵⁶ See *id.* at 44 ("Alcohol dependence and illicit drug use were associated with impairments in output and physical demands.").

¹⁵⁷ *Id.*

¹⁵⁸ See Major Temidayo L. Anderson, *Navigating HIPAA's Hidden Minefields: A Leader's Guide to Using HIPAA Correctly to Decrease Suicide and Homicide in the Military*, ARMY LAW., Dec. 2013, at 15 ("Leaders desire immediate access to accurate, relevant and timely information regarding Soldier behavior and performance to manage risk within their organizations.").

Soldier indicates that he is thinking of hurting himself or another person.

As a practical matter, commanders and leaders must also account for a Soldier's whereabouts. Accountability is a critical component of safety and good order and discipline.¹⁵⁹ If a Soldier has to be hospitalized or will require several appointments over an extended period of time, his chain of command must be aware of the missed duty time. In the same way, commanders can also ensure that Soldiers attend their medical appointments.¹⁶⁰ Finally, if the Soldier's condition interferes with his ability to continue to serve in the military, the commander must know in order to initiate an administrative discharge¹⁶¹ or refer the Soldier to a Medical Evaluation Board (MEB).¹⁶²

VI. Commander's Tools to Access Protected Health Information

To assist commanders in caring for Soldiers and ensuring readiness, there are various tools available that allow commanders to access information regarding a Soldier's mental health. Such tools include special exemptions to privacy laws, as well as command-directed mental health evaluations.

A. HIPAA and the Privacy Rule

Mental-health records are protected health information (PHI). In 1996, Congress enacted the Health Insurance Portability and Accountability Act (HIPAA)¹⁶³ to protect the use and disclosure of

¹⁵⁹ Under the Uniform Code of Military Justice (UCMJ), it is a crime for a Soldier to fail to be at his required place of duty. UCMJ art. 86 (2012) (criminalizing "absence from unit, organization, or place of duty").

¹⁶⁰ See ARMY GOLD BOOK, *supra* note 55, at 65 (discussing the requirement for "doctors to provide commanders with a list of Soldiers' medical appointments without disclosing the reason or the clinic" and reporting that this policy change has cut down on the no-show rate dramatically).

¹⁶¹ U.S. DEP'T OF ARMY, REG. 635-200, ACTIVE DUTY ENLISTED SEPARATIONS paras. 5-13, 5-17 (14 Dec. 2007) (RAR 4 Aug. 2011) (discussing administrative discharges for personality disorders).

¹⁶² U.S. DEP'T OF ARMY, REG. 40-501, STANDARDS OF MEDICAL FITNESS para. 4-23 (14 Dec. 2007) (RAR 4 Aug. 2011) [hereinafter AR 40-501] (establishing standards for psychological fitness); ARMY GOLD BOOK, *supra* note 55, at 66.

¹⁶³ Health Insurance Portability and Accountability Act (HIPAA), Pub. L. No. 104-91, 110 Stat. 1936 (1996) [hereinafter HIPAA].

PHI.¹⁶⁴ Subsequently, under the authority of HIPAA, the Department of Health and Human Services promulgated the Privacy Rule¹⁶⁵ to “set limits and conditions on the uses and disclosures” of PHI without patient authorization.¹⁶⁶ The military health system is subject to HIPAA and the Privacy Rule,¹⁶⁷ and the DoD has a Health Information Privacy Regulation—based on HIPAA—that governs the use and disclosure of PHI in the military.¹⁶⁸

The default rule under HIPAA and DoD policy is that PHI cannot be released unless the patient authorizes release or an exception to HIPAA applies.¹⁶⁹ Nevertheless, there is a HIPAA exception that accounts for the unique nature of the military mission.¹⁷⁰ This “Military Command Authority” exception allows military and civilian treatment facilities to provide appropriate command authorities with access to a Soldier’s PHI

¹⁶⁴ See Anderson, *supra* note 158, at 16–17; Major Kristy Radio, *Why You Can’t Always Have It All: A Trial Counsel’s Guide to HIPAA and Accessing Protected Health Information*, ARMY LAW., Dec. 2011, at 4–5 (providing more information regarding the background and legislative history of HIPAA). Prior to the enactment of HIPAA, “there was no national healthcare privacy law and there were no limits on how healthcare providers, employers, and insurers shared healthcare information.” *Id.* (citing DEVEN MCGRAW, CTR. FOR DEMOCRACY & TECH, HIPAA AND HEALTH PRIVACY: MYTHS AND FACTS 2 (Jan. 2009), available at <https://www.cdt.org/healthprivacy/20090109muthsfacts2.pdf>).

¹⁶⁵ 45 C.F.R. pt. 160 (2007).

¹⁶⁶ *The Privacy Rule*, U.S. DEP’T OF HEALTH & HUMAN SERVS., <http://www.hhs.gov/oct/privacy/hipaa/administrative/privacyrule/> (last visited Jan. 21, 2014).

¹⁶⁷ See ARMY GOLD BOOK, *supra* note 55, at 64 (“The military health system must comply with the requirements of HIPAA, both as a healthcare provider through [Military Treatment Facilities] and as a ‘health plan’ through TRICARE.”).

¹⁶⁸ U.S. DEP’T OF DEF., REG. 6025.18-R, DoD HEALTH INFORMATION PRIVACY REGULATION (24 Jan. 2003) [hereinafter DoDR 6025.18-R].

¹⁶⁹ *Id.* C1.2.3 (“Except for purposes of treatment, payment, and healthcare operations . . . and other exceptions . . . other uses and disclosures of protected health information are generally prohibited without the written authorization of the patient.”); DoDI 6490.08, *supra* note 113, at 3.b (“It is DoD policy that: Healthcare providers shall follow a presumption that they are not to notify a servicemember’s commander when the servicemember obtains mental health care or substance abuse education services.”).

¹⁷⁰ 45 C.F.R. § 164.512(k) (2007) (“A covered entity may use and disclose the protected health information of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities to assure the proper execution of the military mission.”); DoDR 6025.18-R, *supra* note 168 (implementing the HIPAA Privacy Rule and providing notice of who constitutes “appropriate command authorities” and notice of the purposes for which PHI may be used or disclosed).

to facilitate decisions pertaining to medical fitness and readiness.¹⁷¹

To further clarify the HIPAA exception for military readiness, and to control the release of PHI to commanders, the Army's Medical Command (MEDCOM) issued a policy memo in 2012 reminding military healthcare providers of the specific circumstances in which an individual's PHI may be used or disclosed to the individual's chain of command.¹⁷² These circumstances include: to determine a Soldier's fitness for duty; to determine a Soldier's fitness to perform a specific mission; and to "carry out any other activity necessary to the proper execution of the mission of the Armed Forces."¹⁷³ The policy also directs military treatment providers to proactively inform a Soldier's commander of mission-related medical conditions and concerns, such as: medications and conditions that may impair duty performance, and circumstances where notification is necessary to "avert a serious and imminent threat to [the] health or safety of a person."¹⁷⁴ Finally, commanders or their designees may also access general information, such as a Soldier's profile status, adherence to scheduled appointments, and general health status.¹⁷⁵

Notably, the exception to HIPAA does not provide commanders with unlimited access to a Soldier's PHI. Rather, the information released

¹⁷¹ U.S. DEP'T OF ARMY, REG. 40-66, MEDICAL RECORD AND ADMINISTRATION AND HEALTHCARE DOCUMENTATION para. 2-4a(1)(k) (17 June 2008) (RAR 4 Jan. 2010) [hereinafter AR 40-66]. According to this regulation:

Part 164, Title 45, Code of Federal Regulations (45 CFR 164) and DOD 6025.18-R allow a covered entity (including a covered entity not part of or affiliated with the DOD) to use and disclose the PHI of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities to assure the proper execution of the military mission.

Id.

¹⁷² Policy Memorandum 12-062, Office of the Surgeon Gen./Med. Command, U.S. Army, subject: Release of Protected Health Information (PHI) to Unit Command Officials (24 Aug. 2012) [hereinafter OTSG/MEDCOM Policy 12-062]. This policy implements guidance from DoDR 6025.18-R, *supra* note 168.

¹⁷³ OTSG/MEDCOM Policy, *supra* note 172, encl.1.A.

¹⁷⁴ *Id.* encl.1.C.

¹⁷⁵ Information Paper, subject: HIPAA and Command Access to Soldier's Protected Health Information (PHI) (30 Apr. 2013) [hereinafter HIPAA Information Paper]. This information paper was drafted by Mr. Charles Orck, an attorney at the U.S. Army Medical Command's Staff Judge Advocate's Office, and is an excellent resource for judge advocates.

must be the minimum amount of information necessary for mission accomplishment.¹⁷⁶ Nevertheless, out of deference to commanders and for the sake of mission completion, this exception can be quite broad in practice.¹⁷⁷

B. Command-Directed Mental Health Evaluations

Another tool available for commanders is the command-directed mental-health evaluation.¹⁷⁸ If a commander or supervisor has a sincere belief that a subordinate Soldier requires a mental-health evaluation, that commander or supervisor may direct that the Soldier be evaluated.¹⁷⁹ A non-emergency command-directed evaluation may be initiated to address a variety of concerns, including “fitness for duty, occupational requirements, safety issues, significant changes in performance, or behavioral changes that may be attributable to possible mental status changes.”¹⁸⁰ Alternatively, emergency mental-health examinations are available if a commander suspects that a Soldier is suffering from a severe mental disorder or feels that there is likelihood that the Soldier

¹⁷⁶ OTSG/MEDCOM Policy, *supra* note 172, encl. 1.A (directing that “only the minimum necessary PHI of an individual may be used or disclosed to unit command officials”); AR 40-66, *supra* note 171, para. 2-4a.(4) (“Only the minimum necessary PHI will be provided to satisfy the intended purpose.”).

¹⁷⁷ See ARMY RED BOOK, *supra* note 82, at 208 (“The reality of the law is that exceptions to HIPAA allow release of relevant PHI to commanders without the Soldier’s consent.”). See Anderson, *supra* note 158 (providing guidance to leaders to use HIPAA to decrease suicides and homicides in the military). Major Anderson’s article also discusses other non-medical sources of information for commanders that may be indicators of high-risk behavior, such as blotter reports, Army Substance Abuse Program admissions, and Army Emergency Relief loans. *Id.* at 20.

¹⁷⁸ U.S. DEP’T OF DEF., INSTR. 6490.04, MENTAL HEALTH EVALUATIONS OF MEMBERS OF THE MILITARY SERVICES (4 Mar. 2013) [hereinafter DoDI 6490.04] (discussing command-directed mental health evaluations).

¹⁷⁹ *Id.* para. 3.b (“Commanders and supervisors who in good faith believe a subordinate Service member may require a mental health evaluation are authorized to direct an evaluation under this instruction . . .”). A supervisor may only direct a mental-health examination if it is impractical for the Soldier’s actual commander to direct the mental health examination and if they meet the qualifications in DoDI 6490.04. Simply stated, the supervisor must be in the Soldier’s official chain of command and have supervisory authority over the Soldier. *Id.* glossary. In addition, a designated senior enlisted servicemember is authorized to order an emergency evaluation for an enlisted servicemember. *Id.* encl. 3.2.a(1).

¹⁸⁰ *Id.* para. 3.c.

will cause serious injury to himself or others.¹⁸¹ Command-directed referrals are military orders and may be carried out over the objections of the Soldier.¹⁸²

A Soldier's PHI does not have the same protection in a command-referral as it would in a self-referral. After a command-directed mental health evaluation is completed, the mental-health provider must report back to the referring commander or supervisor. The report should:

[A]dvice the commander or supervisor of any duty limitations or recommendations for monitoring or additional evaluation, recommendations for treatment, referral of the [Soldier] to a Medical Evaluation Board for processing through the Disability Evaluation System . . . or administrative separation of the [Soldier] for personality disorder or unsuitability for continued military service.¹⁸³

When properly utilized, the command-directed evaluations are an important tool that can assist commanders with ensuring readiness, Soldier safety, and Soldier wellness.

VII. Striking a Balance

With valid interests on both sides of the policy debate between confidentiality for Soldiers and commanders' mission requirements, balance is critical. Optimum balance permits commanders access to the necessary information needed to "protect and promote the safety and well-being of the Soldiers under their command" while at the same time recognizing a Soldier's need for privacy to overcome the stigma-based barrier to care.¹⁸⁴ This balance can be achieved if commanders and leaders understand the prevailing stigma of mental-health care and

¹⁸¹ See *id.* para. 3.d (outlining three circumstances where a "commander or supervisor will refer a Service member for an emergency [mental health examination]").

¹⁸² *Id.* para. 3.b ("[A] command-directed mental health evaluation (MHE) has the same status as any other military order.").

¹⁸³ *Id.* encl. 3, para. 5.a. Nevertheless, mental-health providers should issue the report using the minimum information necessary to make the disclosure. *Id.* encl. 3, para 5.a.

¹⁸⁴ ARMY GOLD BOOK, *supra* note 55, at 65; see Radio, *supra* note 164, at 5–6 ("[G]iven the unique nature of the military, the DoD has the additional burden of balancing privacy goals against the commander's need to execute a mission.").

respect confidentiality to the greatest extent possible. To this end, commanders are subject to the Privacy Act and service policies. However, to provide clarity and simplicity for commanders, and to emphasize the importance of promoting help-seeking behavior, these policies should be distilled into Army Regulation (AR) 600-20, *Army Command Policy*.¹⁸⁵ Furthermore, AR 600-20 should enumerate specific administrative penalties for commanders and leaders who intentionally use PHI in an impermissible manner or who are grossly negligent in safeguarding privacy or who foster stigma against help-seeking in their organizations. This section discusses existing penalties for privacy violations, and proposes that AR 600-20 be revised to address Soldier fitness and emphasize the importance of privacy.

A. Penalties for Privacy Violations

HIPAA and the Privacy Rule govern the release and use of PHI. However, although the Privacy Rule establishes penalties for non-compliance, it applies only to “covered entities” and not to individual commanders. Specifically a covered entity includes “any health provider, health plan, or clearinghouse that transmits health information in electronic form.”¹⁸⁶ As such, although military health-care providers and military treatment facilities would be subject to the civil and criminal penalties of the Privacy Rule,¹⁸⁷ the average commander or leader would not be.

However, the Privacy Act¹⁸⁸ (distinguishable from the similarly-titled Privacy Rule) does apply to commanders and leaders. Whereas HIPAA and the Privacy Rule cover PHI, the Privacy Act covers all federally-maintained records. Specifically, in many circumstances, the Privacy Act bars agency disclosure of personally identifiable information (PII)¹⁸⁹ without an individual’s consent if that information is maintained

¹⁸⁵ See U.S. DEP’T OF ARMY, REG. 600-20, ARMY COMMAND POLICY (6 Nov. 2014) [hereinafter AR 600-20].

¹⁸⁶ Anderson, *supra* note 158, at 17 (citing U.S. DEP’T OF HEALTH & HUMAN SERVS., OFFICE OF CIVIL RTS., *Summary of the HIPAA Privacy Rule 4* (2003), available at <http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/privacysummary.pdf>).

¹⁸⁷ See Anderson, *supra* note 158, at 17 (discussing the civil and criminal penalties for failure to comply with the Privacy Rule).

¹⁸⁸ 5 U.S.C. § 552a (2006).

¹⁸⁹ As defined by the Privacy Act, PII includes information such as the name, social security number, or photograph of an individual. *Id.* § 552a(4).

in a system of records.¹⁹⁰ The Privacy Act provides for both civil remedies and criminal penalties for violating the disclosure rules. Privacy Act civil remedies are aimed at agency compliance,¹⁹¹ while the criminal penalties are applicable to individual federal agency employees, such as individual leaders and commanders.¹⁹² Willful violation of the Privacy Act is a misdemeanor, which could result in a maximum penalty of \$5,000.¹⁹³ Nevertheless, there are several exceptions to the general rule that are commonly invoked in the military.¹⁹⁴ In practice, these exceptions are very broad and do not impede most information-sharing within the Army and DoD.¹⁹⁵

B. Regulatory Guidance to Protect Confidential Information

In 2011, the DoD published an instruction aimed at providing “guidance for balance between patient confidentiality rights and the commander’s right to know for operation and risk management decisions.”¹⁹⁶ Under DoDI 6490.08, there is a presumption that health-

¹⁹⁰ *Id.* § 552a(b) (“No agency shall disclose any record which is contained in a system of records by any means of communication to any person, or to another agency, except pursuant to a request by, or with the prior written consent of, the individual to whom the record pertains . . .”).

¹⁹¹ *Id.* § 552a(g) (discussing civil remedies for complaining individuals). The civil remedies are aimed at enforcing compliance with the Privacy Act but may also include “reasonable attorney fees and other litigation costs.” *Id.*

¹⁹² *Id.* § 552a(i) (applying to “any officer or employee of an agency, who by virtue of his employment or official position, has possession of, or access to, agency records which contain individually identifiable information . . .”).

¹⁹³ *Id.* (stating that an individual who “knowing that disclosure of the specific material is so prohibited, willfully discloses the material in any manner to any person or agency not entitled to receive it, shall be guilty of a misdemeanor and fined not more than \$5,000”).

¹⁹⁴ *Id.* § 552a(b) (outlining twelve conditions of disclosure). There are five exceptions that are commonly used in the military: (1) “Need to know” for the performance of duties; (2) “Routine Use” as published in the Federal Register; (3) “Law enforcement” for disclosure to a law-enforcement agency; (4) “Public Safety” for compelling circumstances affecting the health or safety of an individual; and (5) “Research.” ARMY RED BOOK, *supra* note 82, at 209.

¹⁹⁵ See ARMY RED BOOK, *supra* note 82 at 209 (“In short, privacy laws are not as limiting as often believed . . .”). For risk reduction and suicide prevention, information sharing between healthcare providers, commanders, law enforcement agencies, judge advocates, and other entities is extremely beneficial: “Leadership must rely on communication, collaboration and experience of this full range of leaders to provide situational awareness and inform decisions regarding mitigation of environmental risk and individual high risk behavior.” *Id.* at 35.

¹⁹⁶ DoDI 6490.08, *supra* note 113.

care providers should not notify a servicemember's commander when that servicemember voluntarily seeks mental-health care or services for substance abuse.¹⁹⁷ Rather, commanders are only to be notified in specific instances that are enumerated in the instruction.¹⁹⁸ These instances include: harm to self; harm to others; harm to mission; a special assignment or job that requires disclosure;¹⁹⁹ required inpatient care; acute medical conditions interfering with duty; entry or discharge from a formal substance abuse treatment program; and command-directed mental health examinations.²⁰⁰ There is also a generalized exception that allows health-care providers to release information in special circumstances where "proper execution of the mission outweighs the interests served by avoiding notification."²⁰¹ However, this determination must be made on a case-by-case basis by a health-care provider or commanding officer in the grade of O-6 or above.²⁰² Disclosures are to be made only to the servicemember's commander or the commander's designated representative,²⁰³ and such disclosures must be limited to the "minimum amount of information necessary to satisfy the purpose of the disclosure."²⁰⁴

¹⁹⁷ *Id.* para 3.

¹⁹⁸ *See id.* encl. 2 ("Command notification by healthcare providers will not be required for Service member self and medical referrals for mental health care of substance misuse education unless disclosure is authorized for one of the reasons listed in . . . this enclosure.").

¹⁹⁹ Special Personnel are described in U.S. DEP'T OF DEF., INSTR. 5210.42, NUCLEAR WEAPONS PERSONNEL RELIABILITY PROGRAM (16 July 2012) [hereinafter DoDI 5210.42]. This category can also include a person in a "position that has been pre-identified by Service regulation or the command as having mission responsibilities of such political sensitivity or urgency that normal notification standards would significantly risk mission accomplishment." DoDI 6490.08, *supra* note 113, encl. 2.

²⁰⁰ DoDI 6490.08, *supra* note 113, encl. 2.

²⁰¹ *Id.*; *see also* U.S. DEP'T OF DEF., INSTR. 6025.18, PRIVACY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION IN DOD HEALTH CARE PROGRAMS para. 4.b (2 Dec. 2009) [hereinafter DoDI 6025.18] ("Health care entities shall, as authorized by and consistent with the procedures of [HIPAA] ensure the availability to appropriate command authorities of health information concerning military personnel necessary to ensure the proper execution of the military mission.").

²⁰² DoDI 6490.08, *supra* note 113, encl. 2 (adding that the decision may also be made by another "authorized official of the medical treatment facility involved").

²⁰³ *Id.* (noting that the commander's representative must be designated in writing).

²⁰⁴ *Id.* The instruction explains that the minimum amount of information necessary to accomplish the mission is typically: "[t]he diagnosis; a description of the treatment prescribed or planned; impact on duty or mission; recommended duty restrictions; the prognosis; any applicable duty limitations; and implications for the safety of self or others." Such disclosures will also generally consist of "ways that the commander can support or assist the Service member's treatment." *Id.*

The Army also has a policy to protect PHI while accommodating mission requirements.²⁰⁵ This policy provides specific guidance to military health-care providers on what information may be released.²⁰⁶ It emphasizes compliance with HIPAA and the DoD policy to disclose only the minimum required information but also mandates that medical commanders provide “timely and accurate information to support unit commander’s decision-making pertaining to the health risks, medical fitness, and readiness of their Soldiers.”²⁰⁷

C. Preventing Stigma through Leaders

In addition to respecting and protecting PHI, military leaders at all levels are responsible for working toward eliminating stigma within their units.²⁰⁸ In a memo addressed to the Pentagon’s top civilian and military leaders, Secretary of Defense Leon Panetta wrote: “commanders and supervisors cannot tolerate any actions that belittle, haze, humiliate, or ostracize any individual, especially those who require or are responsibly seeking professional services.”²⁰⁹ Similarly, DoDI 6490.08 instructs commanders to “reduce stigma through positive regard for those who seek mental health assistance to restore and maintain their mission readiness, just as they would view someone seeking treatment for any other medical issue.”²¹⁰

²⁰⁵ OTSG/MEDCOM Policy Memo 12-062 shows the Army’s efforts to achieve a balance between mission requirements and confidentiality. ARMY GOLD BOOK, *supra* note 55, at 65 (“This memo closed one of the most critical gaps impeding communication and collaboration among the health triad.”).

²⁰⁶ See *supra* notes 173–75 and accompanying text (detailing the specific conditions for release according to OTSG/MEDCOM Policy Memo 12-062).

²⁰⁷ OTSG/MEDCOM Policy Memo 12-062, *supra* note 172, at 2.

²⁰⁸ See, e.g., ARMY GOLD BOOK, *supra* note 55, at 69 (“The key to eliminating stigma is engaged, involved leadership at every level.”); U.S. DEP’T OF ARMY, PAM. 600-24, HEALTH PROMOTION, RISK REDUCTION, AND SUICIDE PREVENTION para. 2-5(a)(8) (17 Dec. 2009) (RAR 7 Sep. 2010) [hereinafter DA PAM 600-24] (charging commanders with reducing stigma and building “a command climate that encourages and enables Soldiers . . . to seek help”).

²⁰⁹ Memorandum from Sec’y of Def. to Sec’ys of the Military Dep’ts et al., subject: Suicide Prevention for Department of Defense Personnel (10 May 2012). He also added that “we must continue to fight to eliminate stigma from those with post-traumatic stress and other mental health issues.” *Id.*

²¹⁰ *Id.* Commanders are also directed to protect privacy of information in accordance with DoDI 6490.08 and DoD Directive 5400.11, *DoD Privacy Program. Id.*

The Army also cautions leaders not to engage in well-intended efforts that may be counterproductive or may perpetuate stigma. Army Regulation 600-63, *Army Health Promotion*, prohibits commanders from identifying Soldiers with suicide-risk symptoms or behaviors through special markings or clothing.²¹¹ For example, leaders should not identify Soldiers undergoing treatment or counseling on a “high-risk” roster by name or restrict a Soldier to the unit’s common area because he is considered to be at-risk of harming himself.²¹² While these actions might be intended to care for or protect the targeted individuals through increased supervision, they often serve to further isolate these Soldiers and perpetuate the stigma associated with mental-health issues.²¹³ Furthermore, these actions might deter other Soldiers in the unit from seeking help or admitting a problem because they are fearful of being subjected to a similar experience.²¹⁴

In order to better inform commanders on fostering stigma-free environments, AR 600-63 prescribes training for commanders “on how to create an atmosphere within their commands that reduces stigma and encourages help-seeking behavior.”²¹⁵ Additionally, DA PAM 600-24, *Health Promotion, Risk Reduction, and Suicide Prevention*, requires commanders to educate “leaders regarding policy to eliminate belittling Soldiers who seek behavioral health assistance.”²¹⁶

D. Recommendation to Centralize Soldier Fitness Policies into AR 600-20

The regulations and policies discussed above are positive steps forward in addressing the issue of mental health in the Army and overcoming barriers to care. However, these policies are not consolidated in one source, and they are sometimes misunderstood by

²¹¹ U.S. DEP’T OF ARMY, REG. 600-63, ARMY HEALTH PROMOTION para. 1-25(e) (7 May 2007) (RAR 7 Sep. 2010) (“[Commanders shall:] Ensure that Soldiers identified with suicide-risk symptoms/behaviors are not belittled, humiliated, or ostracized by other Soldiers and are not identified through special markings or clothing (that is, Soldiers’ wear reflective training vests with signs identifying them as high-risk individuals.)”).

²¹² See ARMY GOLD BOOK, *supra* note 55, at 70 (providing other examples of actions that single out Soldiers).

²¹³ *Id.*

²¹⁴ *Id.*

²¹⁵ AR 600-63, *supra* note 211, para. 4-4j(3).

²¹⁶ DA PAM 600-24, *supra* note 208, para. 4-4.

commanders and leaders.²¹⁷ This confusion can be detrimental. Leaders and commanders may either use PHI incorrectly, thereby reaffirming the stigma-based fears of Soldiers, or they may be too conservative in using PHI and hinder unit wellness or readiness.²¹⁸

Because the mental fitness of the force is of critical importance and is the responsibility of leaders and commanders, the Army should include a section summarizing commander responsibilities regarding mental fitness in its commander's regulation—AR 600-20, *Army Command Policy*. The stated purpose of AR 600-20 is to “prescribe the policies and responsibilities of command, which include the Army Ready and Resilient Campaign . . . , military discipline and conduct, the Army Equal Opportunity . . . Program, and the Army Sexual Harassment/Assault Response and Prevention . . . Program.”²¹⁹ Looking specifically at the Well-being of the Force, which is covered in Chapter 3 of AR 600-20, commanders have an overarching responsibility to take care of people. Well-being is: “the personal—physical, material, *mental*, and spiritual state of the Army Family, including Soldiers . . . and their Families, that contributes to their preparedness to perform and support the Army's mission.”²²⁰ Therefore, mental fitness and policies related to eliminating stigma are surely appropriate material for this regulation. And the inclusion of these policies into AR 600-20 would show commanders the Army's emphasis on and commitment to mental fitness and resiliency.

Army Regulation 600-20 has entire chapters devoted to Equal Opportunity (EO), Prevention of Sexual Harassment (POSH), and the Sexual Assault Prevention and Response Program.²²¹ A chapter for “Mental Fitness” (or “Soldier Fitness” to emphasize the importance of

²¹⁷ See ARMY RED BOOK, *supra* note 82, at 207 (“[T]here appears to be confusion in the field as to the scope of these laws and the limitations they impose.”).

²¹⁸ See *id.* at 207–08 (discussing perceived legal limitations regarding release of PHI and commenting that these misperceptions impede valuable information sharing).

²¹⁹ AR 600-20, *supra* note 185, para. 1-1. Although there are many important regulations that leaders should know and use, AR 600-20 is one of the most useful because it covers a myriad of fundamental topics. To name a few, AR 600-20 addresses topics such as: open-door policies; informal funds; successors in command; fraternization; family care plans; accommodating religious practices; and hazing. See *id.* at i–iv (complete table of contents).

²²⁰ *Id.* para. 3-2 (emphasis added).

²²¹ The Equal Opportunity Program is in Chapter 6, Prevention of Sexual Harassment is in Chapter 7, and the Sexual Assault Prevention and Response Program is in Chapter 8. *Id.*

both mental and physical fitness) could parallel these chapters. It would distill the relevant information for commanders from the numerous statutes, instructions, policy memos, pamphlets, and regulations into one consolidated source. Specifically, this chapter could cover proper use of PHI, training requirements for Soldiers and commanders, and policies promoting stigma-free units. This addition to AR 600-20 would provide commanders with a streamlined source of information and cut down on confusion regarding PHI and privacy issues.

In addition, AR 600-20 could establish a specific penalty for commanders who intentionally disregard privacy or who promote or tolerate stigma in their formations. As discussed previously in section VII, the penalties associated with HIPAA do not apply to commanders because commanders are not “covered entities” under HIPAA. In addition, although commanders are subject to criminal penalties under the Privacy Act, the likelihood and feasibility of a criminal prosecution is minimal.²²² There are also no specific enumerated penalties for leaders or commanders who promote or tolerate stigma.²²³ While there are various policies that caution against promoting stigma,²²⁴ none of them are explicitly punitive in nature. To fill the gap, the addition of a Soldier Fitness chapter into AR 600-20 should include a penalty modeled after the penalties for EO and sexual-harassment policy violations.

Currently, under AR 600-20, commanders must process and investigate EO and sexual-harassment complaints according to specific guidance with strict timelines.²²⁵ To this end, AR 600-20 *requires* supervisors to record significant deviations from EO or POSH policy in

²²² See *supra* notes 188–95 and accompanying text.

²²³ This is not to say that commanders who tolerate or promote stigma are not subject to punitive UCMJ articles in a broad sense. While the specific provisions of the various privacy policies and regulations discussed in this article (with the exception of the Privacy Act) are not punitive in nature, commanders who promote or tolerate stigma may be in violation of the following articles: UCMJ art. 92 (2012) (dereliction of duty); *id.* art. 93 (cruelty and maltreatment, such as belittling a subordinate Soldier); *id.* art. 133 (conduct unbecoming an officer); or *id.* art. 134 (conduct prejudicial to good order and discipline and/or service discrediting). Rather, in comparison to Equal Opportunity violations or Prevention of Sexual Harassment violations, there are no regulations that prescribe specific penalties relating to privacy or stigma.

²²⁴ See *supra* Part VII.

²²⁵ AR 600-20, *supra* note 185, para. 6-9 (“For filing and processing of EO or sexual harassment complaints, follow the procedures outlined in appendix D.”). Appendix D is extremely detailed and addresses issues such as “[a]ctions of the commander upon receipt of complaint” and “[c]onduct of the investigation.” *Id.* app. D.

the offending individual's evaluation report.²²⁶ In order to show that a stigma-free environment is just as important as a discrimination-free and harassment-free environment, AR 600-20 should include similar provisions for Soldier Fitness. Commanders and leaders who tolerate or show blatant disregard for confidentiality and PHI, or who belittle Soldiers who seek help for mental-health conditions, should be penalized for their actions.²²⁷ This could be achieved by requiring negative comments on the evaluation reports of individuals who deviate significantly from Soldier Fitness policies.²²⁸

The purpose of using an evaluation report annotation is that “[t]he performance evaluation process provides commanders and supervisors an excellent opportunity to discuss their goals, objectives, and expectations of the [respective] programs.”²²⁹ This puts command emphasis on the issue, and it presents an opportunity for counseling, discussion, and mentorship.²³⁰ After all, the goal of the Soldier Fitness policy should not be to punish commanders but to promote a stigma-free environment that encourages Soldier wellness. In contrast, merely articulating a standard and then using a General Officer Memorandum of Reprimand (GOMOR) or non-judicial punishment to punish violations of

²²⁶ *Id.* para. 6-11 (“Substantiated EO complaints as a result of an AR 15-6 investigation require a ‘Does not support EO’ on the noncommissioned officer evaluation report or a ‘No’ in Part IV—Performance Evaluation Professionalism, A. Army Values, 5. Respect, on the officer evaluation report.”) (emphasis added). For more information on evaluations, see U.S. DEP’T OF ARMY, REG. 623-3, EVALUATION REPORTING SYSTEM (31 Mar. 2014) [hereinafter AR 623-3].

²²⁷ However, this policy would have to be carefully crafted to only punish blatant disregard for Soldier PHI, as commanders should not be hesitant to use the valid policy exceptions with regard to sharing PHI for the benefit of safety, readiness, or Soldier wellness. An example of an appropriate circumstance for an administrative penalty is for a leader who disparages a Soldier with PTSD by calling him names such as “whack-job” or “head case,” or other disparaging terms.

²²⁸ Arguably, this is already possible under existing evaluation systems. However, as with the EO and POSH programs, *mandatory* language in the evaluation reports shows the importance of the policy, the seriousness of deviations from the policy, and the Army’s commitment to its values. In this era of force reductions, such negative language on an evaluation report will likely prevent the individual from being assigned to subsequent leadership positions, and may even jeopardize that individual’s future in the Army. In addition to requiring supervisor involvement and mentorship, the threat of mandatory language is one that leaders and commanders will surely take seriously.

²²⁹ AR 600-20, *supra* note 185, para. 6-11.

²³⁰ *Id.* (“In counseling session [sic], commanders and supervisors should discuss these programs as expressions of the Army’s values and encourage support of these programs and how they intend to evaluate individual behaviors and actions.”).

that standard does not afford the same opportunity for leadership emphasis and involvement.

For ease of administration, the Soldier Fitness policy could use the procedures and timelines already established in Appendix D of AR 600-20 to receive, process, and investigate Soldiers' complaints. Requiring strict compliance would assure Soldiers that their concerns are taken seriously. As an added benefit, the very existence of a policy and penalties may also provide some level of assurance for Soldiers who would otherwise be afraid to come forward with mental-health issues.

VIII. Career Effects of Mental-Health Issues

In addition to fears of being ridiculed and judged for their mental-health issues, many Soldiers also believe that seeking help or receiving mental-health treatment will harm or even end their careers.²³¹ In particular, these Soldiers fear that they will lose their security clearances or be medically or administratively discharged from the Army if they seek professional mental-health treatment.²³² However, although there is certainly some risk of career impact associated with mental-health issues, the reality is that the circumstances of adverse career impact are rare. As discussed below, the regulations and procedures in place for security clearances and discharges strike a balance between the Army's mission and the protections for individual Soldiers. As such, to mitigate Soldier's fears regarding career impact, there should be greater institutional transparency to, and education for, Soldiers regarding these policies, the uses of PHI, and the actual consequences (or lack thereof) of seeking help from mental-health professionals.

A. Security Clearances

Army Regulation 380-67, *Personnel Security Program*, "prescribes the investigative scope and adjudicative standards and criteria" for access

²³¹ As discussed in Part III of this article, the Army Suicide Prevention Task Force defines stigma as "the perception among Leaders and Soldiers that help-seeking behavior will either be detrimental to their career (e.g., prejudicial to promotion or selection to leadership positions) or that it will reduce their social status among their peers." ARMY RED BOOK, *supra* note 82, at 13.

²³² See *supra* Part III.B.

to classified information in the Army.²³³ While the ultimate decision whether a person can access classified information is based on a common-sense consideration of all available facts, there are several enumerated criteria that investigators look at to determine eligibility for a security clearance.²³⁴ With regard to mental health, mental issues or disorders are of concern only to the extent that they hinder judgment or reliability. Pursuant to AR 380-67, investigators must specifically consider: “Any behavior or illness, including any mental condition, which, in the opinion of competent medical authority, may cause a defect in judgment or reliability with due regard to the transient or continuing effect of the illness and the medical findings in such case.”²³⁵

The criteria regarding mental conditions is further divided into three disqualifying factors including: “Behavior that casts doubt on an individual’s judgment, reliability, and trustworthiness that is not covered under any other guideline, including . . . emotionally unstable, irresponsible, dysfunctional, violent, paranoid, or bizarre behavior”; a “duly qualified mental health professional[‘s]” opinion that an individual has a condition that may impair judgment, reliability, trustworthiness; or the “individual has failed to follow treatment advice.”²³⁶ An individual who satisfies one or more of these factors could be disqualified from obtaining or maintaining a security clearance.²³⁷ However, there are circumstances that could mitigate the disqualifying factors. Such mitigating factors include responsiveness to medication, elimination of any underlying factors that contributed to the bizarre behavior, and conditions that are cured with little to no probability of recurrence.²³⁸

²³³ See U.S. DEP’T OF ARMY, REG. 380-67, PERSONNEL SECURITY PROGRAM, at i (24 Jan. 2014) [hereinafter AR 380-67].

²³⁴ *Id.* para. 2-4 (listing and explaining all seventeen factors); see also U.S. DEP’T OF DEF., DIR. 5200.2-R, PERSONNEL SECURITY PROGRAM (Jan. 1987) (C3, 3 Feb. 1996) [hereinafter DoDD 5200.2-R] (outlining the same factors for the DoD).

²³⁵ See AR 380-67, *supra* note 233, para. 2-4j. Notably, although there is only one factor that specifically mentions mental conditions, there is a separate factor for “[h]abitual or episodic use of intoxicants to excess.” *Id.* para. 2-4m. Mental issues can be comorbid with substance abuse, which could also be disqualifying.

²³⁶ See *id.* para. I-11 (listing the factors).

²³⁷ *Id.* The CCF “serves as the U.S. Army’s executive agency for personnel security determinations in support of Army world-wide missions.” See U.S. Army Intelligence & Sec. Command, Central Clearance Facility, U.S. DEP’T OF THE ARMY, <http://www.inscom.army.mil/MS/CCF.aspx>. If information in an individual’s medical records or application indicates a mental condition that would impair judgment, reliability, or maturity, the Central Clearance Facility (CCF) will request a mental health evaluation of that individual. AR 380-67, *supra* note 233, para. 5-7.

²³⁸ AR 380-67, *supra* note 233, para. I-6.

Notably, even if a Soldier has a valid security clearance and is not due for a renewal, a commander may still suspend the Soldier's security clearance for suspected or actual psychological problems.²³⁹ Under these circumstances, the commander may only reinstate access to classified information if each of the six conditions listed in AR 380-67 are met.²⁴⁰ However, if a Soldier's security clearance was suspended for a suicide attempt, only the Commander of the Central Clearance Facility (CCF) can reinstate his clearance.²⁴¹

Although the regulation certainly allows for mental health to be considered when evaluating the trustworthiness and reliability of an individual, the act of seeking mental-health treatment in and of itself is not disqualifying. In 1995, President Clinton issued Executive Order 12968, which prohibited the drawing of any negative inference concerning an individual's trustworthiness based solely on mental-health counseling.²⁴² In fact, the Executive Order noted that counseling could actually be viewed as a positive factor for eligibility determinations.²⁴³ Similarly, as discussed previously, the DoD amended the security-clearance application in 2008 so that servicemembers do not even have to report counseling related to adjustments from serving in a combat zone.²⁴⁴ In the memorandum implementing this change, DoD officials specifically noted: "Seeking professional care for these mental health

²³⁹ *Id.* para. 8-3 (allowing commanders or heads of organizations to suspend security clearances if "information exists which raises serious questions as to the individual's ability or intent to protect classified information").

²⁴⁰ *Id.* para. 8-3b(2) (describing the factors, including: a medical evaluation that "indicates the condition was a one-time occurrence"; the condition will not have lasting effects on the individual's judgment; there is no requirement for further medical consultation on the condition; the examining physician recommends a full return to duty status; the individual's behavior after the favorable evaluation is acceptable; and the commander "firmly believes the person does not pose a risk to the security of classified information").

²⁴¹ *Id.* ("Only the [Commander], CCF, may reinstate access in cases where the person attempted suicide.").

²⁴² Exec. Order No. 12,968, 60 Fed. Reg. 40,250 (Aug. 7, 1995) ("No negative inference concerning the standards in this section may be raised solely on the basis of mental health counseling."). However, the Executive Order does note that counseling could be a basis for further inquiry. *Id.*

²⁴³ *Id.* ("Such counseling can be a positive factor in eligibility determinations.").

²⁴⁴ See *supra* text accompanying notes 17-18, 106-07; Tamara Haire, *Financial Problems or PTSD Need Not Affect Security Clearance*, U.S. DEP'T OF ARMY, <http://www.army.mil/article/24053/financial-problems-or-ptsd-need-not-affect-security-clearance/>.

issues should not be perceived to jeopardize an individual's security clearance."²⁴⁵

In reality, the fears associated with seeking treatment are undue because seeking treatment for mental-health issues rarely affects an individual's security clearance.²⁴⁶ Rather, it is the failure to seek care that can actually jeopardize an individual's security clearance if that person's psychological distress escalates to serious mental conditions that would "preclude them from performing sensitive duties."²⁴⁷ One report from the CCF found that "99.8 percent of cases with psychological concerns obtained [or] retained their security clearance eligibility."²⁴⁸ The majority of the individuals who had their clearance denied or revoked had other issues accompanying their psychological concerns.²⁴⁹ Indeed, as argued in President Clinton's Executive Order, investigators often view counseling for mental-health issues as a positive factor in the security-clearance process.²⁵⁰

Finally, pursuant to a rapid action revision dated January 24, 2014, AR 380-67 now affords individuals an opportunity to appeal adjudicative decisions to a higher level authority before the adjudicative decision is final. If a Soldier's security clearance or access determination is acted upon unfavorably, the Soldier will receive written notice of this adverse determination from the CCF. Within sixty days of receiving the CCF determination, the Soldier can either request a personal appearance before the Defense Office of Hearings and Appeals (DOHA) or appeal in writing directly to the Army's Personnel Security Appeals Board

²⁴⁵ SF 86 Policy Implementation Memo, *supra* note 106, at 2 (containing a memorandum to "All Individuals Completing the SF86 Questionnaire for National Security Positions" from the Under Secretary of Defense for Personnel and Readiness and the Under Secretary of Defense for Intelligence).

²⁴⁶ See Haire, *supra* note 244, at 1 (quoting the commander of the CCF as saying, "All Army personnel should understand that they can obtain counseling service for financial and mental health issues without undue concern of placing their security clearance status in jeopardy").

²⁴⁷ SF 86 Policy Implementation Memo, *supra* note 106, at 2.

²⁴⁸ Haire, *supra* note 244, at 2 (reporting statistics based off of "CCF's adjudicative history"); see also MILITARY PSYCHOLOGY: CLINICAL AND OPERATIONAL APPLICATIONS 45-46 (Carrie H. Kennedy & Eric A. Zillmer eds., 2006) [hereinafter MILITARY PSYCHOLOGY] (reporting that in 2004 "only 74 clearances were denied or revoked on the basis of mental health issues—out of nearly 500,000 investigations conducted by the Army" (citing personnel communications with LTC S. Harvey)).

²⁴⁹ MILITARY PSYCHOLOGY, *supra* note 248, at 46.

²⁵⁰ *Id.* ("Professional mental health counseling is not a threat to an individual's security clearance; rather it can be a positive factor in the security clearance process.").

(PSAB). This ability to appeal before a determination is final adds another level of protection for the Soldier.²⁵¹

B. Discharges from the Army

1. Medical Boards

If a Soldier is unable to perform military duties because of a behavioral-health condition, he may be referred for processing through the Army's Disability Evaluation System (DES) and may potentially face medical separation or retirement. Army Regulation 40-501, *Standards of Medical Fitness*, prescribes specific physical and mental standards that Soldiers must meet.²⁵² Under the standards established by AR 40-501, a diagnosis of PTSD may result in a referral to the DES.²⁵³ However, in practice, most medical professionals only refer Soldiers with behavioral-health conditions such as PTSD, depression, and panic disorders if they affect a Soldier's ability to perform duties and after all treatment methods have been exhausted with no improvement.²⁵⁴ With regard to PTSD, Soldiers who receive early intervention and treatment benefit greatly, and they are often able to significantly reduce or eliminate their symptoms of PTSD without career consequences.²⁵⁵

As part of the DES process, if a Soldier's behavioral-health condition is found not to meet retention standards, a Soldier with a behavioral-

²⁵¹ AR 380-67, *supra* note 233, para. 8-6(d). If the Soldier chooses to make a personal appearance to the DOHA, "[t]he DOHA will review the facts of the case and make a recommendation to the PSAB." *Id.* The determination of the PSAB (whether considering the DOHA recommendation or a written appeal directly from the individual in question) is final. *Id.*

²⁵² AR 40-501, *supra* note 162.

²⁵³ *Id.* para. 8-24. For more information on personnel separations relating to physical evaluations, see U.S. DEP'T OF ARMY, REG. 635-40, PHYSICAL EVALUATION FOR RETENTION, RETIREMENT, OR SEPARATION (8 Feb. 2006) (RAR 20 Mar. 2012) [hereinafter AR 635-40].

²⁵⁴ See MILITARY PSYCHOLOGY, *supra* note 248, at 42 ("The consensus from the field is that if there is no or minimal improvement after 8 to 12 months of treatment and/or all levels of care have been offered without results . . . and/or the illness has demonstrable and detrimental impact on the member's ability to perform military duties, an MEB should be initiated.").

²⁵⁵ See *Dispelling Myths About Post Traumatic Stress Disorder*, REAL WARRIORS, http://www.realwarriors.net/active/treatment/ptsdmyths.php#_end6 (citing U.S. DEP'T OF DEF., DEPLOYMENT HEALTH CLINICAL CTR., TBI AND PTSD QUICK FACTS, *available at* http://www.pdhealth.mil/downloads/TBI_PTSD_Final04232007.pdf).

health condition will be referred to a Physical Evaluation Board (PEB). In making its determination, the PEB will consider evidence such as a commander's statements, letters from family members, and evaluation reports to determine whether the Soldier can perform his military occupational specialty (MOS).²⁵⁶ The existence of a behavioral-health condition "does not necessarily mean that [a] Soldier is incapable [of] performing [his] assigned duties or that the PEB must find [his behavioral-health] condition unfitting."²⁵⁷ Of note, Soldiers who are deemed to be unfit to continue military service are retired or separated with benefits if their conditions are incurred as a result of military service.²⁵⁸

Soldiers undergoing DES processing are entitled to legal services from the Office of Soldier's Counsel (OSC).²⁵⁹ Attorneys assigned to that office provide "case-specific legal advice and advocacy designed to help Soldiers formulate and achieve their specific goals from the DES."²⁶⁰ To this end, OSC attorneys advocate for "fit for duty" determinations for Soldiers who do not wish to be separated from service. To best serve Soldiers' interests, OSC attorneys are insulated; they "do not advise or represent [c]ommanders, medical personnel, or the MEB."²⁶¹ Rather, they are advocates for the individual Soldier.

2. Administrative Discharges

Even if a Soldier's condition does not warrant DES processing, a commander may still administratively discharge a Soldier for the "Convenience of the Government" pursuant to Army Regulation 635-

²⁵⁶ Information Paper, subject: Behavioral Health Conditions 1 (5 Mar. 2014), *available at* <https://www.jagnet.army.mil/8525740300753073/0/0373E37B596BA094852573F4005520F9?opendocument> (follow "Psychiatric Conditions (5 Mar 14).pdf" hyperlink).

²⁵⁷ *Id.* However, "[i]f the PEB determines that a Soldier cannot perform military duties because of a medical condition, then the PEB will generally find that condition unfitting for continued military service." *Id.*

²⁵⁸ ARMY GOLD BOOK, *supra* note 55, at 66.

²⁵⁹ *Legal Services Available During the MEB and PEB Process*, U.S. DEP'T OF ARMY, <https://www.jagnet.army.mil/8525740300753073/0/56C016A9D039C927852573F000552C3B?opendocument> (providing basic information on the role of the Office of Soldier's Counsel).

²⁶⁰ *Id.*

²⁶¹ *Id.*

200, Active Duty Enlisted Separations.²⁶² Specifically, paragraph 5-17 allows Soldiers to be separated for “physical or mental conditions not amounting to disability [under AR 635-40] . . . that interfere with assignment to or performance of duty.”²⁶³ There are several conditions that may qualify a Soldier for an administrative discharge, including, sleepwalking, dyslexia, and severe nightmares. However, if a Soldier has been deployed to a combat zone but presents with certain specific conditions, that Soldier must be referred under the Physical Disability System and may not be discharged under paragraph 5-17.²⁶⁴ As a final note, Soldiers who are separated pursuant to paragraph 5-17 are normally separated with an honorable characterization of service.²⁶⁵

Soldiers with less than twenty-four months of active-duty service may be separated under the provisions of chapter 5-13 for personality disorders if their condition “interferes with assignment or with performance of duty.”²⁶⁶ This chapter is aimed at new Soldiers who may have an onset of a personality disorder that becomes evident in their inability to adapt to the military environment.²⁶⁷ However, even if a Soldier with less than twenty-four months of active-duty service is diagnosed with a personality disorder, he will not be administratively discharged if “PTSD, TBI and/or other comorbid illness are significant factors to a diagnosis of personality disorder.”²⁶⁸ Rather, this Soldier would be processed under the Physical Disability System.²⁶⁹

Soldiers undergoing administrative separations are afforded due process and are entitled to legal counsel from the Army’s Trial Defense

²⁶² See AR 635-200, *supra* note 161, ch. 5. The authority to approved separations under Chapter 5 is reserved for commanders who are special courts-martial convening authorities (typically at the brigade level or equivalent). See *id.*, para. 1-19 (outlining separation authorities). However, subordinate commanders may initiate separation proceedings.

²⁶³ *Id.* para. 5-17.

²⁶⁴ *Id.*; AR 40-501, *supra* note 162, para. 8-24 (“A Soldier will not be processed for administrative separation under AR 635–200, paragraph 5-17, if PTSD or mTBI are contributing factors to the diagnosis of [personality disorders], but will be evaluated under the physical disability system in accordance with AR 635–40.”).

²⁶⁵ AR 635-200, *supra* note 161, para. 5-1 (noting that Soldiers being separated under chapter 5 will be awarded honorable or under honorable conditions and commenting that under honorable conditions is an inappropriate characterization for most Soldier separated under paragraph 5-17).

²⁶⁶ See *id.* para. 5-13.

²⁶⁷ *Id.*

²⁶⁸ *Id.*

²⁶⁹ *Id.*

Service (TDS).²⁷⁰ Like OSC attorneys, TDS attorneys are insulated from the Soldier's chain of command and represent their client's interests.²⁷¹ In addition, there are procedural protections built into the administrative-separation process, such as administrative boards for qualifying individuals, specific approval authorities above the company commander level, and opportunities for Soldiers to submit matters to the separation authority for consideration.²⁷²

C. Summary of Career Impact

Overall, although there is no guarantee that seeking mental-health treatment will not have any adverse career impacts, the chances of harm to a career for seeking mental-health treatment are exceptionally slim.²⁷³ As previously discussed, the regulations and procedures governing security clearances and discharges from the military strike a balance between advancing the Army's mission and protecting individual Soldiers through specific due-process rights.

In fact, a Soldier is actually more likely to harm his career if he lets a mental issue go untreated. A 2006 Air Force study found that servicemembers who sought out mental-health assistance were significantly less likely to experience negative impacts on their careers

²⁷⁰ U.S. DEP'T OF ARMY, REG. 27-10, MILITARY JUSTICE ch. 6 (3 Oct. 2011) [hereinafter AR 27-10] (discussing the role of the U.S. Army Trial Defense Service, including representation in administrative separation proceedings).

²⁷¹ See *id.* para. 6-11 ("Nothing in this chapter limits a [TDS] counsel's duty to exercise independent professional judgment on behalf of a client."); see generally Lieutenant Colonel Peter R. Masterton, *The Defense Function: The Role of the U.S. Army Trial Defense Service*, ARMY LAW., Mar. 2001, at 1.

²⁷² AR 635-200, *supra* note 161, ch. 2 (outlining "Procedures for Separation"); see Masterton, *supra* note 271, at 10-13 (discussing the role of a TDS attorney in administrative separations).

²⁷³ This conclusion is based on the regulations, guidance, policies, and statistics discussed in this section. However, there may be certain opportunities for special schools and assignments that could be affected. Because the assessment and selection of high risk operational personnel is necessarily kept close-holds, it is difficult to determine how, if at all, help-seeking behavior affects an individual's eligibility and competitiveness for such units. For more information on the assessment and selection of high-risk operational personnel from a military psychology standpoint, see MILITARY PSYCHOLOGY, *supra* note 248, at 353-68. Finally, it is important to note that this impacts only an extremely small percentage of Soldiers.

than those who were command referred.²⁷⁴ Servicemembers in this study were thirteen times “more likely to experience a career impact by avoiding or delaying professional assistance.”²⁷⁵ One explanation relates to comorbidity. These PTSD-related issues, such as alcohol abuse, increased irritability, and inability to focus, can worsen if not identified and treated in a timely matter.²⁷⁶ Left untreated, mental-health issues can escalate and result in misconduct or poor work performance. Put simply, the failure to seek necessary mental-health assistance is often more detrimental to an individual’s career than the actual psychiatric issues.²⁷⁷

Finally, perhaps the best evidence that a Soldier can seek help without harming his career are the examples of Soldiers who have actually received mental-health treatment and gone on to have successful careers. For example, now-retired Sergeant Major of the Army Raymond Chandler sought treatment for PTSD and was in counseling every week for two years. His extensive counseling did not stop him from being selected for that position.²⁷⁸ There have also been general officers, such as General Carter Ham,²⁷⁹ Major General David Blackledge,²⁸⁰ and

²⁷⁴ Rowan et al., *supra* note 9, at 1126 (finding that 3% of self-referred individuals reported impact to career, while 39% of commander-directed individuals reported career impact).

²⁷⁵ *Id.*

²⁷⁶ *See supra* Part V.C.

²⁷⁷ *See* MILITARY PSYCHOLOGY, *supra* note 248, at 46 (noting observations from military mental health practitioners); Dingfelder, *supra* note 103, at 2 (“Seeking mental health care doesn’t harm your career It’s not being able to do your job because of personal issues that can harm your career.” (quoting the chief of the Air Force’s Mental Health Division)).

²⁷⁸ *Video Profile: Sgt. Maj. of the Army Raymond Chandler*, REAL WARRIORS, <http://www.realwarriors.net/multimedia/>. On a previous deployment before becoming Sergeant Major of the Army, SMA Chandler had been working at his desk in his room. He got up from his desk to stretch his legs when a rocket came through the wall of his room and destroyed his desk. Although SMA Chandler is an infantryman and was no stranger to combat, being so close to death in his own room made him feel extremely vulnerable and shook him to the core. After he returned home from the deployment, he started drinking a lot more, and his relationships with his wife and family deteriorated. He finally decided to seek help and received counseling for many years. During his interview for the Sergeant Major of the Army position, General Casey asked SMA Chandler if there was anything that General Casey should know prior to hiring him. Sergeant Major of the Army Chandler disclosed his counseling and said that it may be an embarrassment. General Casey responded by saying that it was not an embarrassment and that it was a good-news story. *Id.*

²⁷⁹ General Carter Ham was in command in Iraq in 2004 when a suicide bomber killed twenty-two people in a mess hall at a base in Mosul. The devastation of this event (General Ham arrived on the scene within twenty minutes) and other experiences during the deployment affected him deeply, and when he returned from the deployment, he

Brigadier General Gary S. Patton,²⁸¹ who have suffered from PTSD and had successful careers after seeking help.²⁸² Finally, Staff Sergeant Ty Carter recently received the Medal of Honor for his heroic actions at Forward Operating Base Keating, Afghanistan, in 2009, after being treated for PTSD resulting from the same battle.²⁸³

D. Transparency for Soldiers

Despite overwhelming evidence that seeking professional mental-health treatment is not career-ending, many Soldiers continue to believe that it is. As such, transparency is critical. To mitigate a Soldier's concerns, there should be institutional transparency and Soldier education on the uses of their PHI and on the due-process safeguards available to them. Without this factual and credible information, Soldiers will be left to assume the worst, and many will consequently

struggled to adjust. Rather than let the stress of his combat service fester and ruin his career, he sought help for PTSD, received counseling, and went on to have an extremely successful career. Tom Vanden Brook, *General's Story Puts Focus on Stress Stemming from Combat*, USA TODAY (Nov. 24, 2008), http://usatoday30.usatoday.com/news/military/2008-11-24-general_N.htm.

²⁸⁰ Major General David Blackledge was in command of a Civil Affairs unit in Iraq in 2004 when his convoy was ambushed. His interpreter was shot in the head, and he sustained several injuries from the attack. As a result, he was evacuated back to the Walter Reed Army Medical Center where he was able to talk to a psychiatrist over the course of eleven months while he received physical therapy for his other injuries. Pauline Jelinek, *General Bucks Culture of Silence on Mental Health*, USA TODAY (Nov. 8, 2008), http://usatoday30.usatoday.com/news/washington/2008-11-08-3632490803_x.htm.

²⁸¹ Brigadier General Gary Patton was a Brigade Commander in the Anbar province of Iraq in 2004. During the course of this deployment, he recalls being exposed to various forms of trauma: "You . . . have the trauma of seeing loss of life, Iraqi citizens, innocents, being blown up by suicide bombs You had the trauma of killing another human being. We killed a lot of terrorists and insurgents in direct combat and gunfights." Tom Vanden Brook, *supra* note 279. Upon returning home, Brigadier General Patton was affected by hyper-vigilance and insomnia. After being able to talk about his experiences with a counselor, he was able to adjust to being home, and was eventually promoted to Brigadier General. *Id.*

²⁸² Dingfelder, *supra* note 103, at 2.

²⁸³ Elizabeth M. Collins, *In the Aftermath of Keating, MOH nominee Carter gets help for PTSD*, U.S. DEP'T OF ARMY, [http://www.army.mil/article/109617/In_aftermath_of_Keating_MOH_nominee_Carter_gets_help_for_PTSDF/](http://www.army.mil/article/109617/In_aftermath_of_Keating_MOH_nominee_Carter_gets_help_for_PTSDF_(recounting_Staff_Sergeant_Carter's_story)) (recounting Staff Sergeant Carter's story).

refrain from seeking help.²⁸⁴

1. Institutional Transparency

Looking first to institutional transparency, the DoD and the Army should take steps to be completely transparent on the actual effects of help-seeking behavior. In addition to general assurances from ranking officials that seeking help for mental-health issues will not harm a Soldier's career,²⁸⁵ the DoD and the Army should publish evidence to support these assertions. For example, to mitigate concerns that seeking help will affect a Soldier's security clearance, the CCF could publish annual statistics on the number or percent of clearances that were actually revoked for reasons purely relating to mental health. Although limited statistics regarding clearances are available in scattered research or news articles, there is currently no centralization of this data.²⁸⁶ These concrete statistics may give Soldiers the assurance they need to seek treatment. In the same way, similar statistics regarding how many Soldiers are medically or administratively discharged involuntarily due to mental-health issues may also be reassuring and encouraging.

2. Soldier Education

Next, education is also critical in mitigating Soldiers' concerns about detriments to their careers. Soldiers should understand exactly how information concerning mental health treatment is or is not used. This includes knowing the parameters of the regulations and policies discussed previously. Currently, MEDCOM has a policy to keep Soldiers informed of the circumstances in which their commander will receive notification of their mental-health treatment.²⁸⁷ While this notification is a step in the right direction, it is not enough. The MEDCOM policy concerns information that medical providers give to their patients. This necessarily implies that the Soldier receiving the information is a patient and has already taken the first big step of seeking help. Unfortunately, the stigma regarding career impact stops many

²⁸⁴ See Rowan et al., *supra* note 9, at 1123 (“S[ervice] M[ember]s’ misconceptions may be corrected in the short term by disseminating factual, credible information regarding the impact on one’s career and confidentiality.”).

²⁸⁵ See *supra* note 277 (quoting the Chief of the Air Force’s Mental Health Division).

²⁸⁶ If these statistics are already maintained, they are not published in a manner that is easily accessible to Soldiers or the general public.

²⁸⁷ OTSG/MEDCOM Policy Memo 12-062, *supra* note 172, at 4.

Soldiers from even asking for help in the first place.²⁸⁸ Education should not be left to medical providers, as the point of increasing transparency is to reach Soldiers who have not yet seen any professional help.

There are other opportunities to inform and educate Soldiers on the potential uses of their private mental-health information and the due-process safeguards available to them. Rather than creating all new training, this information can be efficiently dovetailed with the existing training requirements in AR 350-1, *Army Training and Leader Development*.²⁸⁹ Specifically, training regarding the use of mental-health information could be a part of the mandatory training on Soldier Resilience or the Army Suicide Prevention Program.²⁹⁰ An added benefit of incorporating this information into existing programs under AR 350-1 is that the information and presentation would be standardized and consistently presented throughout the Army.²⁹¹ All Soldiers would receive the message that seeking help is not a career-killer.

IX. Conclusion

Soldiers are the Army's most important resource. For over a decade, they have fought and made personal sacrifices to protect America. But this fighting has come with a high cost and the wounds of Soldiers are often invisible. Many Soldiers have sought and received treatment for their invisible wounds but many more suffer in silence because they fear judgment or harm to their careers. While the military is working on eliminating stigma from its ranks, this requires a major cultural shift and will take time. In the mean time, assurances of confidentiality are extremely important to overcome stigma-based barriers to care.

Since total confidentiality is not possible with the military's mission, finding a balance between a Soldier's interests and a commander's interests is critical. To this end, leaders and commanders must understand their rights and the limits in accessing and using information. They must respect confidentiality and create environments that

²⁸⁸ See *supra* notes 95–100 and accompanying text.

²⁸⁹ U.S. DEP'T OF ARMY, REG. 350-1, ARMY TRAINING AND LEADER DEVELOPMENT (19 Aug. 2014) [hereinafter AR 350-1].

²⁹⁰ *Id.* at tbl.G-1 (listing "Resilience training" as an ongoing training requirement and "Army Suicide Prevention Program" training as an annual and re-deployment training requirement).

²⁹¹ See *id.* para. 1-9 (discussing training objectives).

encourage and applaud efforts to seek help. Promoting a stigma-free environment requires involvement from leaders at all levels, and there should be consequences for leaders and commanders who disregard privacy interests or who tolerate stigma in their formations.

In addition, the DoD and the Army should ensure complete transparency regarding the use of mental-health information to assuage fears of career detriment. Soldiers should be able to seek mental-health treatment without fearing that their careers will be harmed in the process. This also involves educating Soldiers on the current regulations and policies regarding the uses of their mental-health information, as well as on the due-process rights afforded to them by many of these regulations.

Perhaps if Maj John Ruocco had assurances that he would not be ridiculed for seeking professional help, that his private information would only be shared if absolutely necessary, and that he could receive treatment and continue to serve honorably in the Marine Corps, he would still be alive today. It might be too late for Maj Ruocco, but there are still thousands of Soldiers suffering from invisible wounds. Although their wounds may be invisible, they should not have to suffer silently. No Soldier should ever have to bear the burden of a secret like Maj Ruocco's.