LIVES OF QUIET DESPERATION:  
THE CONFLICT BETWEEN  
MILITARY NECESSITY  
AND CONFIDENTIALITY

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ABSTRACT

The recent year has seen the implementation of several measures designed to lessen the stigma of self-reporting for mental impairments, including proposed and implemented rules for post-traumatic stress disorder (“PTSD”) treatment and the revision of security clearance questionnaires. A 2007 RAND Corporation study found that approximately 18.5% of servicemembers returning from Iraq or Afghanistan have either PTSD or depression. A small survey conducted by the American Psychiatric Association in 2008 found that three out of five servicemembers believe that seeking mental health services would have at least some impact on their career. Current Department of Defense (“DoD”) policy under DoD 6025.18-R (Department of Defense Health Information Privacy Information) allows “covered entities” to disclose protected health information of “individuals who are Armed Services personnel for activities deemed necessary by appropriate military command authorities to assure the proper execution of the military mission.”¹ The purposes for which this information may be disclosed include fitness for duty and “to carry out any

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activity necessary to the proper execution of the mission of the Armed Forces.\textsuperscript{2}

This Article will argue that these provisions remain vague and overbroad, thereby permitting the perception (and in some cases, the reality) that Commanders may access mental health records at will, so long as there is some nexus to the "proper execution of the mission of the Armed Forces."\textsuperscript{3} By suggesting that commanders may routinely gain access to information about a soldier's mental health, this policy and the existing authorities may perpetuate the stigma of seeking mental health services, especially for career soldiers.

This Article will examine the different actors in the military health system and their interests in either accessing or withholding protected health information. The military is unique in both mission and demographics. Specifically, this Article will address the commanders' interest in and regulatory authority for accessing a soldier's protected health information, and whether an alternative method for ensuring soldier readiness while shielding protected health information is feasible. This Article will also look at what protected health information soldiers are compelled to provide under the law (specifically for security clearances and deployability), and the dilemma one may face in choosing between his or her career and seeking treatment. Further, this Article will consider the dilemma of the providers whose roles as psychotherapists/physicians may be in conflict with their legal obligations to the military. Finally, this Article will also briefly look at civilian state licensing rules and laws (to which the psychotherapists may be subject) and how different they are from military regulations.

TABLE OF CONTENTS

I. INTRODUCTION .................................. 1005
II. BACKGROUND .................................... 1008
III. THE LIMITS OF CONFIDENTIALITY ............ 1011
IV. THE ACTORS .................................. 1015
   A. SOLDIERS .................................... 1016
   B. COMMANDERS ................................. 1021
   C. MENTAL HEALTH PRACTITIONERS .......... 1026
   D. COST BENEFIT ANALYSIS ................... 1031
V. RECENT DEPARTMENT OF DEFENSE INITIATIVES .... 1033
VI. PROPOSED CHANGES ............................ 1036
VII. CONCLUSION .................................. 1041

2. \textit{Id.} at 70.
3. \textit{Id.}
No matter what our achievements might be, we think well of ourselves only in rare moments. We need people to bear witness against our inner judge, who keeps book on our shortcomings and transgressions. We need people to convince us that we are not as bad as we think we are.

I. INTRODUCTION

Clutching his rifle, an American soldier flattens himself against the ground, trying to avoid detection. He hears his pursuers barking orders to each other in German, dogs snarling, the rustling sound of boots trampling in long, tall grass. He can almost convince himself that it is 1942, not 2008, and that he is a hero and not a criminal. His body aches from lying motionless on the cold, damp ground. He steadies his breathing, uncertain of what to do next. He is tired of running. They are getting close now. Soon it will be over. It will all be over. It is almost a relief when one of the voices bellows in English: “Police! Do not move! Drop your weapon!”

Things had gotten out of control so quickly. This was his third tour with the Army; he had ended his last enlistment with a general discharge for striking an officer. He promised himself that this time it would be different. But, as often happens, life gets in the way. In December he discovered his girlfriend was cheating on him with his roommate. He was homesick and alone in a foreign country at Christmas. Trying to cope with the situation, he overdosed on pills and ended up in the Nevernklink, a German psychiatric hospital, for two weeks. It had been a tough year.

But now the rest of the unit was back from deployment. He could start over again with a new chain of command who knew nothing about his previous discharge or his suicide attempt. He was getting help. He was even interviewing with a new commander for a armorer job. He tried to make a fresh start, but seeing his ex-girlfriend holding hands with his roommate in the parking lot knocked something loose; he became unhinged all over again.

That incident started a chain of events that ended in an open field outside Altershausen, Germany. With a German Special Weapons and Tactics (“SWAT”) team and snarling dogs surrounding him, he

rose, defeated from his prone position. Police snipers immediately trained their scopes on the crazed American who fled into the field after holding a young woman and her mother hostage. The soldier, Private ("PVT") Jeremiah Carmack, raised his rifle. Taking no chances, the Polizei fired. An hour later, doctors pronounced PVT Carmack dead.7

The story made headlines in Germany, particularly because the young woman, who was PVT Carmack's ex-girlfriend, and her mother were German. It seemed to encapsulate all of the bad things Germans believe about Americans—that they are violent, impulsive, and often overstay their welcome. When interviewed by Stars and Stripes, the battalion commander complained bitterly that PVT Carmack's "checkered past and his December suicide attempt should have been caught by a physician assistant . . . especially since [he] was being considered for a job in the armory."8 He laid the blame squarely at the feet of Army medicine, saying a combination of a shortage of physician assistants and a lack of access to medical files kept vital information from the command.9 An investigation conducted in the wake of the tragedy found that a medic performed a medical records check at the battalion aid station as part of the screening process. However, the medic viewed only PVT Carmack's "hard copy" records because he did not have access to the electronic records, which required the authorization of a physician assistant.10 The investigating officer found that "access to medical information [regarding PVT's Carmack's past suicide attempt] is clearly a hindrance to the chain of command attempting to do a background investigation on a soldier for a sensitive or trusted position in accessing critical data about that soldier's mental stability," even though PVT Carmack was never offered the armorer position.11 The solution, the battalion commander said, is "the creation of a list of soldiers not authorized to draw weapons,"12 specifically those undergoing mental health treatment. Private Carmack was a member of an infantry unit.

Tensions are inherent at the intersection of mental health treatment, military necessity, and confidentiality. Military leaders depend

7. MAIN POST, supra note 5.
9. Id.
11. Id.
on their soldiers to be ready to deploy at a moment's notice. As the United States enters its ninth year of war, repeated deployments have inevitably taken their toll on the military's psychological health. Anonymous surveys indicate that between twenty and fifty percent of active and reserve component soldiers redeploying from theater report various psychological symptoms, such as depression, relationship problems, and stress reactions. Yet less than forty percent of the affected population seeks mental health treatment. Army leaders acknowledge that "military training, culture, institutional structures, and policies foster stigma and prevent individuals from seeking care because they fear that using services will limit their military-career prospects and causes them to be viewed as weak or unreliable." At the same time, Army officials recognize privacy in mental health treatment "cannot be guaranteed because of the risk a troubled Soldier will jeopardize a mission."

The purpose of this Article is to examine the interests and roles of the various actors in the military mental health system to include commanders, soldiers, and mental health providers. Part II of this Article will discuss the current mental health issues facing the Department of Defense ("DoD") after nine years of warfare, the current rules and regulations regarding confidentiality and mental health treatment information, and how these rules and regulations impair treatment. Part III of this Article will discuss the soldier's motivations to disclose or withhold mental health treatment information and the commander's interest in knowing a soldier's mental health status to ensure military readiness. Part III will discuss the mental health provider's ethical obligations as both a therapist and a member of the uniformed services and where these roles and motivations might come into conflict. Part IV of this Article will discuss recent DoD changes to confidentiality rules in response to the recent surges in suicides and post-traumatic stress. Part V of this Article will propose regulatory changes to encourage treatment, maintain readiness, and reinforce the resiliency the United States Army has already demonstrated.


This Article will argue that the current scheme of regulations regarding the confidentiality of a soldier's mental health records, while well-intentioned, discourages soldiers from getting the help they need, and that on balance, the costs outweigh the benefits.

II. BACKGROUND

Current Department of Defense ("DoD") policy, DoD 6025.18-R (DoD Health Information Privacy Regulation) allows "covered entities" to disclose protected health information of "individuals who are Armed Services personnel for activities deemed necessary by appropriate military command authorities to assure the proper execution of the military mission."\(^7\) This information may be disclosed for both fitness for duty and "to carry out any other activity necessary to the proper execution of the mission of the Armed Forces" purposes.\(^8\) This language is mirrored in Army Regulation ("AR") 40-66, Record Administration and Healthcare Documentation, which sets the standards for protection and disclosure of protected health information for Army personnel and others treated in most Army medical facilities.\(^9\) The provisions in DoD 6025.18-R and AR 40-66 regarding a commander's access to servicemembers' health information remain vague and overbroad, permitting a commander to access servicemembers' records as long it is necessary for the "proper execution of the mission of the Armed Forces."\(^20\) This language creates the perception—and in some cases, the reality—that commanders may access mental health records at will, so long as they deem it "necessary to the proper execution of the mission of the Armed Forces."\(^21\) By suggesting that commanders may routinely gain access to a soldier's mental health records, these policies perpetuate the stigma against and discourage soldiers from seeking mental health treatment. According to one psychologist treating soldiers in the Fort Carson area, "[t]here really is no

\(^{17}\) U.S. DEP'T OF DEF., REG. 6025.18-R, DO D HEALTH INFORMATION PRIVACY REGULATION 70 (2003), available at http://www.dtic.mil/whs/directives/corres/pdf/602518r.pdf. "General Rule. A covered entity (including a covered entity not part of or affiliated with the Department of Defense) 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." Id. A "covered entity" is a "plan or a healthcare provider who transmits any health information" in an electronic transaction. Id. at 10.

\(^{18}\) Id. at 70.


\(^{20}\) Id. at 7-8.

\(^{21}\) Id.
confidentiality . . . [y]ou can find an exception to confidentiality in pretty much anything one would discuss.\textsuperscript{22}

Recently, the question of providing and encouraging mental health treatment has taken on a compelling urgency. A 2007 DoD Mental Health Task Force report acknowledged “DoD’s mental health mission has fundamentally changed.”\textsuperscript{23} The same report recognized “data from the Post-Deployment Health Re-Assessment (“PDHRA”) . . . indicate that 38 percent of Soldiers and 31 percent of Marines report psychological symptoms”\textsuperscript{24} after returning from deployment. Since 2003, “more than 4,700 servicemembers have been evacuated from Iraq and Afghanistan because of mental disorders.”\textsuperscript{25} The DoD Task Force on Mental Health’s report noted that the impact extends beyond servicemembers, finding that “20 percent of married soldiers planned to separate or divorce . . . a five percent increase from the [survey] of the year prior.”\textsuperscript{26} Perhaps most worryingly, Army suicides have increased sixty-two percent since 2006, the first time the suicide rate for the military surpassed that of the civilian population.\textsuperscript{27}

Both civilian and military leaders are paying attention. In September 2008, former Army Secretary Pete Geren acknowledged, “Army leaders are fully aware that repeated deployments have led to increased distress and anxiety for both soldiers and their families.”\textsuperscript{28} In August 2009, President Obama expressed hope that increasing the size of the military would reduce the incidence of post-traumatic stress disorder (“PTSD”), saying that “[t]here is a direct connection

\textsuperscript{22} James Dao \& Dan Frosch, Military Confidentiality Rules Raise Counseling Questions, N.Y. TIMES, Dec. 7, 2009, at A12.
\textsuperscript{24} Id. at 5. The PDHRA is administered to servicemembers 90 to 120 days after returning from deployment. Id.
\textsuperscript{26} DoD TASK FORCE REPORT, supra note 23, at 5 (citing U.S. DEP’T OF ARMY, OFFICE OF THE SURGEON GEN., OPERATION IRAQI FREEDOM (OIF) MENTAL HEALTH ADVISORY TEAM REPORT (2005)).
\textsuperscript{27} See Wayne V. Hall, Army Releases December Suicide Data, WWW.ARMY.MIL (Jan.15, 2010), http://www.army.mil/article/32886/Army_Releases_December_Suicide_Data/ (stating that “[t]here were 160 reported active-duty Army suicides during 2009”); Lizette Alveraz, Suicides of Soldiers Reach High of Nearly 3 Decades, N.Y. TIMES, Jan. 29, 2009, http://www.nytimes.com/2009/01/30/us/30suicide.html (stating one hundred six active-duty soldiers committed suicide in 2006, the first time soldier suicides passed that of civilians since the Vietnam War).
between the problems of PTSD and the pace of military operations."\textsuperscript{29}

The DoD aggressively recruits mental health professionals to diagnose and treat returning servicemembers.\textsuperscript{30} In 2009, Congress mandated the establishment of a DoD Suicide Prevention Task Force in order to "address trends and causal factors . . . [and] methods to update prevention and education programs."\textsuperscript{31} Announcing the members of the task force, Ellen Embrey, acting Assistant Secretary of Defense for Health Affairs, declared, "One servicemember suicide is too many and DoD is taking a proactive and comprehensive approach towards prevention, with efforts to address the stigma of psychological health issues, reduce barriers to care and research best practices."\textsuperscript{32}

According to the DoD Task Force on Mental Health, "[s]tigma, the shame or disgrace attached to something regarded as socially unacceptable, remains a critical barrier to accessing needed psychological care."\textsuperscript{33} A telephonic survey of 1,965 previously deployed individuals found, "In general, respondents were concerned that treatment would not be kept confidential and would constrain future job assignments and military-career advancement."\textsuperscript{34} In spite of recent education efforts, most soldiers, commanders, and providers remain either ignorant or misinformed about what information they can or cannot release to military authorities.\textsuperscript{35}

Army military treatment facilities
require that soldiers who seek therapy sign waivers acknowledging that if they disclose violations of the Uniform Code of Military Justice, their conversations with therapists might not be kept confidential.\textsuperscript{36} One soldier refused to sign, stating, "How can you go and talk about wartime problems when you feel that if you mention anything wrong, you're going to be prosecuted?"\textsuperscript{37}

\section*{III. THE LIMITS OF CONFIDENTIALITY}

In August 1996, President Bill Clinton signed the Health Insurance Portability and Accountability Act\textsuperscript{38}, commonly known as HIPAA, into law. Though usually associated with medical privacy concerns, HIPAA's main purpose is to allow people to move from job to job without losing their health insurance.\textsuperscript{39} When employers and insurers complained about the added costs and administrative burdens, the federal government "pledged to make it easier for medical providers, insurers and others to swap medical information electronically" by standardizing electronic medical records, "potentially saving as much as \$30 billion over a decade."\textsuperscript{40} Recognizing the potential for abuse of medical privacy, Congress directed the United States Department of Health and Human Services ("HHS") to promulgate regulations for guarding patient privacy to augment various state laws.\textsuperscript{41} In 2003 the Department of Defense ("DoD") published DoD 6025.18-R in order to comply with new HIPAA guidance and HHS privacy rules.\textsuperscript{42}

Most of the language in DoD 6025.18-R echoes its civilian counterpart. Key definitions include "protected health information" ("PHI"), which is individually identifiable health information transmitted or maintained by electronic or any form or medium.\textsuperscript{43} Like the civilian HHS regulations, DoD 6025.18-R provides a general prohibition on disclosure or use of identifiable health information of individuals, except for "specifically permitted purposes."\textsuperscript{44} Disclosures of PHI are subject to the "minimum necessary" rule, which provides when using or disclosing PHI the "covered entity" shall make "reasonable ef-
forts to limit the use, disclosure, or request of protected health
information to the minimum necessary to accomplish the intended
purpose of the use, disclosure, or request.” While ostensibly protect-
ing the servicemember’s privacy, the regulation then proceeds to vir-
tually eviscerate these protections by allowing the disclosure of PHI
for members of the Armed Forces “for activities deemed necessary by
appropriate military command authorities to assure the proper execu-
tion of the military mission” without the consent of the military mem-
ber. These activities include determining both the servicemember’s
fitness for duty and fitness to perform any particular mission, assign-
ment, order or duty, and “to carry out any other activity necessary to
the proper execution of the mission of the Armed Forces.” Michelle
Lindo McCluer, executive director of the National Institute of Military
Justice, has stated that those exceptions are so overbroad that “you
could drive a truck through them.”

Army Regulation (“AR”) 40-66 mirrors the language in DoD
6025.18-R, adding that patient consent is not required for disclosure of
PHI to officers and employees of the DoD who have an official need for
access in the performance of their duties. AR 40-66 does not define
what an “official need for access” is, nor does it give a definition of
“any other activity necessary to the proper execution of the Armed
Forces,” but it does allow release without consent for “judicial or ad-
ministrative proceedings,” to include administration of nonjudicial
punishment.

Recently Army officials released a Rapid Action Revision (“RAR”)
of AR 40-66 in an attempt to clarify those instances in which military
treatment facility (“MTF”) commanders should notify line com-
manders regarding soldiers’ mental health treatment. The RAR
stresses that only the “minimum necessary” of PHI should be dis-
closed, describing those situations requiring command notification as
“instances where the Soldier’s judgment or clarity of thought might be
suspect by the clinician” to include “to avert a serious and imminent
threat of health or safety of a person, such as suicide, homicide, or
other violent action.” However, AR 40-66 states that command noti-

45. Id. at 75.
46. U.S. DEP’T OF ARMY, REG. 40-66, MEDICAL RECORD ADMINISTRATION AND
HEALTHCARE DOCUMENTATION 7 (2010) [hereinafter AR 40-66] (Rapid Action Revision),
47. Id.
48. James Dao & Dan Frosch, Military Confidentiality Rules Raise Counseling
49. AR 40-66, supra note 46, at 7.
50. Id.
51. Id.
52. Id. at 8.
fication is not limited to the situations listed in the regulation. AR 40-66 also notes that “routine behavioral health care would not trigger command notification.”

Nonetheless, AR 40-66 also allows disclosure of PHI to coordinate sick call appointments. If a soldier has a recurring appointment, it is likely his command knows why the soldier sought the appointment. This may raise questions about the soldier’s stability for the command and the commander may believe it is necessary to access the soldier’s PHI in order to allay his concerns. AR 40-66 allows disclosure without a soldier’s consent “for activities deemed necessary by appropriate command authorities to assure the proper execution of the military mission,” including “any other activity necessary to the proper execution of the mission of the Armed Forces.” The exception swallows the rule for those commanders who seek PHI on their soldiers, believing it is necessary to ensure the proper execution of their mission, whether it be turning wrenches or “kicking in doors.”

AR 40-66 also refers to the numerous instances where personnel other than a soldier’s healthcare providers may access his or her records, including mental health records. The list of those with a possible “need to know” purpose include “unit commanders; inspectors general; officers, civilian attorneys, and military and civilian personnel of the Judge Advocate General’s Corps; military personnel officers; and members of the U.S. Army Criminal Investigation Command or military police performing official investigations.” Again, this appears to be an exception that eviscerates the rule. However, this is actually an improvement—until 1999, prosecutors and commanders could look at a soldier’s mental health records at will, without the soldier’s consent or knowledge.

The DoD directive has specific provisions for the handing of psychotherapy notes, defining them, rather confusingly, in the negative:

Notes recorded (in any medium) by a healthcare provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual’s medical record. Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: Diag-

53. Id.
54. Id.
55. Id. at 7-9.
56. Id. at 41.
57. Dao & Frosch, supra note 48, at A12.
nosis, functional status, the treatment plan, symptoms, prog-
nosis, and progress to date.58

Disclosures are only protected if made to a “mental health profes-
sional.” Therefore, a soldier’s disclosure of psychological symptoms to
his primary care physician in order to get a referral would not be
shielded or segregated from his overall treatment record.59

Due to their sensitive nature, psychotherapy notes are afforded
additional safeguards. Generally speaking, psychotherapy notes can-
not be disclosed without consent except to (1) avert a serious, immi-
nent threat to military personnel or members of the public; (2)
respond to instances of abuse, neglect, or domestic violence as re-
quired by law; and (3) respond to the order of a court or administra-
tive tribunal.60 AR 40-66 augments the “serious, imminent threat lan-
guage,” adding that the phrase contemplates “an imminent threat to a
specific military mission or national security under circumstances
which in turn create a serious and imminent threat to a person or the
public.”61 Patient administrators and MTF commanders are en-
couraged, but not required, to seek advice from the local judge advokate
in order to determine the legitimacy of the request.62

As noted above, the material forming the basis of the referral to a
mental health practitioner would not receive these protections and
could be revealed should the commander deem it necessary. In the
Army electronic medical records system, Armed Forces Health Longi-
tudinal Technology Application (“AHLTA”), psychotherapy notes are
marked “SENSITIVE” and segregated from the rest of a patient’s
records.63 Should an unauthorized person with access to AHLTA re-
trieve psychotherapy notes at the behest of a commander, the only
barrier is a screen warning that their access is being logged.64 There
is no centralized system to alert the treatment facility that a patient’s
notes are being accessed. Unauthorized access can only be discovered
after the fact, and only if investigators have a reason to look for it.65

58. DoD 6025.18-R, supra note 42, at 19.
59. Id.
60. See id. at 44-45.
61. AR 40-66, supra note 46, at 10.
62. Id. at 9.
63. Telephone Interview with Dr. (Colonel) Rebecca Tomsyck, U.S. Army Medical
Activity Heidelberg Dept of Behavioral Health (Oct. 8, 2009) (on file with author).
AHLTA is the primary means of maintaining soldiers’ medical records. Paper records do
exist, but the military has largely abandoned the practice of having soldiers hand-carry
these documents, preferring to rely on AHLTA’s world-wide accessibility to track and
transmit medical information. Id.
64. Id.
65. Id.
Both AR 40-66 and DoD 6025.18-R discuss the need to protect an individual’s PHI.\textsuperscript{66} Penalties for unauthorized disclosure of PHI include up to $100 per violation and up to $25,000 for violations of an identical requirement or prohibition in a calendar year.\textsuperscript{67} When a person knowingly and wrongfully discloses PHI the penalty increases to a maximum fine of $50,000 or imprisonment up to one year, or both.\textsuperscript{68} However, in practice, enforcement is inconsistent, and compliance is often only voluntary. An individual may not be aware his information has been improperly disclosed unless the covered entity notifies him.\textsuperscript{69}

Within the military, organizational structure and conflicts of interest further complicate matters. Brigade combat teams have a physician or physician assistant with AHLTA access who is assigned as the brigade’s surgeon.\textsuperscript{70} Although unauthorized access to psychotherapy notes may not be common in consolidated medical facilities, issues may arise when a commander or executive officer pressures a brigade surgeon to access psychotherapy notes, such as when the commander wants to know if the soldier is malingering in order to get out of a duty or deployment.\textsuperscript{71} The assumption is only medical professionals with an official “need to know” purpose are accessing psychotherapy notes.\textsuperscript{72} Though the vast majority of healthcare practitioners are undoubtedly ethical, the potential for abuse is present.

IV. THE ACTORS

In response to the rising number of servicemember suicides and data regarding post-traumatic stress disorder and other negative consequences of wartime service, the Department of Defense ("DoD") has made a concerted effort to remove the stigma associated with seeking

\textsuperscript{66} See AR 40-66, supra note 46, at 4-13; DoD 6025.18-R, supra note 42, at 44-49.
\textsuperscript{67} HIPPA, supra note 38.
\textsuperscript{68} Id.
\textsuperscript{69} Kendra Gray, The Privacy Rule: Are We Being Deceived, 11 DePaul J. Health Care L., 89, 89 (2008).
\textsuperscript{71} Though rare, the author did see such situations arise in her tour as a Deputy Command Judge Advocate for the Europe Regional Medical Command.
\textsuperscript{72} Telephone Interview with Dr. Tomsyck, supra note 63.
mental health services. In his written testimony to the Senate Armed Services Committee for his re-nomination as Chairman of the Joint Chiefs, Admiral Michael Mullen wrote, “As a nation, we have an enduring obligation to care for those who bear the scars of war, seen and unseen. This is why over the past two years I have made reducing the stigma of mental health care a personal priority.”

The Army’s newest suicide prevention regulation, Department of the Army Pamphlet (“DA PAM”) 600-24, concedes, “One of the greatest barriers to preventing suicides is a culture that shames Soldiers into believing it is not safe to seek help . . . we must all reduce actual and perceived stigma of seeking help.”

In spite of these efforts, servicemembers remain reluctant to seek mental health services, even as the crisis worsens. In 2009, 160 active duty soldiers committed suicide, shattering 2008’s record total of 140. This is a sixty-two percent increase since 2006, the first time the suicide rate for active Army soldiers surpassed that of civilians. The next section examines the motivations of the actors in the military health care system and the dilemmas they face in either sharing or safeguarding mental health records.

A. SOLDIERS

In 2000, a General Accounting Office report found in the previous two decades, the attrition rate for first-term enlistees was, on average, thirty percent. Generally speaking, these losses fell into one of three categories: (1) hardship; (2) medical; or (3) behavioral/performance. Of the three groups, recruits with behavioral or performance issues comprised by far the greatest proportion of losses, coming in at a hefty eighty percent of the total.

Eager to cut attrition rates, the DoD in-

76. U.S. GEN. ACCOUNTING OFFICE, MILITARY ATTENTION: DoD COULD SAVE MILLIONS BY BETTER SCREENING ENLISTED PERSONNEL 60 (1997) [hereafter GAO REPORT ON ATTENTION].
roduced two new medical screening forms for potential enlistees, DD Form 2807-1 and DD Form 2807-2. These forms were designed to screen for the most common types of medical separations for recruits and are still in use today, with some revisions. In addition to the stern warnings of imprisonment for falsification of information, these forms require recruits to waive their rights to medical records confidentiality and allow disclosure of all treatment records to the DoD.

Recruits must disclose

all documentation relating to ANY past or present evaluation, treatment or consultation with a psychiatrist, psychologist, counselor or therapist, on an inpatient or outpatient basis for any reason, including but not limited to counseling or treatment for adjustment or mood disorder, family or marriage problem, depression, treatment or rehabilitation for alcohol, drug or other substance abuse, directly from the treating clinician . . . .

Studies have found possession of a high school diploma or General Educational Development (“GED”) certificate, rather than any past interaction with mental health providers, is the best predictor of basic training success. Nevertheless, Dr. (Colonel) Rebecca Tomsyck, an Army psychiatrist with twenty-three years of experience in both civilian and military practice, has noted that overall the psychological screening method for initial enlistees is successful. Dr. Tomsyck stated that the majority of seriously psychologically ill personnel are “weeded out” by the enlistment process; those not caught by enlistment are medically boarded before they ever come to her.

Unfortunately, Dr. Tomsyck said the stigma against mental health treatment exists “at all levels,” and is most apparent in the “Soldiers themselves.” Even though military leaders encourage an environment of tolerance, Dr. Tomsyck said many soldiers are still
very concerned about their careers. The data supports Dr. Tom-syck's observations. In a telephonic survey of 1,965 individuals who had previously deployed to Iraq or Afghanistan who possibly needed mental health services, over forty-three percent cited career concerns as a barrier to getting mental health treatment. Forty-three percent also cited concerns about getting a security clearance. And, in spite of the Health Insurance Portability and Accountability Act ("HIPAA") and DoD 6025.18-R, twenty-nine percent of survey respondents believed that any information shared with the mental health professional would not be kept confidential. The DA PAM 600-40 recognizes the dilemma:

Individuals may not seek help because they believe that their problems or behavioral health issues should remain a secret. Reasons for this may include shame and embarrassment, fear that their careers are affected, concern that personal issues are exposed, belief that seeking help is a sign of weakness, and a feeling of helplessness and hopelessness.

Are these concerns warranted? Army Regulation ("AR") 380-67, Personnel Security Program, regulates the granting or denial of security clearances. It has remained unchanged since it was first promulgated in 1988. Under "Criteria for Application of Security Standards," AR 380-67 states the following may be grounds for denial: "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." AR 380-67 goes on to state that if any information indicates a "history of mental or nervous disorder" the central clearance facility will "request a mental health evaluation to determine whether or not any defect in judgment or reliability or any serious behavior disorder exists." Under paragraph 5-107, "Grounds for denial [of clearance]," AR 380-67 states, "If information developed by the command indicates the existence, current or past, of any mental or nervous disorder or emo-

85. Id.
88. Tanielian et al., supra note 86, at 104.
91. Id. at 5.
92. Id. at 22.
tional instability, a request for a [personnel security investigation] will not be submitted and interim clearance will not be granted. On the face of the regulation, it would appear soldiers’ concerns are well founded.

Until relatively recently, a soldier had little choice but to disclose any visits with mental health professionals if he wanted to get a security clearance. The instructions for Standard Form (“SF”) 86, the “Questionnaire for National Security Positions” state that the purpose of the form is to “gather information to show whether you are reliable, trustworthy, of good conduct and character, and loyal to the U.S.” Question twenty-one was recently changed to the following:

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, grief not related to violence by you; or 2) strictly related to adjustments from service in a military combat environment. If you answered “Yes,” indicate who conducted the treatment and/or counseling, provide the following information, and sign the Authorization for Release of Medical Information Pursuant to the Health Insurance Portability and Accountability Act (HIPAA).

Previously, soldiers were required to disclose any visit to a mental health professional not related to grief or family matters within the past seven years. Even with the changes, the questionnaire raises three questions: (1) what probative value does a visit to a mental health professional have on a person’s reliability, trustworthiness, conduct, character, or loyalty to the United States; (2) if a person visited a mental health professional for reasons other than grief, family, or combat trauma, why is that trauma treated differently than trauma experienced in combat; and (3) does the mere presence of a

93. Id. at 22-23.
95. Id. (emphasis added)

New language for “Question 21” asks if the person consulted with a health-care professional during the past seven years regarding an emotional or mental health condition. It specifies, however, that the answer should be “no” if the care was “strictly related to adjustments from service in a military combat environment.”

Id.
question linking mental health and a person’s security clearance deter personnel from seeking help, no matter what the exclusions are?

Consider a recent congressional hearing, where military doctors treating female veterans said historically, on average, four out of ten female veterans have reported being sexually assaulted while in the military.\textsuperscript{97} Given that sexual assault does not fall in the categories of marital, family, grief, or combat-related trauma, a female servicemember would be forced to disclose any counseling she received for a sexual assault, a deeply intimate and private experience. The consequences for male victims of sexual assault are even worse, given the taboos and stigma involved in male-on-male assault. A male servicemember would have to make the choice between disclosing counseling regarding the assault or lying on his SF 86. Even today, many soldiers operate under the assumption that any type of counseling will have to be disclosed. As long as security clearance and mental health issues are linked, the stigma will continue.

Usually there is no malicious intent behind the command’s treatment of a soldier with mental health issues; however, even a commander’s well-intentioned actions can cause a soldier to be further stigmatized and isolated from his support network. Consider the example of an Army unit in Fort Benning that required its “at-risk” soldiers (those identified as suicide risks) to wear road guard vests.\textsuperscript{98} One recruit said, “You’re in an isolated state . . . . You’ve got the reason you’re on suicide watch to begin with on top of the fact that you stick out like a sore thumb . . . . It’s like you’re walking around in a zoo, and you’re the animal.” In a rapid action revision issued in September 2009, AR 600-63 was amended to state that “[at-risk] Soldiers . . . are not [to be] identified through special markings or


The purpose of the vest is, ostensibly, to make it easy for others to keep an eye on a suicidal soldier, but forcing a soldier to advertise his own depression creates a powerful stigma. “When you see what happens to someone on suicide watch—the orange vest, the trips to the chaplain, the drill sergeant talking about them when they’re not there, saying they can’t handle the military . . . . When you see that, you’re going to think twice about speaking up and saying you need some help. It makes you not want to talk to someone. You don’t want to be like that guy,” the recruit from Benning says.

\textit{Id.}
clothing (that is, Soldiers wear reflective training vests with signs identifying them as high-risk individuals)."\(^{100}\)

What the above story illustrates is that commander's well-intentioned attempts to help a soldier undergoing treatment often compound the problem by either categorizing the soldiers as "non-mission capable" or by further stigmatizing the soldier. The problem is even more acute among combat-arms soldiers, who pride themselves on mental and physical toughness. Steve Robinson, a former Army Ranger who advocates for veterans, attributes the problem to "a macho refusal to acknowledge stress and seek help.... The mentality of this particular group [Special Forces Soldiers] seemed to be 'Ignore what you think and feel and keep doing your job and don't talk to me about that (expletive) combat stress reaction stuff.'"\(^{101}\) Unfortunately, this demographic seems to be most at-risk. According to the Army's Suicide Prevention Task Force, "Although suicide can impact anyone, we're finding that male soldiers in combat-arms occupational specialties, between ages 18 and 27, are more vulnerable."\(^{102}\)

B. Commanders

Commanders at all levels have an enormous responsibility, both to the mission and for the well-being of their soldiers. AR 600-20, "Army Command Policy," states:

Commanders and other leaders at all levels will provide an environment that contributes positively to the physical, material, mental, and spiritual dimensions of the lives of their subordinates and their Families as well as members of the greater, extended Army Family, including veterans, retirees, and DA civilian employees as appropriate.\(^{103}\)

Perhaps commanders' most important responsibility is to "ensure[.] that both Soldiers and equipment are in the proper state of readiness at all times."\(^{104}\) Commanders at all levels are responsible for submitting monthly "unit status reports," reporting the readiness


\(^{104}\) Id. at 1-2.
Personnel readiness, one of four measured areas for determining a unit's overall readiness, is calculated by comparing the available strength, the available military occupational specialty qualified (MOSQ) strength, and the available senior grade strength with the required MTOE or TDA strength. Personnel are considered "non-available" when they are "not available for employment/deployment with their assigned units to meet wartime mission requirements" for reasons such as pregnancy, illness, injury, or legal or child-care issues. Based on those numbers, the Army decides whether a unit is ready to do its combat mission.

Information regarding unit readiness is reported up to the highest levels of the military. Consequently, there is enormous pressure on unit commanders to have an accurate accounting of personnel readiness. Knowing whether a soldier may be non-available for deployment due to psychological impairment is essential for accurate reporting and proper assessment of unit readiness. More importantly, unit cohesiveness is affected when a soldier is removed from deployment after working with his team for some time. Many times the unit has to deploy without anyone in a critical position because one of its soldiers is declared non-available for deployment at the last minute. Much to the commanders' chagrin, the unit is usually unable to get a replacement until that soldier is either transferred or separated from the Army.

Mental health issues do not necessarily make a soldier non-available for deployment. According to guidance issued by the Assistant Secretary of Defense for Health Affairs, Dr. William Wikenweder, "Recovery, amelioration of symptoms, and reduction of behavioral impairment are always goals associated with military mental health treatment, as psychiatric disorders, including posttraumatic stress disorder, are treatable." The memorandum goes on to state that diagnosed psychiatric treatments that are "not amenable to treatment to full functioning within one year" of treatment should either be medically boarded or administratively separated. The responsibility for

106. Id. at 22.
107. Id. at 98, 125-27.
108. Id.
109. Id. at 1-2.
110. The Author has based this on her personal experience as a battalion adjutant.
111. Memorandum from the Assistant Sec'y of Def. for Health Affairs, Dep't of Def., to Sec'y of the Army, Sec'y of the Navy, Sec'y of the Air Force, Chairman of the Joint Chiefs of Staff (Nov. 7, 2006), available at http://www.ha.osd.mil/policies/2006/061107_deployment-limiting_psych_conditions_meds.pdf.
112. Id. at 4.1.1.
113. Id.
identifying these personnel lies in “clinicians who conduct military medical readiness assessment” during Soldier Readiness Processing or Pre-Deployment Processing. Therefore, a mechanism exists to capture those personnel with mental health issues who meet the above criteria without giving commanders access to a soldier’s mental health records.

Unfortunately, the system is not perfect. A recent study by Major Remington L. Nevin, a career Army epidemiologist, found that military health officials relied heavily on self-reporting on pre-deployment forms. The study was the first time anyone had compared a soldier’s answers of the Pre-Deployment Health Assessment (“PDHA”) to the soldier’s electronic medical records. Of those found to have been diagnosed with a potentially disqualifying mental health disorder, “only forty-eight percent answered yes to the question: ‘During the past year, have you sought care or counseling for your mental health?’” The study found that this question essentially determined whether a soldier was seen by a mental health professional, as soldiers who answered “yes” were “30 times more likely to receive a referral [to a mental health professional] than those who answered ‘no.’” Among those personnel who answered “no,” ninety-seven percent were cleared without further evaluation.

Though troubling, the study speaks more to the ability of the military medical system to do an effective screening of deploying soldiers than to the confidentiality of records. Most commanders would not have the time to personally scan every part of their deploying soldiers to look for past mental health issues. Given that most medical records are electronic, it would not be difficult to have a program scan for those issues without a commander’s involvement. Relying on the self-reporting of a soldier on a form that most regard as a “paper drill” is facially ineffective; health care personnel should enforce the policies that are already in place.

Like the National Security Questionnaire, the PDHA question only asks whether a soldier has received treatment, rather than whether the soldier is symptomatic; again, this is a subtle indication that getting help is a problem, rather than the underlying issue.
leader’s knowledge of his personnel would be a more effective way of spotting issues than allowing him access to his soldiers’ medical records.

If a commander feels that a soldier is not fit for duty or deployment, he may refer the soldier to a mental health evaluation, even if the soldier has not been previously diagnosed with a psychiatric condition. The clinician who evaluates the soldier is responsible for providing the commander “a recommendation for return of the servicemember to duty, referral of the servicemember to a Medical Evaluation Board for processing through the Disability Evaluation System, or administrative separation of the servicemember for personality disorder and unsuitability for continued military service.”

Given the size of most company-sized elements, this requires the commander to rely heavily on junior leaders, such as platoon sergeants and squad leaders, to report a soldier’s behavior if it is concerning. Although the topic might be overwhelming to a junior leader, a soldier’s behavior does not necessarily require that he ask that the soldier be referred—only that he knows his soldier well enough to know when something is wrong and let someone in the leadership chain know when there is cause for concern.

However, a soldier may outwardly display all signs of normalcy on-duty and among his peers while still grappling with latent psychological issues. How does a commander identify those “high-risk” soldiers? DA PAM 600-24, Health Promotion, Risk Reduction, and Suicide Prevention, declares, “Commanders have a legitimate ‘need to know’ purpose about the mental and physical capabilities of their soldiers in order to safely and efficiently carry out their mission.” But, does knowing the mental and physical capabilities of one’s personnel necessarily mean giving commanders access to mental health records?

DA PAM 600-24 states, “Individuals who are frequently in close contact with others are often in the best position to identify persons at risk if they know the risk factors and warning signs. Individuals can include leaders, family members, buddies, close friends, and cowork-


121. Id.

122. Some larger units such as maintenance companies can have upwards of three hundred personnel. The author bases this information on her personal experience as a platoon leader and adjutant for a Combat Service Support Battalion.

ers." Therefore, it stands to reason a soldier's squad leader, platoon sergeant, or peers would notice a withdrawal or change in a soldier's personality before a health practitioner would notice the soldier's withdrawal or change, given the amount of time they spend together. A soldier's peers are not licensed mental health professionals; nonetheless, they could serve the function of alerting commanders to the existence of a problem. Army Vice Chief of Staff General Peter Chiarelli said that "leadership intervention is the biggest factor in prevention" of suicide. Part of leadership is knowing your personnel well enough to recognize when there is a problem, rather than relying on a mental health professional who may or may not recognize the difference during an hour-long office visit.

At this point we must acknowledge the biggest issue that commanders face when dealing with personnel with mental health issues: the carrying of firearms with live ammunition. Males aged seventeen to twenty-six compose fifty percent of the United States active duty military. Historically, suicide has been the second most common reason for the death of military personnel in this age group, after accidents. As the tragic example of Sergeant John M. Russell demonstrates, one mentally unbalanced individual in a combat environment puts everyone's lives at risk. Sergeant Russell shot and killed five of his fellow servicemembers at a Combat Stress Clinic on Camp Liberty, Iraq in May 2009. In terms of "composite risk management," the Army's term of art for "the Army's primary decision-making process for identifying hazards and controlling risks across the full spectrum of Army missions," this situation would be termed "highly unlikely" in terms of probability but "catastrophic" in terms of severity.

The Camp Liberty shootings incident is not a cautionary tale of what happens when commanders do not know about their soldiers'

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124. Id. at 13.
127. Id. It should be noted that this comparison was made in the early stages of Operation Enduring Freedom/Operation Iraqi Freedom and therefore may not account for combat-related deaths.
mental health problems. Sergeant Russell's immediate supervisors were aware of his issues and had previously escorted him to the Combat Stress Clinic, going so far as to remove the bolt from his weapon. An investigation conducted in the aftermath of the shootings "found that the Army doesn't emphasize command involvement and responsibility for behavioral problems...the brunt of the responsibility rests with chaplains 'when it should be a Command, and Commanding Officer Program.' Junior leaders did not notify Sergeant Russell's command of his threatened suicide, nor was his command aware that they had removed the bolt from his weapon. Like the case of PVT Jeremiah Carmack above, the point of failure was in the lack of communication between junior and senior leaders in the command. In both cases, the soldiers' junior leaders were aware of potential issues, and, in both cases, they failed to communicate their concerns to their superiors. Still, the command had the information without invading the soldiers' privacy.

C. MENTAL HEALTH PRACTITIONERS

Deployment of soldiers with mental health issues often increases risk of self-harm due to the availability of firearms and ammunition. Studies have shown that the presence of a firearm in the home dramatically increases the chances of completed suicide compared to those without firearms. Crises causing suicidal impulses are often temporary in nature, while the decision to commit suicide itself is also impulsive in nature. While suicide attempts involving overdose or cutting accounted for ninety percent of all suicidal acts, attempts using firearms accounted for fifty-three percent of completed suicides. As one practitioner noted, "A suicide attempt with a firearm rarely affords a second chance." Typically the crises soldiers face in a deployed environment, such as the breakup of a romantic relationship, are self-limiting in nature. Authors of one study observed that "as the acute phase of the crisis passes, so does the urge to

130. McClosky, supra note 129.
131. Id.
132. Id.
133. See id.
135. Id. at 990.
136. Id. at 989. "Among people who made near-lethal suicide attempts, for example, 24 percent took less than 5 minutes between the decision to kill themselves and the actual attempt, and 70 percent took less than 1 hour." Id. (citations omitted).
137. Id. at 989-90.
138. Id. at 990.
attempt suicide." Access to the method and the means to commit suicide in those moments of crisis "make the difference between life and death."

Knowing that deployed soldiers typically carry loaded weapons, face stressful conditions, and simultaneously deal with crises at home can present a dilemma for mental health providers serving the military community. Confidentiality is considered "fundamental to the therapeutic relationship." It is the "duty owed to the client, whereas privilege is the legal right held by the client, as a function of statute . . . or common law . . . psychologists are required by the Ethics Code and by law to maintain the confidentiality of communications shared with them" except in certain cases exempted by law. In Scull v. Superior Court, the Superior Court of Santa Barbara County found "disclosure that an individual is seeing a therapist may well serve to discourage any treatment and thereby interfere with the patient's freedom to seek and derive the benefits of psychotherapy . . . Communications between the patient and psychotherapists are also protected by the constitutional right of privacy."

However, the patient's right to confidentiality and the "patient-psychotherapist privilege is not absolute." In the landmark case, Tarasoff v. The Regents of the University of California, the Supreme Court of California imposed a legal duty on psychotherapists to "exercise reasonable care" to protect potential victims from a "patient's
threatened violent behavior." Since the Tarasoff decision in 1976, twenty-seven states have imposed mandatory "duty to warn" laws while an additional nine states grant psychotherapists permission to breach confidentiality should threats of violence against a third party arise.

For patients at risk of committing suicide, the therapist-patient relationship gives rise to a "special relationship" that imposes a duty to prevent self-harm. This relationship is defined as "[a] relationship founded in trust, reliance, dependence, or confidence, reposed by one person in the integrity and fidelity of another who is in a position of relative dominance and influence." These qualities may be exacerbated while treating military members, as the practitioners either: (1) outrank the patient or (2) have access to and authority to use information that could be very damaging to a patient's career. In civil practice, the determinative factor for liability for a patient's suicide depends on whether or not the patient's suicide was reasonably foreseeable or the death was actually caused by the therapist's negligence. The doctrine set forth in Feres v. United States, which is called the Feres doctrine, generally protects therapists treating military members against liability; however, therapists are still subject to the ethics of their profession and the codes of their various accreditation organizations.

All states impose an explicit duty on psychotherapists to protect their patients when they pose a danger to themselves, although the extent of that duty may be limited by a temporal requirement. In the civilian world, psychotherapists are generally guided by their indi-

ized, intensifying treatment, etc. in addition to the option of warning the potential victim. Id. at 277.


149. Herbert & Young, supra note 148 at 275.

About half of the states (27), following Tarasoff, impose a mandatory duty to warn, although the precise contours of the duty vary considerably. Another 10 jurisdictions (9 states plus the District of Columbia) accord psychotherapists permission to warn (viz., an exception to psychotherapist-patient confidentiality) without explicitly imposing a duty to warn. Id. at 277.

150. Patricia C. Kussmann, Annotation, Liability of Doctor, Psychiatrist, or Psychologist for Failure to Take Steps to Prevent Patient's Suicide, 81 A.L.R. 5th 167 (2000).


152. GOLSTEIN, supra note 143.

153. 340 U.S. 135 (1950). The Feres doctrine bars servicemembers from collecting damages from the United States for personal injuries, whether or not they were suffered in the performance of their duties. It also bars families of servicemembers from filing wrongful death lawsuits when a servicemember is killed or injured. Feres v. United States, 340 U.S. 135 (1950).

154. See generally Herbert & Young, supra note 150.
vidual states' requirements or authorizations to report patients who pose a "substantial likelihood" of hurting themselves in the "near future" or pose an "imminent threat" of self-harm. Though the DoD may waive licensure requirements for mental health practitioners in rare circumstances, the vast majority of providers hired by the DoD are subject to state licensing requirements as well as professional codes of ethics. Should a military mental health practitioner feel it necessary to disclose information to prevent a soldier from harming himself or others, the practitioner is protected by DoD 6025.18, which permits disclosure "necessary to prevent serious harm to the individual or other potential victims."

The nature of military life greatly complicates the decision whether or not to notify a soldier's commander. As in civilian practice, the health care provider is required to notify the commander or law enforcement in cases of imminent threat to self or others. However, the impact of the decision to notify a commander of a potential mental health issue can be much greater in military life. Oftentimes, a clinician must determine whether a soldier is fit for duty as well as whether the soldier is fit to deploy, knowing that the soldier will be carrying a weapon and live ammunition. A pre-existing condition may be exacerbated by the stresses of combat. As one text for military physicians noted, "Determining the level of impairment for some psychiatric conditions can be challenging, given the potential impact of..."

155. See, e.g., VA. CODE ANN. § 37.2-808 (2010).
156. See Health and Human Services Regulations, 45 C.F.R. § 164.512(j) (2010) (discussing uses and disclosures to avert a serious threat to health or safety).
158. Id. at 14-15.

Clinical psychologists who have not been awarded their doctoral degree are required to make continual progress toward completing the doctoral dissertation and meeting State licensure requirements throughout the period of their initial contract with the U.S. Army. Due to differences in dissertation requirements, no specific guidelines can be established for all clinical psychologists. The majority of States require 1 year of postdoctoral supervision before a clinical psychologist is eligible for testing and provisional licensure. Direct accession clinical psychologists must possess a current, active, valid, and unrestricted license upon commissioning (military) or when hired (civilian).

160. Tarasoff, 551 P.2d at 431.
working in the operational theater." At the same time, the consequences of notifying a soldier's chain of command of a potential problem could result in a devastating loss of security clearance, loss of employment (i.e. separation from service), and possible loss of health insurance coverage. There is also the inevitable loss of trust between the soldier and the psychotherapist after the psychotherapist has done the civilian equivalent of "telling your boss." One scholar noted:

The psychiatric patient confides more utterly than anyone else in the world: He exposes to the therapist not only what his words directly express; he lays bare his entire self, his dreams, his fantasies, his sins, and his shame. Most patients who undergo psychotherapy know that this is what will be expected of them, and that they cannot get help except on that condition.

The situation is even more complex for those psychotherapists that wear a uniform. The military is one of several environments where the practitioner's dual loyalties, both to his employer and his patient, may come into conflict. The health care provider also has a duty to support the mission. The issue of divided loyalties particularly comes into play in regards to deciding whether or not the soldier should return to duty. As one text for military physicians observed:

Return-to-duty decisions are fraught with the potential for unintended consequences. For example, a decision not to return a servicemember to duty can, in some cases, result in an administrative separation without disability compensation. And, for some patients, isolation from the soldier's usual environment can prove harmful emotionally. A decision to remove a soldier from harm's way for mental health reasons can potentially stigmatize the soldier.

162. Id.
166. Westfield et al., supra note 162, at 10.
167. Id.
The same text, designed to be a workshop summary for a military ethics seminar, declared any act by a practitioner that deceives either an employer or a patient unethical.\textsuperscript{168} Also, violations of patient privacy that are thought of as “unacceptable in civilian practice except under circumstances strictly defined by law”\textsuperscript{169} are considered to be acceptable if a commanding officer requests information related to a soldier’s military performance.\textsuperscript{170} Such situations may cause conflict between the provider's loyalty to his overall mission of “conserving the fighting strength”\textsuperscript{171} and the desire to respect patient autonomy and nurture the therapeutic relationship. The provider may be further conflicted if a request for information on a soldier’s mental health comes from the provider’s rater or senior rater. Ultimately, decision-making authority as to the fitness of a soldier to return to duty or deploy rests with the commander,\textsuperscript{172} but his decision is heavily influenced by the opinion of the health care provider.\textsuperscript{173}

D. Cost Benefit Analysis

As the above information indicates, there is no easy or simple answer in determining whether to disclose a soldier's confidential mental health information. The soldier, the commander, and the provider have independent reasons for disclosing or withholding information, all of which may affect mission and unit readiness. Any decision regarding disclosure of this information will have drawbacks as well as benefits.

If the rules were made to allow an absolute privilege for the commander to access a soldier’s mental health records, the benefits may come in terms of identifying “high-risk” individuals and possible security risks. However, this benefit would come at the cost of discouraging soldiers from seeking mental health treatment, encouraging them to conceal or downplay psychological wounds, and damaging the therapeutic relationship. Also, the focus on discovering whether a soldier has sought treatment, as opposed to whether or not the soldier actually had observable symptoms or issues, seems to be an effort to absolve unit leaders from responsibility should a soldier act out. As stated above, Army leaders declare that those who interact on a daily

\textsuperscript{168} Id. at 11.
\textsuperscript{169} 1 DAVID E. LOUNSBERRY, MILITARY MEDICAL ETHICS 298 (2003).
\textsuperscript{170} Id.
\textsuperscript{171} William Madden & Brian S. Carter, Physician-Soldier, A Moral Profession, in MILITARY MEDICAL ETHICS, 1-3 (Edmund G. Howe ed., 2003), available at: http://www.battlebook.org/military/bioethics/Medical%20Ethics%201/Ethics-ch-10.pdf. This is the motto of the Military Medical Corps.
\textsuperscript{172} WESTFIELD ET AL., supra note 162 at 9.
\textsuperscript{173} Id.
basis with the soldier are in the best position to determine whether or not the soldier is “at-risk.” Although the military’s overt message is that getting counseling is a good thing, that message is overridden by the unspoken message that links getting therapy to being a security risk. Logic would dictate that seeking therapy is a positive sign of self-awareness, rather than untruthfulness.

However, giving the soldier an unimpeachable right to privacy carries its own risks. As one officer put it, “I want to know if I’m going into battle with something defective.”174 As in battle, if a commander does not have the necessary information on a soldier’s mental status, he risks having to deploy without an essential member of his unit, the loss of the soldier, the loss of his fellow soldiers, and the loss of the battle. At the same time, we must ask ourselves whether or not there is any information related to a soldier’s fitness for duty or deployment that thoughtful and careful leadership and observation could not gather.

There is also the consideration that allowing soldiers total confidentiality puts national security at risk. If a soldier is not required to disclose past mental health issues, including psychiatric hospitalization, the potential exists for someone with impaired judgment to have access to sensitive data. Arguably, if a soldier has such a severe defect of judgment as to render the soldier a security risk (such as schizophrenia or pathological lying), the soldier should have been identified by the soldier’s leadership or physician and either administratively or medically separated from the military. Though the risk looms large in the minds of some commanders, the possibility of it actually happening is actually quite small.

Lastly, there is the danger that comes from having a mentally unbalanced person placed in a stressful situation while carrying firearms and live ammunition. Is this a gamble military leaders are willing to take with the lives of their fellow soldiers at risk? First, one has to consider whether a mental health professional is better equipped than the unit’s leadership to make such predictions. In Tarasoff v. The Regents of the University of California,175 the American Psychiatric Association categorically denied the ability to predict future harm.176 One study, the Kozol study, showed a sixty-six percent error rate in regards to abilities of clinicians to predict future dangerousness.177 Another study found an eighty-percent error rate, concluding that

174. This comment was spoken by an unidentified military officer during a roundtable discussion on the subject.
177. Harry L. Kozol et al., The Diagnosis and Treatment of Dangerousness, 18 CRIME & DELINQ. 371, 371 (1972).
"[current] clinical acumen is so limited that neither psychiatrists nor behavioral scientists can select persons who will become dangerous without designating many times more who will not be dangerous."\(^7\) Also, consider that in both the Carmack and Russell shootings at some point the chain of command was aware that the soldier had psychological issues. The question then becomes: Does the benefit gained by allowing wholesale access to mental health records outweigh the costs of deterring individuals from getting help?

V. RECENT DEPARTMENT OF DEFENSE INITIATIVES

As noted above, the Department of Defense ("DoD") recognizes both the psychological toll taken on the United States forces as well as the stigma that exists regarding mental health treatment in military culture.\(^7\) The recent change to the "Questionnaire for National Security Positions" regarding mental health services is one example of where the DoD has been proactive in addressing this stigma.\(^8\) A recent memorandum issued by Gail H. McGinn, Acting Undersecretary of Defense for Personnel and Readiness, acknowledges "the current low thresholds for notifying commanders of Service members' involvement in mental health care result in members not seeking treatment, yet continuing in their operational roles, while their problems grow worse."\(^8\) The memorandum goes on to state that a mental health provider must notify a commander when a servicemember presents "with a mental health condition" in cases of "harm to self;" "harm to others;" "harm to mission;" "special personnel;" and "inpatient care" while protecting patient confidentiality within those parameters.\(^8\) This memorandum comes very close to aligning the notification standards to that of civilian practice, other

than the provisions for harm to mission and special personnel (those involved in the Personnel Reliability Program, i.e. those who have access to nuclear weapons.) The memorandum also specifies that “harm to mission” requires “a serious risk of harm to a specific military operational mission” rather than a generalized possibility that the servicemember’s condition may impact mission accomplishment. 183 The new Rapid Action Revision of Army Regulation 40-66 borrows heavily from the memorandum. However, neither the memorandum nor the regulation affect the commander’s access to a soldier’s records should the commander seek them on his own prerogative. An Army Medical Command (“MEDCOM”) Policy memorandum echoes these provisions, emphasizing the need to authenticate the reason for the request and the requirement to only release the “minimum necessary information.” 184 Nonetheless, the memorandum goes on to note at least twenty-seven instances where a soldier’s protected health information may be released to the chain of command, including “other regulations carrying out any other activity necessary to the proper execution of the mission of the Army” 185 while still neglecting to define what those activities are. This remains a significant hole in the regulatory scheme, allowing providers and commanders to determine which activities are “necessary to the proper execution of the mission” with little oversight or consequences.

Other DoD initiatives include re-designating “mental health” departments as “behavioral health,” 186 and requiring commanders to ensure that soldiers identified as “high risk” are managed in a consistent manner and are not belittled or ostracized by their fellow soldiers. 187 A memorandum released in August of 2010 by MEDCOM requires medical treatment facilities to screen soldiers as they out-process an installation between permanent change of station moves. 188 Soldiers who have had previous contact with a behavioral health provider receive face-to-face counseling to ensure continuity of care. 189 Soldiers are checked periodically in a systematic fashion in order to ensure that both care and medications are continued during the stressful transitions that can sometimes come with changing duty stations.

183. Id.
184. Memorandum from U.S. Dep’t of Army to Unit Command Officials, Release of Protected Health Information (June 20, 2010).
185. Id.
187. Id.
188. Memorandum from the U.S. Dep’t of Army, Procedures for Transferring Care During Permanent Change of Station (PCS) for Soldiers Involved with Family Advocacy Program (FAP) and Behavioral Health (Aug. 30, 2010).
189. Id.
Further, this process provides a "built-in" checkpoint by requiring providers to screen both electronic and hard-copy medical records.

Perhaps most significantly, the Army is testing a new pilot program for its Army Substance Abuse Program ("ASAP"). It is well known that substance and alcohol abuse are highly correlated with depression and post-traumatic stress disorder. Previously, even voluntary enrollment in ASAP triggered command notification, kept a soldier from re-enlisting or getting promoted, and was noted in the soldier's permanent personnel records. The new test program allows soldiers to attend ASAP sessions voluntarily without automatic notification of his or her command and without interfering with promotion or reenlistment. Commanders are still required to be notified if the counselor feels that the soldier is at risk for harming himself or others.

The military is also making a strong effort at preventive care, also known as resiliency training. According to Brigadier General Rhonda Cornum, director of the Comprehensive Soldier Training Center, the goal of such training is to "re-frame" traumatic events so that soldiers can see them as opportunities for growth, developing soldiers who are psychologically fit as well as physically fit.

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192. See generally U.S. DEP’T OF ARMY, REG. 600-85, THE ARMY SUBSTANCE ABUSE PROGRAM (Dec. 2, 2009) [hereinafter AR 600-85], available at www.apd.army.mil/pdfs/p600_85.pdf. Commanders are required to enroll their soldiers in ASAP involuntarily (called a 'command referral') when they are involved in alcohol-related incidents. If a soldier "flunks" ASAP, he may be processed for automatic separation from the military under Chapter 9 of U.S. DEP’T OF ARMY, REG. 635-200, ACTIVE DUTY ENLISTED ADMINISTRATIVE SEPARATIONS (2010) [hereinafter AR 635-200] (Rapid Action Revision), available at http://www.apd.army.mil/pdfs/r635_200.pdf. Also, even if the soldier attends ASAP voluntarily, his command is notified and that attendance is noted in his records. Should he have to attend ASAP a second time, he may be processed for separation from the military. Id.
193. Weaver, supra note 191.
194. Id.
196. Sheehy, supra note 195.
197. Id.
Army eventually plans to train all 1.1 million members of the Army in order to prevent any stigma associated with the training.\textsuperscript{198}

VI. PROPOSED CHANGES

Ten years of warfare have taxed both soldiers and families. In recent years, the Army's leadership has sought to dispel the stigma that attaches to those who seek help for mental health issues. However, its work is not complete. Changes must be made to the current statutory and regulatory scheme to encourage soldiers to seek and receive mental health treatment without fear of adverse career consequences. First, the privilege and confidentiality between a psychotherapist and patient must be treated as absolute, except under judicial order or when a mental health professional determines there is a reasonable possibility of self-harm or threats to harm others. Second, the Department of Defense ("DoD") must sever the presumed nexus between mental health treatment and access to security clearances.

Currently the military reserves the absolute right to access records for "judicial or administrative proceedings,"\textsuperscript{199} to include nonjudicial punishment and "for activities deemed necessary by appropriate military command authorities to assure the proper execution of the military mission,"\textsuperscript{200} without a legally trained fact-finder to determine whether such releases are necessary and appropriate. The current regulation allows members of the chain of command to access medical records at will for trivial matters appropriate for nonjudicial punishment, to include tardiness and disrespect. This authority to access records is broader than that found in a civilian environment. Therefore, in a military setting, soldiers have reason to suspect that their confidentiality may be violated, thereby creating a disincentive to seek mental health treatment.

In other professional relationships, a strong presumption of privilege exists between a professional and a soldier, even when the information disclosed is in regards to a soldier's mental health. For


\textsuperscript{199} U.S. DEP'T OF ARMY, REG. 40-66, MEDICAL RECORD ADMINISTRATION AND HEALTHCARE DOCUMENTATION 7 (2010) (Rapid Action Revision), \textit{available at} http://armypubs.army.mil/epubs/pdf/R40_66.pdf. Note that this provision also exists in the HIPAA regulatory scheme. However, due to the unique authority a commander holds, such a provision allows someone like a commander or first sergeant not legally trained to access medical records at will. Some kind of exception for military members, a provision restricting access for nonjudicial punishment, or additional fact-finder would have to be added in the law.

\textsuperscript{200} \textit{Id.}
example, the Army recognizes the confidential nature of the relationship between a unit chaplain and a soldier.\textsuperscript{201}

The privilege of confidential communication with a Chaplain is a right of every individual and an essential component of the Chaplains [sic] ministry. Confidential communication is any communication given to a Chaplain in trust by an individual, to include enemy prisoners of war (EPWs), if such communication is made either as a formal act of religion or as a matter of conscience. It is a communication that is made in confidence to a Chaplain acting as a spiritual advisor or to a Chaplain Assistant aiding a spiritual advisor. Also, it is a communication not intended to be disclosed to third party persons in any context, legal, or otherwise.\textsuperscript{202}

Confidential communications between a soldier and a chaplain may be indistinguishable from those made to a mental health provider, especially when the chaplain is providing pastoral counseling. Many commanders who might hesitate to ask a chaplain to reveal information obtained during a pastoral counseling session may nonetheless suggest that psychotherapists reveal such information. Another example would be a confidential communication between a legal assistance attorney and her client: “In reliance on the attorney-client privilege, clients are entitled to expect that communications within the scope of the privilege will be protected against compelled disclosure. The attorney-client privilege is that of the client and not of the lawyer.”\textsuperscript{203} Encouraging soldiers to seek help for psychological issues means the military must protect therapist-patient confidentiality as rigorously as that between a chaplain and a soldier or an attorney and a client. As long as regulations continue to allow a commander to access mental health records, soldiers cannot be assured of absolute confidentiality. Consequently, soldiers will continue to avoid getting treatment.

Restricting the disclosure of such records can increase the potential risks to other soldiers and burden commanders responsible for unit readiness. Under the majority of existing state law and professional codes of ethics, psychotherapists are required to notify others if a soldier is at risk of harming himself or others.\textsuperscript{204} Those who surreptitiously seek treatment and are able to conceal their problems from


\textsuperscript{202} Id.


their fellow soldiers would be the rare exception. The possibility that the therapist might identify a previously unknown problem affecting the mission or performance is highly unlikely. As the Carmack and Russell cases above demonstrate, more often than not someone in the chain of command is aware when soldiers are struggling with mental health issues. The point of failure was the lack of communication between junior and senior leaders and between present and previous chains of command. The conclusion must be made that if and when therapists must contact commanders regarding the potential for soldiers to harm themselves or others the diagnosis should not come as a complete surprise to the leadership. Leaders interact with their soldiers on a daily basis, upwards of eight hours at a time, so they should already know when their soldiers are struggling. The notification requirement in cases of threats of violence to others or suicide would preempt any need the commander has to directly access medical records.

In regards to the second proposed change, the military should weigh the benefits of encouraging treatment against the potential cost of missing the few who have had treatment, who are so impaired that they pose a national security risk, and who have not been separated from the military. Linking the issuance of a security clearance to mental health issues perpetuates the stigma of getting mental health treatment. Questions on the security clearance form for new recruits for past mental health problems are prudent, given the economic resources that will be invested in training these new soldiers over succeeding years. Yet such questions during the renewal of a security clearance have much less value—those seeking renewal of a security clearance have either been in the Army a while (i.e. getting their periodic renewal every five or ten years, depending on the level of clearance they hold)\textsuperscript{205} or are seeking a higher level of clearance in order to advance their career. In either case the Army has already made a substantial investment in the training of that soldier. The requirement of disclosing past mental health treatment on the security clearance questionnaire means that the soldier must choose between disclosure of such treatment, possible revocation of the clearance, falsifying the answer, or avoiding treatment altogether. For many soldiers, even the remote possibility of losing their career due to loss of clearance outweighs any gains from treatment.

Furthermore, the questionnaire provides little consistency in determining what treatment should be disclosed. The phrasing of the question that allows soldiers to withhold information regarding coun-

saling for marital, grief, or combat-related trauma may discriminate against soldiers who have been the victims of sexual assault. As one therapist has said, "Trauma is trauma. Whether you have [post-traumatic stress disorder] from a car accident or a rape or combat you are still suffering, and you still need to get help." 206  

If a soldier is so impaired as to be a security risk, mechanisms already exist to address the problem. The commander always has the option of a command-referred mental health referral. If a soldier is "hearing voices" or psychotic or severely impaired, then the soldier should be hospitalized and either medically or administratively separated from the military. As the "defective" comment above demonstrates, far too often our culture equivocates "mental health" with "crazy" and "broken."  

As the impact of the war on the military's psychological health becomes more and more apparent, the Army has signaled a willingness to embrace confidentiality. Initiatives such as the pilot substance abuse program allowing self-referral without commander notification as well as the change of Army Regulation 40-66 emphasizing that therapists, under normal circumstances, should not feel compelled to contact the command, tacitly acknowledge the importance of respecting a soldier's wishes for privacy in a therapeutic setting. Nonetheless, the current initiatives are scattershot, piecemeal, and are often not communicated to the everyday soldier. A change in the current regulation and DoD directives that protected confidentiality except in instances of self-harm, harm of others, or judicial order that is aggressively communicated to all levels would send a bold message to soldiers needing therapy: "We are not trying to kick you out. We respect your need for privacy in dealing with certain issues. We want you to get better so you can go on to soldier another day."  

The keys to making the proposed changes work are communication, enforcing the screening processes already in place, and implementing better methods of screening for signs of psychological distress. As shown above, relying on self-reported data is ineffective. The pre-deployment/Soldier Readiness Process should include some method of being able to search the Armed Forces Health Longitudinal Technology Application automatically for potential issues (i.e. those medical or psychological problems that cannot be treated in an operational environment). A face-to-face follow-up interview done in a confidential manner with those identified by a mental health professional

206. Telephone Interview with Dr. Darrah Westrup, Ph.D., former director of the Women's Trauma Recovery Program in Menlo Park, Cal. (Oct. 15, 2009) (on file with author).
would ensure no one slips through the cracks simply because he or she failed to disclose a previous issue.

Communication between junior and senior leaders is essential to making these proposed changes work. The signs and symptoms of distress are apparent to colleagues ninety-nine times out of one hundred. Being able to communicate those concerns and not having them dismissed as “whining” is critical. A structured method of educating soldiers on how to identify signs of distress as well as an emphasis on communicating those concerns to the leadership (i.e. “Never leave a fallen comrade”) would let soldiers know that they are not alone, and they should not try to handle their peers’ problems on their own.

Because it has already made steps towards embracing confidentiality, the Army can implement these changes more readily. Recently the Army issued a directive requiring raters to counsel officers and noncommissioned officers on “how their actions in handling Soldiers with behavioral health issues impact command climate and overall unit performance.” The directive goes on to say, “The Army’s Goal is to increase leader awareness and support in removing the stigma associated with Soldiers seeking the psychological counseling/care they need . . . .” The directive also states all rated officers and noncommissioned officers will identify performance objectives in supporting behavioral health goals on both the officer and noncommissioned officer support forms. As a result, baseline questions like “how are you doing?” and “how is your family?” will become part of monthly counseling and should be used to assist leadership in identifying whether or not there are issues. Bottom line, leaders must be present, they must be proactive, and they must be involved. Because the cultural shift regarding mental health services has already begun, the cost to officially implement the above proposals would be minimal compared to the benefits gained.

Unfortunately, recent events are also pushing the Army in the opposite direction. The recent report of investigation on the Fort Hood shootings recommends the DoD “consid[er] new clearance procedures and sensitive new policies to share medical information with commanders and supervisors so that ‘information regarding individuals who may commit violent acts’ becomes ‘available to appropriate authorities.’” The report also recommends keeping indications of


208. Id.

209. Id.

drug or alcohol abuse in personnel and medical files throughout a soldier's career, rather than clearing indications once the soldier has completed the Army Substance Abuse Program. The panel stated that "ongoing past drug or alcohol abuse can lead to violent acts." This policy, if enacted, would mean that a soldier would always carry the stigma of being a potential murderer because he attended substance abuse counseling. The accused in the Fort Hood shootings, Major Hasan, never had any indication of psychological, drug, or alcohol counseling in his records. In fact, as a military psychiatrist, he would have been the one doing the screening. In fact, Major Hasan's colleagues, all behavioral health providers, missed the signs that he was capable of such a horrendous act and failed to notify anyone when they noticed his strange behavior.

VII. CONCLUSION

When it comes to mental health issues, there are no easy answers. Before any operation, leaders are required to weigh the severity of risks against the likelihood of those risks occurring. Leaders must then take measures to develop controls that lessen either the severity of the hazard or the probability of that risk occurring. However, even after implementing those controls some residual risk may exist, whether it is due to the inherent dangerousness of wartime operations or lack of materiel. Very rarely will an operation or a mission exist that is completely risk-free. Once the residual risk is determined, it is incumbent upon the commander to determine whether or not the risk is acceptable.

In providing communications between a psychotherapist and a patient, the same confidentiality and privilege as that between a chaplain and a soldier, commanders must take a calculated risk. A commander must weigh the benefits of encouraging treatment against the very remote possibility that a soldier who had a problem in the past, unknown and undetected by his leadership, harms himself, another,
or the mission. This possibility is made even more remote by those situations in which allowing a commander unencumbered access to the soldier’s records would change the outcome: those where the soldier had spoken with a therapist, the soldier had indicated an intent to do himself or others harm, and the therapist disregarded state regulations and a professional code of conduct by failing to notify authorities. Clearly, those cataclysmic situations that these rules are designed to prevent are so unlikely as to be nonexistent.

Studies have repeatedly shown that one out of every five soldiers returning from Iraq and Afghanistan display symptoms of post-traumatic stress disorder.217 Forty-three percent of 1,965 servicemembers identified as having potential mental health issues upon returning from Iraq and Afghanistan said career concerns are a significant barrier to getting treatment.218 Twenty-nine percent said they doubted their information would be kept confidential.219 Forty-three percent said they were concerned about losing their clearance.220 Forty-three percent of 1,965 is 844. Potentially 844 individuals who were in pain, who were suffering because of their wartime service, may not have sought treatment, just in this one study. Is the suffering of those 844 personnel worth capturing the hypothetical one or two who slip through the cracks?

Some soldiers are fortunate enough to have leaders who care and who are alert to behavioral changes. Private Jeremiah Carmack, the soldier profiled at the beginning of this Article, was not so fortunate. His leaders believed that lack of sufficient access to his medical or therapeutic records, compounded by turnover of leadership, impaired the new leadership’s ability to “know” Private Carmack was suffering. However, it is unlikely Private Carmack would have communicated his plans to his therapist, and his suicide attempt in December pointed to a cry for help for monitoring and assistance from his leadership, even after a new commander and first sergeant came on board. It is unreasonable to conclude that access to Private Carmack’s records was the single factor that might have prevented this horrible tragedy. Had the leadership refused to issue Private Carmack a weapon based on his status as a mental health patient, it is likely that

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219. Id.

220. Id.
he would have found another means to commit suicide and that other soldiers would conclude that seeing a therapist would automatically stigmatize them in the eyes of the Army. It is doubtful that Private Carmack intended to injure anyone other than himself. In their after-action review, the German police stated they believed Private Carmack was trying to commit “suicide by cop,” especially in light of his December suicide attempt.221 Rather than relying on access to mental health records, leaders should be encouraged to reach out to their soldiers who are suffering.

The relevant policy documents—Department of Defense Regulation 6025.18 and Army Regulations 40-66 and 380-67—should be amended to allow communications with therapists to remain confidential under all circumstances except for instances of harm to self or others and judicial order. This is in line with civilian practice. If the military is serious about removing the stigma of mental health treatment, communications with providers should receive the same protections as those with chaplains222 and should only be divulged in the cases of imminent harm. Furthermore, the military should be willing to accept the very small risk that someone may have a mental health problem that renders them untrustworthy in exchange for the benefit of encouraging hundreds, if not thousands, of personnel to seek treatment without worrying about risking their careers or their security clearance. Only then will we be able to truly say that getting mental health treatment is a mark of strength, rather than a sign of weakness.

222. U.S. DEP’T OF ARMY, REG. 165-1, ARMY CHAPLAIN CORPS ACTIVITIES 49-50 (2009), available at www.apd.army.mil/pdffiles/r165_1.pdf. A privileged communication is defined as any communication to a chaplain or chaplain assistant given as a formal act of religion or as a matter of conscience. It is communication that is made in confidence to a chaplain acting as a spiritual advisor or to a chaplain assistant aiding a spiritual advisor. Also, it is not intended to be disclosed to third persons other than those to whom disclosure furthers the purpose of the communication, or to those reasonably necessary for the transmission of the communication. Id.