

Command-Directed Mental Health Evaluations
and Mental Health Related Discharges from the United States Military:
An Argument for Command Authority

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Abstract

The United States military is under fire. The American public and Congress have criticized the state of behavioral health treatment both during and after military service. A commander-driven process, readiness assessment demands adherence to physical fitness standards, including mental stability. However, the process of assessing, treating and discharging service members with behavioral health issues is seen as fundamentally unfair to the members as well as inadequate to address mental health concerns. From a legal perspective, this process is consistently upheld as valid by the courts, along with the vast majority of other decisions made by military commanders. Behind the rhetoric that the military and veterans' services are not doing enough for military members with mental health issues are studies showing that the vast majority of mental health issues are not acquired as a result of military service, but were present and unreported or undiagnosed before military service. By examining the process, judicial history and unique mission of the military, one can understand why military commanders are given such autonomy. The military is by no means perfect, but commanders are the best assessment tool for their troops and should remain in that critical role.

Introduction

Since September 11th, 2001, the United States military has endured the burden of two major conflicts in the Middle East. These conflicts resulted in the deaths of thousands of United States' Soldiers, Sailors, Airmen and Marines.¹ Deployments were (and still are) lengthy and taxing to an already stressed military community. Service members are reporting that they are mentally exhausted, lacking in fundamental resources to complete their missions, and physically drained.²

The number of service members who seek, or are ordered to seek, mental health services has risen sharply over the past few years.³ Most analysts speculate that the relatively recent uptick in deployments to Iraq and Afghanistan has contributed significantly to the overall mental health concern in the modern military.⁴ The Department of Defense, through the National Defense Authorization Act (NDAA) of 2015, recently mandated that expenditures on mental health assistance shall be focused on reducing the stigma of seeking mental health services and on encouraging service members to seek mental health care should the need arise.⁵

Yet, while the military has embraced and cultivated better access to mental health care, it continues to receive criticism for the continued use of command-directed mental health evaluations and mental health discharges.⁶ Commanders may order subordinates to undergo a mental health evaluation pursuant to authority granted by Congress and codified in federal law,⁷ provided the commander has a good faith belief that the subordinate requires a mental health evaluation.⁸ The NDAA has since been implemented in Department of Defense Instructions (DoDIs)⁹, and again in Air Force Instructions (AFIs)¹⁰ (as well as other service regulations) over the years as a tool to be used when there is a concern that the member may be "suffering from a legitimate mental health problem that may affect the member's ability to carry out the mission."¹¹ The law contemplates that commanders are in the best position to observe and make an informed decision about their troops. Also, commanders have the requisite authority under the

¹ Defense Casualty Analysis System, U.S. Military Casualties – OCO Casualty Summary by Casualty Type (2016), https://www.dmdc.osd.mil/dcas/pages/report_sum_reason.xhtml, last accessed August 8, 2016.

² David Larter, *America's Military: The Crushing Deployment Tempo*, Military Times, December 12, 2014, <http://www.militarytimes.com/story/military/2014/12/14/americas-military-deployment-tempo-troops-families/20191377/>, last accessed August 12, 2014.

³ Larine Barr, *Air Force Mental Health Programs Encourage Seeking Help*, United States Department of the Air Force, May 28, 2016, <http://www.af.mil/News/ArticleDisplay/tabid/223/Article/485084/air-force-mental-health-programs-encourage-seeking-help.aspx>, last accessed June 26, 2016.

⁴ Larine Barr, *Air Force Mental Health Programs Encourage Seeking Help*, United States Department of the Air Force, May 28, 2016, <http://www.af.mil/News/ArticleDisplay/tabid/223/Article/485084/air-force-mental-health-programs-encourage-seeking-help.aspx>, last accessed June 26, 2016.

⁵ National Defense Authorization Act of 2015, 113 Pub. L. No. 291, § 701 (2015).

⁶ Charles C. Engel, M.D., M.P.H., *Compromised Confidentiality is Harmful: Military Owes Proof to the Contrary*, Psychiatric Times, December 29, 2014.

⁷ 10 U.S.C.S. § 1090a, Reference (d), current through P.L. 114-163 (2016).

⁸ Mental Health Evaluations of Members of Military Services, DoDI § 6490.04(3)(b) (2013).

⁹ Mental Health Evaluations of Members of Military Services, DoDI § 6490.04 (2013), Maintenance of Psychological Health in Military Operations, DoDI § 6490.05 (2011).

¹⁰ Mental Health, Confidentiality, and Military Law, Air Force Instruction (AFI) 44-109 (2010), including Medical Readiness Program Management, Air Force Guidance Memorandum (AFGM) 41-106 (2016) and Deployment Health, AFGM 48-122 (2014).

¹¹ *Commander Directed Mental Health Evaluations*, The Military Commander and the Law (2016), pg. 302-305.

law to order a subordinate to mental health services. Even recent legislation which requires civilian health insurance plans to cover and treat mental health issues has (to date) only been interpreted as guidance by the DoD.

However, public outcry that service members are not receiving adequate mental health care, or being punished for adverse mental health conditions, has raised questions about commanders' role in the process. The discharge process is also under scrutiny as more and more service members are diagnosed with mental health conditions and subsequently discharged from active duty. Yet, when Congress investigates alleged abuses of the system, it finds that the issue is not so easily explained. Studies have shown that discharges for mental health conditions are not necessarily related to combat stress, a factor that the public assumes must be present in all military veterans. The American media is quick to correlate any prior military service with violent acts. In truth, of the numerous mass shootings in the last few decades, only a hand full are committed by service members or veterans and, of those, even fewer that served in a combat zone.¹² Somewhere between rhetoric about the failures of the military and the Department of Veterans' Affairs (VA) to detect and treat mental health conditions, and the available medical data, is the truth about the status of mental health in the military.

This paper addresses the legislative, administrative and judicial bases for command-directed evaluations. It also discusses the mental health discharge process and public concern of the manner in which service members are cared-for after separation. The first section summarizes the history and intent of command-directed mental health evaluations and the issue of mental health concerns in the military. It addresses mandatory medical pre-screening before entry into active duty. It also examines the referral and discharge process for mental health issues before initial assentation and during active duty.

The second section discusses sources and application of command authority afforded commanders for mental health concerns as well as other inherent obligations of military command. This section reviews the *Feres* doctrine as well as other legal precedent in support of command authority. The third section discusses the current public perceptions of military mental health and addresses the sharp rise in the incidence of mental illness in the armed forces, as shown by statistics. It also includes a case-by-case analysis of recent ex-military mass shootings and connections (if any) to combat stress in the military.

The fourth section addresses parity, a recent requirement by Congress to treat mental health diagnosis as any other physical diagnosis and require that insurance companies cover treatment. Specifically, it discusses recent regulations passed by the federal government regarding Tricare (the military's health management and payment entity) coverage and payment. The fifth section addresses the evaluation and treatment process for mental health conditions in the military and under the Department of Veterans' Affairs (VA). It includes a discussion on mental health cost statistics and predictions for future care needs. It explains substance abuse discharges in the military and the Air Force's Alcohol and Drug Abuse Prevention and Treatment (ADAPT) program.

Finally, the sixth section addresses the applicability of the Health Insurance Protection and Portability Act (HIPAA) to military mental health records, and the mechanism for obtaining mental health records of service members. It compares civilian requirements for protection of confidential mental health information under HIPAA to military requirements and exceptions to privacy under the act.

¹² The Los Angeles Times Staff, *Deadliest Mass U.S. Shootings*, June 12, 2016, <http://timelines.latimes.com/deadliest-shooting-rampages/>, last accessed July 20, 2016.

Commanders are asked to make difficult decisions on a daily basis. The unique mission of the military is afforded deference under the law to manage its own affairs, and courts have been historically unwilling to interfere in the absence of a gross abuse of discretion. As long as due process is provided to service members, courts will continue to uphold a commander's authority to subject a subordinate to mental health evaluation and treatment as both necessary and lawful. Additionally, mental health discharges are unfairly portrayed by the media and Congress as both unnecessarily rampant and severe in their effects on exiting service members. However, statistics show that many mental health diagnoses made during periods of active duty service are actually completely related to combat stress or occupational stress, but are preexisting conditions not previously discovered or diagnosed.

1. History and Intent

Since its inception and codification in the early 1990s, command-directed mental health evaluations have provided a means for the military to refer at-risk personnel for a variety of mental health conditions while still preserving procedural rights. Unlike civilian organizations or other federal entities, the military shoulders a unique mission that demands physical, mental and emotional fitness at all times. Heavy deployment schedules, lengthy duty days, and demanding military occupations have contributed to a fighting force that is both mentally and physically stressed. Without a means to quickly and effectively address individuals who exhibit signs of mental instability, the military would endure devastating consequences, including mass suicides and mass shootings. In recognition of these increasing demands on service members, Congress has wisely continued to expand command-directed evaluation requirements to protect individual service members, while preserving a commander's authority to make the initial referral decision.

The 1991 NDAA¹³ was the first time Congress established a mental health evaluation process at commanders' discretion. There were two caveats: "(1) a prohibition on inappropriate referral for a mental health evaluation as reprisal for making or preparing to make a protected communication; and (2) procedural protections for a member referred for a mental health evaluation following a protected communication, including the right to challenge the referral."¹⁴ These provisions demonstrate that Congress contemplated circumstances in which a commander could overstep his or her authority. Much like military whistleblower protections enacted in the 1989 NDAA¹⁵, the NDAA of 1991 placed requirements on the military to provide a means to challenge a mental health referral.

The NDAA of 1993¹⁶ increased procedural requirements on military commanders. This became known as the Boxer Amendment, due to the involvement of Senator Barbara Boxer, a zealous advocate for military whistleblower protections.¹⁷ In addition to existing requirements, the Boxer Amendment required the commander to first consult with a mental health professional

¹³ The National Defense Authorization Act for Fiscal Year 1991, 101 Pub. L. 510, § 554 (1990).

¹⁴ Robin Brodrick, *The Evolution of Command-Directed Mental Health Evaluations in the Air Force*, *The Air Force Medical Law Quarterly*, Vol. 23, Spring 2015, pg. 1, citing the National Defense Authorization Act for Fiscal Year 1991, 101 Pub. L. No. 510, § 554 (1990).

¹⁵ The National Defense Authorization Act for Fiscal Year 1989, 100 Pub. L. No. 456, § 846 (1988).

¹⁶ The National Defense Authorization Act for Fiscal Year 1993, 102 Pub. L. No. 484, § 546 (1992).

¹⁷ Robin Brodrick, *The Evolution of Command-Directed Mental Health Evaluations in the Air Force*, *The Air Force Medical Law Quarterly*, Vol. 23, Spring 2015, pg. 2.

prior to referral, except in emergency circumstances.¹⁸ It also required that referrals be in writing (again, except in emergency situations). It required that the member be given the following: a brief explanation of the basis of the referral and why it was deemed necessary; the name(s) of the mental health professional the commander consulted with; the positions and contact information of military attorneys and Inspector General (IG) offices with whom the member could consult; and a list of specific rights.¹⁹ In addition to requiring the signature of the person being referred, specific, required legal notifications to the service member included information on how to obtain advice on legal redress (if requested), and an advisement to the service member of his or her right to an investigation by the office of the IG for improper referral, the right to be evaluated by a medical professional of the service member's choosing (if reasonably available), the right to communicate with the office of the IG, an attorney, a member of Congress or others involved in the referral process, and the right to meet with an attorney or other party 48 hours before the actual evaluation.²⁰

The Boxer Amendment remained intact for nearly 20 years. However, recent focus on military mental health awareness prompted Congress to reexamine the command-directed referral process in 2012. Deployment and operational tempos increased significantly during Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF), creating a recognition of the need for increased mental health services. The NDAA of 2012²¹ added a specific section for mental health evaluations²² of service members while deployed in support of a contingency operation. A contingency operation is designated by the Secretary of Defense as one in which members of the armed forces may become involved in military actions, operations or hostilities against an enemy of the United States or during a national emergency as declared by Congress or the President.²³ This reflects Congress' heightened concern to more readily "identify post-traumatic stress disorder, suicidal tendencies, and other behavioral health conditions identified among members ... in order to determine which such members are in need of additional care and treatment for such health conditions."²⁴ In addition, the 2012 NDAA replaced the Boxer Amendment with an even more stringent process.²⁵ This historical analysis of Congress' shaping of the command-directed mental health process illustrates that, while some notification requirements have changed, the role of the commander has remained consistent.

¹⁸ Robin Brodrick, *The Evolution of Command-Directed Mental Health Evaluations in the Air Force*, *The Air Force Medical Law Quarterly*, Vol. 23, Spring 2015, pg. 2, citing the National Defense Authorization Act for Fiscal Year 1993, 102 Pub. L. No. 484, § 546 (1990).

¹⁹ Robin Brodrick, *The Evolution of Command-Directed Mental Health Evaluations in the Air Force*, *The Air Force Medical Law Quarterly*, Vol. 23, Spring 2015, pg. 2, citing the National Defense Authorization Act for Fiscal Year 1993, 102 Pub. L. No. 484, § 546 (1990).

²⁰ Robin Brodrick, *The Evolution of Command-Directed Mental Health Evaluations in the Air Force*, *The Air Force Medical Law Quarterly*, Vol. 23, Spring 2015, pg. 2, citing the National Defense Authorization Act for Fiscal Year 1993, 102 Pub. L. No. 484, § 546 (1990).

²¹ The National Defense Authorization Act of 2012, 112 Pub. L. No. 81, 125 (2011).

²² The National Defense Authorization Act of 2012, 112 Pub. L. No. 81, § 702, 125 (2011).

²³ 10 U.S.C. 101(a)(13) (2016).

²⁴ The National Defense Authorization Act of 2012, 112 Pub. L. No. 81, § 702 (2011).

²⁵ The National Defense Authorization Act of 2012, 112 Pub. L. No. 81, § 711 (2011).

Initial Medical Pre-Screenings

It is common knowledge that before entry into the armed services of the United States, military recruits are subjected to strenuous medical testing, records review and physical examination. Recently updated in 2015, AFI 48-123, *Medical Examinations and Standards*, outlines medical requirements that must be met to be granted an enlistment or commission into the United States Air Force.²⁶ It is the policy of the Air Force to “ensure accession and retention of members who are medically acceptable for military duty.”²⁷ Medical criteria vary, but include testing for Human Immunodeficiency Virus (HIV) antibodies, color vision screening, and urine screenings for illegal drugs.²⁸ The actual physical examination for all military personnel is conducted according to applicable service instructions. All applicants are asked a series of questions to address the existence of a mental health disorder, for example, whether the applicant had been seen previously by a mental health counselor, evaluated or treated by a mental health professional or attempted suicide.²⁹ When providing health information, the applicant acknowledges that “the information ... is true and complete to the best of [the applicant's] knowledge and belief, and [that] no person has advised [the applicant] to conceal or falsify any information about [applicant's] physical and mental history.”³⁰ Data from a 2009 DoD report to Congress revealed that 1,018 potential recruits were denied entry for personality disorder, and another 9,698 for other mental health conditions.³¹ Ultimately 168,968 enlisted recruits were allowed to enter military service.³² Mental health information is unique, and has the potential to be undisclosed should the applicant omit information or mental health records. Many signs and symptoms of a behavior health issue require acknowledgement from the patient, and may not be reported by a casual observer, even a doctor. Additionally, the sensitive nature of medical records and restricted release regulations may mean that evaluating doctors do not have all the information necessary to adequately screen applicants. Often, reviewing doctors must rely on “yes or no” answers on medical application forms. They may not ask probative questions of the applicant who does not initially disclose a prior mental health diagnosis. The DoD has expressed concern that the process is far from perfect:

“[T]he screening process is certainly one that presents some difficulties. It does rely upon self-volunteered information. In many cases, people with personality disorders may never have been diagnosed. There have been additions of additional mental health questions to the screening questionnaire, but again, that hasn't identified a great number of people, and it is usually in the performance of

²⁶ *Medical Examinations and Standards*, AFI 48-123 (2015), citing *Medical Standards for Appointment, Enlistment and Induction*, DoDI 6130.03 (2011).

²⁷ *Medical Examinations and Standards*, AFI 48-123, ¶ 1.1 (2015).

²⁸ *Medical Examinations and Standards*, AFI 48-123, ¶ 1.2.4 (2015).

²⁹ Assentions Medical Prescreen Report, DD Form 2807-2, (2015), available at <http://www.109aw.ang.af.mil/shared/media/document/AFD-151108-006.pdf>, last accessed July 26, 2016.

³⁰ Assentions Medical Prescreen Report, DD Form 2807-2 (2015), available at <http://www.109aw.ang.af.mil/shared/media/document/AFD-151108-006.pdf>, last accessed July 26, 2016.

³¹ *Personality Disorder Discharges: Impact on Veterans' Benefits Before the Comm. on Veterans' Affairs, U.S House of Representatives*, 111th Cong. 2 (2010) (Statement of Learn J. Herbert, Acting Director, Officer and Enlisted Personnel Management, Office of the Deputy Under Secretary of Defense (Military Personnel Policy), U.S. Department of Defense).

³² Lawrence Kapp and Charles A. Henning, Cong. Research Serv., RL32965, *Recruiting and Retention: an Overview of FY 2008 and FY 2009 Results for Active and Reserve Component Enlisted Personnel* (2009).

duties that problems come to light and then can be more thoroughly evaluated by medical personnel after they {have} been accessioned.”³³

For many young men and women, the military is the first professional experience of their lives. Symptoms of a behavioral disorder may simply not manifest until an individual recruit becomes stressed during basic training or subsequent military assignments.

If the initial physical assessment reveals a physical or mental defect that bars entry onto active duty, the applicant may request and receive a waiver under certain circumstances.³⁴ In 2009, of the thousands of applicants initially denied entry into the armed forces, 182 waivers were granted.³⁵ Additionally, statements made by the applicant during the medical examination are considered binding and enforceable if found to be fraudulent under the Uniform Code of Military Justice (UCMJ).³⁶ Of course, there are cases in which a military member innocently omits information concerning diagnosis and treatment of a mental health condition that is discovered later during the course of the member’s military service. In those cases, a waiver is available on a case-by-case basis. If the airman entered active duty and concealed the existence of an otherwise disqualifying condition, but has served a good portion of their enlistment already, and the airman had an honest belief that that condition would not preclude him or her from serving, then a waiver could be granted.³⁷ The same waiver is available to officers who are appointed to military service, but mistakenly believe that a then-existing mental health condition would not bar them from service.³⁸ However, the ultimate authority for the discharge of officers is the individual service’s secretary, which is typically a lengthier process than for enlisted members.³⁹

The Discharge Process for Conditions that Interfere with Military Service

The mechanism for adjudicating potential discharge actions regarding unfitting or unsuiting medical conditions in the military is largely administrative in nature. “Any condition that appears to significantly interfere with performance of duties appropriate to a service member's office, grade, rank or rating will be considered.”⁴⁰ For the Air Force, AFI 44-170, *Preventive Health Assessments*,⁴¹ provides guidance on periodic physical examinations, which include regular mental health assessments to determine medical readiness. This instruction

³³ *Personality Disorder Discharges: Impact on Veterans’ Benefits Before the Comm. on Veterans’ Affairs, U.S House of Representatives*, 111th Cong. 2 (2010) (Statement of Dr. Jack Smith, Deputy Secretary Assistant of Defense for Clinical and Program Policy).

³⁴ Medical Examinations and Standards, AFI 48-123, ¶ 6.2.1 (2015).

³⁵ *Personality Disorder Discharges: Impact on Veteran’ Benefits Before the Comm. on Veterans’ Affairs, U.S House of Representatives*, 111th Cong. 2 (2010) (Statement of Learnis J. Herbert, Acting Director, Officer and Enlisted Personnel Management, Office of the Deputy Under Secretary of Defense (Military Personnel Policy), U.S. Department of Defense).

³⁶ Fraudulent Enlistment, Appointment or Separation, Uniform Code of Military Justice, Article 83 (2012).

³⁷ Administrative Separation of Airmen, AFI 36-3208, ¶ 5.20.1.1.2 (2016).

³⁸ Administrative Discharge Procedures for Commissioned Officers, AFI 36-3206 (2016).

³⁹ Administrative Discharge Procedures for Commissioned Officers, AFI 36-3206, ¶ 4.9 (2016).

⁴⁰ *Military Medical Policies*, Military Law Task Force of the National Lawyers’ Guild (2007), mltf@militarylawtaskforce.org, citing Disability Evaluation System, DoDI 1332.38, Enclosure 4.1.3 (2014).

⁴¹ Preventive Health Assessments, AFI 44-170 (2016).

explicitly “[e]stablishes a command expectation that unit [commanders] and individual Airmen will meet [medical] requirements.”⁴²

In the Air Force, involuntary discharge due to mental health concerns must meet the following general criteria: “[A] psychiatrist or a PhD-level clinical psychologist [must] confirm a diagnosis of a mental disorder...that is so severe the member’s ability to function effectively in the military environment is significantly impaired.”⁴³ A diagnosis must be articulated according to the most current Diagnostic and Statistics Manual (DSM) and provide a synopsis as to why the disorder is so severe that it prevents the airman from serving in the military.⁴⁴ All military services refer to DoD guidance for a list of mental health conditions warranting consideration, but are free to promulgate their own service regulations with additional mental health diagnoses.⁴⁵ The Air Force Instruction lists personality disorders, disruptive behavior disorders, adjustment disorders, impulse control disorders, and “other disorders.”⁴⁶ Discharge for officers is subject to the same requirements and conditions.⁴⁷

If a member of the Air Force has a qualifying mental health condition that significantly interferes with the member’s ability to function in the military, then the commander will initiate discharge. The military member's rank (whether enlisted or officer), and time in service will dictate the amount of due process procedural requirements.⁴⁸ The more senior in rank and time in service, the more procedural requirements are afforded the military member. This is also true for non-probationary officers,⁴⁹ who are afforded the opportunity to present their case to a board of inquiry. Most mental health discharges warrant an honorable separation, unless there is additional misconduct that merits consideration of other discharge characterizations such as under honorable conditions (general) and under other than honorable conditions (UOTHC).⁵⁰ The initiating commander must consider many factors such as the “member’s potential for future, useful service” and consider facts they find to be “material and relevant.”⁵¹ The instruction specifically declares that commanders’ “specialized training, duties, and experience enable them to weigh such matters in making recommendations and decisions.”⁵²

One potential flaw in this system is that mental health disorders are generally not compensable as a disability if the military member is separated.⁵³ Specifically, AFI 36-3208, ¶ 5.11, *Conditions that Interfere with Military Service*, states that “[a]irman must be counseled that

⁴² Preventive Health Assessments, AFI 44-170, ¶ 1.2.8.1 (2014).

⁴³ Administrative Separation of Airmen, AFI 36-3208, ¶ 5.11 (2015).

⁴⁴ Administrative Separation of Airmen, AFI 36-3208, ¶ 5.11.9 (2015).

⁴⁵ *Military Medical Policies*, Military Law Task Force of the National Lawyers’ Guild (2007), mltf@militarylawtaskforce.org, citing Army Regulation (AR) 635-200, Chapter 5, § 5-13 and 5-17; Naval Military Personnel Manual (MILPERSMAN) § 1910-120 and 1910-122; Marine Corps Separation and Retirement Manual (MARCORSEPMAN) § 6203; and AFI 36-3208, § 5.11.

⁴⁶ Administrative Separation of Airmen, AFI 36-3208, ¶ 5.11.9.1 – 5.11.9.5 (2015).

⁴⁷ Administrative Discharge Procedures for Commissioned Officers, AFI 36-3206, ¶ 2.3.7 (2013).

⁴⁸ Administrative Separation of Airmen, AFI 36-3208, Ch. 6, Procedures for Involuntary Discharge (2015).

⁴⁹ “A Regular officer with five or more years of active commissioned service, computed from the total active federal commissioned service date or a Reserve officer with five or more years of commissioned service computed from the total federal commissioned service date.” Administrative Discharge Procedures for Commissioned Officers, AFI 36-3206, pg. 49 (2013).

⁵⁰ Administrative Discharge Procedures for Commissioned Officers, AFI 36-3206 ¶ 6.9.2 (2013), Administrative Separation of Airmen, AFI 36-3208, ¶ 5.11.9.1 – 5.11.9.5 (2015).

⁵¹ Administrative Separation of Airmen, AFI 36-3208, ¶ 6.1, 6.1.2 (2015).

⁵² Administrative Separation of Airmen, AFI 36-3208, ¶ 6.1.2 (2015).

⁵³ Administrative Separation of Airmen, AFI 36-3208, ¶ 5.11 (2015).

discharge for any condition under this paragraph does not qualify as a disability under AFI 36-3212 [*Physical Evaluation for Retention, Retirement and Separation*].”⁵⁴ Additionally, many mental health disorders often present with related misconduct and/or substance abuse. In such cases, the basis for discharge might be considered joint: mental health disorder unsuited for continued service and minor disciplinary infractions, drug abuse, or failure in the Alcohol and Drug Abuse Prevention and Treatment program discussed later in this paper.⁵⁵ To further complicate matters, most mental health disorders are considered to be "unsuited," and thus are not compensable for disability.⁵⁶ “Unsuited disorders are conditions that interfere with military service and must not be confused with disorders that render a member medically unfit for duty. These conditions [unsuited disorders] are not entered into the disability evaluation system.”⁵⁷ Examples of conditions that are unsuitable for further military service in the Air Force are Dyslexia, Enuresis, sleep walking, mood disorders and Attention Deficit Hyperactivity Disorder (ADHD).⁵⁸ Discharges for disciplinary infractions, drug abuse and failure in the ADAPT program are also not compensable for disability purposes. Certain disorders, such as Post-Traumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI), can be excepted from the “unsuited” presumption, if the service member also served in an imminent pay danger area, or the condition is linked to their military service and are given special processing considerations.⁵⁹

Medical conditions that render a member “unfit” are treated separately by the Department of Defense and are compensable. AFI 48-123, *Medical Examinations and Standards*, defines a "medically unfit condition" as one incurred by “members, who because of physical disability, are unfit to perform their duties.”⁶⁰ This category is inclusive, and does not list specific disorders that a military member must fall under in order to qualify. A member separating due to a medical condition that renders the service member unfit for continued military service must go before a medical evaluation board (MEB).⁶¹ It is the duty of the MEB to evaluate a service member’s medical condition and determine whether or not the service member is fit for duty and, if not, recommend discharge and disability evaluation.⁶² Conditions exempted from disability evaluation are non-duty related medical conditions, or “[i]mpairments that were neither incurred nor aggravated while the member was performing duty.”⁶³

2. Sources of Authority

As the Commander in Chief, the President of the United States asserts ultimate command authority over all uniformed personnel serving on active duty orders under Title 10 of the United States Code. This authority is delegated to individual secretaries of the armed services, who, in

⁵⁴ Administrative Separation of Airmen, AFI 36-3208, ¶ 5.11 (2015).

⁵⁵ Administrative Separation of Airmen, AFI 36-3208, Joint Processing, Section 6H (2015).

⁵⁶ Disorders that are Unsuited, AFI 48-123, ¶ 1.2.8 (2015).

⁵⁷ Disorders that are Unsuited, AFI 48-123, ¶ 1.2.8 (2015).

⁵⁸ Administrative Separation of Airmen, AFI 36-3208, ¶ 5.11 (2015).

⁵⁹ Administrative Separation of Airmen, AFI 36-3208, ¶ 5.11 (2015), Imminent Danger Pay is designated by the Undersecretary of Defense for Personnel Readiness, DoDI 1340.09, Hostile Fire Pay and Imminent Danger Pay, ¶ 4(b) (2010).

⁶⁰ Medical Examinations and Standards, AFI 48-123, Preamble, pg. 1 (2013).

⁶¹ Operational Standards for the Disability Evaluation System (DES), DoDI 1332.18, Enclosure 3, ¶ 2(e) (2014).

⁶² Operational Standards for the Disability Evaluation System (DES), DoDI 1332.18, Enclosure 3, ¶ 2(e) (2014).

⁶³ Glossary, DoDI 1332.18, Definitions, Part II (2014).

turn, appoint commanders from among the ranks by general orders as necessary.⁶⁴ In general, commanders are expected to execute their designated mission and hold subordinates accountable for their occupational roles and responsibilities.⁶⁵ As mentioned above, one of the tasks a commander is responsible for is ensuring a fit fighting force and initiating command-directed mental health evaluations and resulting discharge actions when warranted.

A general misconception is that the military must accommodate physical, mental or emotional conditions for those who wish to continue to serve on active duty. There is no constitutional right to serve in the military, and lawsuits that challenge the means and findings of mental health evaluations are usually dismissed in deference to commander authority.⁶⁶

Charles C. Engal, a senior health scientist at RAND, stated that military mental health reflects the seemingly “jarring and institutionalized military failure to place adequate boundaries between the workplace and the therapist's office,”⁶⁷ arguing that commanders regularly invade subordinates’ privacy in mental health treatment. This is due to the erroneous perception that military commanders have very little functional oversight and frequently overstep their bounds of authority. As discussed earlier, the mental health evaluation process requires due process not only for an initial evaluation, but also for a resulting discharge action. Another well-established legal doctrine limits military members’ ability to recover damages from alleged wrongful discharge actions or invasions of mental health privacy.

The *Feres* Doctrine

Unlike other federal positions, military members are judicially barred from seeking civil remedies from the federal government for injuries arising out of their military service. This is known as the *Feres* doctrine after the seminal case *U.S. v. Feres*,⁶⁸ which bars military members from seeking civil relief from the government while on active duty in the United States military. The Federal Tort Claims Act⁶⁹ would be the mechanism for military members to recover damages for harms suffered while on active military status. However, the *Feres* doctrine has been successfully used by the Government to avoid liability for a wide variety of tort actions such as medical malpractice, labor and employment issues, and even failure to prevent sexual assault.⁷⁰ The rationale underpinning the *Feres* doctrine is that courts are ill equipped to substitute their own judgment for that of military decision makers.

In *Hwang v. United States*, 92 Fed. Cl. 259 (2010), the court considered pro se plaintiff Mr. Hwang’s claim that he was wrongfully discharged from the Army due to the diagnosis of a delusional disorder.⁷¹ “Mr. Hwang alleged that the Army wrongfully discharged him and

⁶⁴ Appointment to and Assumption of Command, AFI 51-604, Roles and Responsibilities, and Announcement of Command, Section 12, (2016).

⁶⁵ Appointment to and Assumption of Command, AFI 51-604, Characteristics of Command Leadership, Section 4 (2016).

⁶⁶ *Chappell v. Wallace*, 462 U.S. 296, 305 (1983), *United States v. Marcum*, 60 M.J. 198, 206 (C.A.A.F. 2004).

⁶⁷ Charles C. Engel, M.D., M.P.H., *Compromised Confidentiality is Harmful: Military Owes Proof to the Contrary*, *Psychiatric Times*, December 29, 2014, <http://www.rand.org/blog/2014/10/compromised-confidentiality-in-the-military-is-harmful.html>, last accessed July 6, 2016.

⁶⁸ *Feres v. United States*, 340 U.S. 135 (1950).

⁶⁹ 28 U.S.C. 117 § 2675 (1946).

⁷⁰ *Feres v. United States*, 340 U.S. 135 (1950), *Doe # 1 v. Rumsfeld*, 297 F. Supp. 2d 119, 126 (2003), *Cioc. v. Rumsfeld*, 720 F. 3rd 505, (2013).

⁷¹ *Hwang v. United States*, 92 Fed. Cl. 259, 264 (2010).

violated its own regulations as well as his First, Fifth, and Fourteenth Amendment rights under the United States Constitution by failing to refer him to the Medical Evaluation Board ("MEB") prior to his separation."⁷² Mr. Hwang petitioned the Army Board of Corrections of Military Records (ABCMR), which declined to expunge the diagnosis, but did offer Mr. Hwang an opportunity to be evaluated medically to determine whether or not his diagnosis was unfitting for continued military service.⁷³ As noted earlier in this section, most mental health diagnoses are considered non-compensable, and thus considered a "mental condition not amounting to disability."⁷⁴ Mr. Hwang requested back pay, a reinstatement into the Army, and that his diagnosis be expunged from his military records.⁷⁵

In the Court's analysis, it heavily referenced the process by which Mr. Hwang was informed of his mental health referral and the evidence surrounding his commander's decision. After Mr. Hwang was stationed in Korea, he told other Army personnel that he had been harassed for years by a group called "The Inflictors," and that they were causing his roommate to grind his teeth, keeping Mr. Hwang awake at night. Mr. Hwang also suggested that his commander might himself be an "Inflictor." He complained that a radio station in California was intercepting his telephone calls and disclosing his personal information.⁷⁶ Based on this information, his commander referred him to an inpatient mental health facility and his supervisor formally counseled him on his rights pursuant to Army guidance and the reason for his referral: "namely that he potentially posed a safety risk to himself and others."⁷⁷

Mr. Hwang was subsequently diagnosed by the treating psychiatrist with a delusional disorder that "would cause significant defects in judgment, responsibility or reliability" and "likely create additional management problems for the commander."⁷⁸ Mr. Hwang was returned to his unit and instructed to stay in close communication with his chain of command. However, Mr. Hwang showed reluctance to conform to his treating psychiatrist's recommendations and was counseled for his behavior. Based on Army guidance, the commander determined that "adequate counseling and rehabilitative measures [had been] taken before initiating separation proceedings and "determin[ed] that [Mr. Hwang had] no potential for further useful service and therefore, should be separated."⁷⁹ Mr. Hwang was properly notified of his rights, including his right to seek legal counsel and the reasons for the discharge recommendation.⁸⁰ Despite his objections, Mr. Hwang was discharged with an honorable service characterization.⁸¹

After initially filing suit in federal court, Mr. Hwang filed a motion for voluntary remand to the Army Board for the Correction of Military Records (ABCMR), which concluded that Mr. Hwang's discharge was properly initiated and effectuated, and even offered Mr. Hwang the remedy of undergoing an MEB for his diagnosis, an opportunity not afforded most mental health discharges.⁸² Mr. Hwang rejected this offer and filed a number of motions alleging various legal errors in ABCMR's review and findings in his case. The United States filed a motion to dismiss,

⁷² *Hwang v. United States*, 92 Fed. Cl. 259, 264 (2010).

⁷³ *Hwang v. United States*, 92 Fed. Cl. 259, 264 (2010).

⁷⁴ *Hwang v. United States*, 92 Fed. Cl. 259, 264 (2010), citing AR 635-200, ¶ 5-18(9)(b).

⁷⁵ *Hwang v. United States*, 92 Fed. Cl. 259, 264 (2010).

⁷⁶ *Hwang v. United States*, 92 Fed. Cl. 259, 264-265, 272 (2010).

⁷⁷ *Hwang v. United States*, 92 Fed. Cl. 259, 265 (2010).

⁷⁸ *Hwang v. United States*, 92 Fed. Cl. 259, 265 (2010).

⁷⁹ *Hwang v. United States*, 92 Fed. Cl. 259, 265 (2010), citing AR 635-200, ¶ 1-16(a).

⁸⁰ *Hwang v. United States*, 92 Fed. Cl. 259, 266 (2010).

⁸¹ *Hwang v. United States*, 92 Fed. Cl. 259, 266 (2010).

⁸² *Hwang v. United States*, 92 Fed. Cl. 259, 267 (2010).

stating that Mr. Hwang could not demand that the ABCMR decision be reversed absent a showing that the review was “arbitrary, capricious, contrary to law, or unsupported by substantial evidence.”⁸³ The appellate court found that the ABCMR correctly reviewed Mr. Hwang’s case, finding that:

“Mr. Hwang (1) was properly referred for a mental status evaluation by his commander; (2) was examined by a qualified psychiatrist; (3) given ‘ample opportunity’ to overcome his medical deficiency; and (4) was separated in accordance with “regulatory notification requirements . . . based on the diagnosis and recommendation of competent medical authority.”⁸⁴

Based on this finding (and many others), the Court declined to award any back pay, declined to reinstate Mr. Hwang to his former position in the Army and declined to find that Mr. Hwang’s commander acted contrary to Army and DoD regulations.⁸⁵ Even though the Court found error in the failure of Mr. Hwang’s commander to notify Mr. Hwang of his right to complain to the IG or to seek a second medical opinion, it found the error harmless given the sufficient evidence contained in the record.⁸⁶ Additionally, the policy was later amended in 2012 and no longer required formal, written notification in the case of emergency mental health evaluations.⁸⁷

Commander Authority Upheld

Broader grounds for upholding commander authority also exist. In *In re Grimley*, 137 U.S. 147 (1890), the United States Supreme Court held that once a citizen entered into military service, they became a soldier and thus a contract was formed between the United States and that individual.⁸⁸ The *Grimley* court also remarked upon the relationship between a commanding officer and subordinate military members:

“An army is not a deliberative body. It is the executive arm. Its law is that of obedience. No question can be left open as to the right to command in the officer, or the duty of obedience in the soldier. Vigor and efficiency on the part of the officer and confidence among the soldiers in one another are impaired if any question be left open as to their attitude to each other. So, unless there be in the nature of things some inherent vice in the existence of the relation, or natural wrong in the manner in which it was established, public policy requires that it should not be disturbed.”⁸⁹

More recently, in *Parker v. Levy*, 417 U.S. 733 (1974), the Supreme Court held that military commanders’ ability to govern their troops was justified given the unique circumstances and mission of military forces. In *Parker*, a military member made racially charged comments regarding the war in Vietnam and refused to obey orders to serve overseas.⁹⁰ The military member was subsequently convicted of violations of Article 133, *Conduct Unbecoming an Officer and a Gentleman*, and Article 134, *All Disorders and Neglects to the Prejudice of Good*

⁸³ *Hwang v. United States*, 92 Fed. Cl. 259, 267 (2010), citing *Roth v. United States*, 378 F.3d 1371, 1381 (2004).

⁸⁴ *Hwang v. United States*, 92 Fed. Cl. 259, 266-267 (2010).

⁸⁵ *Hwang v. United States*, 92 Fed. Cl. 259, 273-277 (2010).

⁸⁶ *Hwang v. United States*, 92 Fed. Cl. 259, 273-276 (2010).

⁸⁷ Robin Brodrick, *The Evolution of Command-Directed Mental Health Evaluations in the Air Force*, *The Air Force Medical Law Quarterly*, Vol. 23, Spring 2015, pg. 1, citing the NDAA of 2012, 112 Pub. L. No. 81, 125 (2011).

⁸⁸ *In re Grimley*, 137 U.S. 147, 152-153 (1890).

⁸⁹ *In re Grimley*, 137 U.S. 147, 153 (1890).

⁹⁰ *Parker v. Levy*, 417 U.S. 733, 736-737 (1974).

Order and Discipline in the Armed Forces, of the Uniform Code of Military Justice.⁹¹ The Court found that “[t]he fundamental necessity for obedience, and the consequent necessity for imposition of discipline, may render permissible within the military that which would be constitutionally impermissible outside it.”⁹²

The United States Supreme Court most recently addressed the question of whether or not service members could maintain a civil suit against their commanding officers for wrongs alleged to have occurred during military service in *Chappell v. Wallace*, 462 U.S. 296 (1983). In this case, a group of service members alleged that superior non-commissioned and commissioned officers in their chain of command repeatedly violated their constitutional right to an environment free of racial discrimination.⁹³ Citing *Feres*, the court found that even alleged violations of constitutional rights by military members are not justiciable under the Federal Tort Claims Act.⁹⁴

“The special nature of military life -- the need for unhesitating and decisive action by military officers and equally disciplined responses by enlisted personnel -- would be undermined by a judicially created remedy exposing officers to personal liability at the hands of those they are charged to command.”⁹⁵

This theme of granting deference to military commanders’ decision making does not completely deprive military members of the opportunity to seek redress in the civil courts. As Chief Justice Warren once stated: “our citizens in uniform may not be stripped of basic rights simply because they have doffed their civilian clothes.”⁹⁶ However, the presumption in favor of upholding commanders’ decisions is strong, and rarely successfully challenged outside the military system.

3. Increased Military Deployments and Perceived Effects on Mental Health

The practice of discharging military service members without disability compensation for disciplinary infractions, rather than a potential mental health disorder received scrutiny from Congress in December of 2015.⁹⁷ An article by National Public Radio alleged that since 2009, the United States Army had discharged over 22,000 soldiers for misconduct who were later diagnosed with post-traumatic stress disorder (PTSD) or traumatic brain injury (TBI).⁹⁸ In response, Acting Army Secretary Eric K. Fanning launched an investigation in December 2015, directing a “thorough, multidisciplinary review of the issues.”⁹⁹

⁹¹ *Parker v. Levy*, 417 U.S. 733, 737-738 (1974).

⁹² *Parker v. Levy*, 417 U.S. 733, 758 (1974).

⁹³ *Chappell v. Wallace*, 462 U.S. 296, 297 (1983).

⁹⁴ *Chappell v. Wallace*, 462 U.S. 296, 299 (1983).

⁹⁵ *Chappell v. Wallace*, 462 U.S. 296, 304 (1983).

⁹⁶ *Chappell v. Wallace*, 462 U.S. 296, 304 (1983), citing Chief Justice Earl Warren, *The Bill of Rights and the Military*, 37 N. Y. U. L. Rev. 181, 188 (1962).

⁹⁷ Michelle Tan, *Army Launches Review of Soldier Misconduct Discharges*, Army Times, December 3, 2015, <http://www.armytimes.com/story/military/pentagon/2015/12/03/army-launches-review-soldier-misconduct-discharges/76731238/>, last accessed July 11, 2016.

⁹⁸ Daniel Zwelderling, *Missed Treatment: Soldiers with Mental Health Issues Dismissed for ‘Misconduct,’* National Public Radio, October 28, 2015, <http://www.npr.org/2015/10/28/451146230/missed-treatment-soldiers-with-mental-health-issues-dismissed-for-misconduct>, last accessed July 11, 2016.

⁹⁹ Michelle Tan, *Army Launches Review of Soldier Misconduct Discharges*, Army Times, December 3, 2015, <http://www.armytimes.com/story/military/pentagon/2015/12/03/army-launches-review-soldier-misconduct-discharges/76731238/>, last accessed July 11, 2016.

The American public and Congress are not alone in their concerns with the current state of the military's mental health. The Department of Defense has also taken note of increased mental health visits by military personnel. "The rate of major depression is five times as high among soldiers as civilians, intermittent explosive disorder six times as high, and post-traumatic stress disorder (PTSD) nearly 15 times as high."¹⁰⁰ According to a publication by the Journal of the American Medical Association (JAMA) of Psychiatry in 2014,

"Almost 25% of nearly 5,500 active-duty, non-deployed Army soldiers surveyed tested positive for a mental disorder of some kind, and 11% within that subgroup also tested positive for more than one illness. Some of those conditions are related to the hard experience of a wartime Army, but ... nearly half of the soldiers who were diagnosed with a mental disorder had it when they enlisted."¹⁰¹

Certainly, the public and government's concern over the mental well-being of the military is not misplaced given the most recent conflicts in Iraq and Afghanistan, but this study's findings would seem to suggest that many diagnoses are unrelated to deployments to combat zones. Additionally, in 2015, Congress and the DoD (in response to the perception that not enough is being done to help service members diagnosed with mental health disorders) has ordered further investigations into mental health access across services in an attempt to remove the stigma of seeking mental health services.¹⁰² While the military and other concerned organizations continue to study why military members exhibit higher rates of mental health disorders, it remains unclear whether the Department of Defense should strengthen entry standards and screening processes or continue to bolster mental health awareness in order to identify and address potentially afflicted military members.

Of note, some military members who deploy are not active duty, but reserve and guard personnel. From September 11, 2011, until December 31, 2010, 2.1 million service members have been deployed in support of OEF, OIF and Operation New Dawn (OND).¹⁰³ Over half of those deployed were in the Army (including reservists, national guard and active duty).¹⁰⁴ However, the overwhelming majority of deployed service members were active duty, approximately 1.4 million.¹⁰⁵ It is significant to note that service members are subject to the same commander-directed evaluation process while on Title 10 status (federally activated) or

¹⁰⁰ Val Willingham, *Study: Rates of Many Mental Disorders Much Higher in Soldiers than in Civilians*, The Central News Network, March 4, 2014, <http://www.cnn.com/2014/03/03/health/jama-military-mental-health/>, last accessed July 12, 2016.

¹⁰¹ Val Willingham, *Study: Rates of Many Mental Disorders Much Higher in Soldiers than in Civilians*, The Central News Network, March 4, 2014, <http://www.cnn.com/2014/03/03/health/jama-military-mental-health/>, last accessed July 12, 2016, citing Ronad D. Kessler et al., *Thirty-Day Prevalence of DSM-IV Mental Disorders Among Nondeployed Soldiers in the US Army Results from the Army Study to Assess Risk and Resilience in Service members*, JAMA Psychiatry, May, 2014.

¹⁰² National Defense Authorization Act of 2015, 113 Pub. L. No. 291, § 732 (2015).

¹⁰³ Committee on the Assessment of the Needs of Military Personnel, Veterans, and Their Families; Board on the Health of Selected Populations; Institute of Medicine, National Academies Press, Summary, March 12, 2013, http://www.ncbi.nlm.nih.gov/books/NBK206853/#sec_0009, last accessed July 20, 2016.

¹⁰⁴ Committee on the Assessment of the Needs of Military Personnel, Veterans, and Their Families; Board on the Health of Selected Populations; Institute of Medicine, National Academies Press, Table 3.1, March 12, 2013, http://www.ncbi.nlm.nih.gov/books/NBK206853/#sec_0009, last accessed July 20, 2016.

¹⁰⁵ Committee on the Assessment of the Needs of Military Personnel, Veterans, and Their Families; Board on the Health of Selected Populations; Institute of Medicine, National Academies Press, Table 3.1, March 12, 2013, http://www.ncbi.nlm.nih.gov/books/NBK206853/#sec_0009, last accessed July 20, 2016.

Title 32 status (national guard).¹⁰⁶ However, given the limited amount of time reservist and national guard troops are subject to military orders (generally one weekend a month in addition to two weeks a year), there is no separate system for mental health treatment.¹⁰⁷ In cases involving a national guard or reservist military member, those personnel would be referred to mental health services (either by a command-directed evaluation or otherwise) by utilizing an authorized active duty military facility or contracted provider.¹⁰⁸

Recent rampage shootings by ex-military have called into question the efficacy of the military mental health complex. In fact, of the deadliest shootings in the United States since 1984, only a handful are attributed a person with any military affiliation.¹⁰⁹ Forty-seven mass shootings in the United States are responsible for the deaths of hundreds of people, yet only 8 (17%) involve a perpetrator with any military affiliation.¹¹⁰ The more common themes cited by mass shooters include anger, employment dissatisfaction, disillusionment, racism, and more recently, Islamic extremism.¹¹¹ There is only one case in this time period involving a United States service member who both deployed overseas and was involved in an actual traumatic, combat event.

In 2014, Specialist Ivan A. Lopez was assigned to a transportation unit at Fort Hood, Texas, when he killed three unarmed fellow soldiers and wounded 16 more. Army officials stated that Specialist Lopez showed “no warning signs that he could be violent,” but “had a long history of troubling behavior, financial difficulties and problems in his personal life that may have played a factor in his rampage.”¹¹² Though Specialist Lopez claimed to have been exposed to an improvised explosive device (IED) attack while deployed to Iraq in December of 2011, there are numerous accounts and records that place him well outside of the blast radius.¹¹³ Even if the Army gave some deference to his claim of exposure to combat stress, Specialist Lopez had numerous other difficulties that most likely caused his deadly rampage including a secret, online love life, language barriers, and the deaths of his mother and grandfather.¹¹⁴ Specialist Lopez was in the process of being evaluated for PTSD at the time, a common practice for personnel who have deployed. He was also being treated for anxiety, sleep disorder and depression most

¹⁰⁶ Mental Health, AFI 44-172, pg. 1-2 (2015), http://static.e-publishing.af.mil/production/1/af_sg/publication/afi44-172/afi44-172.pdf, last accessed July 20, 2016.

¹⁰⁷ Mental Health, AFI 44-172, pg. 2 (2015), http://static.e-publishing.af.mil/production/1/af_sg/publication/afi44-172/afi44-172.pdf, last accessed July 20, 2016.

¹⁰⁸ Tricare Operations and Patient Administrative Functions, AFI 41-210, pg. 21, Section 2B, (2012).

¹⁰⁹ The Los Angeles Times Staff, *Deadliest Mass U.S. Shootings*, June 12, 2016, <http://timelines.latimes.com/deadliest-shooting-rampages/>, last accessed July 20, 2016.

¹¹⁰ The Los Angeles Times Staff, *Deadliest Mass U.S. Shootings*, June 12, 2016, <http://timelines.latimes.com/deadliest-shooting-rampages/>, last accessed July 20th, 2016., these numbers do not include the most recent shootings in Dallas, Texas, on July 7, 2016 and Baton Rouge, Louisiana, on July 18, 2016.

¹¹¹ The Los Angeles Times Staff, *Deadliest Mass U.S. Shootings*, June 12, 2016, <http://timelines.latimes.com/deadliest-shooting-rampages/>, last viewed July 20, 2016.

¹¹² Dan Lamothe, *Army Details the Strange, Downward Spiral of Fort Hood Shooter Ivan Lopez*, The Washington Post, January 23rd, 2015, <https://www.washingtonpost.com/news/checkpoint/wp/2015/01/23/army-details-the-downward-spiral-of-the-fort-hood-shooter-ivan-lopez/>, last accessed July 22, 2016.

¹¹³ Dan Lamothe, *Army Details the Strange, Downward Spiral of Fort Hood Shooter Ivan Lopez*, The Washington Post, January 23rd, 2015, <https://www.washingtonpost.com/news/checkpoint/wp/2015/01/23/army-details-the-downward-spiral-of-the-fort-hood-shooter-ivan-lopez/>, last accessed July 22, 2016.

¹¹⁴ Dan Lamothe, *Army Details the Strange, Downward Spiral of Fort Hood Shooter Ivan Lopez*, The Washington Post, January 23rd, 2015, <https://www.washingtonpost.com/news/checkpoint/wp/2015/01/23/army-details-the-downward-spiral-of-the-fort-hood-shooter-ivan-lopez/>, last accessed July 22, 2016.

likely unrelated to his deployment.¹¹⁵ However, the Army acknowledges that any “underlying medical conditions ... are the direct precipitating factor” of the shooting. However, the Army cites the escalation of a recent argument Specialist Lopez had with his work center as the cause of the rampage.¹¹⁶

On July 7, 2016, Micah Johnson, a former Army reservist who deployed once in support of OEF, opened fire on police officers in Dallas, Texas, killing five. One of Mr. Johnson’s neighbors reported that: “[s]omething must have happened to that young man. He was in the military. Maybe he just snapped.” But Mr. Johnson, thus far, does not have a military record that confirms exposure to any kind of combat stress. In fact, Mr. Johnson was described as a mediocre soldier by his supervisor. Though it is too soon to conclude as much, it seems that Mr. Johnson’s “snap” was due to anger against white police officers and not mental health related combat stress. Mr. Johnson opened fire on police officers during a “Black Lives Matter” protest.¹¹⁷ Mr. Johnson had deployed to Afghanistan as a reservist from 2013 to 2014.¹¹⁸ However, he never left the confines of his base in Afghanistan and was not exposed to combat stress. In fact, Johnson was relieved of his weapon and put on restrictive duty after an investigation revealed that he had stolen a fellow female soldier’s underwear and was attempting to dispose of them to avoid culpability.¹¹⁹ This event led to his subsequent discharge from the military. However, despite his military service, there are no indications that his time overseas or in the military was the cause of his decision to kill policeman. Mr. Johnson had become fascinated by the “Black Lives Matter” movement and had posted several comments online that he was angry at the deaths of black men.¹²⁰ The media was quick to point out that he served in Afghanistan, but his military record was less than stellar and did not reveal some kind of traumatic event that could account for his decision to shoot police officers.

Gavin Long, a former Marine deployed to Iraq between 2005-2010, ambushed police in Baton Rouge, Louisiana, on July 17, 2016, killing three police officers.¹²¹ Thus far, sources have confirmed his service time, rank of Sergeant, and deployment for seven months to Iraq, but no

¹¹⁵ Ray Sanchez and Ben Brumfield, *Fort Hood Shooter Was Iraqi Vet Being Treated for Mental Health Issues*, Central News Network, April 4th, 2014, <http://www.cnn.com/2014/04/02/us/fort-hood-shooter-profile/>, last accessed on July 22, 2016.

¹¹⁶ Ray Sanchez and Ben Brumfield, *Fort Hood Shooter Was Iraqi Vet Being Treated for Mental Health Issues*, Central News Network, April 4th, 2014, <http://www.cnn.com/2014/04/02/us/fort-hood-shooter-profile/>, last accessed July 22, 2016.

¹¹⁷ Nicole Gaouette and Steve Visser, *Dallas Police Shooter a Reclusive Army Reservist*, The Central News Network, July 11th, 2016, <http://www.cnn.com/2016/07/08/us/micah-xavier-johnson-dallas-shooter/>, last accessed July 22, 2016.

¹¹⁸ Nicole Gaouette and Steve Visser, *Dallas Police Shooter a Reclusive Army Reservist*, The Central News Network, July 11, 2016, <http://www.cnn.com/2016/07/08/us/micah-xavier-johnson-dallas-shooter/>, last accessed July 22, 2016.

¹¹⁹ Joseph Stepansky, *Dallas Cop Shooter Micah Johnson Was Booted from Afghanistan Amid Sexual Harassment Accusations*, New York Daily News, July 10, 2016, <http://www.nydailynews.com/news/national/dallas-shooter-accused-sexual-harassment-army-tour-article-1.2705323>, last accessed July 22, 2016.

¹²⁰ Nicole Gaouette and Steve Visser, *Dallas Police Shooter a Reclusive Army Reservist*, The Central News Network, July 11, 2016, <http://www.cnn.com/2016/07/08/us/micah-xavier-johnson-dallas-shooter/>, last accessed July 22, 2016.

¹²¹ Steve Visser, *Baton Rouge Shooting: 3 Officers Dead; Shooter Was Missouri Man, Sources Say*, The Central News Network, July 18, 2016, <http://www.cnn.com/2016/07/17/us/baton-route-police-shooting/>, last accessed July 22, 2016.

further details about his time in service and possible combat have been revealed.¹²² What is known is that like Mr. Johnson, Mr. Long was a staunch supporter of the “Black Lives Matter” movement and praised Mr. Johnson’s actions stating that Mr. Johnson was “one of us!”¹²³ Again, the media was quick to search for a connection between the shooting and Mr. Long’s prior military service, but found instead that he was mainly motivated by perceived injustices by African-American males in the United States. And yet, the government is renewing efforts to call for better mental-health care of former and current service members in order to prevent such attacks from recurring.

Senator Ray Blunt (R-Missouri) expressed renewed concern for military mental health access following the Dallas, Texas, and Baton Rouge, Louisiana, shootings.¹²⁴

“We’ve seen the Congress in the last few years, trying to force the Veterans Administration to just be more responsive but also just to be one of the competitors for the kind of help that our veterans need...I think there are many better ways to provide the kind of help and benefits that veterans need than the VA is willing to provide or maybe even able to provide.”¹²⁵

Citing the newly passed Excellence in Mental Health Act,¹²⁶ Senator Blunt stressed the need for integration of mental health services, addiction services, and familial/social services for veterans.¹²⁷ The Expand Excellence in Mental Health Act would improve state participation in providing Medicaid services related to mental health, but has a low chance in passing the Senate.¹²⁸

Despite these concerns raised by Congress, the Army continues to have faith in this commander-initiated process stating that “[t]he decision to separate a soldier from the Army for any reason is not an easy one, which is why we require a thorough review of the facts in each and every case.” As outlined above, instead of questioning the process, Congress has focused on providing more robust mental health care for transitioning members to civilian life. It has also focused funding on educating military members about mental health care and reducing stigma associated with going to a mental health provider.

¹²² Steve Visser, *Baton Rouge Shooting: 3 Officers Dead; Shooter Was Missouri Man, Sources Say*, The Central News Network, July 18, 2016, <http://www.cnn.com/2016/07/17/us/baton-route-police-shooting/>, last accessed July 22, 2016.

¹²³ Steve Visser, *Baton Rouge Shooting: 3 Officers Dead; Shooter Was Missouri Man, Sources Say*, The Central News Network, July 18, 2016, <http://www.cnn.com/2016/07/17/us/baton-route-police-shooting/>, last accessed July 22, 2016.

¹²⁴ Alisa Nelson, *Blunt: Police Attacks Show Need for Greater Access to Mental Health Services for Military*, Missouri.net, July 20, 2016, <http://www.missourinet.com/2016/07/20/blunt-police-attacks-show-need-for-greater-access-to-mental-health-services-for-military/>, last accessed July 22, 2016.

¹²⁵ Alisa Nelson, *Blunt: Police Attacks Show Need for Greater Access to Mental Health Services for Military*, Missouri.net, July 20, 2016, <http://www.missourinet.com/2016/07/20/blunt-police-attacks-show-need-for-greater-access-to-mental-health-services-for-military/>, last accessed July 22, 2016.

¹²⁶ Excellence in Mental Health Act, 113 U.S.C 264 (2013).

¹²⁷ Alisa Nelson, *Blunt: Police Attacks Show Need for Greater Access to Mental Health Services for Military*, Missouri.net, July 20, 2016, <http://www.missourinet.com/2016/07/20/blunt-police-attacks-show-need-for-greater-access-to-mental-health-services-for-military/>, last accessed July 22, 2016.

¹²⁸ Expand Excellence in Mental Health Act of 2016, 114 H.R. 4567 (2016).

4. Mental Health Parity Requirements under Recent Legislation and Impacts on Tricare The Origins and Role of Tricare

Prior to the 1950s, all service members received medical care at medical treatment facilities (MTFs) co-located with their station.¹²⁹ Subsequently in 1956 and 1966, Congress passed the Dependents' Medical Care Act and Military Medical Benefits Amendment of 1966 respectively, which mandated (among other things) health care for military dependents and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).¹³⁰ CHAMPUS morphed into what is known today as Tricare in the 1980s and 1990s.¹³¹ Tricare receives its funding exclusively from the federal government through the passage of annual defense appropriation bills discussed in the first section of this paper. As with any funding bill passed by Congress, each NDAA carries with it restrictions and mandates dictating Tricare's coverage authorizations how such coverage should be determined.

Today, Tricare's funds are stressed by retiring service members, who require the lion's share of health care as compared to their active duty counterparts. In fact, the cost of providing healthcare to all beneficiaries has increased 130% from 2010 to 2012, with an overall price tag of 52 billion dollars in 2012 alone.¹³² Tricare offers a variety of health care plans, with three prominent plans as the most-elected options.¹³³ Tricare Prime is the default choice for active duty families, Tricare Standard services non-active duty beneficiaries (Guard and Reserve), and Tricare for Life supplements retired seniors also enrolled in Medicare parts A and B.¹³⁴ Though not an insurance company *per se*, Tricare operates like a health management organization (HMO), requiring enrollees to first use providers in its active duty or contracted civilian network unless referred by a primary physician or in emergency circumstances.¹³⁵

Mental Health and Substance Abuse Parity

As discussed in the fifth section of this paper, mental health care and substance abuse treatment are both provided by Tricare and encouraged by the DoD for active duty military members and their dependents. However, both programs currently have limitations under Tricare, though these limitations have eroded over the last few decades. Most recently, the NDAA of 2015 removed statutory limitations on inpatient treatment of substance use disorders (SUDs) and mental health treatment. While the DoD recognizes the Affordable Care Act of

¹²⁹ Michelle Dolfoni-Reed and Jennifer Jebo, *The Evolution of the Military Healthcare System: Changes in Public Law and DoD Regulations*, Center for Naval Analysis, pg. 4 (2000).

¹³⁰ Dependents' Medical Care Act, 84 P.L. 569 (1956), Military Medical Benefits Amendments of 1966, 89 P.L. 613 (1966).

¹³¹ Michelle Dolfoni-Reed and Jennifer Jebo, *The Evolution of the Military Healthcare System: Changes in Public Law and DoD Regulations*, Center for Naval Analysis, pg. 2 (2000).

¹³² Approaches to Reducing Federal Spending on Military Health Care, pg. 1, Congressional Budget Office Report, January 16, 2014, <https://www.cbo.gov/sites/default/files/113th-congress-2013-2014/reports/44993-MilitaryHealthcare.pdf>, last accessed July 29, 2016.

¹³³ http://tricare.mil/Plans/Enroll.aspx?utm_source=i-want-to&utm_medium=organic&utm_campaign=enroll, last accessed on July 29, 2016.

¹³⁴ http://tricare.mil/Plans/Enroll.aspx?utm_source=i-want-to&utm_medium=organic&utm_campaign=enroll, last accessed July 29, 2016.

¹³⁵ Tricare Website, Referrals and Authorizations, <http://tricare.mil/FindDoctor/Appointments/Referrals>, last accessed July 29, 2016.

2010¹³⁶ and the Mental Health and Addiction Equity Act¹³⁷, it does not agree that they apply to Tricare. Specifically, in a proposed amendment to Tricare policies and procedures, the DoD stated:

“The requirements of the Mental Health Parity Act (MHPA) of 1996 and the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008, as well as the plan benefit provisions contained in the Patient Protection and Affordable Care Act (PPACA) do not apply to the TRICARE program. The provisions of MHPAEA and PPACA serve as models for TRICARE in proposing changes to existing benefit coverage. These changes intend to reduce administrative barriers to treatment and increase access to medically or psychologically necessary mental health care consistent with TRICARE statutory authority.”¹³⁸

The DoD’s reluctance to conform completely to mental health and substance parity concepts most likely stems from the unique requirements of the military and reluctance of commanders to allow the legislature to erode their authority. Commanders must have a mechanism to evaluate and initiate discharge for military members who are unwilling or unable to control addiction behaviors. No doubt, the military would receive criticism if it allowed taxpayer money to fund lingering alcohol and drug addicts who show indifference or inability to respond to treatment. Any proposal that would require military units to retain service members that were no longer able to perform their duties in support of the mission while undergoing treatment would be counter-productive. Again, the DoD is not seeking to avoid treating service members with SUDs or behavioral health disorders, but it is unlikely to implement changes that might curtail commanders’ unique duty to assess their personnel for readiness and expediently remove those who cannot perform.

5. The Process of Evaluation and Treatment of Mental Health Conditions by the Military Health Care System and Veterans’ Administration (VA)

General Overview: From Military Discharge to Veteran Status

Upon discharge from the military, potential beneficiaries of VA’s medical care benefits must be eligible for medical services. To be eligible, one must first meet the requirements of the definition of a United States veteran. “The term ‘veteran’ means a person who served in the active military, naval, or air service, and who was discharged or released therefrom under conditions other than dishonorable.”¹³⁹ Honorable discharges are by far the most common, with only 9% of all personnel discharged in 2014 receiving an other-than-honorable, bad conduct or dishonorable discharge.¹⁴⁰ In order to receive most benefits, separating personnel must have an

¹³⁶ Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 (2010).

¹³⁷ Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act, 117 H. R. 1424 (2008).

¹³⁸ Department of Defense Code of Federal Regulations, 32 C.F.R. 199, TRICARE; Mental Health and Substance Use Disorder Treatment, § 1(a)(1), (Secretary of the Department of Defense., Proposed Official Draft 2016).

¹³⁹ 38 U.S.C. 101 § (2) (2012).

¹⁴⁰ Jim Salter, *Some Levels of Military Discharge Can Mean No Benefits for Former Service Members*, U.S. News, December 24, 2015, <http://www.usnews.com/news/us/articles/2015-12-24/some-military-discharges-mean-no-benefits-after-service-ends>, last accessed July 26, 2016.

honorable, general or (depending on the VA's evaluation), an other than honorable service characterization.¹⁴¹ Since most personnel receive an honorable discharge, most personnel separating from the United States military are able to apply for VA medical benefits. Additionally, there are minimum duty requirements (generally 24 months or more of total active duty service) in order to be eligible for VA services.¹⁴²

“[E]ligible veterans can get the health care they need from VA, whatever their mental health or physical health diagnosis and whatever their diagnosis when they leave the military, assuming that they are eligible, and that is based on two factors--the character of the discharge and the completion of service. If they enter VA care, they will be routinely screened on an early visit to primary care for PTSD, for depression, for problem drinking, for TBI, for military sexual trauma. And if any of those screens are positive, there will be a full evaluation and a full diagnostic process to guide health care decisions.”¹⁴³

The process for evaluating, treating and compensating separating military members has become more efficient in recent years. Once qualified as a veteran, the former military member must show that the disabling illness or injury was “service connected,” or incurred incident to military service or a preexisting condition aggravated by military service.¹⁴⁴ This evaluation is generally made while the service member is pending discharge in order to facilitate transition and provision of benefits and services from the military medical system to the VA.

The Integrated Disability Evaluation System (IDES) marries medical discharge with disability evaluation and provides service members with their disability rating prior to separation from service.¹⁴⁵ However, the two systems are considered separate and distinct: the discharge process for medical issues evaluates whether the service member can continue to serve and the disability compensation process evaluates the severity and practical impacts on life activities in order to assign a disability rating.¹⁴⁶ However, “if the VA provides a different diagnosis than the military, then the condition is considered to have been incurred on active duty. Service connection may then be established.”¹⁴⁷ It is possible for the VA to determine a service connection, but assign a 0% disability rating if there are no adverse impacts to life function.¹⁴⁸

For example, if an airman broke an arm while participating in physical training, but it

¹⁴¹ There are six discharge characterizations: Honorable, General (Under Honorable Conditions), Under Other than Honorable Conditions, Bad Conduct and Dishonorable. *Military Law, Discharges and their Effects on Veteran Benefits*, <http://military-law.lawyers.com/veterans-benefits/discharges-and-their-effect-on-veteran-benefits.html>, last accessed July 26, 2016.

¹⁴² Health Benefits, U.S. Department of Veterans Affairs, Veterans Eligibility, <http://www.va.gov/healthbenefits/apply/veterans.asp>, last accessed July 26, 2016.

¹⁴³ *Personality Disorder Discharges: Impact on Veteran' Benefits Before the Comm. on Veterans' Affairs, U.S House of Representatives*, 111th Cong. 2 (2010) (Statement of the Antonette M. Zeiss, Phd., Acting Deputy Chief Patient Care Services Officer for Mental Health, Office of Patient Care Services, Veterans Health Administration).

¹⁴⁴ Federal Benefits for Veterans, Dependents and Survivors, U.S. Department of Veterans Affairs, Office of Public Affairs, http://www.va.gov/opa/publications/benefits_book/benefits_chap02.asp, last accessed July 26, 2016.

¹⁴⁵ Pre-Discharge, U.S. Department of Veterans Affairs, Office of Public Affairs, <http://www.benefits.va.gov/predischarge/>, last accessed July 26, 2016.

¹⁴⁶ Federal Benefits for Veterans, Dependents and Survivors, U.S. Department of Veterans Affairs, Office of Public Affairs, http://www.va.gov/opa/publications/benefits_book/benefits_chap02.asp, last accessed July 26, 2016.

¹⁴⁷ *Personality Disorder Discharges: Impact on Veteran' Benefits Before the Comm. on Veterans' Affairs, U.S House of Representatives*, 111th Cong. 2 (2010) (Statement of the Hon. Steve Buyer).

¹⁴⁸ Federal Benefits for Veterans, Dependents and Survivors, U.S. Department of Veterans Affairs, Office of Public Affairs, http://www.va.gov/opa/publications/benefits_book/benefits_chap02.asp, last accessed July 26, 2016.

was successfully treated with no lingering impairments, then she would most likely receive a 0% disability rating. On the other hand, if an airman was diagnosed with irritable bowel syndrome (IBS) while on active duty, and it affects his quality of life daily, then the VA would award him a higher percentage due to evidence of service connection and degradation of quality of life. Qualifying veterans can seek medical care from the VA for other illnesses or injuries incurred after military service, or preexisting conditions that have no service connection. However, these conditions may require some amount of co-payment depending on the veteran's income and/or have a longer wait time as they have a lower priority.¹⁴⁹

As mentioned previously in this paper, if a military service member is found to have a mental health condition that is unsuited for continued military service, the member is subject to discharge if the mental health condition is found to interfere with continued military service. Again, in order to be compensable for disability from the VA, the applicant must show that the mental health condition was either caused or aggravated by their military service. In this respect, “[t]hese men and women continue to face an uphill battle when they seek benefits and services at the [VA] because they must somehow prove that the so-called preexisting condition was aggravated or worsened by their military service.”¹⁵⁰ Thus, “[b]ecause Personality Disorder (for example) is a preexisting condition, soldiers discharged with it cannot collect disability benefits. They cannot receive long-term medical care like other wounded soldiers.”¹⁵¹ In these cases, the “DoD's policy (of non-combat related mental health discharges) improperly shifts costs from the Federal Government to veterans and private insurance companies as well as to State and local governments.”¹⁵²

Costs of Mental Health Treatment of the Active Duty Population and Veterans

According to reports submitted to Congress by the DoD, from 2002 to 2007, approximately 22,600 Army soldiers were discharged due to personality disorder and not combat-related PTSD or traumatic brain injury (TBI).¹⁵³ It is estimated that by discharging these service members under this provision and not PTSD, TBI or another compensable medical basis, the DoD has saved over \$12.5 billion dollars in disability payments and medical care.¹⁵⁴ To explain why the military health complex might lean toward misdiagnosing separating service members, critics cite former Secretary Robert Gates' pressure to reduce federal spending on the

¹⁴⁹ Federal Benefits for Veterans, Dependents and Survivors, U.S. Department of Veterans Affairs, Office of Public Affairs, http://www.va.gov/opa/publications/benefits_book/benefits_chap02.asp, last accessed July 26, 2016.

¹⁵⁰ *Personality Disorder Discharges: Impact on Veteran' Benefits Before the Comm. on Veterans' Affairs, U.S House of Representatives*, 111th Cong. 2 (2010) (Statement of Chairman Bob Filner, Chairman).

¹⁵¹ *Personality Disorder Discharges: Impact on Veteran' Benefits Before the Comm. on Veterans' Affairs, U.S House of Representatives*, 111th Cong. 2 (2010) (Statement of Joshua Kohrs, Investigative Reporter, The Nation Magazine).

¹⁵² *Personality Disorder Discharges: Impact on Veteran' Benefits Before the Comm. on Veterans' Affairs, U.S House of Representatives*, 111th Cong. 2 (2010) (Statement of Paul Sullivan, Executive Director, Veterans for Common Sense (VCS)).

¹⁵³ *Personality Disorder Discharges: Impact on Veteran' Benefits Before the Comm. on Veterans' Affairs, U.S House of Representatives*, 111th Cong. 2 (2010) (Statement of Chairman Bob Filner, Chairman).

¹⁵⁴ *Personality Disorder Discharges: Impact on Veteran' Benefits Before the Comm. on Veterans' Affairs, U.S House of Representatives*, 111th Cong. 2 (2010) (Statement of Joshua Kohrs, Investigative Reporter, The Nation Magazine).

DoD's budget.¹⁵⁵ However, the 2011 Budget Control Act recently sought to do just that through drastic personnel cuts and sequestration.¹⁵⁶ Former Secretary Gates has since denounced sequestration as "a completely mindless and cowardly vehicle for budget cutting,"¹⁵⁷ but was still pressured in a post-war Congress to keep the DoD's spending in check.

"In 2011, mental disorders accounted for more hospitalizations of service members than any other illness and more outpatient care than all illnesses except musculoskeletal injuries and routine medical care."¹⁵⁸ From 2006 to 2009, hospitalizations for mental health related diagnoses rose more than 50%, due primarily to depression, substance abuse and PTSD.¹⁵⁹ From roughly 2007 to 2012 the cost of active duty mental health care went from \$468 million to \$998 million, more than double the cost.¹⁶⁰

Although the DoD is functionally a separate entity entirely from the VA, their budget appropriations from Congress encompass both agencies. This fiscal year, the DoD was allotted \$1.15 trillion dollars in spending by Congress after a budgetary stalemate immediately before Christmas of 2015.¹⁶¹ Of that, the VA saw a 10% increase in funds (\$71.4 billion dollars) with \$7.5 billion dollars going directly to mental health operations.¹⁶²

These statistics confirm observations made in the first section of this paper: the cost of mental health related care for United States veterans and active duty personnel is rising. Earlier studies conducted in 2004 indicate that the cost of health care in the VA was relatively low compared to civilian medical care.¹⁶³ However, cost comparisons today are difficult since the VA does not regularly release information on its costs.¹⁶⁴ "Of the estimated 22 million living

¹⁵⁵ *Personality Disorder Discharges: Impact on Veteran's Benefits Before the Comm. on Veterans' Affairs, U.S. House of Representatives*, 111th Cong. 2 (2010) (Statement of Paul Sullivan, Executive Director, Veterans for Common Sense (VCS)).

¹⁵⁶ Budget Control Act of 2011, 112 P.L. 25 (2011).

¹⁵⁷ Charles Hoskinson, *Gates: Obama Should Accept Flawed Defense Budget*, *The Washington Examiner*, October 21, 2015, <http://www.washingtonexaminer.com/gates-obama-should-accept-flawed-defense-budget/article/2574592>, last accessed July 27, 2016.

¹⁵⁸ Katherine Blakeley and John J. Janson, Cong. Research Serv., R43175, *Post-Traumatic Stress Disorder and Other Mental Health Problems in the Military: Oversight Issues for Congress* (2013), citing *Mental Disorders and Mental Health Problems, Active Component, U.S. Armed Forces, 2000-2011, Medical Surveillance Monthly Report*, vol. 19, no. 6 (June, 2012), pg. 11-17.

¹⁵⁹ Katherine Blakeley and John J. Janson, Cong. Research Serv., R43175, *Post-Traumatic Stress Disorder and Other Mental Health Problems in the Military: Oversight Issues for Congress*, Figure 5, pg. 6 (2013), citing *Hospitalizations for mental disorders, active components, U.S. Armed Forces, January 2000-December 2009, Medical Surveillance Monthly Report*, Vol. 17, No 11, November 2010, pg. 10.

¹⁶⁰ Katherine Blakeley and John J. Janson, Cong. Research Serv., R43175, *Post-Traumatic Stress Disorder and Other Mental Health Problems in the Military: Oversight Issues for Congress*, Figure 8, pg. 14 (2013).

¹⁶¹ Leo Shane III, *2016 Defense Budget Deal Finally Nailed Down by Congress*, *Military Times*, December 18, 2015, <http://www.militarytimes.com/story/military/capitol-hill/2015/12/18/omnibus-passage-partisan-success/77569538/>, last accessed July 27, 2016.

¹⁶² Leo Shane III, *Budget Deal Nails Down Fiscal 2016 Spending for DoD, VA*, December 16, 2015, <http://www.militarytimes.com/story/military/2015/12/16/budget-omnibus-fy16-defense-veterans-affairs-pentagon/77416466/>, last accessed July 27, 2016.

¹⁶³ *Comparing the Costs of the Veterans' Health Care System with Private-Sector Costs*, Congressional Budget Office, December 2014, https://www.cbo.gov/sites/default/files/113th-congress-2013-2014/reports/49763-VA_Healthcare_Costs.pdf, last accessed July 27, 2016.

¹⁶⁴ *Comparing the Costs of the Veterans' Health Care System with Private-Sector Costs*, Congressional Budget Office, December 2014, https://www.cbo.gov/sites/default/files/113th-congress-2013-2014/reports/49763-VA_Healthcare_Costs.pdf, last accessed July 27, 2016.

veterans in the United States, nearly 9 million were enrolled in [the Veterans' Health Administration] (VHA) in 2013. About 40 percent of those enrollees had either a service-connected disability or a severe impairment; those veterans accounted for about half VHA's \$54 billion in total spending that year."¹⁶⁵ The VA is also tasked with providing medical care to a unique subset of the population. As such, many of the services they offer, such as specialized PTSD treatment due to combat stress, do not have a direct equivalent in the civilian sector.¹⁶⁶

Substance Abuse Discharges Including the Alcohol and Drug Abuse Prevention and Treatment (ADAPT) Program

"We know of the negative impact that PTSD and TBI can have on the individual's mental health, physical health, work, and relationships. We also know that veterans attempt to self-medicate by using alcohol and drugs."¹⁶⁷ In fact, from between 2000 and 2010, over 141,000 active duty service members were diagnosed with an alcohol dependency issue.¹⁶⁸ Over that same period of time, drug abuse accounted for 4% of all mental health diagnosis.¹⁶⁹

The Air Force's ADAPT program, and other like programs across the DoD, is required to both deter substance abuse and help those who seek treatment.¹⁷⁰ Unlike civilian referral programs, ADAPT is not a "no penalty" program and requires that the airman solicit services before indicia of potential criminal activity.

"[Air Force] members with substance abuse and misuse problems are encouraged to seek assistance... Self-identification is reserved for members who are not currently under investigation or pending action... [commanders] will grant limited protection for members who reveal [drug use] information with the intention of entering drug treatment."¹⁷¹

Limited protection does not apply when drug or alcohol abuse is discovered by a criminal investigation, if a urine sample is ordered, or after initiation of the discharge process, for example.¹⁷² Air Force members whose substance abuse is discovered by an other than protected process can still be referred to ADAPT for treatment, but they are not afforded the deference of self-reporting prior to the initiation of an investigation for any pending judicial or administrative

¹⁶⁵ *Comparing the Costs of the Veterans' Health Care System with Private-Sector Costs*, pg. 2-3, Congressional Budget Office, December 2014, https://www.cbo.gov/sites/default/files/113th-congress-2013-2014/reports/49763-VA_Healthcare_Costs.pdf, last accessed July 27, 2016.

¹⁶⁶ *Comparing the Costs of the Veterans' Health Care System with Private-Sector Costs*, Congressional Budget Office, December 2014, https://www.cbo.gov/sites/default/files/113th-congress-2013-2014/reports/49763-VA_Healthcare_Costs.pdf, last accessed July 27, 2016.

¹⁶⁷ *Personality Disorder Discharges: Impact on Veteran' Benefits Before the Comm. on Veterans' Affairs, U.S House of Representatives*, 111th Cong. 2 (2010) (Statement of Chairman Bob Filner, Chairman).

¹⁶⁸ Katherine Blakeley and John J. Janson, Cong. Research Serv., R43175, *Post-Traumatic Stress Disorder and Other Mental Health Problems in the Military: Oversight Issues for Congress*, Figure 5, pg. 6 (2013), citing Alcohol-Related Diagnosis, active components, U.S. Armed Forces, January 2000-December 2011, *Medical Surveillance Monthly Report*, Vol. 17, No. 10, October 2011, p. 9-11.

¹⁶⁹ Katherine Blakeley and John J. Janson, Cong. Research Serv., R43175, *Post-Traumatic Stress Disorder and Other Mental Health Problems in the Military: Oversight Issues for Congress*, Figure 13, pg. 34 (2013), citing Tammy Servies, Zheng Hu and Angela Eick-Cost, *Substance Use Disorders in the U.S. Armed Forces, 2000-2011*, *Medical Surveillance Monthly Report*, Vol. 19, No. 11, November 2012, pg. 11.

¹⁷⁰ Alcohol and Drug Abuse Prevention and Treatment (ADAPT) Program, AFI 44-121 (2014).

¹⁷¹ Alcohol and Drug Abuse Prevention and Treatment (ADAPT) Program, AFI 44-121, ¶ 3.7.1 (2014).

¹⁷² Alcohol and Drug Abuse Prevention and Treatment (ADAPT) Program, AFI 44-121, ¶ 3.7.1.2.4 (2014).

actions.¹⁷³ It should also be noted that drug “abuse” is defined differently under applicable discharge regulations:

“Drug abuse for purposes of this regulation is the illegal, wrongful, or improper use, possession, sale, transfer, or introduction onto a military installation of any drug. This includes improper use of prescription medication. The term drug includes any controlled substance in schedules I, II, III, IV, and V of Title 21 U.S.C., Section 812. It also includes anabolic/androgenic steroids, and any intoxicating substance, other than alcohol, that is inhaled, injected, consumed, or introduced into the body in any manner for purposes of altering mood or function.”¹⁷⁴

One-time use of any intoxicating substance for an “other than lawful purpose” constitutes abuse and mandates discharge consideration by the commander.¹⁷⁵

Substance abuse could lead to administrative separation for a number of reasons. Certainly, if the member is convicted at a court-martial for illegal substance abuse, there is the potential of a bad conduct or dishonorable discharge. Drug abuse, in particular, if discovered through a non-protected individual disclosure for the purposes of treatment, carries with it the requirement that the commander consider initiating discharge or waiver in appropriate circumstances.¹⁷⁶ A third discharge consideration is whether or not the military member successfully completes their individual ADAPT treatment plan. Discharge is appropriate where an airman fails due to “[i]nability ...[r]efusal to participate [and/or] ...[u]nwillingness to cooperate.” Examples of such behavior are missing required counseling sessions or testing positive for drugs or alcohol during treatment.

If an airman has a co-occurring presentation of a mental health issue and substance abuse issue, and discharge is appropriate, both conditions will be cited as a basis for discharge. The airman is required to be notified of both and provided an opportunity to respond as explained in section one of this paper.¹⁷⁷

6. The Right to Privacy in Mental Health Records in the Military

Another criticism of the command directed evaluation and discharge involves commanders’ right to obtain mental health records in order to assess military readiness. The Health Insurance Portability and Accountability Act (HIPAA) requires protection of health care records from unlawful disclosure.¹⁷⁸ But this protection is not absolute, and commanders may utilize exceptions in order to evaluate military members for conditions that could affect the unit’s ability to execute military missions.¹⁷⁹ The commander needs not ask permission of a board, supervisory authority or the military member for access to protected mental health information. They must have a good faith belief that the member may be suffering from a mental health

¹⁷³ Alcohol and Drug Abuse Prevention and Treatment (ADAPT) Program, AFI 44-121, ¶ 3.7.2-3.7.3 (2014).

¹⁷⁴ Administrative Separation of Airmen, AFI 36-3208, ¶ 5.54.1, (2016).

¹⁷⁵ Administrative Separation of Airmen, AFI 36-3208, ¶ 5.54.4.1, (2016).

¹⁷⁶ Administrative Separation of Airmen, AFI 36-3208, ¶ 5.54 (2016), AFI 36-3206, Administrative Discharge Procedures for Commissioned Officers, ¶ 3.6.3 (2016).

¹⁷⁷ Administrative Separation of Airmen, AFI 36-3208 (2016), Administrative Discharge Procedures for Commissioned Officers AFI 36-3206 (2016).

¹⁷⁸ The Health Insurance Portability and Accountability Act, 104 Pub. L. No. 81 (1966).

¹⁷⁹ 45 C.F.R. § 164.512(e) and 45 C.F.R. § 164.512(k) (2016).

condition that is affecting the unit's ability to perform.¹⁸⁰

Military Exceptions to Confidentiality in Mental Health Records

Military medical facilities are considered to be “covered entities” under HIPAA privacy directives.¹⁸¹ As such, protected patient information, such as mental health information, is to be safeguarded from disclosure. But HIPAA also creates exceptions to the general rule that the military has used to successfully request mental health records without the consent or knowledge of military members. Department of Defense Regulation 6025.18R (2002), which applies HIPAA to military personnel, contains a provision that permits command disclosure “for activities deemed necessary by appropriate military command authorities to assure the proper execution of the military mission.”¹⁸² Enumerated reasons include: to determine fitness for duty, compliance with standards, fitness to perform a particular or specialized mission, to report casualties and, a “catch-all” provision “[t]o carry out any other activity necessary to the proper execution of the mission of the Armed Forces.”¹⁸³ The regulation states that:

“[i]n some cases, protected health information that is the subject to a request for access ... is also subject to the access rules of the Privacy Act. In such cases, access must be granted unless the protected health information may be withheld pursuant to both the provisions of this Regulation...and the Privacy Act Regulation.”¹⁸⁴

The governing regulation leans towards disclosure in the absence of a conflict between HIPAA and commander-requested disclosures.

Conclusion

Public attention on the DoD's policy towards mental health conditions has been unfairly demonized. Over time, a fair and equitable policy of treatment and discharge options for those serving in the United States military has evolved to ensure the mission success to the United States and procedural fairness to the service member. The military already requires that an identified mental health condition also be severe enough to endanger the mission or render the military member unable to perform their duties. It is not a “catch all” program to get rid of problem soldiers. The general public may not have faith in one person making inherently medical decisions without the benefit of a medical degree, but the military does. It places faith in its chosen leaders to make important decisions and requires adherence to strict standards in order to ensure the safety and security of the United States.

Though not perfect, commanders are rightfully empowered to manage the affairs of their subordinates without interference. This includes ordering subordinates who exhibit mental health symptoms to be evaluated by a qualified professional. The unique mission of the United States Military requires that commanders be able to quickly evaluate and discharge personnel that threaten mission effectiveness. To counter balance this authority, applicable laws and

¹⁸⁰ 45 C.F.R. § 164.512(e) and 45 C.F.R. § 164.512(k) (2016).

¹⁸¹ 45 C.F.R. § 160.103 (2016).

¹⁸² Major Jennifer A. Neuhauser, *Lives of Quiet Desperation: The Conflict Between Military Necessity and Confidentiality*, 44 Creighton L. R. 1003, Vol. 44 (2011), citing DoD 6025.18-R, ¶ C7.11.1.2 (2003).

¹⁸³ DoD 6025.18-R, ¶ C7.11.1.3.1-C7.11.1.3.5 (2003).

¹⁸⁴ DoD 6025.18-R, ¶ C7.11.1.4 (2003).

regulations have given military personnel procedural rights to ensure commanders do not have unfettered authority in such sensitive, personal issues.

This paper seeks to educate the general public about need to preserve commander directed evaluations and mental health discharges to execute the military mission. Despite criticism that a lack of civil remedy and overly broad HIPAA exceptions are inherently unfair to military members, commanders' inherent authority to govern the affairs of subordinates is judicially bulletproof. The assumptions of Congress and the American public that most (if not all) service members have mental health issues stemming from their service has not been borne out by the data. The vast majority of service members do not have a mental health diagnosis related to their service. Those that do had it before joining the military and are identified throughout the course of their assignment. The relatively small population of service members that are diagnosed with a mental health disorder receive treatment. But this small percentage is receiving disproportionate congressional attention.

Military commanders, therefore, are still the best source for ensuring an effective fighting force. It is a fundamental duty of military commanders to train and evaluate their troops. They take this responsibility seriously, and are not simply free to abuse their authority. Due process requirements mandated by Congress check their authority. Those veterans that are in true need of mental health services due to PTSD and TBI are receiving appropriate treatment from the VA with the help of numerous outreach organizations. Commanders are aware of the consequences of discharging one of their own, but also understand that the needs of the military warfighter to sustain an effective fighting force outweigh any perceived unfairness by the public. The United States military appoints trusted commanders to make these difficult decisions. The American public should do the same.