



George E. Lamson, *Law and Medicine*

Courtesy of George E. Lamson. This image is a reproduction of a graphite drawing by the artist, George E. Lamson, in collaboration with Joseph B. Topinka, a retired military attorney who spent many years providing legal support to personnel in the Military Health System. Lamson's artwork illustrates the synergy between both the military legal and medical communities in support of military personnel, family members, and retirees.

Chapter 2

LEGAL OVERVIEW OF CONFIDENTIALITY AND REPORTING OF MILITARY BEHAVIORAL HEALTH RECORDS

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INTRODUCTION

On Monday, June 3, 2013, President Barack Obama began a mental health conference at the White House designed to encourage greater openness in dealing with mental illnesses. President Obama noted that “[t]here should be no shame in discussing or seeking help for treatable illnesses that affect too many people that we love.”¹ He further stated that “[w]e see it in veterans who come home from the battlefield with the invisible wounds of war but who feel somehow, that seeking treatment is a sign of weakness when, in fact, it’s a sign of strength.”¹ Treating behavioral health illnesses for military personnel is only possible when soldiers, sailors, airmen, and marines seek help. They need assurance that privacy and confidentiality will be protected, and they need to know that their

providers understand the laws and rules that apply to their patients’ protected health information (PHI). This chapter will attempt to discuss some of the issues facing behavioral health providers. Specifically, it will discuss the armed forces exception to confidentiality of PHI as applied particularly to behavioral health records under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Department of Defense (DoD) policy. It will also address how Military Rule of Evidence (MRE) 513 is involved in this confidentiality. Some common scenarios confronted by behavioral health providers will be evaluated, and discussions will cover whether a behavioral health provider has a duty to report a service member’s past law of armed conflict violations.

OVERVIEW

HIPAA applies to the DoD. The definition of “health plan” in HIPAA (Public Law 104-191) specifically includes “the health care program for active military personnel under Title 10, United States Code.” While HIPAA applies in the US military, HIPAA itself provides an exception—the armed forces exception. The armed forces exception is found in Title 45, Code of Federal Regulations (CFR), Section (§) 164.512(k). DoD Regulation 6025.18-R, Health Information Privacy

Regulation, largely restates the HIPAA exceptions, and chapter 7 of that DoD regulation lists those exceptions to confidentiality that do not require a patient’s opportunity to agree or object. In addition, as a result of President Bill Clinton’s issuance of Executive Order 13140 in October 1999, the military rule of privilege for communications between psychotherapists and patients was created, which is implemented through MRE 513, Psychotherapist–patient Privilege.

APPLICATION OF THE ARMED FORCES EXCEPTION

For the military behavioral health provider, the application and operationalization of the HIPAA armed forces exception presents more difficult legal questions.

45 CFR § 164.512(k) and DoD 6025.18-R, Chapter C7.11, provides the following:

A covered entity (including a covered entity not part of or affiliated with the Department of Defense) may use and disclose the protected health information of individuals who are armed forces personnel for activities deemed necessary by appropriate military command authorities to assure the proper execution of the military mission.²

For this section to apply, the individual patient must be a member of the armed forces—either on active duty or in some other military duty status—to be eligible for medical treatment or disability evaluation through the DoD.³ This section specifically allows for disclosure to appropriate military command authorities, including all commanders, other persons designated by such commanders to receive information, and other designated officials, to ensure the military mission’s

proper execution.⁴ Such information may only be used or disclosed under certain circumstances including to determine the member’s fitness for duty and for performing any particular mission, assignment, order, or duty; to report casualties on any military operation or activity; and to carry out any other activity necessary for the proper execution of the mission of the armed forces.⁵

Note that the HIPAA regulation and DoD 6025.18-R both use the permissive term “may” rather than the mandatory term “shall” in discussing disclosures under the armed forces exception. In addition, any disclosures under the exception must comply with 45 CFR § 164.512(k) and DoD 6025.18-R, Chapter 8, minimum disclosure requirements, which require providers to “make reasonable efforts to limit the use, disclosure, or request of protected health information to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request.”⁶ The “minimum necessary” requirement allows a military provider to exercise professional judgment in evaluating the scope of release under the armed forces exception.

In an effort to dispel the myth that broad disclosure is the norm and to foster a culture of support for service members seeking behavioral health and substance abuse education services (as distinguished from treatment), DoD issued DoD Instruction (DoDI) 6490.08, *Command Notification Requirements to Dispel Stigma in Providing Mental Health Care to Service Members*, in August 2011. The instruction requires healthcare providers to follow a “presumption not to notify a Service member’s commander” when that service member obtains mental healthcare or substance abuse educational services. Unless the presumption is overcome by one of the enumerated notification standards, “there shall be no notification.” Furthermore, in making any permitted disclosure, providers “shall provide the minimum amount of information to the commander concerned as required to satisfy the purpose of the disclosure.”⁷ The nine enumerated notification standards include the following:

1. **Harm to Self.** The provider believes there is a serious risk of self-harm by the service member either as a result of the condition itself or medical treatment of the condition.
2. **Harm to Others.** The provider believes there is a serious risk of harm to others either as a result of the condition itself or medical treatment of the condition. This includes any disclosures concerning child abuse or domestic violence consistent with DoD Instruction 6400.06, *Domestic Abuse Involving DoD Military and Certain Affiliated Personnel*.
3. **Harm to Mission.** The provider believes there is a serious risk of harm to a specific military operational mission. Such serious risk may include disorders that significantly affect impulsivity, insight, reliability, and judgment.
4. **Special Personnel.** The service member is in the Personnel Reliability Program as described in DoD Instruction 5210.42, *Nuclear Weapons Personnel Reliability Program*, or is in a position that has been pre-identified by service regulation or the command as having mission responsibilities of such potential sensitivity or urgency that normal notification standards would significantly risk mission accomplishment.
5. **Inpatient Care.** The service member is admitted or discharged from any inpatient mental health or substance abuse treatment facility as these are considered critical points in treatment and support nationally recognized patient safety standards.
6. **Acute Medical Conditions Interfering With Duty.** The service member is experiencing an acute mental health condition or is engaged in an acute medical treatment regimen that impairs his or her ability to perform assigned duties.
7. **Substance Abuse Treatment Program.** The service member has entered into, or is being discharged from, a formal outpatient or inpatient treatment program consistent with DoD Instruction 1010.6, *Rehabilitation and Referral Services for Alcohol and Drug Abusers*, for the treatment of substance abuse or dependence.
8. **Command-Directed Mental Health Evaluation.** The mental health services are obtained as a result of a command-directed mental health evaluation consistent with DoD Directive 6490.1, *Mental Health Evaluations of Members of the Armed Forces*.
9. **Other Special Circumstances.** The notification is based on other special circumstances in which proper execution of the military mission outweighs the interests served by avoiding notification, as determined on a case-by-case basis by a healthcare provider (or other authorized official of the medical treatment facility involved) at the pay grade of O-6 or its equivalent level or above or a commanding officer at the pay grade of O-6 or above.⁷

Notably, the DoDI uses the term “shall,” in effect, requiring disclosure when one of the nine criteria is met. However, interestingly, the DoDI does not mandate the blanket disclosure of violations of the Uniform Code of Military Justice (UCMJ) or the law of international armed conflict unless the nature of the information otherwise falls under one of these nine categories.

The following two case examples illustrate some of the complexities in the application and operationalization of the HIPAA armed forces exception.

Case Example 2-1: Sergeant Smith has posttraumatic stress disorder (PTSD) symptoms. After hearing radio and television advertisements saying “It’s a sign of strength to seek help,” he self-reports to Army Behavioral Health and is diagnosed with PTSD. Smith is prescribed sertraline and receives weekly psychotherapy sessions. His unit is scheduled to deploy in 2 months. Under DoD policy, what information can Army Behavioral Health share with Smith’s commander?

In analyzing this case under the nine criteria previously listed, the provider arguably has a duty to notify the command under category three or six, harm to mission or acute medical condition that affects Smith's fitness for duty. To be certain, providers would need to consult any service-specific guidance. In Smith's example, the Army Regulation 40-501, Standards of Medical Fitness, provides further details on when psychiatric conditions affect deployability. Specifically, paragraph 5-14 provides that "Psychiatric disorders that meet medical retention standards must demonstrate a pattern of stability without significant symptoms for at least 3 months prior to deployment." Furthermore, medications prescribed within 3 months prior to deployment that have "yet to demonstrate efficacy or free of significant impairing side effects" are disqualifying for deployment.⁸

Since Smith's diagnosis and prescribed medications occurred within the 3-month window before deployment, it is clear that the provider should notify Smith's commander. The final question is what information should be conveyed. DoDI 6490.08, Enclosure 2, provides that:

in making a disclosure pursuant to the circumstances described . . . healthcare providers shall provide the minimum amount of information to satisfy the purpose of the disclosure. In general, this shall consist of: (1) The diagnosis; a description of the treatment prescribed or planned; impact on duty or mission; recommended duty restrictions; the prognosis; any applicable duty limitations; and implications for the

safety of self or others. (2) Ways the command can support or assist the service member's treatment.⁹

Therefore, the provider should follow the DoDI 6490.08 guidance and disclose Smith's PHI consistent with the minimum necessary requirement. Nothing in the case example or DoDI 6490.08 would warrant disclosing any PHI obtained during Smith's psychotherapy sessions.

Case Example 2-2: Private First Class Jones is command-referred pursuant to DoD Directive 6490.1, Mental Health Evaluations of Members of the Armed Forces, for behavioral health treatment after a fellow soldier finds him attempting to cut his wrist in the barracks bathroom. The medical provider admits him briefly to the inpatient service and then refers him for outpatient follow-up. During follow-up as an outpatient, Jones admits to recent synthetic drug use, but says he is not using now. What PHI should be shared with the command?

In Jones' example, he was both command-referred for treatment and admitted to an inpatient facility, which are specific circumstances warranting minimum necessary disclosures to the command pursuant to DoDI 6490.08. In an added twist, however, Jones later admits to recent but not ongoing synthetic drug use. Under this example, and in the absence of additional facts, Jones' admission of a past crime does not fall under any of the nine enumerated criteria in DoDI 6490.08; therefore, the provider has no duty to disclose his admission.

PSYCHOTHERAPIST-PATIENT PRIVILEGE UNDER UNIFORM CODE OF MILITARY JUSTICE, MILITARY RULE OF EVIDENCE 513

Case Example 2-3: Senior Gunnery Sergeant Jones seeks care from Military One Source. Military One Source refers him to a civilian provider because there are no available appointments at the clinic on base. Eventually, the civilian provider retires, and Jones' care and a summary of his records are transferred back to the base clinic. The military provider notes that Jones spoke to the civilian provider about possible war crimes. What should the military provider report?

In this final section, as the case example intimates, the authors will address the psychotherapist-patient privilege under MRE 513 and the perceived tension between the duty of confidentiality and the duty to report a service member's violations of the UCMJ, particularly in relation to the violations of the laws of international armed conflict.

In a December 6, 2009 article, "Military rules said to hinder therapy," *New York Times* reporters James

Dao and Dan Frosch interviewed Private First Class Jeffery Meier, who was struggling with PTSD and drug addiction after two deployments to Iraq.¹⁰ According to the article, when Meier arrived for his first behavioral health counseling session, he was asked to sign a waiver explaining that under certain circumstances, including if he admitted violating military laws, his conversations with his therapist might not be kept confidential. He refused to sign. Meier stated, "How can you go and talk about wartime problems when you feel that if you mention anything wrong, you're going to be prosecuted?"

The article later quotes Cynthia L Vaughan, a spokeswoman for the US Army Medical Command, who stated that the rules mandate reporting child or spousal abuse, but not possible war crimes. However, the article also quotes unnamed military officials who stated that Major Nidal Hasan, who was prosecuted at Fort Hood, Texas, would have been within his rights to report his

behavioral health patients to authorities for admitting to serious UCMJ and law of international armed conflict violations in previous deployments. Therefore, if it is true that behavioral health providers have no duty to report violations of the law of international armed conflict, it is equally true that there is lingering confusion on this issue, as evidenced by the article.

So where does the perceived duty to report war crimes originate? DoD Directive 2311.01E, DoD Law of War Program, provides specific guidance in paragraph 6.3:

Reports of Incidents. All military and US civilian employees, contractor personnel, and subcontractors assigned to or accompanying a DoD Component shall report reportable incidents through their chain of command.¹¹

Reportable incidents are defined as “a possible, suspected, or alleged violation of the law of war, for which there is credible information, or conduct during military operations other than war that would constitute a violation of the law of war if it occurred during an armed conflict.”¹¹ The DoD directive does not explicitly state that it is a punitive regulation enforced under Article 92 of the UCMJ. However, even if not enforceable as a violation of regulation, the DoD directive may otherwise create a duty to act, the failure of which may be punishable under a separate provision of Article 92, dereliction of duty.

Therefore, and despite no reference to the DoD HIPAA regulations and directives, the plain and admittedly broad language of the DoD directive includes military behavioral health providers when mandating that DoD personnel report evidence of war crimes, if that information rises to the level of “credible information.” But how does this take into account the psychotherapist–patient privilege?

MRE 513, which provides a psychotherapist–patient privilege, was created in 1999, following the US Supreme Court decision in *Jaffee v Redmond*, 518 US 1 (1996), which recognized a psychotherapist–patient privilege in federal court. MRE 513 provides in pertinent part:

(a) General rule of privilege. A patient has a privilege to refuse to disclose and to prevent any other person from disclosing a confidential communication made between the patient and a psychotherapist or an assistant to the psychotherapist, in a case arising under the UCMJ, if such communication was made for the purpose of facilitating diagnosis or treatment of the patient’s mental or emotional condition.¹²

A frequent complaint is that the exceptions to MRE 513 are broad. For example, MRE 513 does not apply

when “there is a duty to report under federal law, state law, or service regulations.”¹² While laws mandating disclosure to prevent child abuse and imminent harm to self or others are generally acknowledged and accepted, the broad inclusion of a duty to report under service regulations gives pause to behavioral health providers. Since DoD Directive 2311.01E creates a duty to report law of war violations, and MRE 513 does not apply when there is a duty to report under service regulations, behavioral health providers are naturally concerned with the perceived limits of confidentiality for those service members returning from deployment who admit to violating the laws of international armed conflict. As a result, it is the provider’s duty to advise the returning service members of the limits of confidentiality that may handicap the therapeutic relationship from the start, as noted in the *New York Times* article previously referenced. For example, under the current Army Medical Command policy, any service member being evaluated or treated for a suspected behavioral health diagnosis must be provided a Limits of Confidentiality Form (Department of Army Form 8001; Figure 2-1) unless the behavioral health provider determines that concerns related to the patient’s mental state may indicate he or she is unable to understand it or delay the evaluation or treatment, and this would not be in the patient’s best interest. The form provides various exceptions to confidentiality, including, for legal purposes, the following disclaimer:

Legal: If you are involved in legal actions/proceedings, your records may be subject to subpoena or lawful directive from a court. Under the UCMJ, we have a limited ‘privileged communication’ that may prevent your records from being disclosed in legal proceedings. This privilege is not absolute and there may be situations involving violations of the UCMJ or civil law where we may be required to divulge that information to the chain of command and/or other authorities. If you have any concerns related to this, please contact an attorney.¹³

One could argue that the broad duty in DoD Directive 2311.01E conflicts with the more recent and specific duty contained in DoDI 6490.08, which clearly and unambiguously limits a behavioral health provider’s responsibility to disclose criminal conduct involving child abuse and domestic violence. However, until there is clarifying legal guidance from DoD that the specific duties in DoDI 6490.08 trump the general duty in DoD Directive 2311.01E, particularly as it applies to behavioral health providers, there will likely be continuing confusion.

LIMITS OF CONFIDENTIALITY		
For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.		
<p>As part of your healthcare team, our goal is to provide you with quality care and to protect the privacy of your personal information. The care we provide you may include, but is not limited to: assessment, referral, individual therapy, couples therapy, family therapy, group therapy, substance abuse treatment, psychiatric evaluation and medications.</p> <p>As your providers, we will document information about your visits in your military health record (written and electronic) to ensure continuity of care. Your health record is maintained as the property of the U.S. Government. In the majority of cases, we will not disclose any of your personal information nor confirm/deny that we have met with you unless you provide us with written authorization to disclose your personal information. There are a few exceptions, under which we may be required to release your personal information without obtaining your prior authorization. However, we will discuss these with you at the beginning of treatment and throughout treatment, whenever possible. For example:</p>		
<ol style="list-style-type: none"> 1. Safety: If you threaten to harm yourself, we may seek hospitalization and/or contact others to ensure your safety. If you threaten serious bodily harm to another, we are required to take protective actions, such as contacting the potential victim, police, chain of command, or seeking hospitalization. 2. Abuse: If we believe that a child, spouse, or vulnerable adult is being abused, we will be required to file a report. 3. Legal: If you are involved in legal actions/proceedings, your records may be subject to subpoena or lawful directive from a court. Under the Uniform Code of Military Justice (UCMJ), we have a limited "privileged communication" that may prevent your records from being disclosed in legal proceedings. This privilege is not absolute and there may be situations involving violations of the UCMJ or civil law where we may be required to divulge that information to the chain of command and/or other authorities. If you have any concerns related to this, please contact an attorney. 4. Self Referrals: In accordance with DoDI 6490.08, healthcare providers will notify commanders if it is determined that your mental health condition represents a risk of harm to self, others or mission; impairs you in performing potentially sensitive or urgent requirements; is likely to impair your judgment or reliability to protect classified information; requires inpatient care; interferes with ability to perform duties; or requires substance abuse treatment. 5. Substance Abuse: If you are a Service member, records related to any treatment for substance abuse will be released to individuals within the Armed Forces who have an official need to know. If you are a Service member and information is released to someone outside of the Armed Forces or you are a civilian, all releases of information related to any treatment for substance abuse are subject to additional federal regulations under Code of Federal Regulation, Title 42, Part 2, Chapter 1. 6. Fitness for Duty/Command-Directed Referrals: If you are command-referred, your chain of command will not be authorized to view your medical record, but is entitled to limited information pertinent to any duty limitation or restriction, security clearance, or treatment that might affect duty performance or jeopardize the safety of yourself or co-workers. 7. Care Coordination: Because we operate as a team with other healthcare staff to provide you the best possible services, other members of the military medical system are permitted access to your record. In most cases, your information will not be disclosed outside the clinic/hospital setting without your written permission. If you are in treatment for substance abuse, access to your individual records can only be disclosed between the rehabilitation staff members and personnel involved in your rehabilitation, and to those required to determine compliance with AR 600-85, The Army Substance Abuse Program. 8. Quality Care Review: Quality assurance personnel may review your record to ensure that care standards are being met. If this occurs, the reviewer is required to keep your identity confidential. 		
If you have any questions or concerns, please feel free to discuss it with us.		
STATEMENT OF UNDERSTANDING/CONSENT TO ASSESSMENT and/or TREATMENT		
Patient's Statement:		
I have read the above and understand that clinical information about me will be safeguarded within the limitations mentioned above and under the provisions of the Privacy Act - DD Form 2005 and the Health Insurance Portability and Accountability Act (HIPAA) of 1996.		
PATIENT/CAREGIVER NAME	PATIENT/CAREGIVER SIGNATURE	DATE (YYYYMMDD)
Provider's Statement:		
I have explained the nature of the assessment and treatment(s) including benefits and risks of proposed and alternatives treatments.		
PROVIDER NAME	PROVIDER TITLE	
DEPARTMENT/SERVICE/CLINIC/MTF CODE	PROVIDER SIGNATURE	DATE (YYYYMMDD)
PATIENT'S IDENTIFICATION (For typed or written entries give: Name-last, first, middle; grade; SSN; date; hospital or medical facility)		

Figure 2-1. Limits of Confidentiality Form.

CONCLUSION

Although the US military is unique in having an exception under HIPAA, its culture and conduct do not always lend themselves clearly to other aspects of the law and other medical information-related matters, as the cases demonstrated. Clearly, DoD and the three branches of the armed forces have taken steps to clarify confusion regarding behavioral health matters. DoDI 6490.08 was a giant step in the

right direction. Efforts by the Army and the Army Medical Command to write forward-leaning policy that considers the needs of commanders, providers, and patients have set the standard for other services to follow. Ultimately, the key to success with HIPAA and medical information-related issues is good communication among commanders, medical providers, service members, and legal counsel.

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