

# Navigating HIPAA's Hidden Minefields: A Leader's Guide to Using HIPAA Correctly to Decrease Suicide and Homicide in the Military

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## I. Introduction

In the early hours of 6 November 2009, Private Jonathan Law murdered Corporal Jonathan Hartzell outside his barracks room in Camp Lejeune, North Carolina.<sup>1</sup> Corporal Hartzell was a stranger to Private Law. Corporal Hartzell was simply talking to his girlfriend on his cellular phone when Private Law came across the courtyard and beat Hartzell's head repeatedly with a ten-pound jack hammer spike. Private Law then dragged Corporal Hartzell's lifeless body across the road, through a parking lot, and into the woods, where he partially covered him with pine straw. The military police apprehended Private Law in the bathroom of his barracks room with self-inflicted injuries to his wrist, neck, and lower abdomen. Moments before this deadly incident, Private Law told his friend, Private RT, that he wanted to kill someone. Private RT dismissed his comment as just the typical unusual behavior of Private Law.<sup>2</sup> To him, this was just Law being Law.

Private Jonathan Law had a long history of self-mutilation, substance abuse, and mental illness dating back to his teen years. This erratic behavior continued during his time in the Marine Corps. In the months preceding the murder, Private Law drank profusely, used controlled substances, "and was seen more than ten times at the Naval Hospital Camp Lejeune Mental Health Clinic."<sup>3</sup>

In hindsight, greater communication between the command and mental health providers may have led to high-risk mitigation strategies targeted at stopping Private Law's downward spiral toward homicide. Prior to the murder, Private Law was on suicide watch and expressed a need for psychological help.<sup>4</sup> The command knew that Private Law was acting strangely, but were simply unaware of Private Law's rapidly deteriorating mental condition in the months

preceding the murder. His mental condition made him a homicidal or suicidal risk.

High risk indicators are critical information for a commander. Military commanders assume great responsibility for the servicemembers entrusted to them by the mothers and fathers of America. Commanders want to guard against preventable deaths, but are often unaware of the tools available to identify and manage individuals at high risk for homicidal/suicidal acts. Astute commanders may seek answers from the physicians treating their Soldiers. Consequently, judge advocates routinely face questions regarding the acquisition, use, and release of medical records in these cases.

The Health Insurance Portability and Accountability Act (HIPAA) governs the use and disclosure of protected health information.<sup>5</sup> The mere mention of HIPAA strikes fear in the minds of many health care professionals cautiously navigating inquiries that may result in HIPAA violations. As a result, many are reluctant to discuss patient issues with commanders. In the military context, however, HIPAA is not as restrictive. In fact, HIPAA can help foster greater coordination between commanders and mental health professionals when used correctly. The HIPAA and the Department of Defense (DoD) Health Information Privacy Regulation<sup>6</sup> recognize the unique nature of the military and grant commanders limited access to Soldiers' protected health information (PHI)<sup>7</sup> without their consent in certain

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<sup>1</sup> Carly Swain, *Marine Facing Murder Sentence*, WCTI12.COM (Jan. 19, 2011), <http://www.wcti12.com/Marine-Facing-Murder-Sentence/-/13530288/13642870/-/mia1f5/-/index.html>.

<sup>2</sup> *United States v. Law*, NMCCA 201100286, 2012 WL 4342068 (N-M. Ct. Crim. App. Sept. 21, 2012).

<sup>3</sup> *Id.* at 1.

<sup>4</sup> Hope Hodge, *Killer of Marine from Hamilton Admits Guilt*, DAYTON DAILY NEWS (Dec. 14, 2010), <http://www.daytondailynews.com/news/news/crime-law/killer-of-marine-from-hamilton-admits-guilt/nMmZ2/>.

<sup>5</sup> Health Insurance Portability and Accountability Act (HIPAA), Pub. L. No. 104-191, 110 Stat. 1936 (1996) [hereinafter HIPAA].

<sup>6</sup> U.S. DEP'T OF DEF. REG. 6025.18-R, DOD HEALTH INFORMATION PRIVACY REGULATION (23 Jan. 2003) [hereinafter DODR 6025.18-R]. This regulation prescribes the uses and rules for disclosure of protected health information. *Id.* at 2. The regulation is based on HIPAA requirements. *Id.*

<sup>7</sup> Protected Health Information (PHI) is "individually identifiable health information" held or transmitted by a covered entity or its business associate in any form. U.S. DEP'T OF HEALTH & HUM. SERVS., OFFICE OF CIVIL RTS., Summary of the HIPAA Privacy Rule 4 (2003), available at <http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/privacysummary.pdf> [hereinafter HHS HIPAA Summary].

"Individually identifiable health information" is information, including demographic data, that relates to: the individual's past, present or future physical or mental health or condition; the provision of health care to the individual; or the past, present, or future payment for the provision of health care to the individual, and that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual. Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, [s]ocial [s]ecurity [n]umber).

circumstances. The military exception may grant commanders limited access to high-risk Soldiers' PHI so that they can develop proactive risk mitigation strategies when there is a threat to the life or health of a servicemember. Interdisciplinary risk mitigation strategies can be used to avoid homicides and suicide attempts like those of Private Law. Commanders, however, must conscientiously balance the Soldier's right to the privacy of her PHI with mission requirements and the commander's right to know. "It would be counterproductive for Soldiers to perceive increased stigma, or not seek medical care, because of the inappropriate release of PHI."<sup>8</sup>

This article provides judge advocates, commanders, and medical providers with an overview of the relevant portions of HIPAA related to PHI. It outlines various methods available to access PHI that will help identify high-risk Soldiers before they engage in a harmful act. Parts II and III of this article provides judge advocates with an overview of the relevant portions of HIPAA; the scope of the suicide issue; the type of information that commanders are likely to request for high-risk Soldiers; guidance regarding HIPAA's application within the DoD and the Department of the Army; and current restrictions regarding PHI.

Part IV discusses methods for properly requesting PHI from military and civilian facilities, focusing on cases when a commander recognizes high-risk behavior that is likely to result in a suicidal or homicidal act. The sections that follow expand on this issue by addressing PHI request authority and limits related to disclosure of this information from the provider and commander's perspective. The article concludes with the proper format for drafting a PHI request and guidance on developing multi-discipline high-risk boards to analyze high-risk behavior and develop risk mitigation strategies, and provides examples of how multi-discipline high-risk boards can function successfully within the limits of HIPAA.

## II. Background: HIPAA and the Privacy Rule

### A. Legislative History

In 1996, America witnessed the landmark evolution of patient rights with the enactment of HIPAA and the corresponding Privacy Rule.<sup>9</sup> Before 1996, there was no

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*Id.* See *infra* Part II (discussing covered entities).

<sup>8</sup> Press Release, Jerry Harben, Release of Protected Health Information, [www.ARMY.MIL](http://www.army.mil/article/46691/) (Oct. 18, 2010), <http://www.army.mil/article/46691/> (quoting then Vice Chief of Staff of the Army, General Peter W. Chiarelli).

<sup>9</sup> The HIPAA created new rules that limited the disclosure of protected health information, but did not include an enforcement provision. HHS HIPAA Summary, *supra* note 7. As a result, the U.S. Department of Health and Human Services (HHS) issued the Privacy Rule to implement HIPAA's requirements. *Id.* The Standards for Privacy of Individually Identifiable

national healthcare privacy law and there were no limits on how healthcare providers, employers, and insurers shared healthcare information.<sup>10</sup> Although some state regulations existed, requirements varied, and there were far too many cases of providers failing to safeguard PHI, such as leaving medical records lying around on fax machines and publicizing employees' mental health issues to employers.<sup>11</sup>

Congress enacted HIPAA primarily to increase the portability and continuity of health insurance, to simplify administrative procedures, and to reduce health care costs.<sup>12</sup> The cornerstone of HIPAA's "administrative simplification" provision was the electronic record, "believed in the 1990s to be the future key to the efficient delivery of health care."<sup>13</sup> Consequently, HIPAA mandated national standards for electronic medical data management.<sup>14</sup> Americans perceived the shift from paper-based to systematized electronic records as a threat to the confidentiality of sensitive patient information.<sup>15</sup> As a result, HIPAA also authorized the Secretary of the U.S. Department of Health and Human Services (HHS) to promulgate standards governing disclosure of PHI in the event Congress "did not pass privacy legislation within three years of HIPAA's enactment."<sup>16</sup> Due to congressional inactivity, HHS

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Health Information (Privacy Rule) established a "set of national standards for the protection of certain health information." *Id.* The Privacy Rule addresses the use and disclosure of individuals' health information by organizations subject to the rule. Such organizations are called covered entities. *Id.* Within HHS, the Office for Civil Rights (OCR) implements and enforces the Privacy Rule through "voluntary compliance activities and civil money penalties." *Id.*

<sup>10</sup> Deven McGraw, *HIPAA and Health Privacy: Myths and Facts*, CTR. FOR DEMOCRACY & TECH. 2 (Jan. 2009), available at <https://www.cdt.org/healthprivacy/20090109mythsfacts2.pdf>.

<sup>11</sup> Major Kristy Radio, *Why You Can't Always Have It All: A Trial Counsel's Guide to HIPAA and Accessing Protected Health Information*, ARMY LAW., Dec. 2011, 1 at 4. Marianne Lavelle, *Health Plan Debate Turning to Privacy; Some Call for Safeguards on Medical Disclosure. Is a Federal Law Necessary?*, NAT'L L.J., May 30, 1994, at A1. A Midwestern banker and member of the local county health board cross-referenced a health board's lists of patients suffering from various diseases with a list of the bank's customers. The banker then accelerated the mortgages of anyone suffering from cancer, thus requiring the borrower to pay off the loan immediately; see also Christina A. Samuels, *Allen Makes Diagnosis of Depression Public; Medical Records Mailed Anonymously*, WASH. POST, Aug 26, 2000, at V1 (discussing privacy violations that followed the enactment of HIPAA). An anonymous person sent a Maryland School Board member's medical records to the school board, revealing that he had been treated for depression, along with a note that read, "Is this the kind of person we want on the School Board?" *Id.*

<sup>12</sup> HIPAA, *supra* note 5.

<sup>13</sup> Diane Kutzko, Gilda L. Boyer, Deborah J. Thoman & Nicholas L. Scott, *HIPAA in Real Time: Practical Implications of the Federal Privacy Rule*, 51 DRAKE L. REV. 403, 407 (2003).

<sup>14</sup> *Arons v. Jutkowitz*, 9 N.Y.3d 393, 412 (2007).

<sup>15</sup> *Id.*

<sup>16</sup> *Id.*

promulgated the Privacy Rule: the HIPAA enforcement regulation.<sup>17</sup>

## B. The Privacy Rule and Penalties for Not Complying

The Privacy Rule defines and limits the circumstances in which an individual's PHI may be used or disclosed by covered entities. A covered entity is any health care provider, health plan,<sup>18</sup> or clearinghouse that transmits health information in electronic form.<sup>19</sup> The general rule is that covered entities may not use or disclose PHI, except either: (1) as the Privacy Rule permits or requires; or (2) as the individual who is the subject of the information (or the individual's personal representative) authorizes in writing.<sup>20</sup> The Privacy Rule was designed to be flexible enough to permit the flow of health information needed to promote high quality health care and protect the public's health, but structured enough to guard against business practices that threaten patient privacy.<sup>21</sup> The Physician's Hippocratic Oath serves as an underlying tenet: "All that may come to my knowledge in the exercise of my profession . . . which ought not be spread abroad, I will keep secret and will never reveal."<sup>22</sup> In essence, the law recognizes the fiduciary relationship between medical providers and patients and seeks to facilitate greater trust through regulation.

The HIPAA provides civil and criminal penalties for entities that violate this fiduciary duty. The Director of HHS is charged with monitoring compliance. There is no private cause of action for a HIPAA violation because HIPAA confers "benefits" or "interest" upon individuals, not rights that grant parties standing to sue in court.<sup>23</sup> Notably, HHS

may impose civil money penalties on a covered entity of \$100 per failure to comply with a Privacy Rule requirement.<sup>24</sup> The penalty cannot exceed \$25,000 per year for multiple identical violations of the Privacy Rule.<sup>25</sup> A civil money penalty cannot be imposed under special circumstances, such as when the violation is due to reasonable cause, did not involve willful neglect, and the covered entity corrected the violation within thirty days of when it knew or should have known of the violation.<sup>26</sup>

Violations of the Privacy Rule can also result in criminal penalties. The Department of Justice prosecutes such violations, but cannot request both civil and criminal penalties for the same act.<sup>27</sup> A person who knowingly obtains or discloses individually identifiable information in violation of HIPAA faces a fine of \$50,000 and up to one year of imprisonment.<sup>28</sup> If the wrongful act involves false pretenses, the penalty increases to \$100,000 and up to five years of imprisonment.<sup>29</sup> The Privacy Rule's military exception provides commanders with valuable options that can prevent these violations when exercised properly. Leaders can use these exceptions to facilitate greater communication with medical providers when they observe individuals with high-risk traits that make them a suicide or homicide risk.

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Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress. . . .

<sup>17</sup> Jennifer Gunthrie, *Time Is Running Out—The Burdens and Challenges of HIPAA Compliance: A Look at Preemption Analysis, the "Minimum Necessary" Standard, and the Notice of Privacy Practices*, 12 ANNALS HEALTH L.J. 143, 145 n.8 (2003). The HHS issued the final regulation on 28 December 2003 after reviewing over 52,000 public comments. HHS HIPAA Summary, *supra* note 7, at 2.

<sup>18</sup> A group health plan "with less than 50 participants administered solely by the employer that establishes and maintains the plan is not considered a covered entity." HHS HIPAA SUMMARY *supra* note 7, at 2. Two types of government-funded programs are also not covered entities: (1) programs whose principal purpose is not providing or paying for health care, such as food stamp programs; and (2) those whose principal activity is directly providing health care, such as a community health center, or making of grants to fund the direct provision of health care. *Id.*

<sup>19</sup> *Id.*

<sup>20</sup> 45 C.F.R. § 164.502(a) (2013).

<sup>21</sup> HHS HIPAA Summary, *supra* note 7, at 1.

<sup>22</sup> See STEDMAN'S MED. DICT. 650 (5th ed. 1982) (defining the Hippocratic Oath).

<sup>23</sup> While there are statutes that do not specifically provide for a private cause of action, 42 U.S.C. § 1983 (2006) may provide a vehicle to bring a civil cause of action for violations of federal rights. 42 U.S.C. § 1983 allows plaintiffs to sue parties who deprive them of federally secured rights. *Id.* It provides:

*Id.* In *Gonzaga University v. Doe*, the Supreme Court significantly limited a civil right plaintiff's ability to bring a private action under § 1983, stating that a violation of a "federal right," not merely a violation of a "federal law," is required to establish an action under § 1983. *Gonzaga Univ. v. Doe*, 536 U.S. 282 (2002) (quoting *Blessing v. Freestone*, 520 U.S. 329, 340 (1997)). For a statute to confer a right upon an individual, it must be "phrased in terms of the person benefited," rather than the institution that it seeks to regulate. *Id.* at 284 (quoting *Cannon v. Univ. of Chi.*, 441 U.S. 677, 692 n.13 (1979)). Unambiguous congressional intent dictates whether a case is actionable under § 1983. *Id.* The Privacy Rule enforcement provisions "unquestionably fail to confer enforceable rights" because they focus on regulating covered entities rather than describing the rights available to health care consumers. *Id.* at 287. The language used in HIPAA implies that Congress never intended to confer rights upon health care consumers. *Id.* Thus, §1983 does not grant consumers a private cause of action for a HIPAA violation. *Id.*

<sup>24</sup> HIPAA, *supra* note 5, § 1176(a)(1).

<sup>25</sup> *Id.*; see also 42 U.S.C. § 1320d-5.

<sup>26</sup> HHS HIPAA Summary, *supra* note 7, at 17.

<sup>27</sup> *Id.*

<sup>28</sup> *Id.* at 18.

<sup>29</sup> *Id.*

### III. The Suicide Problem in the Military

Since the appearance of Durkheim's *Le Suicide*<sup>30</sup> in 1897, sociologists have developed studies to understand suicide patterns and rates across society.<sup>31</sup> Suicide is a devastating event that affects everyone. What was once considered a private affair or family matter now threatens military readiness.<sup>32</sup> Equally alarming is the increasing number of Soldiers who engage in high-risk behavior.<sup>33</sup>

Few could have foreseen the impact of eleven years of war on our Soldiers. The last decade revealed that equivocal deaths, deaths by drug toxicity, accidental deaths, attempted suicides, and drug overdoses reduced the ranks and negatively affected the Army's ability to engage in contingency operations in Iraq and Afghanistan.<sup>34</sup> The

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<sup>30</sup> French sociologist Émile Durkheim published *Le Suicide (Suicide)* in 1897. *Le Suicide* was a case study of suicide; a publication unique for its time, as it provided an example of the sociological monograph of the late eighteenth century. His controversial findings, geared toward classifying suicide based on social causation, were as follows:

Suicide rates are higher in men than women.

Suicide rates are higher for those who are single than those who are married.

Suicide rates are higher for people without children than people with children.

Suicide rates are higher among Protestants than Catholics and Jews.

Suicide rates are higher among Soldiers than civilians.

Suicide rates are higher in times of peace than in times of war (the suicide rate in France fell after the *coup d'état* of Louis Bonaparte, for example. War also reduced the suicide rate; after war broke out in 1866 between Austria and Italy, the suicide rate fell by 14% in both countries).

Suicide rates are higher in Scandinavian countries.

The higher the education level, the more likely it was that an individual would commit suicide; however, Durkheim established that there is more correlation between an individual's religion and suicide rate than an individual's education level; Jewish people were generally highly educated but had a low suicide rate.

EMILE DURKHEIM, *LE SUICIDE: A STUDY IN SOCIOLOGY* 186, 153–57, 233–64 (George Simpson ed. & John A. Spaulding trans., The Free Press 1979).

<sup>31</sup> Daniel S. Hamermesh & Neal M. Soss, *An Economic Theory of Suicide*, 82 J. POL. ECON. 83, 83 (1974) (discussing the economic implications of suicide and whether suicide involves individual decision making).

<sup>32</sup> VICE CHIEF OF STAFF, U.S. DEP'T OF ARMY, *ARMY HEALTH PROMOTION RISK REDUCTION SUICIDE PREVENTION REPORT 1* (2010) [hereinafter *ARMY SUICIDE PREVENTION REPORT*].

<sup>33</sup> *Id.* at 1.

<sup>34</sup> *Id.* at 1.

reality of multifaceted war is that leaders must focus on the next deployment to maintain the pace of intense and protracted engagements.<sup>35</sup> Consequently, enforcement of good order and discipline atrophies while high-risk behavior increases, eroding the health of the force.<sup>36</sup> Understanding and taking steps to identify high-risk behavior and risk mitigation strategies is one way to curb this alarming trend. Society benefits from risk management because as in Private Law's case, high-risk behavior can transcend harm to the servicemember.

#### A. The Suicide Rate in the Military During Peak Deployments: Rates and Statistics 2001–2008

Suicide rates are typically reported by listing the number of cases per 100,000 people. A 2011 study by RAND Corporation reviewed suicide statistics from 2001 to 2008. In 2008, the suicide rate across DoD was 15.8, up from 10.3 in 2001—an increase of about fifty percent.<sup>37</sup> Commanders may be interested in how these figures compare with the rest of America. From 2001–2006, the suicide rate in America was about 10 cases per 100,000.<sup>38</sup> The adjusted rate for Americans during the same period was twice as much.<sup>39</sup> Although the number of suicides in the general public was significantly greater than those in the DoD, the gap between the civilian and military suicide rate that began closing in 2007 is now closed, as the military suicide rate has increased.<sup>40</sup>

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<sup>35</sup> Press Release, Office of the Chief of Pub. Affairs, Army Health Promotion, Risk Reduction and Suicide Prevention Report, [WWW.ARMY.MIL](http://www.army.mil/article/42934) (July 28, 2010), <http://www.army.mil/article/42934> [hereinafter *Press Release, Army Suicide Prevention Report*].

<sup>36</sup> *Id.*

<sup>37</sup> Thus, 15.8 and 10.3 deaths per 100,000 people, respectively. RAJEEV RAMCHAND ET AL., *THE WAR WITHIN: PREVENTING SUICIDE IN THE U.S. MILITARY*, at xiv (RAND Corporation ed., 2011). In 2008, the U.S. Marine Corps (USMC) and the U.S. Army reported the highest rates of suicide, 19.5 and 18.5, respectively. *Id.* The Air Force and the Navy had the lowest rates at 12.1 and 11.6, respectively. *Id.* The study revealed that among the services, Army suicides showed a steady increase from 2001 to 2008. *Id.*

<sup>38</sup> *Id.* at xv. This figure, however, includes a demographic profile that is not consistent with the typical age and gender composition of the military. *Id.* Americans with a similar demographic composition (predominantly males aged eighteen to twenty-five) were twice as likely to commit suicide from 2001–2006. *Id.*

<sup>39</sup> *Id.* The adjusted rate refers to the use of a civilian demographic that matches the military demographic. *See id.*

<sup>40</sup> *Id.* Between 2006 and 2008, the gap narrowed significantly. The most notable increase in DoD suicide statistics occurred between the years 2007 and 2008. *Id.*

## B. Military Intervention: Recent Suicide Statistics

Committed to suicide prevention, the Secretary of Defense established the Defense Suicide Prevention Office (DSPO) in November 2011.<sup>41</sup> The DSPO now spearheads all DoD suicide prevention programs, policies, and surveillance activity.<sup>42</sup> Every servicemember death is reviewed by the Armed Forces Medical Examiner System (AFMES).<sup>43</sup> When the AFMES rules a death a suicide, a service professional reviews records, conducts interviews, and responds to DoD Suicide Event Report (DODSER) requests via a secure web-based DODSER application.<sup>44</sup> A 2012 study provided updated statistics for each service for calendar year 2011.<sup>45</sup> In 2011, AFMES found that 301 servicemembers died by suicide (Air Force = 50, Army = 167, Marine Corps = 32, Navy = 52).<sup>46</sup> What is even more striking is the number of suicide attempts. In 2011, 915 servicemembers attempted suicide (Air Force = 241, Army = 432, Marine Corps = 156, Navy = 86).<sup>47</sup> Many of those who attempted suicide did so for the first time, and 40% had a history of multiple deployments.<sup>48</sup> In 2012, the military suicide rate reached a record high of 349.<sup>49</sup> The 2012 rate exceeds the number of Americans who died fighting in Afghanistan in 2012—295.<sup>50</sup> The 2012 figure is the equivalent of 17.5 cases per 100,000.<sup>51</sup>

## C. Who Is at Risk?

The RAND Study found that those with the highest suicide risk fell into the following categories: prior suicide

<sup>41</sup> Laura Junor, Deputy Assistant Sec’y of Def. (Readiness), *Introduction to NAT’L CTR. FOR TELEHEALTH AND TECH., U.S. DEP’T OF DEF., DODSER DEP’T OF DEFENSE SUICIDE EVENT REPORT: CALENDAR YEAR 2011 ANNUAL REPORT* (2011) [hereinafter *DOD SUICIDE EVENT REPORT*].

<sup>42</sup> *Id.*

<sup>43</sup> *Id.* at 1.

<sup>44</sup> *Id.* The secure DODSER application is available at <https://dodser.t2.health.mil>. *Id.* (login required).

<sup>45</sup> *Id.*

<sup>46</sup> *Id.* This number includes deaths with a strong probability of suicide that are still awaiting final determination. *Id.*

<sup>47</sup> *Id.*

<sup>48</sup> *Id.* at 1–4.

<sup>49</sup> Bill Chappell, *U.S. Military's Suicide Rate Surpassed Combat Deaths in 2012*, *THE TWO-WAY: BREAKING NEWS FROM NPR* (Jan. 14, 2013), <http://www.npr.org/blogs/thetwo-way/2013/01/14/169364733/u-s-militarys-suicide-rate-surpassed-combat-deaths-in-2012>.

<sup>50</sup> *Id.*

<sup>51</sup> *Id.* “While some of the deaths can be linked to the stresses of being deployed in a war zone, a third or more of those who killed themselves were never deployed.” *Id.*

attempts; mental disorders;<sup>52</sup> substance-abuse disorders;<sup>53</sup> head trauma/traumatic brain injury (TBI); those suffering from hopelessness, aggression and impulsivity, and problem-solving deficits; those suffering from acute stressful life events; those with firearm access; and teens influenced by excessive coverage of another person’s suicide.<sup>54</sup>

## D. Dispositional and Personal Factors Related to Suicide

The 2011 DODSER report indicated that servicemembers who were non-Hispanic Caucasian “or Latino, under the age of twenty-five, junior enlisted (E-1 to E-4), or high school educated” had an increased risk of suicide relative to other demographic groups.<sup>55</sup> Divorced servicemembers had a 55% higher suicide rate than those who were married.<sup>56</sup> In addition, female servicemembers “accounted for 5.32% of suicides and 26.52% of suicide attempts in 2011.”<sup>57</sup> Across the United States, American Indian/Alaskan Native males have an increased risk of suicide followed by non-Hispanic White males.<sup>58</sup> The

<sup>52</sup> RAMCHAND, ET AL., *supra* note 37, at xvi–xvii (“Certain mental disorders that carry an increased risk of suicide, such as schizophrenia, are of minimal concern to the military because many learning, psychiatric, and behavioral disorders warrant rejection at enlistment and training.”). Frequent deployments to Iraq and Afghanistan highlight new specific mental health concerns relevant to the military population. *Id.* These include “depression and anxiety disorders (including post traumatic stress disorder, or PTSD).” *Id.* at xvi. The Institute of Medicine (IOM) estimates that approximately four percent of those suffering from depression will die by suicide and, “though the same figure is not yet known for those with PTSD, community-based surveys indicate that PTSD patients are more likely than those without the disorder to report past suicide attempts and ideations.” *Id.*

<sup>53</sup> *Id.* Heavy alcohol use and certain types of drug abuse place individuals at greater risk of suicide if they also possess other disorders. *Id.* Drug abuse is not common in the military due to routine testing and a culture based on strict disciplinary standards. *Id.* However, approximately twenty percent of servicemembers report heavy alcohol use (consuming five or more drinks per drinking occasion at least once a week). *Id.*

<sup>54</sup> *Id.* at xvii. There is a new effort to combat the suicide issue. President Barack Obama supports ending “this epidemic of suicide among our veterans and troops.” Moni Basu, *Why Suicide Rate Among Veterans May Be More Than 22 a Day*, CNN U.S. (Nov. 14, 2013), <http://www.cnn.com/2013/09/21/us/22-veteran-suicides-a-day/m>. President Obama signed “an executive order calling for stronger suicide prevention efforts. A year later, he announced \$107 million in new funding for better mental health treatment for veterans with post-traumatic stress and traumatic brain injury, signature injuries of the wars in Afghanistan and Iraq.” *Id.* Note that most people with military service never consider suicide; only thirty percent of veterans consider suicide. *Id.*

<sup>55</sup> DOD SUICIDE EVENT REPORT, *supra* note 41.

<sup>56</sup> *Id.*

<sup>57</sup> *Id.* at 2.

<sup>58</sup> Nat’l Suicide Statistics at a Glance: Suicide Rates Among Persons Ages 10–24 Years, by Race/Ethnicity and Sex, United States, 2005–2009, CTR. FOR DISEASE CONTROL AND PREVENTION, <http://www.cdc.gov/ViolencePrevention/suicide/statistics/rates03.html> (last visited Nov. 5, 2013).

military generally follows this trend.<sup>59</sup> Studies have also revealed an increase in the number of suicides committed by African-American males.<sup>60</sup>

#### E. Suicide Methods

Death by firearms is the number one cause of military suicides, accounting for 59.93% of all suicides in 2011, followed by hanging at 20.56%.<sup>61</sup> Easy access to firearms is a key component of this figure.<sup>62</sup> Servicemembers who merely attempted suicide used other methods. Those who attempt suicide frequently overdose on drugs or injure themselves with a sharp or blunt object.<sup>63</sup> As some might suspect, alcohol and drug use were common factors in many nonfatal events.<sup>64</sup> In line with national drug statistics, prescription drugs were frequently misused when drugs were a factor.<sup>65</sup> The majority of servicemembers who committed

or attempted suicide did not communicate their intent to harm themselves to others.<sup>66</sup> Those who do communicate most frequently do so with spouses, friends, and other family members.<sup>67</sup> Communication is normally oral, but other modes include text messages and *Facebook*.<sup>68</sup> Recognizing that warning signs are displayed via different means is a great first step in prevention.

#### IV. Information Commanders May Require to Avert Harmful Behavior

Army leaders are committed to “promoting resiliency, coping skills, and help-seeking behavior across our force.”<sup>69</sup> Many regard the Army as a reflection of society, “but we have [S]oldiers today who are experiencing a lifetime of stress during their first six years of service.”<sup>70</sup> Like war, suicide factors are complex. Commanders look for key indicators that their Soldiers are a harm to themselves or others. Leaders desire immediate access to accurate, relevant, and timely information regarding Soldier behavior and performance to manage risk within their organizations.<sup>71</sup> Commanders look for risk or stress indicators like law enforcement contacts, family problems, substance abuse, legal issues, indebtedness, and accidents.<sup>72</sup> Commanders look carefully at such documents such as blotter reports,<sup>73</sup> Army Substance Abuse Program (ASAP) admissions, and Army Emergency Relief (AER) loans to assess risk. They will also carefully examine prolonged profiles and systemic injuries that may signal pain management issues.<sup>74</sup> Data that

<sup>59</sup> RAMCHAND ET AL., *supra* note 37, at 21.

For example, between 1999 and 2007, suicide rates were highest in the Navy among Native Americans (19.3 per 100,000) and among non-Hispanic Whites (11.9 per 100,000), whereas the rate in all other racial and ethnic groups was at or under 10 per 100,000. The rate in the Marine Corps for the same period was highest among those indicating that their race was “other or unknown” (25.0 per 100,000) and was also noticeably high among non-Hispanic Whites (16.2 per 100,000) and Asians/Pacific Islanders (15.2 per 100,000). In 2006 and 2007, there was a slightly higher proportion of white suicide cases than in the Army overall (in 2006, 64% compared with 62%; in 2007, 67% compared with 63%).

*Id.*

<sup>60</sup> *Id.* at xv.

<sup>61</sup> DOD SUICIDE EVENT REPORT, *supra* note 41, at 2.

<sup>62</sup> *Id.* Over 50% of suicide decedents had firearms in their home or immediate environment. *Id.*

<sup>63</sup> *Id.* Drug overdoses accounted for 59.93% of all suicide attempts, while injury with a sharp or blunt object occurred in 11.98% of these cases. *Id.*

<sup>64</sup> *Id.* Drugs were involved in 598 (63.96%) suicide attempts, while alcohol was involved in 292 (31.23%) attempts. *Id.*

<sup>65</sup> *Id.* Among servicemembers who attempted suicide with known drug use, prescription drugs were involved in 63.88% of those cases. *Id.* In 2007, fatal prescription drug overdoses surpassed car crashes as the leading cause of accidental death in the United States. Dr. Joseph M. Mercola, *Suicide Overtakes Car Accidents as Leading Cause of Injury Related Death*, MERCOLA.COM: TAKE CONTROL OF YOUR HEALTH (Oct. 11, 2012), <http://articles.mercola.com/sites/articles/archive/2012/10/11/suicide-and-poisoning-rate-increased.aspx>. Many prescription drug overdoses involved the use of opioid painkillers; there were more opioid overdose deaths than cocaine and heroin combined. *Id.* Opioid painkillers include opium-like prescription drugs that include morphine, codeine, and hydrocodone. Dr. Joseph M. Mercola, *The Silent Epidemic—Legal Prescription Drug Abuse*, MERCOLA.COM: TAKE CONTROL OF YOUR HEALTH (May 25, 2010), <http://articles.mercola.com/sites/articles/archive/2010/05/25/the-silent-epidemic-legal-prescription-drug-abuse.aspx>. The only thing that distinguishes some prescription drugs from street drugs is their legal status. *Id.* Actor Heath

Ledger “had Vicodin (hydrocodone), OxyContin (oxycodone), Valium (diazepam), and Xanax (alprazolam) in his bloodstream when he died. All are legal opiates.” Nancy Rosen-Cohen, *The Quiet Epidemic: Prescription Drug Abuse Destroys Millions of Lives*, BALTIMORE SUN (April 21, 2010), [http://articles.baltimoresun.com/2010-04-21/news/bs-ed-prescription-drug-abuse-20100421\\_1\\_prescription-drugs-opiates-addictive](http://articles.baltimoresun.com/2010-04-21/news/bs-ed-prescription-drug-abuse-20100421_1_prescription-drugs-opiates-addictive).

<sup>66</sup> DOD SUICIDE EVENT REPORT, *supra* note 41, at 2. In fatal events, 73.87% of decedents were not known to have communicated suicidal intent. *Id.* Seventy-five percent of servicemembers who attempted suicide did not communicate their intent to harm themselves. *Id.*

<sup>67</sup> *Id.*

<sup>68</sup> *Id.*

<sup>69</sup> Press Release, Army Suicide Prevention Report, *supra* note 35 (quoting then Vice Chief of Staff of the Army, General Peter W. Chiarelli).

<sup>70</sup> *Id.*

<sup>71</sup> ARMY SUICIDE PREVENTION REPORT, *supra* note 32, at 203.

<sup>72</sup> *Id.*

<sup>73</sup> Blotter reports contain information related to misconduct or serious incidents within the command.

<sup>74</sup> Judge advocates are encouraged to review Department of Defense Health Information Privacy Regulation (DODR 6025.18-R). This regulation provides guidance similar to the Privacy Rule that focuses on the military healthcare system. DOD HEALTH PRIVACY REGULATION, *supra* note 6. There are, however, instances in which the Department of Defense must

may be simply compiled for a weekly unit readiness review can enable high-risk intervention.<sup>75</sup>

## V. HIPAA's Application in High-Risk Cases Like Private Law's

Assume that Private Law's commander, Captain (CPT) Jones,<sup>76</sup> learned from the rumor mill that Private Law was drinking heavily, cutting himself, and seeing a psychiatrist. He also noticed that Private Law recently made several unusual outbursts in formation. Captain Jones may want more information about his mental condition to fully understand the scope of the problem and assess risk. A straight-laced commander like CPT Jones would probably pick up the phone and call a mental health provider, or perhaps ask the brigade's surgeon to screen Private Law's records. The response from the medical community might surprise you. As a general rule, PHI is confidential and will not be released to anyone unless:

- a. The patient authorizes release, or
- b. An exception to HIPAA applies.

Captain Jones could certainly ask Private Law for authorization to view his behavioral health records. However, the commander might be reluctant to do so for obvious reasons.<sup>77</sup> In this case, CPT Jones will naturally look for an alternative. The Privacy Rule of the HIPAA provides standards for the disclosure of PHI to DoD or Armed Forces members without their authorization.<sup>78</sup> Congress created exceptions to support the unique needs of the military.<sup>79</sup> Disclosures under the military exception are permitted, although not required, because Congress recognized the important contributions that health information can make outside of the health care context.<sup>80</sup>

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follow state law, such as in cases of protected health information regarding a family member or minor. U.S. DEP'T OF ARMY, REG. 40-66, MEDICAL RECORD AND ADMINISTRATION AND HEALTHCARE DOCUMENTATION para. 2-6a(1) (17 June 2008) [hereinafter AR 40-66].

<sup>75</sup> ARMY SUICIDE PREVENTION REPORT, *supra* note 32, at 203.

<sup>76</sup> Captain Jones is not actually the name of Private Law's commander. Captain Jones is a fictional character used for demonstrative purposes only.

<sup>77</sup> Captain Jones may choose not to address the issue with Private Law because he does not want to incite or embarrass the Soldier.

<sup>78</sup> HHS HIPAA Summary, *supra* note 7. Patient authorization is not required to use or disclose protected health information for certain essential government functions. *Id.* In the military context, those functions include: "assuring proper execution of a military mission, conducting intelligence and national security activities that are authorized by law, providing protective services to the President . . . protecting the health and safety of inmates or employees in a correctional institution, and determining eligibility for or conducting enrollment in certain government benefit programs." *Id.*

<sup>79</sup> *Id.*

<sup>80</sup> *Id.*

Specific limitations apply, striking the balance between an individual's privacy interest and the public's interest in this information.<sup>81</sup> Army regulations describe the relevant exceptions to the Privacy Rule.<sup>82</sup>

## VI. Army Regulations: Disclosure Without Patient Consent

In certain limited circumstances, the military treatment facility (MTF) or dental treatment facility (DTF) may, subject to certain terms and conditions, disclose PHI to DoD employees who have an official access requirement<sup>83</sup> in the performance of their duties.<sup>84</sup> Examples of key exceptions that allow commanders to access PHI without patient authorization include the following circumstances: medically administering flying restrictions,<sup>85</sup> allowing senior commanders to review a Soldier's medical information to assess Warrior Transition Unit (WTU) eligibility, and to "avert a serious threat to health or safety."<sup>86</sup> Many key exceptions are related to uses that comport with the regulatory command program.<sup>87</sup> The key is to respect the

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<sup>81</sup> *Id.*

<sup>82</sup> AR 40-66, *supra* note 74, para. 2-4.

<sup>83</sup> *Id.* Army Regulation 40-66 defines official access requirements as:

When required by law or Government regulation . . .  
For public health purposes.  
Inquiries involving victims of abuse or neglect.  
For health oversight activities authorized by law.  
For judicial or administrative proceedings.  
Incidents concerning decedents in limited circumstances.  
For cadaveric organ, eye, or tissue donation purposes.  
For research involving minimal risk.  
To avert a serious threat to health or safety.  
For specialized Government functions, including certain activities related to Armed Forces personnel.

*Id.* Note that ordinarily, direct access to medical records is not permitted. *Id.* para. 2-4a(1) (without the individual's authorization or opportunity to object); *see also* DODR 6025.18-R, *supra* note 6.

<sup>84</sup> AR 40-66, *supra* note 74, para. 2-4a.

<sup>85</sup> *Id.* para. 2-4a(1)(a)(10). Flying restrictions must be executed IAW AR 40-8 and AR 40-501. *Id.*

<sup>86</sup> *Id.*

<sup>87</sup> *Id.* para. 2-4(1)(a). Examples of regulatory programs that do not require a Soldier's authorization for PHI disclosure include:

1. To coordinate sick call, routine and emergency care, quarters, hospitalization, and care from civilian providers using DD Form 689 (Individual Sick Slip) in accordance with this regulation and AR 40-400.
2. To report results of physical examinations and profiling according to AR 40-501.
3. To screen and provide periodic updates for individuals in special programs, such as those described in AR 50-1, AR 50-5, AR 50-6, and AR 380-67.
4. To review and report according to AR 600-9.

exception and protect it from abuse by complying with the requirement to disclose the minimum information necessary to answer key command questions related to deployability or fitness for service.<sup>88</sup>

#### A. Application: Private Law's Commander Calls a Provider

Returning to the example involving Private Law, if his commander, CPT Jones, requests information about Law's psychiatric condition (because he suspects that Private Law has a mental or medical condition) via telephone or in writing, he will have to articulate how the request is related to a regulatory command program.<sup>89</sup> If the request is connected with a regulatory command management

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5. To initiate line of duty (LOD) determinations and to assist investigating officers according to AR 600-8-4.

6. To conduct medical evaluation boards and administer physical evaluation board findings according to AR 635-40 and similar requirements.

7. To review and report according to AR 600-110.

8. To carry out activities under the authority of AR 40-5 to safeguard the health of the military community.

9. To report on casualties in any military operation or activity according to AR 600-8-1 or local procedures.

10. To medically administer flying restrictions according to AR 40-8 and AR 40-501. To participate in aircraft accident investigations according to AR 40-21.

11. To respond to queries of accident investigation officers to complete accident reporting per the Army Safety Program according to AR 385-10.

12. To report mental status evaluations according to guidance from MEDCOM (MCHO-CL-H).

13. To report special interest patients according to AR 40-400.

14. To report the Soldier's dental classification according to AR 40-3 and HA Policy 02-011.

15. To carry out Soldier Readiness Program and mobilization processing requirements according to AR 600-8-101.

16. To provide initial and follow-up reports according to AR 608-18.

17. To contribute to the completion of records according to AR 608-75 and MEDCOM (MCHO-CL-H) guidance.

18. To allow senior commanders to review Soldier medical information to determine eligibility of assignment/attachment to a warrior transition unit (WTU). (FRAGO 3 Annex A to EXORD 118-07, 010900Q JULN 2008).

19. According to other regulations carrying out any other activity necessary to the proper execution of the Army's mission.

*Id.*

<sup>88</sup> Policy Memorandum 12-062, Headquarters, U.S. Dep't of Army, Med. Command, subject: Release of Protected Health Information (PHI) to Unit Command Officials 3 (24 Aug. 2012) [hereinafter Release of PHI Policy Memorandum].

<sup>89</sup> AR 40-66, *supra* note 74.

program,<sup>90</sup> the MTF will honor the request.<sup>91</sup> In this case, Private Law's commander could indicate that Private Law's increased drinking, self-mutilation, and unusual outbursts make him a potential harm to himself or others, and that risk research is necessary to avert a serious threat to his or other's health or safety.<sup>92</sup> The MTF provider may agree that this request for PHI falls within the regulatory exceptions to the Privacy Rule, but require that CPT Jones document his request. Further, DOD personnel should submit PHI requests using the appropriate DA form.<sup>93</sup> The MTF should respond to PHI requests within thirty days.<sup>94</sup> Commanders and judge advocates should know that the MTF will provide the minimum information necessary to satisfy the intended purpose, and will only provide information to designated unit command officials.<sup>95</sup> Unit commanders must designate unit command officials in writing who will be responsible for requesting and receiving PHI.<sup>96</sup> Unit command officials include "commanders, executive officers, first sergeants, platoon leaders, and platoon sergeants."<sup>97</sup> The MTF is not required to provide information to others.

#### B. Application: Requests for PHI When There Is No Regulatory Purpose

An e-mail or phone request by DoD personnel that is not connected with a regulatory command program is a navigable obstacle. The MTF will honor the request, but limit the disclosure.<sup>98</sup> They will address only the Soldier's "general health status, adherence to scheduled appointments, profile status, and medical readiness requirements."<sup>99</sup> This

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<sup>90</sup> *Id.*

<sup>91</sup> Release of PHI Policy Memorandum, *supra* note 88.

<sup>92</sup> AR 40-66, *supra* note 74. Captain Jones should document his suspicions in a memorandum for record that includes witness sworn statements as allied documents. Sworn statements can be recorded on Department of the Army Form 2823.

<sup>93</sup> U.S. Dep't of Army, DA Form 4254, Request for Private Medical Information (Feb. 2003) [hereinafter DA Form 4254]. Most military treatment facilities require that units submit PHI requests on DA Form 4254. See Appendix A (providing a sample DA Form 4254). Department of the Army Form 4254 should normally be routed through hospital administration for action.

<sup>94</sup> See AR 40-66, *supra* note 75, para. 2-5. In urgent situations, disclosure requests may be faxed. *Id.* Oral requests for PHI disclosure in urgent cases of rape, assault, child abuse, or death may be submitted to the MTF for action. *Id.* Requesters should supplement the oral request with a written request in accordance with law and regulation at the first available opportunity. *Id.*

<sup>95</sup> *Id.* para. 2-4a(4).

<sup>96</sup> Release of PHI Policy Memorandum, *supra* note 88.

<sup>97</sup> *Id.*

<sup>98</sup> *Id.*

<sup>99</sup> *Id.*

means that if Private Law's commander wanted to know whether Private Law was diagnosed with post-traumatic stress or bipolar disorder, for example, the MTF would not normally provide a general diagnosis unless they found that his mental condition rendered him unfit for duty.<sup>100</sup> They would, however, mention whether he kept appointments, current profiles, and whether he is medically fit for deployment.<sup>101</sup> Commanders who require more information are encouraged to request additional PHI for a regulatory command function using the DA Form 4254.<sup>102</sup>

## VII. Guidance for Providers

### A. When to Proactively Inform a Commander of Medical Concerns

The unique nature of military service creates circumstances that may necessitate providers proactively "inform a commander of a Soldier's minimum necessary PHI or medical/behavioral health condition."<sup>103</sup> Those instances focus on cases where a Soldier's "judgment or clarity of thought may be suspect by the clinician."<sup>104</sup> This includes information that suggests the servicemember is a danger to himself or others.<sup>105</sup> A provider can give warnings to avoid a *serious* or *imminent* threat to the health or safety of a person, such as suicide or homicide.<sup>106</sup>

Providers may also disclose information that specifically relates to the patient's duty performance.<sup>107</sup> If a Soldier needs to be hospitalized or prescribed medication that affects his duty performance or mission, the provider has an "affirmative duty" to notify the unit of a change in duty status.<sup>108</sup> If, for example, the Soldier is a paratrooper and has an ankle injury that will affect his ability to jump out of airplanes, the provider will inform the unit of the medical issue.<sup>109</sup> Providers may also notify the unit if an individual

is prescribed psychotropic drugs that affect mission readiness.<sup>110</sup> Significantly, providers must also alert the command of high-risk Soldiers who receive multiple behavioral health services when they require high-risk multidisciplinary treatment plans.<sup>111</sup>

There are certainly key considerations related to this proactive approach that are not well defined in current regulations. For example, it is not clear what conditions pose a *serious* risk.<sup>112</sup> Another issue is that providers are not aware of every mission requirement.<sup>113</sup> While brigade surgeons<sup>114</sup> attached to select units may have some operational knowledge, there are still information gaps that prevent consistent application of this rule. Advanced care is often executed by hospital providers outside the brigade. Hospital providers are detached from units and have little operational awareness.<sup>115</sup> One solution is for brigade surgeons to assess patient/candidate records prior to training and deployments. Commanders can also continually track Soldiers with a profile indicating they are medically non-deployable. The purpose of this data collection should be focused on adjusting the Soldier's mission to lower risk rather than creating barriers to promotion or ostracism.<sup>116</sup>

### B. Limits on Disclosure

While the military exception does provide some latitude, providers must remain vigilant to avoid HIPAA violations. Providers should use screening procedures that will ensure disclosure of the minimum amount necessary to satisfy the request for information, in accordance with DoD

<sup>100</sup> *Id.*

<sup>101</sup> *Id.*

<sup>102</sup> *Id.* See DA Form 4254, *supra* note 93.

<sup>103</sup> AR 40-66, *supra* note 74, para. 2-4(2).

<sup>104</sup> *Id.*

<sup>105</sup> *Id.*

<sup>106</sup> Telephone Interview with Charles Orck, Attorney Advisor, U.S. Army Medical Command (Oct. 17, 2012) [hereinafter Orck Telephone Interview].

<sup>107</sup> AR 40-66, *supra* note 74, para. 2-4(2)(c); see also Information Paper, U.S. Dep't of Army, Med. Command, MCJA, subject: HIPAA and Command Access to Soldier's Protected Health Information (PHI) (14 Mar. 2012) [hereinafter HIPAA and PHI Information Paper].

<sup>108</sup> HIPAA and PHI Information Paper, *supra* note 107, at 2.

<sup>109</sup> Orck Telephone Interview, *supra* note 106. Another example includes medications that could impair the Soldier's duty performance. AR 40-66, *supra* note 74, para. 2-4(2)(c). Lithium, for example, can reach toxic levels if a Soldier is dehydrated. *Id.* A Soldier cannot deploy if they are on lithium. *Id.*

<sup>110</sup> Orck Telephone Interview, *supra* note 107. Extended exposure to psychotropic drugs or sedatives may affect their judgment or reflexes. *Id.* Providers can also alert the unit when an injury indicates a safety problem or battlefield trend, there is a risk of heat or cold weather injury, a Soldier requires hospitalization, or the Soldier is categorized as seriously ill or very seriously ill. AR 40-66, *supra* note 74, para. 2-4a(2).

<sup>111</sup> AR 40-66, *supra* note 74, para. 2-4a(2).

<sup>112</sup> Orck Telephone Interview, *supra* note 106.

<sup>113</sup> *Id.*

<sup>114</sup> U.S. DEP'T OF ARMY, FIELD MANUAL 4-02.21, DIVISION AND BRIGADE SURGEONS HANDBOOK HEADQUARTERS, DEPARTMENT OF THE ARMY: TACTICS, TECHNIQUES, AND PROCEDURES para. 2-1 (15 Nov. 2000) [hereinafter FM 4-02.21]. Division and brigade surgeons are attached to most forces command units. *Id.* The brigade surgeon is a medical corps officer on the special staff who plans and coordinates brigade combat health service activities with the brigade adjutant. *Id.* The brigade surgeon is assigned to the headquarters and headquarters company (HHC) of a maneuver brigade. *Id.* The surgeon maintains technical control of all medical activities in the command. *Id.*

<sup>115</sup> Orck Telephone Interview, *supra* note 106.

<sup>116</sup> U.S. DEP'T OF DEF., INSTR. 6490.08, COMMAND NOTIFICATION REQUIREMENTS TO DISPEL STIGMA IN PROVIDING MENTAL HEALTH CARE TO SERVICE MEMBERS 6 (17 Aug. 2011) [hereinafter DODI 6490.08].

regulations.<sup>117</sup> Covered entities should also follow the presumption that they should not notify a servicemember's commander when the servicemember obtains mental health care or substance abuse education services, unless this presumption is overcome by one of the notification standards in applicable guidance.<sup>118</sup>

### VIII. Guidance for Judge Advocates: Issues with Disclosure to Commanders

One issue that judge advocates will encounter is that commanders may want to know too much.<sup>119</sup> For example, commanders may want to know whether a Soldier has been seen at behavioral health simply because they were prescribed an opioid or central nervous system drug.<sup>120</sup> A prescription alone is not a rational basis for PHI disclosure.<sup>121</sup> Drugs used to suppress the central nervous system are not solely administered for mental health issues; they are also used for allergies.<sup>122</sup> Judge advocates should also note that many instances require a proper mental health evaluation in accordance with DoD instructions (DoDI).<sup>123</sup>

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<sup>117</sup> U.S. DEP'T OF DEF., REG. 6025.18-R, DoD HEALTH INFORMATION PRIVACY REGULATION para. C7 (23 Jan. 2003) [hereinafter DODR 6025.18-R].

<sup>118</sup> See Appendix B, Department of Defense Instruction (DODI) 6490.08, dated 17 August 2011.

<sup>119</sup> Orck Telephone Interview, *supra* note 106.

<sup>120</sup> *Id.*

<sup>121</sup> *Id.*

<sup>122</sup> *Id.*

<sup>123</sup> A commanding officer or supervisor should refer a servicemember for an emergency mental health evaluation as soon as practicable whenever:

- (1) A Service member, by actions or words, such as actual, attempted, or threatened violence, intends or is likely to cause serious injury to him or herself or others.
- (2) When the facts and circumstances indicate that the Service member's intent to cause such injury is likely.
- (3) When the commanding officer believes that the Service member may be suffering from a severe mental disorder.

U.S. DEP'T OF DEF., INSTR. 6490.04, MENTAL HEALTH EVALUATIONS OF MEMBERS OF THE MILITARY SERVICES (4 Mar. 2013) [hereinafter DoDI 6490.04]. Practitioners should note that DODI 6490.04 incorporates and cancels DoDD 6490.1, MENTAL HEALTH EVALUATIONS OF MEMBERS OF THE ARMED FORCES (1 Oct. 1997). Department of Defense Instruction 6490.04 also reissues DoDI 6490.4, *Requirements for Mental Health Evaluations of Members of the Armed Forces* (28 Aug. 1997). Department of Defense Instruction 6490.04 establishes policy, assigns responsibilities and prescribes procedures for the "referral, evaluation, treatment, and medical and command management of Service members who may require assessment for mental health issues." *Id.* The new instruction expands who can refer a servicemember for an emergency or non-emergency mental health evaluation. Department of Defense Directive 6490.1 only authorized commanders to take emergency action. Department of Defense Instruction

To that end, DoDI 6490.04, provides numerous due process rights<sup>124</sup> that should not be circumvented by using the military exception to the Privacy Rule. The bottom line is that commanders would love to data mine<sup>125</sup> information, but simply do not have the time or resources to commit to this arduous task.<sup>126</sup> Commanders often try to find out why Soldiers commit suicide, but there is often no single reason.<sup>127</sup> Typically, the issue is related to stress, but a stress reaction to one ubiquitous catalyst is often different for each servicemember.<sup>128</sup>

### IX. Guidance for Commanders: A Duty to Safeguard Disclosed PHI

Commanders are not covered entities under HIPAA, but their conduct is still covered by the Privacy Act. Once information is transferred from the MTF to a commander, it is no longer governed by HIPAA, but it is governed by the Privacy Act of 1974 and should be safeguarded.<sup>129</sup> However, in May 2010, the Vice Chief of Staff of the Army determined that commanders have the same responsibilities as healthcare providers to safeguard PHI.<sup>130</sup> Information should be restricted to personnel who have a specific need to know within the scope of their official duties.<sup>131</sup>

### X. High-Risk Panels

A multidisciplinary high-risk panel (High-Risk Panel) can be an effective tool in the fight against suicide,

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6490.04 now authorizes commanders and supervisors to do so. *Id.* See also U.S. DEP'T OF DEF., DIR. 6490.1, MENTAL HEALTH EVALUATIONS OF MEMBERS OF THE ARMED FORCES (1 Oct. 1997) [hereinafter DODI 6490.1] (consult DoDD 6490.1 to compare the old and new policy only).

<sup>124</sup> DODI 6490.04, *supra* note 123, at 9. Enclosure 3 of DoDI 6490.1 explains servicemember rights.

<sup>125</sup> Data mining is the practice of searching through large amounts of computerized data to find useful patterns or trends. MERRIAM WEBSTER, <http://www.merriam-webster.com/dictionary/data%20mining> (last visited Dec. 9, 2013).

<sup>126</sup> Orck Telephone Interview, *supra* note 106.

<sup>127</sup> *Id.*

<sup>128</sup> *Id.*

<sup>129</sup> *Id.*

<sup>130</sup> All Army Activities (ALARACT) Message 160/210, 282049Z May 10, Vice Chief of Staff, Army, subject: VCSA Sends on Protected Health Information (PHI); see also U.S. DEP'T OF DEF., DIR. 5400.1, DEPARTMENT OF DEFENSE PRIVACY PROGRAM (7 May 2007).

<sup>131</sup> U.S. DEP'T OF DEF., INSTR. 6490.08, COMMAND NOTIFICATION REQUIREMENTS TO DISPEL STIGMA IN PROVIDING MENTAL HEALTH CARE TO SERVICE MEMBERS 6 (17 Aug. 2011) [hereinafter DODI 6490.08].

homicide, and high-risk activity.<sup>132</sup> A High-Risk Panel at the battalion level is most effective and will allow the Army to overcome current impediments created by the current data infrastructure.<sup>133</sup> Panels may be comprised of the brigade surgeon and physician's assistant, brigade judge advocate, chaplain, command financial specialist,<sup>134</sup> company commanders, first sergeants, unit social workers, and the battalion leadership. During the High-Risk Panel, company commanders nominate Soldiers to whom they assign a label of medium to high risk. Company commanders can use an index card with key historical data and proposed risk mitigation strategies related to that servicemember.<sup>135</sup>

Commanders may seek professional input from panel members based on the unique needs of each candidate. For example, if confronted with a Soldier who makes repeat suicide attempts, the brigade surgeon might recommend a command-directed mental health evaluation. The brigade judge advocate in turn could immediately educate the commander about the requirements for this action and the rights afforded servicemembers who are hospitalized or evaluated in accordance with DoDI 6490.04.<sup>136</sup> The unit first sergeant (1SG) could discuss relevant risk factors

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<sup>132</sup> *Id.* Army leaders can effectively oversee health promotion, risk reduction, and suicide prevention by accessing relevant, timely, and actionable information regarding individual Soldier behavior and program performance. *Id.* Multidisciplinary panels are often a great way to assemble this information quickly.

<sup>133</sup> This assertion is based on the author's recent professional experiences working as brigade judge advocate for the 15th Sustainment Brigade, Fort Bliss, Texas, from 17 January 2011 to 7 July 2012 [hereinafter Professional Experiences]. At the battalion level, leaders and staff are often more closely acquainted with the circumstances related to individual servicemembers. *Id.* Company commanders can comment on key trends and generally know details related to each candidate. *Id.* Lieutenant Colonel Litonya J. Wilson, current Deputy Chief of Staff, 1st Armored Division and Fort Bliss, used this strategy effectively while serving as the Commander, 15th Special Troops Battalion, 15th Sustainment Brigade, Fort Bliss, Texas. *Id.* Today, Fort Bliss has the lowest suicide rate in the Army. Angela Kocherga, *Fort Bliss Suicide Rate Declines to Army's Lowest*, KVUE.COM (Feb. 5, 2013), <http://www.kvue.com/news/189921231.html>.

<sup>134</sup> The Command Financial Specialist (CFS) is normally a non-commissioned officer appointed by the commander to provide "financial education and training, counseling and information referral at the command level. Command Financial Specialists are trained to establish, organize and administer the command's personal financial management (PFM) program. The CFS should be the first stop for the military member who has questions or issues about financial readiness." Financial Specialists, COMMANDER NAVAL INSTALLATIONS COMMAND (CNIC), [http://www.cnic.navy.mil/CNIC\\_HQ\\_Site/WhatWeDo/FleetandFamilyReadiness/FamilyReadiness/FleetAndFamilySupportProgram/CommandFinancialSpecialist/index.htm](http://www.cnic.navy.mil/CNIC_HQ_Site/WhatWeDo/FleetandFamilyReadiness/FamilyReadiness/FleetAndFamilySupportProgram/CommandFinancialSpecialist/index.htm) (last visited Dec. 11, 2013). The CFS can provide guidance to the multidisciplinary panel related to financial issues and programs available.

<sup>135</sup> See Appendix C (providing an example of the U.S. Army Soldier Leader Risk Reduction Tool and Guide (USA SLRRT) used at Fort Bliss). See also <http://www.armyg1.army.mil/hr/suicide/spmonth/docs/Guide%20for%20the%20Use%20of%20the%20USA%20SLRRT.pdf> for an implementation manual that provides guidance for the use of the USA SLRRT.

<sup>136</sup> DoDI 6490.04, *supra* note 123.

associated with the candidate, such as a history of underage drinking, absenteeism, and minor disciplinary issues. The 1SG might also suggest a buddy for the Soldier who has completed Applied Suicide Intervention Skills Training (ASIST).<sup>137</sup>

The brigade judge advocate may also discuss long-term risk aversion measures,<sup>138</sup> should the panel and medical professionals determine that the stress of military service presents harm to the servicemember that is beyond rehabilitation. If the candidate is diagnosed with a severe mental health condition, the brigade judge advocate may discuss the process and options available for discharge.<sup>139</sup> The battalion commander ultimately will determine, based on the facts and guidance provided, what risk level the candidate should be assigned. The battalion commander may choose whether to issue guidance directly to the company commander during the meeting.

## XI. Conclusion

Today we face an Army-wide problem "that can only be solved by the coordinated efforts of our commanders, leaders, program managers and service providers."<sup>140</sup> The suicide statistics paint a vivid picture of significant issues that leaders must address to reverse the trend. The good news is that military intervention is working because the suicide rate is leveling off. Between 2003 and 2010, the active duty suicide rate doubled from 10 per 100,000 to 21 per 100,000 troops.<sup>141</sup> In 2010, the suicide rate in the active Army leveled off, but the rate increased across the National

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<sup>137</sup> Applied Suicide Intervention Skills Training (ASIST) is a program offered quarterly on each post. As part of the U.S. Army's suicide prevention campaign, "gatekeepers" are trained and available in each unit to assist those experiencing thoughts of suicide and those attempting to help them. *Suicide Prevention Training*, ARMY G-1 ARMY SUICIDE PREVENTION PROGRAM, <http://www.armyg1.army.mil/hr/suicide/training.asp> (last visited Dec. 5, 2013). Like CPR-trained individuals for those with cardio-pulmonary difficulties, ASIST-trained individuals have been taught the signs and symptoms, how to assess the risk of suicidal behavior, and "how to appropriately intervene in an at-risk situation." *Id.*

<sup>138</sup> Long-term risk aversion measures could include assigning an ASIST trained buddy to the at-risk Soldier, promoting counseling, and other treatment.

<sup>139</sup> U.S. DEP'T OF ARMY, REG. 635-200, ACTIVE DUTY ENLISTED SEPARATIONS (5 June 2005) (RAR, 6 Sept. 2011).

<sup>140</sup> ARMY SUICIDE PREVENTION REPORT, *supra* note 32, at i.

<sup>141</sup> Elspeth Cameron Ritchie, *Suicide and the United States Army: Perspectives from the Former Psychiatry Consultant to the Army Surgeon General*, DANA FOUNDATION AND THE DANA ALLIANCE FOR BRAIN INITIATIVES (Jan. 25, 2012), <http://www.dana.org/news/cerebrum/detail.aspx?id=35150> (The rate of suicide in the U.S. Army active-duty force remained relatively stable from 1990 to 2003, hovering at about 10 per 100,000 Soldiers per year. This is approximately half the civilian rate. But in 2004 it began to rise, and from 2003 to 2010 the suicide rate for this group doubled, to about 21 per 100,000 Soldiers.).

Guard.<sup>142</sup> More work is necessary. Currently, Army medical, legal, and law enforcement systems are not integrated.<sup>143</sup> A net-centric environment could integrate information capability, providing leaders with predictive analysis tools to inform proactive planning and risk mitigation measures, such as conducting high-risk panels.<sup>144</sup>

The benefits associated with a multidisciplinary High-Risk Panel are vast, but the opportunity for violations of the Privacy Rule is still present. Using the guidance included in this article, practitioners and leaders can avoid pitfalls on the

road to successful risk mitigation. The aforementioned strategy is not perfect, but may help to avoid future incidents as that of Private Law. Preventing our servicemen and women from ever reaching the point of suicide or homicide is paramount and half the battle.

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<sup>142</sup> *Id.*

<sup>143</sup> ARMY SUICIDE PREVENTION REPORT, *supra* note 32, at 203.

<sup>144</sup> *Id.*

**Appendix A**

**Sample DA Form 4254\***

<b>REQUEST FOR PRIVATE MEDICAL INFORMATION</b> For use of this form, see AR 40-66; the proponent agency is the OTSG		1. Date (YYYYMMDD)
2. Patient's Name and SSN.	3. Medical Treatment Facility (Name and Location)	
4. Reason for Request.		
5. Private Medical Information Sought (Specify dates of hospitalization or clinic visits and diagnosis, if known)		
6. Requestor's Name, Title, Organization and SSN.		
<i>FOR USE OF MEDICAL TREATMENT FACILITY ONLY</i>		
7. Check applicable box. <input type="checkbox"/> Approved <input type="checkbox"/> Disapproved (State reason for disapproval)		
8. Summary of Private Medical Information Released.		
9. Signature of Approving Official.	10. Date (YYYYMMDD)	

DA FORM 4254, FEB 2003

DA FORM 4254-R, NOV 91, IS OBSOLETE.

USAPA V1.01ES

\*The social security number (SSN) field on DA Form 4254 may be eliminated pending the creation of new forms based on changes to the DoD's SSN policy. U.S. DEP'T OF DEF., INST. 1000.30, REDUCTION OF SOCIAL SECURITY NUMBER (SSN) USE WITHIN DOD (1 Aug. 2012) [hereinafter DoDI 1000.30]. Until then, good judgment requires that the SSN be eliminated in accordance with the guidance provided in the DoDI 1000.30.

## Appendix B

DoDI 64590.08, August 17, 2011

### ENCLOSURE 2 PROCEDURES

#### 1. HEALTHCARE PROVIDERS.

a. Command notification by healthcare providers will not be required for Service member self and medical referrals for mental health care or substance misuse education unless disclosure is authorized for one of the reasons listed in subparagraphs 1.b.(1) through 1.b.(9) of this enclosure.

b. Healthcare providers shall notify the commander concerned when a Service member meets the criteria for one of the following mental health and/or substance misuse conditions or related circumstances:

(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 (Reference (f)).

(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 impact impulsivity, insight, reliability, and judgment.

(4) Special Personnel. The Service member is in the Personnel Reliability Program as described in DoD Instruction 5210.42, 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 the Service member's 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 (Reference (h)) 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 (Reference (i)).

(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 health care provider (or other authorized official of the medical treatment facility involved) at the O-6 or equivalent level or above or a commanding officer at the O-6 level or above.

c. In making a disclosure pursuant to the circumstances described in subparagraphs 1.b.(1) through 1.b.(9) of this enclosure, 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.

d. Healthcare providers shall maintain records of disclosure of protected health information consistent with DoD 6025.18-R, DoD Health Information Privacy Regulation, January 24, 2003.

2. COMMANDER DESIGNATION. Notification to the commander concerned pursuant to this Instruction shall be to the commander personally or to another person specifically designated in writing by the commander for this purpose.

3. COMMANDERS. Commanders shall protect the privacy of information provided pursuant to this Instruction and DoD Directive 5400.11 as they should with any other health information. Information provided shall be restricted to personnel with a specific need to know; that is, access to the information must be necessary for the conduct of official duties. Such personnel shall also be accountable for protecting the information. Commanders must also reduce stigma through positive regard for those who seek mental health assistance to restore and maintain their mission readiness, just as they would view someone seeking treatment for any other medical issue.

## Appendix C

### U.S. Army Soldier Leader Risk Reduction Tools and Guides

#### U.S. ARMY SOLDIER LEADER RISK REDUCTION TOOL (USA SLRRT)

The Privacy Act prohibits use of the USA SLRRT as a form to collect and retain data on individuals. Leaders should document pertinent findings and plan of actions on the DA 4856 (Developmental Counseling Form) and not use the USA SLRRT for retaining information on individual Soldiers.



#### Frequency - Counseling sessions using the USA SLRRT should be conducted:

- Within 30 days of arrival at the current permanent duty station.
- Prior to attendance at Noncommissioned Officer Education System (NCOES), advanced leader courses (ALC) and senior leader courses (SLC), officer advanced courses (OAC), WOBC, and BOLC-B.
- Approximately 90 days prior to deployment.
- Within 30 days of returning to duty after deployment.
- When Soldiers are administratively removed from a school and returned to the unit or organization.
- When leaders determine the Soldier would benefit from an assessment because of changes or transitions in the Soldier's personal or professional life or when the leader identifies a risky behavior.
- At least annually to ensure that low risk Soldiers have not elevated to moderate or high risk.

#### Soldiers on Assignment:

**Moderate/Medium Risk Soldiers** - losing commanders (battalion level/equivalent or above) should inform gaining commanders via an encrypted email message no later than 30 days before the transfer.

**High Risk Soldiers** - Commanders (battalion level/equivalent or above) should work with Human Resource Command (HRC) to defer or delete assignment instructions. Once a battalion/equivalent or higher level commander determines that the Soldier's risk level has been mitigated to moderate or low risk, they should work with HRC on the Soldier's assignment instructions.

## U.S. Army Soldier Leader Risk Reduction Tool (USA SLRRT)

### INSTRUCTIONS FOR LEADERS

This tool is designed to help leaders identify potential risks among their Soldiers. If a Soldier has a concern or problem, provide him/her with options (suggestions are provided under "Leader Action" for each issue of concern), ensure that you follow up with him/her, and continue to address the plan of action as necessary. Document any pertinent issues of concern and the associated action plan on the Developmental Counseling Form, DA Form 4856.

Refer to Appendix B in the 'Guide for Use of the USA SLRRT' for a more complete list of resources available to assist Soldiers.

Leaders should consult with legal counsel if Article 31 rights may apply.

#	ISSUES OF CONCERN	LEADER ACTIONS
1	Has the Soldier been command referred for any assistance (e.g., legal, financial, spiritual, alcohol, family/relationship, behavioral health, other)? Does the Soldier wish to disclose receiving any similar types of assistance for which he/she was not command referred?	Refer Soldier to appropriate resources. Reserve Component (RC) ensure referral is with appropriate local resource.
2	Is the Soldier experiencing any difficulties getting the assistance he/she needs either on-post or off-post?	Refer Soldier to appropriate resources. RC ensure referral is with appropriate local resource. Follow-up with Soldier within 14 days to ensure that any difficulties have been overcome or resolved.
3	Has the Soldier been unsuccessful in meeting military requirements or standards (e.g., duty performance, PT, Battle Assembly participation (RC only), weight control, weapons qualification, MOS training)?	Develop and implement a plan of action to meet the requirements/standards. Closely monitor the Soldier's progress.
4	Has the Soldier received negative counseling or evaluations since arriving at the current unit or organization?	Determine if this is a current concern. Develop and implement a plan of action to meet the requirements/standards. Closely monitor the Soldier's progress.
5	Has the Soldier been denied promotion or attendance to schools, or barred from reenlistment for any reason?	Determine if this is a current concern. Develop and implement a plan of action to meet the requirements/standards. Closely monitor the Soldier's progress.
6	Is the Soldier currently undergoing a UCMJ action?	Ensure Soldier has adequate support, to include legal.
7	Does the Soldier have financial or employment concerns, such as inability to cover basic monthly expenses, home foreclosure, difficulty meeting child support payments, or inability to repay loans?	Refer Soldier to unit or installation financial representative or Army Community Service Financial Readiness Program. RC ensure referral is with appropriate local resource.
8	Has the Soldier experienced an accident, injury, illness, or medical condition that resulted in current fitness for duty limitations?	Ensure Soldier has appropriate medical follow-up. Ensure updated medical profile in e-Profile.
9	Does the Soldier have a current medical profile (temporary or permanent)?	Ensure Soldier has appropriate medical follow-up. Ensure updated medical profile in e-Profile.
10	Does the Soldier have any concerns about medical care, medications or supplements he/she is taking?	Refer to Primary Care Manager or Military Treatment Facility (MTF). RC ensure referral is with appropriate local resource.
11	Is the Soldier currently experiencing problems related to sleep (e.g., trouble falling asleep, trouble staying asleep, performance problems related to sleep, consistently getting less than 7-9 hours of sleep, using alcohol or other substances to get to sleep)?	Refer to Primary Care Manager or MTF. RC ensure referral is with appropriate local resource.
12	Does the Soldier tend to withdraw or socially isolate himself/herself from others?	Refer to Unit Ministry Team (UMT), Primary Care Manager, MTF, or Unit Behavioral Health Team, as appropriate. RC ensure referral is with appropriate local resource.
13	Has the Soldier exhibited excessive anger or aggression in the past three months?	Refer to Unit Ministry Team (UMT), Primary Care Manager, MTF, Unit Behavioral Health Team, Anger Management, or other appropriate support. RC ensure referral is with appropriate local resource.
14	Is the Soldier experiencing serious marital/relationship issues, or immediate family concerns, such as a serious illness in a family member?	Refer to Army Community Services, Military Family Life Counselor, Military OneSource, Unit Ministry Team (UMT), or Unit Behavioral Health Team, or other appropriate support. RC ensure referral is with appropriate local resource.
15	Has the Soldier been involved in any incidents of domestic violence or child abuse/neglect?	Refer to Family Advocacy Program. RC ensure referral is with appropriate local resource.
16	Has the Soldier experienced any condition that may be considered cruel, abusive, oppressive, or harmful, to include hazing or assault?	Connect Soldier with appropriate support (e.g. SHARP, EO, Family Advocacy, Unit Ministry, Primary Care Manager, MTF). RC ensure referral is with appropriate local resource.
17	Has the Soldier received a citation for speeding (10 miles over the posted limit) or reckless driving in the past 6 months?	Provide appropriate counseling to ensure Soldier understands good driving habits.
18	Has the Soldier been cited for engaging in risky behavior while in a vehicle (e.g., texting while driving, not utilizing a hands-free cell phone while driving, riding without a seatbelt)? Has the Soldier been informed that such activities are inherently unsafe, in violation of law and policy, and potentially punishable under UCMJ?	Provide appropriate counseling to ensure Soldier understands good driving habits. Ensure the Soldier has been informed that such activities are inherently unsafe, in violation of law and policy, and potentially punishable under the UCMJ.

Appendix D

High Risk Soldier Packet Assessment Template



REPLY TO  
ATTENTION OF

DEPARTMENT OF THE ARMY  
HEADQUARTERS, 2d BRIGADE COMBAT TEAM, 1st ARMORED DIVISION  
20500 COLD WAR ROAD  
FORT BLISS, TX 79918

AFAD-BCT-PE

5 February 2013

MEMORANDUM RECORD

SUBJECT: High Risk Soldier Commander's Assessment

- DD Form 2808, Report of Medical Examination (Page 1 and 3 only)
  - Provider will review medication profiles and document any polypharmacy issues
- DA Form, 3822, Report of Mental Status Evaluation (May utilize discharge evaluation if available)
- Criminal Background Check

The Soldier is:

- Fit for duty; no additional follow-up (must annotate below; BN CDR is the approval authority)
- Fit for duty; requires additional follow-up (see below)
- Not fit for duty; requires further action (see below)

The fit for duty follow up plan includes:

- |  |                                       |
|--|---------------------------------------|
| <input type="checkbox"/> Behavioral health                   | <input type="checkbox"/> JAG/Legal    |
| <input type="checkbox"/> Army Substance Abuse Program (ASAP) | <input type="checkbox"/> Finance      |
| <input type="checkbox"/> ACS                                 | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> WFC                                 |                                       |

The not fit for duty follow up plan includes:

- Chapter Action: (Type) \_\_\_\_\_
- Medical Evaluation Board (MEB)
- Other: \_\_\_\_\_

First Sergeant Assessment: (Use additional sheets as necessary)

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Commander's Assessment: (Use additional sheets as necessary)

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BN Commander Approval