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Perceptions of Mental Health Confidentiality Policies and Practices in the U.S. Military

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About This Report

The Office of the Secretary of Defense contracted with the RAND Corporation to examine the potential impact of existing U.S. military mental health confidentiality policies on service members seeking assistance for mental health issues. RAND was tasked with conducting a multimethods investigation involving key-stakeholder interviews with military mental health providers, commanding officers, and enlisted service members, as well as conducting a survey of the active component regarding knowledge, understanding, and practices associated with mental health confidentiality policies in the military. This report provides findings from all data collection efforts and is intended for Office of the Secretary of Defense personnel who are responsible for psychological health treatment policies and practices.

An annex to this report—with the survey instrument; survey methodology; survey results by service branch, pay grade, and mental health need, with and without nonresponse; interview protocols; and a comparison of Department of Defense Instruction 6490.08 versions—is available at www.rand.org/t/RRA2681-1.

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RAND National Security Research Division

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Summary

Issue

High rates of mental health issues among service members and a reluctance to access mental health services together represent one of the greatest ongoing threats to U.S. military readiness. Concerns about the confidentiality of mental health services received within the military have been documented as a significant barrier to service members obtaining needed treatment. Under certain circumstances, U.S. Department of Defense (DoD) policy states that mental health information can be shared with a member's commanding officer. DoD Instruction (DoDI) 6490.08 (2011), *Command Notification Requirements to Dispel Stigma in Providing Mental Health Care to Service Members*, lays out these circumstances. Principal among them is whether there is a serious risk of self-harm, harm to others, or harm to a specific military mission.[1] DoDI 6490.08 specifies that providers "shall provide the minimum amount of information to satisfy the purpose of the disclosure," which includes "ways the command can support or assist the Service member's treatment."[2] DoDI 6490.08 also stipulates in its instruction to commanders that information "shall be restricted to personnel with a specific need to know."[3]

Commanding officers are entrusted with the responsibility of ensuring the success of military operations and the protection of personnel. Mental health conditions can potentially affect functioning and job performance such that the safety of service members and the military mission can be endangered. At times, disclosing mental health information to commanding officers may be necessary so that informed decisions can be made about duty assignments, needed accommodations, unit resources, or deployments.

Service member concerns about the disclosure of treatment information to the chain of command are closely tied to the potential career consequences that could ensue (e.g., fitness-for-duty limitations that may affect promotion). To the extent that these concerns deter service members from obtaining needed mental health services, military readiness could be undermined. The challenge the U.S. military faces is how to optimally protect service members'

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[1] This research was completed before the 2023 reissuance of DoDI 6490.08. During the publication process, we added notes where there are differences between the 2011 and 2023 versions of the policy.

[2] The wording in DoDI 6490.08 (2023) is "ways the disclosing health care provider determines that command can support or assist the Service member's treatment."

[3] DoDI 6490.08 (2023) removed the need-to-know clause, and guidance regarding which personnel commanders can provide information to is not specified. However, the following instruction is provided: "The commander should aim to interact and cooperate with the provider in a manner that does not breach confidentiality as described in this instruction. This interaction should occur with the intent of building partnerships, enabling, and encouraging Service members to feel comfortable in obtaining care via self or medical referrals while furthering the successful accomplishment of the military mission."

privacy so that mental health services are sought and needs are not driven underground—while also ensuring successful execution of the military mission.

The purpose of this study was to assess service members' understanding and perceptions of confidentiality policies and practices and whether these perceptions affect their decisions to seek mental health care. The analysis could inform policy and practices that aim to balance "patient confidentiality rights and the commander's right to know for operation and risk management decisions" (DoDI 6490.08, 2011).[4] This is the first study to conduct a comprehensive examination of these issues.

Approach

We conducted a mixed-methods study that included developing the 2022 Health Care Privacy in the Military (HCPM) Survey, fielding the survey to the active component, and conducting interviews with service members in key roles associated with mental health care in the military. The HCPM Survey was administered online from August 8 to October 17, 2022, using email recruitment. Our sampling frame comprised all active component U.S. military personnel not enrolled as cadets in service academies, senior military colleges, or other Reserve Officer Training Corps programs as of March 2022, drawn from the Defense Manpower Data Center Active Duty Master File (N = 1,326,607). Flag officers (those at or above the pay grade of O-7) were also excluded to ensure the confidentiality of the results.[5] Out of 60,623 individuals who had an email address and were randomly selected for an invitation to participate, 1,873 respondents were considered as completing the survey based on a minimum survey response threshold, for an overall response rate of 2.8 percent.[6]

Survey weights were used to ensure that the analytic sample of respondents matched the overall active component on a variety of demographic and military characteristics. We aimed to field a survey that was representative of the active component military, but participants in the HCPM Survey likely included more members who have a personal interest in the survey topic—that is, those who have mental health symptoms or have sought treatment in the past—compared with the active component as a whole. Statistical techniques used to ensure that survey responses are representative of the active component likely could not fully account for this bias. The service members who self-selected into taking the survey repre-

[4] DoDI 6490.08 (2023) states, "[T]he commander's need to know certain information for military operational and risk management decisions, ensuring, except in a case in which there is an exigent circumstance, the confidentiality of mental health care services provided to members who voluntarily seek such services."

[5] The number of Space Force respondents was too small to produce estimates that would be both sufficiently precise and nonidentifiable, so they were combined with the Air Force. Members of the Coast Guard were also excluded.

[6] This is the percentage of usable responses within the analytic sample, out of the total number sampled minus ineligibles (1,873/67,095), which corresponds to the American Association for Public Opinion Research's response rate 1.

sent a group with a particular interest in military policies around mental health care and are likely those for whom the confidentiality policies are designed to reassure and encourage treatment. Thus, these results are still useful for policymakers and provide key insights into how policies in effect during the time of the study that remain unchanged are working for those individuals who are most directly concerned with the confidentiality of treatment. The HCPM Survey provides estimates of the prevalence of perceptions related to confidentiality limits, the implementation of confidentiality policies, and the impact of the policies for the population surveyed, but results cannot be generalized to the larger DoD population.

Semistructured interviews, conducted between December 2020 and March 2022, included three stakeholder groups—commanding officers (O-1 to O-5), military mental health providers (above the rank of O-3), and other enlisted service members—recruited from each service branch (excluding the Coast Guard) and among varying ranks and experiences. We conducted a total of 46 in-depth interviews. Findings from the stakeholder interviews should also be considered in light of certain study limitations. With assistance from the Psychological Health Center of Excellence, the Behavioral Health Clinical Community,[7] and installation commands, we identified large installations for purposive recruitment of providers and commanding officers. We did not have representation of Army commanding officers and some provider types that deliver care to service members in the Navy and Marine Corps. Nonetheless, the interviews enabled a deeper examination of how confidentiality policies are implemented, particularly with respect to the nature of information sharing between providers and commanding officers within populations that are absent of Army commanding officers and some provider types that deliver care to service members in the Navy and Marine Corps.

Key Findings

Out of 60,623 individuals who had an email address and were invited to participate, 2,069 (3.4 percent) proceeded to the first survey question. The final analytic sample comprised 1,873 respondents, each of whom completed the demographic and military service questions, as well as at least one question about the confidentiality of mental health services, which yielded a 2.8 percent response rate.[8]

Findings from the HCPM Survey and our interviews with key military stakeholders shed light on the various perceptions held by service members on the limits to mental health confidentiality and how policy implementation influences service members' decisions regarding mental health care in the military.

[7] Behavioral Health Clinical Community is a group consisting of psychological health leadership from the Defense Health Agency and each of the services.

[8] This is the percentage of usable responses within the analytic sample, out of the total number sampled minus ineligibles (1,873/67,095), which corresponds to the American Association for Public Opinion Research's response rate 1.

Service members had varied perceptions of the limits to mental health treatment confidentiality in the military. Specifically, the mental health–related circumstances perceived as requiring command notification were subject to varying interpretations:

- Perceptions varied on what constitutes harm to self and harm to others (e.g., suicidal or homicidal *ideation* versus *having a plan*).
- Perceptions varied on what constitutes harm to mission (e.g., harm depends on the members' job, and there is higher scrutiny for jobs involving weapons or national security).
- Perceptions varied on what circumstances require command notification. A substantial proportion of respondents held erroneous beliefs, perceiving that command notification was required *whenever* a service member misses a mental health appointment (56.2 percent), receives prescription mental health medication (31.7 percent), receives a mental health diagnosis (30.9 percent), receives mental health care for any reason (23.3 percent), and is undergoing a marital separation (20.3 percent).

Service members also had varying perceptions regarding what types of information can be shared with command:

- Interpretations varied on what constitutes DoDI 6490.08's (2011) "minimum amount of information" to disclose and the "ways the command can support or assist the service member's treatment."
- Fifty-eight percent of survey respondents and 80.3 percent of respondents with unmet mental health needs viewed service members as being often or always unsure of what information might be released to commanding officers.[9]

Perceptions related to which personnel or entities can access service members' mental health information also differed. Examples of this include the following:

- Interpretations of DoDI 6490.08's (2011) instructions to commanders to restrict information to "personnel with a specific need to know" ranged from the "leadership triad" (e.g., commanding officer, executive officer, and first sergeant) to being determined on a case-by-case basis.
- Survey respondents were concerned that, if they were to receive mental health treatment, their information would be shared with future nonmilitary employers (55.0 percent), promotion review boards (54.9 percent), future medical insurers (52.7 percent), other providers (51.9 percent), and the Department of Veterans Affairs Veterans Disability Panel (45.5 percent).

[9] *Unmet mental health need* is defined as a service member with serious psychological distress or self-perceived mental health needs 12 months prior to the survey who had not received treatment in the same period.

We also identified important takeaways regarding the implementation of mental health treatment confidentiality policies and practices, according to service members' perceptions:

- Training and education on confidentiality policies and practices are insufficient for providers, commanding officers, and service members at large.
- Current policy implementation processes may compromise confidentiality (e.g., through informal command notification mechanisms).
- Monitoring and enforcement of mental health confidentiality policies, particularly commanding officers' communication about service members' mental health information, are lacking.

Last, we found that perceptions of limited mental health treatment confidentiality affect service members' decisions regarding mental health treatment and that perceived negative consequences of getting mental health care continue to be a pervasive barrier to care for military service members. Examples include the following:

- More than half of respondents agreed or strongly agreed that the following concerns might affect their decisions to seek mental health treatment: impact on the ability to deploy (61.0 percent), effect on security clearance (59.8 percent), harm to career (57.4 percent), and entry into military training or school (56.3 percent).
- Nearly 90 percent of respondents indicated that they would limit what they would share with military mental health providers because of privacy concerns.
- Approximately half of service members reported they would delay or avoid treatment for issues such as depression (52.6 percent), thoughts of self-harm (48.6 percent), anxiety or worries (48.5 percent), or having trouble adjusting after a stressful life event (47.5 percent) because it could damage their military careers.
- More than 40 percent of respondents reported that they would seek treatment outside the Military Health System (42.7 percent) or that it would be helpful to get care after hours for privacy (44.6 percent).

Perhaps most notably, confidentiality concerns were more prevalent among service members with mental health needs and even more so among the subset with unmet mental health needs than service members with no mental health needs.

Recommendations

We recommend that DoD take the following actions to improve military personnel's understanding of confidentiality policies regarding mental health treatment, strengthen processes to ensure that policies are implemented as intended, and mitigate the consequences associated with limited confidentiality around mental health treatment in the military.

Improve Understanding of Mental Health Confidentiality Policies

- Clarify aspects of policies that are unclear and susceptible to provider and commander discretion and variability in implementation.
- The Defense Health Agency, installation commands, and line supervisors should ensure that policies, manuals, forms, and informational resources are clear and widely accessible.

Strengthen Supports and Accountability Measures to Ensure That Mental Health Confidentiality Policies Are Implemented as Intended

- Enforce mandatory education and training for all military personnel on mental health confidentiality policies and practices. This requires some level of standardization of training materials across services, installations, and provider and commander training programs. Given the number of stakeholders and training settings, specific offices or organizations within DoD should be tasked with leading the development of standardizing materials.
- Use structured documentation to facilitate communications between providers and commanding officers to limit open-ended dialogue and to increase the transparency of the nature of communications so that service members understand what is shared and what is not shared.
- Use structured, standardized documentation to facilitate and limit communications within the chain of command.
- Ensure that policy is revised to include guidance, monitoring, enforcement, accountability, and evaluation of policy compliance when service members' mental health information is disclosed throughout the chain of command.

Mitigate Consequences Associated with Limited Confidentiality Around Mental Health in the Military

- The Defense Health Agency should explore the feasibility of expanding treatment options that afford greater privacy to service members (e.g., telehealth, services during nonwork hours, and services, such as Military OneSource or the Military and Family Life Counseling Program, that are subject to fewer privacy exceptions).
- Modify policies to increase confidentiality protections and minimize adverse consequences associated with limited confidentiality while protecting the needs of the warfighting mission of DoD. Empirical support for the effectiveness of confidentiality policies around military mental health treatment is currently lacking. To best balance service members' right to privacy with commanders' need to know certain information for operational and risk management purposes, future research is necessary to examine whether increasing confidentiality protections (e.g., by restricting disclosure of information to duty limitations) might improve mental health service use and readiness while successfully executing the military mission.

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CHAPTER 1

Introduction

High rates of mental health issues among service members and a reluctance to access mental health services together represent one of the greatest ongoing threats to U.S. military readiness (Kessler et al., 2014; Institute of Medicine, 2013). Fewer than one in three service members with a mental health issue obtain treatment, according to estimates from a systematic review (Hom et al., 2017). A well-established barrier to seeking mental health care is service members' concerns about mental health confidentiality protections in the military (Carey et al., 2015; Institute of Medicine, 2013; Layson et al., 2022; Milliken, Auchterlonie, and Hoge, 2007). For example, a 2013 Institute of Medicine report identified service members' concerns about the privacy of military mental health information as a deterrent to seeking care, because members feared that seeing a mental health provider would be reported to a member's chain of command.

The U.S. Department of Defense's (DoD's) 2016 Status of Forces Survey of Active Duty Members found that 42.7 percent of active duty service members who reported experiencing suicidal ideation or a suicide attempt during military service but had never considered seeking care reported that they "did not think treatment would be kept confidential" and cited that as a reason for not obtaining help (Ho et al., 2018). Of the 6.8 percent of active component service members in the 2018 DoD Health Related Behaviors Survey who had not received mental health services despite having documented mental health needs, 30 percent reported not seeking care out of concern that the information shared would not be kept confidential (Meadows et al., 2021).

Indeed, confidentiality protections for U.S. service members are limited. For instance, Department of Defense Instruction (DoDI) 6490.08 (2011), *Command Notification Requirements to Dispel Stigma in Providing Mental Health Care to Service Members*, outlines nine circumstances under which health care providers are required to disclose service members' protected health information (PHI) to command to promote informed operation and risk management decisions (see Table 1.1).[1] It may be necessary for providers to inform leaders

[1] This research was completed before the 2023 reissuance of DoDI 6490.08. During the publication process, we added notes where there are differences between the 2011 and 2023 versions of the policy.

DoDI 6490.08 (2023) provides additional guidance for circumstances involving harm to self, harm to others, harm to mission, problematic substance-use treatment program (referred to as "substance abuse treatment program" in 2011), and other special circumstances ("GS-15 civilian equivalent level or above, or

TABLE 1.1
Nine Circumstances That Require Provider Disclosure to the Commander

Circumstance	Description
Harm to self	There is a serious risk of self-harm by the member.
Harm to others	There is a serious risk of harm to others. This includes any disclosures concerning child abuse or domestic violence.
Harm to mission	There is a serious risk of harm to a specific military mission.
Special personnel	The member is in the Personnel Reliability Program (DoDI 5210.42, 2019) or has mission responsibilities of such potential sensitivity or urgency that normal notification standards would significantly risk mission accomplishment.
Inpatient care	The member is admitted or discharged from any inpatient mental health or substance-misuse treatment facility.
Acute medical conditions interfering with duty	The member is experiencing an acute mental health condition or is engaged in an acute medical treatment regimen that impairs the member's ability to perform assigned duties.
Substance misuse treatment program	The member has entered into, or is being discharged from, a formal outpatient or inpatient treatment program for the treatment of substance misuse.
Command-directed mental health evaluation	The mental health services are obtained as a result of a command-directed mental health evaluation.
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 covered entity (i.e., health care provider at the O-6 level or above) or a commanding officer at the O-6 level or above.

SOURCES: Definitions of the circumstances specified in DoDI 6490.08, 2011, are stated in Privacy and Civil Liberties Office, 2022.

regarding service members' mental health state if their ability to perform critical job duties is impaired or the safety of service members are put at risk.

DoD has prioritized increasing access to mental health treatment by strengthening confidentiality. Most recently, the Brandon Act, part of the National Defense Authorization Act for Fiscal Year 2022 (Pub. L. 117-81, 2021), aims to promote help-seeking by creating a self-initiated referral process and allowing service members to seek mental health help confidentially (Cisneros, 2023). Specifically, the Brandon Act allows service members to request a referral for a mental health evaluation from any supervisor at the E-5 level or higher. Under the act, commanding officers or supervisors must refer the service member as soon as practicable, and service members can use duty time to attend the appointment (Schogol, 2023). DoD is working on a phased strategy for implementation, beginning with active duty service

a military medical treatment facility" commander at the O-6 level or above were added as entities that could execute the case-by-case determinations).

members and then expanding to all service members not on active duty. As of the writing of this report in 2023, it remains unclear how this policy will be implemented in a way that preserves service members' privacy or augments current protections that allow service members to self-refer and obtain mental health care without command involvement.

Confidentiality is vital to mental health treatment, as it safeguards personal information gathered in an intimate setting (e.g., patient-provider session) and protects that information from being disclosed to third parties without consent (Committee on Health Research and the Privacy of Health Information: The HIPAA Privacy Rule, Institute of Medicine, 2009). Unauthorized disclosures of personal information gathered in a patient-provider context are considered breaches of confidentiality and consequently can cause harm (e.g., discrimination) (Gostin and Hodge, 2002). Without clear assurances of confidentiality, individuals may be reticent to seek care or honestly disclose personal information to their health care providers (Gostin, 2001).

Confidentiality plays an important role in mental health treatment engagement, communication with providers, and effective treatment (Pritts, 2008). Several studies have shown that a patient's willingness to self-disclose information critical for mental health treatment decreases "as the perceived negative consequences of a breach of confidentiality increase" (Roback and Shelton, 1995). In fact, an assessment of how anonymity influences service members' willingness to report mental health issues (i.e., on a routine postdeployment screening) found that service members who screened positive for a mental health condition (e.g., depression, posttraumatic stress disorder [PTSD]) were more likely to report that they were uncomfortable disclosing honestly and were also significantly less willing to seek care than those who screened negative (Warner et al., 2011).

Each of these studies points to the significance of confidentiality perceptions and how these shape an individual's propensity to seek mental health care or disclose information to a mental health professional. However, many of these studies are limited to civilian populations or international military organizations and do not address how U.S. active duty service members' perceptions of confidentiality affect their engagement with the military mental health system. Thus, the extent to which concerns about confidentiality of mental health treatment affect treatment-seeking, treatment uptake, and treatment effectiveness among U.S. service members is largely unknown.

Concerns about the confidentiality of mental health treatment can be amplified in military settings, in which negative consequences can ensue if a service member's mental health issues become known. For example, a recent qualitative study identified "confidentiality concerns" as one of the primary barriers to mental health treatment-seeking in the military (Bogaers et al., 2020). That study, which examined the perspectives of service members (with and without mental health conditions) and those of mental health professionals, found that fear of confidentiality breaches fed into other barriers, such as fear of negative career consequences, fear of social rejection, and lack of trust in medical providers (Bogaers et al., 2020).

Tensions exist between protecting service members' privacy when seeking mental health care and ensuring that commanders maintain visibility on unit readiness to carry out mili-

tary missions (Acosta et al., 2014; U.S. Government Accountability Office, 2016). Military commanders are responsible for maintaining the readiness of their units to successfully carry out their missions. Commanders must therefore have access to information that affects readiness, such as personnel health or legal problems. Service members with undetected and untreated health problems could put others' lives and military missions at risk. Thus, commanders monitor their troops in a variety of ways (e.g., the Commander's Risk Reduction Toolkit), relying on real-time data monitoring of such factors as legal history, substance misuse, and suicidality. Another readiness tracking tool is the Army's Medical Protection System (MEDPROS), which contains the immunization, medical readiness, and deployability status of service members. In the Army, access to the Commander's Risk Reduction Toolkit is granted to battalion and company commanders, battalion and company command sergeants major, and company first sergeants. The first sergeant serves as the senior enlisted adviser to the commander, and the first sergeant's role is to attend to the needs of their unit personnel and their families. The first sergeant's job is to know their unit members and keep commanders informed about issues affecting readiness (Air Force Instruction [AFI] 36-2113, 2020). Those in the chain of command must make duty determinations about fitness and temporary restrictions for service members—determinations that affect unit readiness. For all these reasons, privacy protections for service members may be limited under certain circumstances to ensure personnel readiness and successful execution of military missions.

Overview of Military Mental Health Confidentiality Policies

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was established to govern the protection of health information (Pub. L. 104-191, 1996). DoD HIPAA policies are detailed in the DoDI 6025.18 (2019), *Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule Compliance in DoD Health Care Programs*, and the implementation procedures for the DoDI are specified in DoD Manual 6025.18 (2019), *Implementation of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule in DoD Health Care Programs*. DoD designated the Military Health System (MHS) and its business associates as covered entities governed by HIPAA that are required to safeguard PHI.

HIPAA permits PHI to be disclosed by covered entities (e.g., MHS providers) to commanding authorities under specific circumstances. Military commanding authorities include commanders who exercise authority over a service member or other people designated by commanders. To balance mission readiness, encourage help-seeking, and destigmatize mental health issues, in 2011 DoD published DoDI 6490.08, *Command Notification Requirements to Dispel Stigma in Providing Mental Health Care to Service Members*. This policy directs military health providers to disclose "the minimum amount of information to the commander as required to satisfy the purpose of the disclosure" (p. 2).[2] The stated purpose of the instruction

[2] The wording in DoDI 6490.08 (2023) is "the minimum amount of information to the commander as required to address the exigent circumstance that overcomes the presumption of confidentiality."

is to offer guidance "for balance between patient confidentiality rights and the commander's right to know for operation and risk management decisions," as well as to ensure that providers do not share treatment-related information with the commander unless one of the nine notification standards are met. These nine circumstances make up the "military command exceptions" and are described in Table 1.1.

There are several other key policies that govern the creation, protection, and disclosure of PHI for military service members (Table 1.2). These policies generally fall into three cat-

TABLE 1.2
Key DoD Policies About the Management of Privacy and the Protection of Mental Health Information

Policy	Title	Purpose
DoDI 5400.11 (2020)	*DoD Privacy and Civil Liberties Programs*	To maintain comprehensive privacy and civil liberties programs that comply with related laws and regulations
DoDI 5210.42 (2019)	*DoD Nuclear Weapons Personnel Reliability Assurance*	To select and maintain only the most-reliable people to perform duties associated with nuclear weapons and other specified duties
DoDI 6130.03 (2022)	*Medical Standards for Military Service: Retention*	To establish policy, assign responsibilities, and prescribe procedures for medical standards for military services
DoDI 6025.18 (2019)	*Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule Compliance in DoD Health Care Programs*	To define DoD's policies for compliance with federal laws governing the privacy of health information (DoD's HIPAA policy)
DoDI 6490.04 (2020)	*Mental Health Evaluations of Members of the Military Services*	To specify required assessment for mental health issues, including "referral, evaluation, treatment, and medical and command management"
DoDI 6490.05 (2020)	*Maintenance of Psychological Health in Military Operations*	To establish activities that support psychological health during military operations and early recognition of stress reactions to preserve warfighting capabilities
DoDI 6490.07 (2013)	*Deployment-Limiting Medical Conditions for Service Members and DoD Civilian Employees*	To define readiness to deploy with physical and mental health conditions
DoDI 6490.12 (2013)	*Mental Health Assessments for Service Members Deployed in Connection with a Contingency Operation*	To detail the requirements and procedures for person-to-person mental health assessments at four points before and after deployment
DoDI 8580.02 (2015)	*Security of Individually Identifiable Health Information in DoD Health Care Programs*	To ensure the security of individually identifiable health information created, received, maintained, or transmitted in electronic form
Directive-Type Memo 23-005	*Self-Initiated Referral Process for Mental Health Evaluations of Service Members*	To request referral through a "supervisor who is in a grade above E-5 on any basis, at any time, in any environment" and foster a culture of support that promotes help-seeking

egories that are not mutually exclusive. DoD and the service branches rely on instructions, regulations, and manuals to implement procedures to comply with policies:

1. **instructions that specify privacies granted to service members** (DoDI 5400.11 [2020], *DoD Privacy and Civil Liberties Programs*, and DoDI 6025.18 [2019], *Health Insurance Portability and Accountability Act [HIPAA] Privacy Rule Compliance in DoD Health Care Programs*)
2. **instructions specific to service members' health information and surveillance**, including personnel practices with respect to mental health evaluation and assessment (DoDI 6490.12 [2013], *Mental Health Assessments for Service Members Deployed in Connection with a Contingency Operation*; DoDI 5210.42 [2019], *Nuclear Weapons Personnel Reliability Assurance*; and DoDI 6490.04 [2020], *Mental Health Evaluations of Members of the Military Services*)
3. **instructions that articulate scenarios in which disabilities**, including mental health–related disabilities, become duty limitations (DoDI 6130.03 [2022], *Medical Standards for Military Service: Retention*, Volume 2, and DoDI 6490.07 [2013], *Deployment-Limiting Medical Conditions for Service Members and DoD Civilian Employees*; service-specific policies include AFI 10-203 [2014], *Duty Limiting Conditions*, and Army Regulation [AR] 40-8 [2022], *Temporary Flying Restrictions to Exogenous Factors Affecting Aircrew Efficiency*).

Each service branch established additional policy guidance and procedural manuals governing the service's implementation of DoD privacy policies. For instance, the Army Privacy and Civil Liberties Program is detailed in AR 25-22 (2016); the Air Force Privacy and Civil Liberties Program is detailed in AFI 33-332 (2020); and the Department of Navy Privacy Program is detailed in Secretary of the Navy Instruction 5211.5F (2019). Other service-specific policies govern unique programs, such as the Marine Corps Force Preservation Council Program. That program is detailed in Marine Corps Order 1500.60 (2016) and is intended to improve individual and unit readiness by identifying high-risk individuals for risk management.

The U.S. Air Force published AFI 10-203 (2014) to stipulate duty-limiting conditions associated with specific jobs (e.g., pilots) that may have unique health requirements and fewer privacy protections. There are also service-level policies that direct important efforts to structure and standardize the content of medical profiles, such as Office of the Surgeon General/U.S. Army Medical Command (OTSG/MEDCOM) Policy Memo 21-019, "Behavioral Health eProfiling Standardization Policy" (Headquarters, U.S. Army Medical Command, 2021). That policy provides examples of appropriate and inappropriate information to include in an eProfile for mental health and is a model for detailing and standardizing the sharing and transmission of readiness-related health information.

In conjunction with these and a multitude of personal and personnel readiness policies, the Defense Health Agency's (DHA's) Psychological Health Center of Excellence (PHCoE)

developed informational resources and tools to help equip providers and leaders to address concerns about confidentiality as a barrier to mental health care (see MHS and DHA, 2021). These informational resources address mental health confidentiality concerns by clarifying who may access service members' mental health information, what information might be disclosed and under what circumstances, and parameters of commanders' access to service members' mental health care information (i.e., only when meeting certain criteria) (PHCoE, 2020a, 2020b).

Despite the DoDIs, service-specific policies, and PHCoE's efforts to clarify the rules around military mental health confidentiality protections and circumstances for PHI disclosure, the definitions and guidance provided in the policies still leave room for interpretation and discretionary judgment (Engel, 2014; Frey, 2017; King and Snowden, 2020; Neuhauser, 2011). Consequentially, concerns about privacy and variations in confidentiality policy practices are clear disincentives to mental health care for military members (U.S. Government Accountability Office, 2016; Neuhauser, 2011).

Implementation of Military Mental Health Confidentiality Policies

The ways in which military mental health confidentiality policies are implemented affect service members' views about the confidentiality of their mental health information. Inherent in each of the nine circumstances requiring provider disclosure of PHI to command as specified in DoDI 6490.08 (2011) is a judgment about whether a certain threshold is met (see Table 1.1). What constitutes serious risk of self-harm is a matter of clinical judgment. Must someone have a suicide plan, or would suicidal intent meet the risk of self-harm criteria? Whether a person may be or become a threat to the mission depends on their symptoms, coping skills, and type of mission. For example, anxiety or self-doubt in a drone operator has the potential to harm a mission, whereas that is unlikely the case when a service member's mission is to maintain the landscape on an installation. That there exists an "other special circumstances" condition for disclosure of PHI to commanding authorities underscores the lack of standardization and openness to interpretation of DoDI 6490.08.

Further, DoDI 6490.08 (2011) states that only the minimum amount of information necessary ("minimum necessary") be conveyed by the provider to the commanding authority or designate. DoDI 6490.08 also defines the commander's role in safeguarding PHI by specifying that information should be restricted to personnel with an explicit "need to know"—that is, information "necessary for the conduct of official duties."[3] However, the policies lack clarity on *how* PHI should be disclosed, *who* has a need to know, and *what* is the minimum nec-

[3] DoDI 6490.08 (2023) eliminated the reference to commanders restricting the sharing of PHI to personnel with an explicit need to know. Guidance for commanders sharing of service members' PHI obtained from providers with others is not provided.

essary information. Also unspecified is how the provider identifies and contacts the service member's command authority or their designate, whom a command authority can designate to receive PHI, and how the PHI should be transferred. The DHA Privacy and Civil Liberties Office's guidance on the Military Command Exception rule, for example, states, "Commanders or other authorized officials receiving PHI from a covered entity shall protect the information in accordance with the Privacy Act to ensure it is only provided to personnel with an official need to know" (Privacy and Civil Liberties Office, 2022; also see Pub. L. 93-579, 1974). However, this policy guidance does not offer any further clarification on what constitutes an official need to know or which personnel are involved.

DoDI 6490.08 (2011) states that the minimum necessary information to satisfy the purpose of the disclosure generally consists of "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." The policy then goes on to state that the disclosure may indicate "ways the command can support or assist the service member's treatment." Much of this information is subject to the provider's judgment and discretion, and commanders and providers may hold different views of what information is needed to "support or assist the service member's treatment."[4]

In Jennifer Neuhauser's exploration of the tension between confidentiality and military necessity, she concluded that there "remains a significant hole in the regulatory scheme, allowing providers and commanders to determine which activities are 'necessary to the proper execution of the mission' with little oversight or consequences" (2011, p. 1034). Previous studies have suggested modifying current policies (Rona, Hyams, and Wessely, 2005) and developing explicit ethical guidelines for military behavioral health providers (Johnson, Grasso, and Maslowski, 2010; Orme and Doerman, 2001). One study specifically recommended the development of an objective and measurable definition for the concept of need to know (Orme and Doerman, 2001).

Issues facing military mental health providers identified in the literature include dual agency (i.e., providers' duty to protect both the patient and the mission) and ambiguity in policies (Acosta et al., 2014; Frey, 2017; Johnson, Grasso, and Maslowski, 2010; King and Snowden, 2020; Topinka, 2014). However, to our knowledge, no studies have evaluated and reported on service members' views of confidentiality policies and practices or commanding officers' view of their need to know and understanding of existing policies.

The ambiguity regarding how confidentiality policies should be implemented, such as procedures for disclosure, may result in variation in how the policies are applied, feeding into service members' concerns. Further, variation in training and education requirements for providers and leaders can contribute toward noncompliance, adherence issues, and documentation discrepancies. No studies have examined how the implementation of mental

[4] The wording in DoDI 6490.08 (2023) is "ways the disclosing health care provider determines that command can support or assist the Service member's treatment."

health confidentiality policies in the U.S. military may affect service members' perspectives and behaviors toward mental health treatment.

Consequences Associated with Limited Mental Health Confidentiality in the Military

A consequence of ambiguous policies, unstructured implementation, and limited confidentiality protections is that service members may not seek treatment or disclose personal details and fully engage in treatment. Treatment confidentiality ensures that individuals can receive care without fear of discrimination or stigma. It is well documented that stigma continues to be a pervasive barrier to mental health care in the military (Institute of Medicine, 2013; Kim et al., 2010). *Stigma* is a broad term, and examinations of treatment barriers describe multiple components (Acosta et al., 2014; Bogaers, 2020)—for instance, self-stigma (internalized negative beliefs about needing help) and public stigma (belief that others view needing help negatively). DoD has been trying to decrease mental health–related stigma and increase access to mental health treatment since the early 2000s. Acosta and colleagues reported on not only attitudinal stigma related barriers to care in the military (e.g., not wanting to be seen as weak, fearing negative career consequences for seeking treatment) but also perceived structural barriers (e.g., difficulty getting appointments or time off work) (Acosta et al., 2014).

Recent research has documented progress in the areas of symptom recognition and reduced stigma associated with seeking mental health care in the military (Fikretoglu et al., 2022); however, concerns about confidentiality policies and negative effects on military careers remain persistent barriers to mental health care. For example, the 2018 Health Related Behaviors Survey found that 34 percent of the active component U.S. military service members believed that seeking mental health treatment would harm their careers (Meadows et al., 2021), and Heyman and colleagues reported in their systematic review of career impacts of mental health evaluation and treatment that more than half of service members who screen positive for mental health issues believe that seeking mental health treatment will damage their careers (Heyman et al., 2022). Another study showed that service members who screened positive for a mental health issue or concern were more likely to separate from service following deployment (for any reason) than those who screened negatively. Heyman and colleagues caution that causality has not been established and that longitudinal studies are needed to assess whether mental health treatment truly has a negative impact on one's military career.

U.S. military service members receive nearly all their mental health care within the MHS (Meadows et al., 2018), which is directed by DoD and partly staffed by uniformed military providers. This factor may contribute to service members' perceptions that confidential mental health treatment options are not available (Davis et al., 2007). Concerns about the confidentiality of mental health services received in the MHS could lead to a host of adverse consequences, such as service members refraining from disclosing mental health problems,

deferring or avoiding necessary mental health care, prematurely terminating treatment, or withholding reporting of mental health impairment or symptoms (e.g., workplace errors, violent, or suicidal ideation). Each of these situations may increase the risk of unfavorable or even catastrophic outcomes for service members and the military. On the other hand, limiting confidentiality protections by disclosing mental health information to command when necessary could yield positive effects, including increased command involvement in support of service members' mental health treatment, early mitigation of potential threats to mission or the safety of other service members, better coordination and reinforcement of treatment and safety plans, and increased service member accountability to command.

Study Purpose and Approach

The purpose of this research was to understand how mental health confidentiality limitations in the U.S. military shape service member perspectives and behaviors. This report is the first in-depth investigation into service members' perspectives on mental health confidentiality—including their concerns, opinions, and perceived implications of limited confidentiality. The ultimate aim of the research is to inform efforts to promote use of mental health services within the military, given the trade-offs between privacy and mission readiness.

To achieve this objective, we reviewed international and U.S. military policies and the research literature to develop and conduct key-stakeholder interviews (i.e., providers, commanding officers, and enlisted service members) and a survey of the active component, the 2022 Health Care Privacy in the Military (HCPM) Survey. The international military policy review (conducted in the year 2018) consisted of a review of military mental health care confidentiality policies of four nations participating in the Five Eyes English-speaking intelligence alliance (Australia, Canada, New Zealand, and United Kingdom). These were useful comparison countries to the United States based on their common language and shared political, intelligence, cultural, and historical ties. In general, the armed forces of Australia, Canada, New Zealand, United Kingdom, and the United States all followed the conventional rule that PHI is confidential and its disclosure requires service member consent. All countries have established exceptions to this general rule that commonly centered on the protection of life, mission, and public safety. For example, across countries, disclosure of PHI was permitted in the following circumstances: to prevent or lessen serious harm to self or others, to reduce operational risk, and to mitigate risks resulting from service members who may be unfit to perform critical duties. Some policy variations were observed across the countries. For example, although U.S. military policy allows for the disclosure of information on diagnosis, treatment, and prognosis, policies from Australia, Canada, and New Zealand held the expectation that specific diagnoses should not be disclosed to command unless there is a serious reason to do so (e.g., potential operational consequence or a public health or public safety issue). Canadian policy required that the specific diagnosis and treatment prescribed are also protected and shall not be disclosed without the service member's consent. The United Kingdom's poli-

cies did not specify whether a diagnosis is required to be shared with command under various circumstances. The U.S. military policy review (also conducted in 2018) entailed a review of DoD, Army, Navy, Marine Corps, and Air Force policies pertaining to mental health confidentiality that were available in the public domain. Mental health confidentiality policies spanned several content domains, including the storage and potential disclosure of PHI, referral and evaluation for mental health and substance use services, fitness for military duty, health surveillance and assessments, and mental health care quality, coordination, and delivery. U.S. military policies highlighted the wide-ranging types of situations in which service members mental health information could be disclosed.

A review of the research literature was conducted to better understand the main issues and concerns surrounding mental health confidentiality policies in the military. The research literature review included published and unpublished studies identified in a search of nine databases (i.e., Academic Search Complete, CINAHL, Military Database, Military and Government Collection, PsycINFO, PubMed, Scopus, Sociological Abstracts, and Web of Science) up until June 2019. Descriptions of commander, mental health provider, and service member perceptions of confidentiality policies and practices were a significant proportion of the literature. With respect to commanders, there was a nearly singular focus on commanders' assertions of their need to know the mental health information of service members to ensure force readiness (Anderson, 2013; Hoyt, 2013; Iversen et al., 2011). For mental health providers, a major issue focused on the potential conflict posed by their dual agency (i.e., their simultaneous obligation to provide optimal care to service members and to protect national security interests) (Johnson, Grasso and Maslowski, 2010; Kennedy and Johnson, 2009; Warner et al., 2009). Some providers described adopting workaround strategies to protect service members' confidentiality (e.g., minimal documentation in mental health records, thorough informed consent before the start of treatment as well as disregarding certain regulatory requirements) (Kennedy and Johnson, 2009; Johnson, 2008; Johnson, Grasso, and Maslowski, 2010). In addition, the lack of clarity of policies were described as creating challenges for providers to know how to operationalize and comply with command exceptions to confidentiality (Orme and Doerman, 2001; Moore, 2010). From the perspective of service members, the limited confidentiality afforded by military behavioral health services were cited as engendering fear and concerns that one's military career might be damaged if a commander learns that they have a mental health problem (Hoge et al., 2004; Kim et al., 2010; Meadows et al., 2018; Sims et al., 2015). Service members were also described as having limited or inaccurate understanding of mental health confidentiality policies (Dean and McNeil, 2012; Ghahramanlou-Holloway et al., 2018).

Our review of the literature and policies related to military readiness, mental health confidentiality, and PHI disclosure informed the content of the key-stakeholder interview protocols and survey of the active component. This study explores how mental health confidentiality policies are understood and practiced by stakeholders and aims to unearth examples of how policies are applied in practice. Our mixed-methods approach employed the interviews and survey to understand the following three domains: (1) perceptions of mental health

confidentiality limits, (2) perceptions of the implementation of mental health confidentiality policies, and (3) the perceived impact of mental health confidentiality policies and practices.

It should be noted that service members who completed this study's HCPM Survey reported high rates of psychological distress. Although this implies that our sample likely suffers from selection bias, this bias is toward the service members most affected—namely, those with mental health issues. However, the survey results presented in this report should not be interpreted as fully representative of the knowledge and opinions of all service members due to evidence of substantial self-selection of struggling or affected service members.

We also identified and recruited military stakeholders (i.e., mental health providers, commanders, and enlisted service members) and conducted semistructured interviews. Our qualitative research focused on stakeholders' knowledge and understanding of relevant policies, experiences with practical applications of confidentiality policies, concerns about the confidentiality of mental health information, and the impact of stakeholders' views on willingness to seek care and reveal sensitive information to providers. Findings from the stakeholder interviews should also be considered in light of certain study limitations. Our interview findings come from individual anecdotes and experiences and cannot be generalized. With the assistance of PHCoE, the Behavioral Health Clinical Community, and installation commands, we identified large installations for purposive recruitment of providers and commanding officers. We did not have representation of Army commanding officers and some provider types that deliver care to service members in the Navy and Marine Corps.

Organization of This Report

In the next chapter, we describe the development, fielding, and results of the survey with active component service members. In Chapter 3, we present our interview methods and results, focused primarily on the opinions of commanding officers, mental health providers, and enlisted service members. We sought to understand the nature of these stakeholders' interactions with one another, their understanding of relevant policies, and their perceptions or experiences of how these polices are implemented. In Chapter 4, we integrate the survey and interview findings to make recommendations for how DoD might modify policies and practices to increase the likelihood of service members accessing needed mental health treatment while ensuring the successful execution of military missions.

The report also contains an annex that is available online at www.rand.org/t/RRA2681-1. The annex contains the survey instruments (Appendix A); detailed survey methods (Appendix B); tabular results of the survey by service branch, pay grade, and mental health need (Appendix C); details on survey nonresponse (Appendix D); stakeholder interview protocols (Appendix E); and a comparison of DoDI 6490.08's 2011 and 2023 versions (Appendix F).

CHAPTER 2

The Health Care Privacy in the Military Survey

We developed the 2022 HCPM Survey to assess service members' perceptions and understanding of U.S. military mental health confidentially policies and practices. We surveyed service members across the following domains:

- perceptions of limits to mental health confidentiality in the military
- perceptions regarding the implementation of mental health confidentiality policies and practices
- perceived impact of mental health confidentiality on service members.

The HCPM Survey was administered online using email recruitment. The sample was a stratified probability sample of the DoD active component. The target population included all active component personnel not enrolled as cadets in service academies, senior military colleges, and other Reserve Officers' Training Corps (ROTC) programs as of March 2022. Flag officers (i.e., those at or above the pay grade of O-7) were also excluded to ensure the confidentiality of the results.[1] A total of 60,623 individuals were invited to participate, and 2,069 proceeded to the first survey question. The final analytic sample contained 1,873 service members, each of whom completed the demographic and military service questions, as well as at least one question about confidentiality of mental health services, yielding an overall response rate of 2.8 percent.[2]

Survey weights were used to account for the sample design and nonresponse to ensure that the analytic sample of service members matched the overall active component on a variety of demographic and military characteristics. Weighted percentages are provided for sample descriptives. By service branch, the sample was composed of 35.8 percent Army, 25.9 percent Air Force, 13.2 percent Marine Corps, and 25.6 percent Navy service members. For pay grade, the sample was composed of E-1–E-4 (42.1 percent), E-5–E-6 (28.7 percent), E-7–W-5

[1] The number of Space Force respondents was too small to produce estimates that would be both sufficiently precise and nonidentifiable, so they were combined with the Air Force. Members of the Coast Guard were also excluded.

[2] This is the percentage of usable responses within the analytic sample, out of the total number sampled minus ineligibles (1,873/67,095).

(11.6 percent), O-1–O-3 (10.5 percent), and O-4–O-6 (7.1 percent) service members. Service members had a mean age of 29.2 (standard deviation [SD] = 0.23) and mean years of service of 8.2 (SD = 0.19).

Although the survey design intended to generate a representative sample, the final analytic sample should be interpreted as a largely self-selected sample, rather than a fully representative probability sample. There was evidence of substantial self-selection through survey nonresponse and survey breakoff, which is unlikely to have been fully mitigated through survey weights. We believe that the survey results are likely to overrepresent members who have a personal interest in the survey topic, including those who have mental health symptoms or have sought treatment in the past. Conversely, the results likely underrepresent the opinions of members who have not experienced mental health problems or are otherwise not interested in or knowledgeable about confidentiality policies. It is also possible that service members who have concerns about DoD confidentiality protections might have been hesitant to participate in a DoD-sponsored study and might have also been underrepresented.

Despite these limitations, the results of the survey may still be useful to policymakers and military leaders because the service members who self-selected into the study may represent a group of particular interest for military policies around mental health care. The purpose of treatment confidentiality is to encourage individuals who need care to get it without fear of discrimination or stigma. This survey effectively overrepresents individuals who need treatment and who have mental health symptoms. These are precisely the individuals the policies were designed to reassure and to encourage to seek treatment. Although the survey sample is not fully representative of the military, key insights may still be gleaned about how policies during the time the study was conducted and that have remained unchanged are working for those individuals who are most directly concerned with the confidentiality of treatment. To get a clearer picture of this subgroup's perceptions, some of our analyses focused on respondents who had a need for mental health treatment in the past year.

A copy of the HCPM Survey is provided in the online annex, in Appendix A. Additionally, detailed information regarding the methods employed to conduct the HCPM Survey is available in Appendix B. This includes descriptions of measures, design of the sampling plan, administration of the survey, development of survey weights, sample characteristics, and the final analytical approach.

In the remainder of this chapter, we present results from the HCPM Survey. We begin by presenting information on the demographic characteristics of the weighted respondent sample. We then examine results across each of the survey domains for the overall respondent sample and then by subgroups (i.e., service branch, pay grade, and mental health need). *Service branch* subgroups encompassed the active component of the Army, Marine Corps, Navy, and Air Force (including the Space Force). *Pay grade* was grouped into the following categories: E-1–E-4, E-5–E-6, E-7–E-9/W-1–W-5, O-1–O-3, and O4–O-6. Omnibus tests (Rao-Scott chi-square tests) were conducted to assess overall differences between subgroups.

With respect to *mental health need*, we categorized respondents according to whether they had *mental health needs* (n = 765, 57.5 percent) versus those who had *no mental health needs* (n = 577, 42.5 percent). *Mental health need* was defined as having *any* of the following

in the 12 months prior to the survey: met criteria for serious psychological distress based on the Kessler-6 scale (Kessler et al., 2003), self-reported a perceived need for mental health treatment, or saw a mental health provider or general medical provider for a mental health problem.[3]

The subgroup of respondents with mental health needs were further classified into two subcategories: *met* mental health needs (n = 512, 61.9 percent) versus *unmet* mental health needs (n = 251, 38.1 percent). *Met* mental health needs consisted of respondents who in the past 12 months had mental health needs and had obtained mental health treatment. *Unmet* mental health needs consisted of respondents who in the past 12 months had mental health needs but did *not* obtain mental health treatment. Rao-Scott chi-square tests were conducted to examine group differences between service members with mental health needs versus no mental health needs and, among the subset of service members with mental health needs, those with met mental health needs versus unmet mental health needs.

For each of the survey domains, key findings are outlined for the overall sample and by service branch, pay grade, and mental health need when notable subgroup differences were observed.

Perceptions of Limits to Mental Health Confidentiality in the Military

We assessed perceptions of limits to mental health confidentiality in the military by asking respondents to indicate under what circumstances military health providers are required to notify a command about service members' mental health issues (see Table 2.1), in effect assessing respondents' understanding of current DoD policy.

As described in Chapter 1, DoDI 6490.08 (2011), *Command Notification Requirements to Dispel Stigma in Providing Mental Health Care to Service Members*, outlines nine mental health–related circumstances in which "healthcare providers shall notify the commander." The first three items in Table 2.1 correspond to the following circumstances specified in DoDI 6490.08: harm to others, harm to self, and acute medical conditions interfering with duty. The remaining circumstances listed in Table 2.1 are not explicitly described in DoDI 6490.08 as situations requiring command notification. Moreover, DoDI 6490.08 stipulates, "Healthcare providers shall follow a presumption that they are not to notify a Service member's commander when the Service member obtains mental health care" unless the presumption is superseded by one of the nine specified notification standards.[4]

[3] According to the 2018 DoD Health Related Behaviors Survey, approximately 16.4 percent of active component service members reported serious psychological distress in the prior 12 months, compared with 34.6 percent of HCPM Survey respondents (Meadows et al., 2021).

[4] DoDI 6490.08 (2023) states: "A Service member's use of military health system mental health care resources, to include substance misuse education services, will not be reported to their commander except under the exigent circumstances defined in this instruction."

TABLE 2.1
Circumstances Perceived as Requiring Command Notification

A military health provider is required by regulation to notify a commanding officer whenever a service member . . .	Yes	95% confidence interval
Is at serious risk of harming others[a]	85.3%[b]	83.0–87.6
Is at serious risk of self-harm[a]	84.3%[b]	81.9–86.7
Has a mental health diagnosis that interferes with assigned duties[a]	77.1%[b]	74.4–79.8
Has a mental health diagnosis and is assigned to carry a loaded weapon	75.3%[b]	72.6–78.1
Misses a mental health treatment appointment	56.2%[b]	53.1–59.4
Has a mental health diagnosis and arrives at a new duty station	34.6%	31.4–37.7
Is prescribed any medication for a mental health issue	31.7%[b]	28.5–34.9
Receives any mental health diagnosis	30.9%[b]	27.8–34.0
Receives mental health services for any reason	23.3%	20.3–26.2
Is going through a marital separation	20.3%	17.5–23.1

NOTE: All data are weighted. Percentages are calculated using nonmissing values. The average number of respondents across items for the table is unweighted n = 1,865 (99.6%).

[a] These circumstances are specified in DoDI 6490.08 (2011) as requiring command notification.

[b] Level of agreement differed significantly by service branch ($p < 0.05$).

We found that awareness of DoD policy about command notification varied. In addition, we found misperceptions: A sizable percentage of respondents thought, incorrectly, that notification rules applied in cases where they do not.

The three circumstances most highly recognized as requiring command notification were serious risk of harm to others (85.3 percent), serious risk of self-harm (84.3 percent), and having a mental diagnosis that interferes with assigned duties (77.1 percent) (see Table 2.1). It is notable that between 15 percent and 23 percent of respondents did not view these circumstances as requiring command notification, given that they are specified in DoDI 6490.08 as exceptions to confidentiality. Additionally, we found the following:

- More than half of respondents (56.2 percent) were under the impression that a command would be notified *whenever* a service member misses a mental health treatment appointment.
- More than a third of respondents thought that command notification is required by regulation *whenever* a service member arrives at a new duty station with a mental health diagnosis (34.6 percent), is prescribed *any* mental health medication (31.7 percent), or receives any mental health diagnosis (30.9 percent).
- One in five respondents held the impression that health providers are required to notify commanding officers *whenever* a service member is going through a marital separation.

Differences by service branch were observed (see Table C.1 in Appendix C). Key findings were as follows:

- For seven of the ten circumstances (connoted by a superscript *b*), we observed significant variation across service branches. The Air Force had the highest rates of endorsement across six circumstances, and Marine Corps respondents were the lowest across four circumstances.
- Air Force respondents were the most likely and Marine Corps respondents the least likely to recognize the required command notifications harm to others (86.6 percent versus 75.5 percent), self-harm (88.8 percent versus 76.7 percent), and interference with duties (82.0 percent versus 69.0 percent).

Significant pay grade differences were found across all ten of the presented situations (see Table C.2 in Appendix C). Key findings were as follows:

- Junior enlisted (E-1–E-4) respondents had the lowest rates of endorsement for four of the presented conditions (harm to others, self-harm, interference with assigned duties, and assigned to carry a weapon with a mental diagnosis).
- E-1–E-4 respondents also had the highest rates of endorsement for three of the conditions (i.e., arrival at a new duty station with a mental diagnosis, prescribed mental health medication, and undergoing a marital separation).

A few differences by mental health need were observed (see Table C.3 in Appendix C):

- Among respondents with mental health needs, a smaller percentage (30.8 percent) thought that arrival at a new duty station with a mental health diagnosis was always grounds for command notification than peers with no mental health needs (39.9 percent).
- Among respondents with no mental health needs, a smaller proportion (51.5 percent) thought that command notification is required whenever a service member misses treatment appointments, compared with respondents with mental health needs (60.9 percent); this belief was even more prevalent among those with unmet mental health needs (67.7 percent).

Perceptions Regarding the Implementation of Mental Health Confidentiality Policies and Practices

We investigated two aspects of the implementation of mental health confidentiality policies and practices. First, we assessed respondents' perceptions of how often service members are unsure of what types of information might be released to commanding officers. Second, we

assessed respondents' perceptions regarding the management of service members' mental health information.

As seen in Table 2.2, more than half of respondents (58.0 percent) thought that service members are often or always unsure of what types of mental health information might be released to a commanding officer.

Key findings regarding respondents' perceptions of how service members' mental health information is protected were as follows:

- About a fifth of respondents thought that the following happens often or always: mental health information that is shared with commanding officers spreads to other unit members (21.8 percent), and mental health information is shared with commanding officers without service members' knowledge or consent (20.0 percent). Similar perceptions were observed for physical health, with 22.1 percent respondents thinking that military health providers often or always share service members' physical health information with their commanding officers without service members' knowledge or consent.
- A smaller proportion of respondents thought that service members' mental health information is often or always accessed without proper authorization (14.5 percent).
- A few service branch differences were observed (see Table C.4 in Appendix C). Specifically, the Marine Corps had the lowest proportion of respondents who thought that the following often or always occurs:

TABLE 2.2

Perceptions Regarding the Implementation of Confidentiality Policies and Practices

How often do you believe the following occurs in the military?	Never	Sometimes	Often	Always
Service members are unsure what types of mental health information might be released to a commanding officer	16.0% (13.7–18.4)	25.9% (22.9–29.0)	41.6% (38.4–44.9)	16.4% (14.0–18.8)
A service member's mental health information is shared with a commanding officer, and the information spreads to other unit members	37.6% (34.4–40.8)	40.6% (37.4–43.9)	16.0% (13.5–18.5)	5.8% (4.0–7.6)
Military health providers share service members' mental health information with their commanding officer without service members' knowledge or consent	35.6% (32.4–38.8)	44.3% (41.0–47.6)	15.1% (12.7–17.6)	4.9% (3.5–6.4)
Military health providers share service members' physical health information with their commanding officer without service members' knowledge or consent	37.0% (33.9–40.2)	40.9% (37.9–44.2)	15.8% (13.4–18.1)	6.3% (4.5–8.2)
Service members' mental health information is accessed without proper authorization	43.8% (40.5–47.1)	41.7% (38.4–45.0)	10.9% (8.6–13.1)	3.6% (2.5–4.7)

NOTE: All data are weighted. 95 percent confidence intervals are presented in parentheses. Percentages are calculated using nonmissing values. The average number of respondents across items for the table is unweighted n = 1,774.

- Service members are unsure of what types of mental health information might be released to commanding officers (43.9 percent, in contrast to 60.7 percent of Navy respondents)
- Service members' mental health information is shared with commanding officers and then spreads to the unit (15.5 percent, in contrast to 26.9 percent of Army respondents).

Several differences by pay grade groups were also observed (see Table C.5 in Appendix C):

- Only 9 percent of O-4–O-6 respondents thought that mental health information that is shared with commanding officers often or always spreads to other unit members, in contrast to slightly more than 20 percent of respondents across the other pay grades.
- In contrast, those in the O-4–O-6 pay grade had the highest proportion of respondents (79 percent) who perceived service members as being often or always unsure of what types of mental health information might be released to commanding officers; this is in comparison to 49.1 percent of E-1–E-4 respondents, who had the lowest proportion endorsing this same perception.

Differences by mental health need were evidenced as well (see Table C.6 in Appendix C):

- Respondents with mental health needs (66.1 percent) were more likely than those with *no* mental health needs (52.0 percent) to think that service members are often or always uncertain of what types of mental health information might be released to commanding officers. Viewing service members as frequently lacking certainty about what types of information might be disclosed to commanding officers was even more prevalent among respondents with unmet mental health needs (80.3 percent).
- Perceptions that military health providers often or always share mental health information with commanding officers without service members' consent or knowledge were more widely held by respondents with mental health needs (23.7 percent) than their peers with no mental health needs (16 percent). This belief was even more widespread among respondents with unmet mental health needs (30.7 percent).

Perceived Impact of Mental Health Confidentiality Policies and Practices

We examined the respondents' concerns about the confidentiality of mental health treatment and perceptions regarding the consequences associated with receiving mental health treatment before ultimately assessing their effects on respondents' treatment-seeking intentions.

Concerns About the Confidentiality of Mental Health Treatment

We assessed concerns about the confidentiality of mental health treatment in the following areas: the privacy of medical records, confidence in the safeguards for medical records and

having control over one's mental health information, and concerns about the entities that might obtain service members' mental health information.

Concerns About the Privacy of Medical Records

The DHA Privacy and Civil Liberties Office guidance on the *Military Command Exception and Disclosing PHI of Armed Forces Personnel* specifies that "the Exception does not permit a Commander's direct access to a Service member's electronic medical record, unless otherwise authorized by the Service member or the HIPAA Privacy Rule" (Privacy and Civil Liberties Office, 2022; also see MHS and DHA, 2023).

HCPM Survey respondents were asked about their degree of concern regarding the privacy of health information contained in medical records if they were to (hypothetically) receive mental health counseling or mental health medication (see Table 2.3). Key findings were as follows:

- Nearly half of respondents expressed that they would be somewhat or very concerned about the privacy of health information contained in medical records if they were receiving mental health counseling (46.2 percent) or medication (47.2 percent)
- Nearly one in four respondents reported having no concerns at all about the privacy of their medical records.

No notable service branch or pay grade group differences were observed (see Tables C.7 and C.8 in Appendix C). Group differences by mental health needs were found. Specifically, a greater proportion of respondents with mental health needs expressed they were somewhat or very concerned about the privacy of health information in their medical records if they were to receive mental health counseling (52.8 percent) or medication (54.5 percent), in comparison to respondents with no mental health needs (38.1 percent and 38.3 percent, respectively) (see Table C.9 in Appendix C).

TABLE 2.3
Concerns About Privacy of Medical Records

To what extent would you be concerned about the privacy of health information contained in your medical records if you were receiving . . .	Not at all concerned	A little bit concerned	Somewhat concerned	Very concerned
Mental health counseling	24.3% (21.0–27.6)	29.4% (26.4–32.5)	22.8% (19.9–25.8)	23.4% (20.3–26.5)
Mental health medication	24.9% (21.7–28.1)	27.9% (24.8–31.1)	20.6% (17.8–23.3)	26.6% (23.2–29.9)

NOTE: All data are weighted. 95 percent confidence intervals are presented in parentheses. The average number of respondents across items for the table is unweighted n = 1,530.

Confidence in Safeguards for Medical Records and Having Control over One's Mental Health Information

The DHA Privacy and Civil Liberties Office is tasked with assisting the MHS with complying with the HIPAA Privacy Rule, which defines how service members' PHI should be safeguarded, limits when PHI can be used and disclosed without service members' authorization (MHS and DHA, 2022), and provides service members some control over their own PHI (DHA Administrative Instruction 5400.01, 2022).

As seen in Table 2.4, key findings regarding HCPM Survey respondents' confidence in safeguards over medical records and control over the access of mental health information indicated the following:

- Fewer than one in five respondents felt very confident that safeguards are in place to protect medical records from being seen by people who not permitted to do so.
- Only 12.8 percent of respondents felt very confident that they had control over who is allowed to collect, use, and share their mental health information.

Service branch group differences were not observed (see Table C.10 in Appendix C). Pay grade and mental need group differences were found (see Tables C.11 and C.12, respectively). Key findings were as follows:

- Respondents in higher pay grades were less confident about having some control over who accesses their mental health information. For instance, only 6.6 percent of O-1–O-3 and 10.0 percent of O-4–O-6 respondents reported feeling very confident in having some control over who is allowed to collect, use, and share their mental health information, compared with 17.6 percent of E-1–E-4 respondents.
- Among the subset of respondents with unmet mental health needs, only 6.3 percent felt very confident in having some control over who accesses their mental health infor-

TABLE 2.4
Confidence in Safeguarding Medical Records and Control over Health Information

How confident are you that . . .	Not at all confident	A little bit confident	Somewhat confident	Very confident
Safeguards (including the use of technology) are in place to protect your medical records from being seen by people who are not permitted to see them	16.3% (13.8–18.8)	29.5% (26.4–32.7)	35.2% (31.6–38.8)	18.9% (16.1–21.8)
You have some control over who is allowed to collect, use, and share your mental health information	34.3% (30.9–37.6)	27.1% (23.9–30.2)	25.9% (22.6–29.2)	12.8% (10.2–15.4)

NOTE: All data are weighted. 95 percent confidence intervals are presented in parentheses. Percentages are calculated using nonmissing values. The average number of respondents across items for the table is unweighted n = 1,521.

mation, compared with 13.0 percent of respondents with met mental health needs and 15.6 percent of those with no mental health needs.

Concerns About Entities That Might Obtain Service Members' Mental Health Treatment Information

DHA PHCoE clarified that the following entities may have access to service members' mental health information: coordinating military treatment facility (MTF) providers (as part of treatment planning) and the chain of command (on a "need-to-know basis only") (PHCoE, 2020b). HCPM Survey respondents were asked about their concerns related to the entities that may be able to access their mental health information if they were to receive mental health treatment from a military health care provider. Entities included individuals within the chain of command, as well as a host of others (see Table 2.5).

Key findings were as follows:

- Approximately half or more respondents were concerned that their mental health information would be shared with a variety of entities if they received mental health treatment.
- These entities included individuals who could have an impact on respondents' careers, such as commissioned officers directly above them in the chain of command (55 percent), promotion review boards (54.9 percent), direct supervisors (48.6 percent), and potential future employers outside the military (55 percent).
- Respondents also had concerns about entities in the health care system accessing their mental health information, including potential future medical insurers (52.7 percent), military health providers not involved in service members treatment (51.9 percent), and Department Veterans Affairs Veterans Disability Panel (45.5 percent).

TABLE 2.5

Concerns About Entities That Might Obtain Service Members' Mental Health Treatment Information

If you were receiving mental health treatment from a military provider, would you be concerned that your mental health information would be shared with:	Yes	95% confidence interval
The commanding officer directly above you in the chain of command	55.0%	51.4–58.6
Potential future employers outside the military	55.0%	51.5–58.6
Promotion Review Boards	54.9%	51.3–58.5
Potential future medical insurer, including Veterans Affairs	52.7%	49.2–56.3
Military health providers who are not involved in your treatment	51.9%	48.4–55.5
Your direct supervisor	48.6%	45.0–52.2
Veterans Disability Panel	45.5%	41.9–49.0

NOTE: All data are weighted. Percentages are calculated using nonmissing values. The average number of respondents across items for the table is unweighted n = 1,548.

No notable group differences by service branch or pay grade were observed (see Tables C.13 and C.14 in Appendix C). However, group differences by mental health need were evidenced (see Table C.15 in Appendix C). Significant differences by mental health need were observed for five of the seven entities shown in Table 2.5:

- Respondents with mental health needs versus those with no mental health needs had higher levels of concerns that their mental health information would be shared with the following entities if they sought mental health treatment:
  - commanding officers in the direct chain of command (61.5 percent versus 47.5 percent)
  - promotion review boards (58.6 percent versus 48.6 percent)
  - future medical insurers (56.1 percent versus 47.9 percent)
  - direct supervisors (53.4 percent versus 40.3 percent)
  - Veterans Disability Panel (49.4 percent versus 39.8 percent).
- These concerns were even more prominent among the subset of respondents with unmet mental health needs versus those with no mental health needs for the following entities:
  - commanding officers in the direct chain of command (70.1 percent versus 47.5 percent)
  - future employers (62.6 percent versus 52.2 percent)
  - future medical insurers (62.8 percent versus 47.9 percent)
  - direct supervisors (60.5 percent versus 40.3 percent).

Perceived Consequences Associated with Receiving Mental Health Treatment

Given that the Military Command Exception under HIPAA allows military treatment providers to disclose armed forces personnel PHI to command authorities for certain authorized activities (e.g., fitness-for-duty determinations; see DoDI 6490.08, 2011; DoDI 6025.18, 2019), understanding the types and prevalence of concerns associated with others knowing about service members' mental health issues or treatment may provide potential targets for intervention.

In this section, we present findings related to the following domains:

- service members' concerns about how commanding officers in their *direct chain of command* might respond if they learned that service members were receiving mental health treatment
- the same set of concerns with respect to how *immediate supervisors* might respond if they learned that service members were receiving mental health treatment; for some respondents, the commanding officer in the direct chain of command and immediate supervisor could be the same individual

- concerns that might affect service members' decisions about whether to receive mental health counseling or treatment (e.g., whether counseling or treatment might affect members' ability to deploy or maintain security clearances)
- types of mental health issues (e.g., depression, anxiety) service members would delay or avoid treatment for because of concerns that treatment might damage their military careers.

Concerns About Responses to Service Members Receiving Mental Health Treatment by Commanding Officers in the Direct Chain of Command

HCPM Survey respondents were asked to rate how concerned they would be about different ways the commanding officer directly above them in the chain of command might respond if they found out that respondents were receiving mental health treatment (see Table 2.6).

Key findings were as follows:

- More than half or nearly half of service members conveyed that, if they had a mental health issue, they would be a lot or somewhat concerned that the commanding officer directly above them in their chain of command would treat them differently (52.8 percent) or hinder their promotion or career advancement (46.7 percent).
- Roughly four in ten service members were a lot or somewhat concerned that the officer directly above them in the chain of command would tell others about their mental health issue (43.9 percent), ask their health provider for information that they do not want shared (42.3 percent), or limit or restrict normal work activities (40.6 percent).

TABLE 2.6

Concerns About Responses to Service Members Receiving Mental Health Treatment by Commanding Officers in the Direct Chain of Command

I would be concerned the officer directly above me in the chain of command would . . .	Not at all	A little	Somewhat	A lot
Treat me differently	21.9% (19.1–24.6)	25.3% (22.3–28.3)	19.3% (16.4–22.1)	33.5% (30.1–36.9)
Hinder my promotion or career advancement	33.5% (30.4–36.7)	19.8% (16.8–22.8)	14.4% (11.9–16.9)	32.3% (28.9–35.7)
Tell others about my mental health issue	32.9% (29.6–36.1)	23.1% (20.2–26.1)	16.7% (14.2–19.3)	27.2% (23.9–30.6)
Ask my health provider for information that I do not want shared	36.5% (33.2–39.9)	21.1% (18.3–23.8)	17.1% (14.4–19.9)	25.2% (22.1–28.4)
Limit or restrict my normal work activities	30.8% (27.7–33.8)	28.6% (25.3–31.9)	22.5% (19.5–25.5)	18.1% (15.3–20.9)
Blame me for getting mental health treatment	52.7% (49.2–56.3)	15.4% (13.0–17.9)	9.7% (7.5–12.0)	22.1% (19.0–25.2)

NOTE: All data are weighted. 95 percent confidence intervals are presented in parentheses. Percentages are calculated using nonmissing values. The average number of respondents across items for the table is unweighted n = 1,578.

- Approximately a third of service members expressed being a lot or somewhat concerned that the officer directly above them in the chain of command would blame them for getting treatment (31.8 percent).

Significant group differences were not observed by service branch but were by pay grade and mental health need (see Tables C.16–C.18 in Appendix C). Key findings were as follows:

- Overall pay grade differences were detected across each of the concerns assessed. O-4–O-6 respondents had the lowest prevalence of concern across all of the concerns, except for concerns about being treated differently by commanding officers in the direct chain of command, which was lowest among E-7–E-9/W-1–W-5 respondents.
- Concerns about the negative consequences associated with a commanding officer learning about a service member's mental health treatment were significantly higher among respondents with mental health needs than among those with no mental health needs for four of the five concerns assessed. This appeared to be driven by respondents with unmet mental health needs.
  - Specifically, when comparing respondents with unmet mental health needs versus those with no mental health needs, 70.1 percent versus 44.3 percent expressed having somewhat or a lot of concern that their commanding officers would treat them differently, hinder promotion or career advancement (56.0 percent versus 39.7 percent), tell others about their mental health issues (54.7 percent versus 37.3 percent), ask health providers for information that they do not want shared (58.9 percent versus 34.5 percent), and blame them for getting mental health treatment (40.7 percent versus 25.1 percent).

Concerns About Responses to Service Members Receiving Mental Health Treatment by Immediate Supervisors

HCPM Survey respondents were asked to rate their level of concern with how their immediate supervisors would respond if they were to learn that respondents were receiving mental health treatment, and the survey used the same set of items asked about commanding officer responses (see Table 2.7).

Key findings were as follows:

- The prevalence of concerns with respect to immediate supervisors' responses to service members with mental health issues appeared to reflect a pattern similar to concerns expressed regarding commanding officers directly above in the chain of command.
- More than four in ten respondents reported being a lot or somewhat concerned that their immediate supervisor would treat them differently (44.6 percent) or tell others about their mental health issue (41.4 percent) if they found out respondents were receiving mental health treatment.
- More than a third of respondents indicated they would be a lot or somewhat concerned that their immediate supervisors would hinder their promotions or careers (38.1 per-

TABLE 2.7

Concerns About Responses to Service Members Receiving Mental Health Treatment by Immediate Supervisors

I would be concerned my immediate supervisor would . . .	Not at all	A little	Somewhat	A lot
Treat me differently	28.9% (25.8–32.0)	26.5% (23.5–29.5)	14.6% (12.0–17.2)	30.0% (26.6–33.4)
Hinder my promotion or career advancement	42.9% (39.4–46.3)	19.1% (16.3–21.8)	9.9% (7.8–12.0)	28.2% (24.9–31.5)
Tell others about my mental health issue	36.7% (33.3–40.1)	21.9% (19.1–24.7)	13.9% (11.5–16.3)	27.5% (24.1–30.9)
Ask my health provider for information that I do not want shared	47.6% (44.1–51.1)	17.6% (15.0–20.3)	11.5% (9.1–13.9)	23.3% (20.1–26.4)
Limit or restrict my normal work activities	36.5% (33.1–39.9)	25.7% (22.8–28.6)	19.2% (16.3–22.2)	18.6% (15.6–21.5)
Blame me for getting mental health treatment	56.9% (53.4–60.5)	11.9% (9.7–14.1)	9.3% (6.9–11.7)	21.9% (18.8–25.0)

NOTE: All data are weighted. 95 percent confidence intervals are presented in parentheses. Percentages are calculated using nonmissing values. The average number of respondents across items for the table is unweighted n = 1,562.

cent), ask their health providers for information that they do not want shared (34.8 percent), blame them for getting treatment (31.2 percent), or limit or restrict normal work activities (37.8 percent).

Significant group differences by service branch were not evident (see Table C.19 in Appendix C). As seen in Table C.20 in Appendix C, significant pay grade differences were observed for all of the concerns assessed. Key findings were as follows:

- E-1–E-4 respondents had the highest level of concerns about their immediate supervisors hindering their career advancement (42.9 percent), telling others about their mental health issues (46.3 percent), asking providers for information they do not want shared (40.4 percent), and blaming them for getting treatment (36.9 percent).
- In contrast, concerns about being treated differently (49.6 percent) and limiting or restricting normal work activities (41.4 percent) by their immediate supervisors were highest among E-5–E-6 respondents.
- With the exception of concerns about being treated differently, O-4–O-6 respondents had the lowest level of concerns.

With respect to differences by mental health need (see Table C.21 in Appendix C), key findings were as follows:

- A greater proportion of respondents with mental health needs than those with no mental health needs expressed being a lot or somewhat concerned that their supervisors would treat them differently (49.8 percent versus 38.3 percent), tell others about their mental health issues (45.8 percent versus 35.6 percent), and blame them for getting mental health treatment (34.5 percent versus 26.2 percent).
- Further, some of these observed differences appeared to be driven by the even higher levels of concern observed among respondents with unmet mental health needs with respect to concerns about being treated differently (56.6 percent) and supervisors telling others about service members' mental health issues (52.9 percent).

Anticipated Consequences of Receiving Mental Health Services in the Military Health System That Might Affect Decisions to Receive Mental Health Counseling or Treatment

HCPM Survey respondents were asked to rate the extent to which they agreed or disagreed that each of the possible concerns listed in Table 2.8 might affect their decision to receive mental health counseling or treatment in the MHS.

Key findings were as follows:

- The top four most highly endorsed concerns that might affect service members' decision to receive military mental health counseling or treatment were career-related worries. More than half of respondents agreed or strongly agreed that the following concerns might affect their decisions to seek mental health treatment: impact on ability to deploy (61.0 percent), effect on security clearance (59.8 percent), harm to career (57.4 percent), and entry into military training or school (56.3 percent).
- The next mostly highly endorsed concerns were related to fears of being viewed negatively. More than half of respondents agreed or strongly agreed that concerns about peers having less confidence in them (53.8 percent), being seen as weak (45.1 percent), and peers thinking that respondents are faking mental health issues to get out of responsibilities (40.4 percent) might affect their decision to receive military mental health treatment.
- More than a third agreed or strongly agreed that decisions to receive mental health treatment might be affected by concerns that it would be too embarrassing (37.7 percent) or that a supervisor would be angry for taking time off to go to treatment (31.6 percent).
- Concerns about mental health care were also a factor, with 30.1 percent of respondents agreeing or strongly agreeing that concerns about not trusting mental health professionals might affect their help-seeking, while 15.8 percent agreed or strongly agreed that mental health care not working might affect decisions to receive mental health counseling or treatment.

With respect to group differences by service branch, Air Force respondents had the lowest proportion of respondents who agreed or strongly agreed that the following concerns might

TABLE 2.8

Concerns That Might Affect Decisions to Receive Military Health Counseling or Treatment

Possible concern	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
It might affect my ability to deploy	29.2% (25.9–32.6)	31.8% (28.2–35.4)	23.3% (19.8–26.8)	9.2% (7.1–11.2)	6.5% (5.0–8.0)
It might affect my security clearance	29.8% (26.4–33.3)	30.0% (26.5–33.5)	19.6% (16.3–22.9)	11.9% (9.4–14.4)	8.7% (7.0–10.4)
It would harm my career	27.5% (24.1–30.9)	29.9% (26.6–33.2)	20.6% (17.1–24.2)	13.7% (11.2–16.1)	8.3% (6.3–10.2)
It might affect my chances of entry into military training or school	28.0% (24.7–31.4)	28.3% (25.0–31.6)	25.6% (21.9–29.3)	10.3% (8.4–12.2)	7.7% (5.9–9.6)
Members of my unit who are peers might have less confidence in me	21.1% (17.7–24.5)	32.7% (29.3–36.2)	20.5% (17.4–23.7)	16.7% (13.9–19.6)	8.9% (6.9–11.0)
I would be seen as weak	21.8% (18.5–25.2)	23.3% (20.3–26.2)	20.8% (17.6–24.0)	22.3% (19.0–25.6)	11.8% (9.5–14.0)
Members of my unit who are my peers would think I'm faking it to get out of responsibilities	18.5% (15.5–21.6)	21.9% (18.7–25.1)	22.8% (19.4–26.1)	20.7% (17.8–23.6)	16.1% (13.4–18.8)
It would be too embarrassing	10.3% (7.9–12.7)	27.4% (24.0–30.8)	22.5% (19.2–25.9)	23.3% (20.1–26.5)	16.4% (13.8–19.1)
My supervisor will be angry if I take time off to go to treatment	14.7% (11.8–17.7)	16.9% (14.1–19.6)	20.9% (17.7–24.1)	25.7% (22.4–29.0)	21.8% (18.7–24.8)
I don't trust mental health professionals	15.0% (12.2–17.8)	15.1% (12.6–17.6)	28.5% (25.0–32.0)	24.3% (21.0–27.7)	17.1% (14.3–19.8)
Mental health care doesn't work	6.1% (4.4–7.7)	9.7% (7.7–11.7)	30.1% (26.4–33.8)	28.8% (25.4–32.1)	25.4% (22.0–28.7)

NOTE: All data are weighted. 95 percent confidence intervals are presented in parentheses. Percentages are calculated using nonmissing values. The average number of respondents across items for the table is unweighted n = 1,390.

affect decisions to receive military mental health counseling or treatment: effects on chances of military training or school (48.4 percent), being seen as weak (35.9 percent), peers thinking that respondents are faking mental health issues to get out of responsibilities (31.7 percent), and believing that mental health care does not work (9.1 percent). See Table C.22 in Appendix C.

Tables C.23 and C.24 in Appendix C display group differences by pay grade and mental health need, respectively. Key findings by pay grade were as follows:

- Across pay grades, O-1–O-3 respondents reported the highest level of concerns related to effects on ability to deploy (76.0 percent), security clearance (75.0 percent), harm to

career (66.9 percent), entry into military training or school (67.4 percent), and losing the confidence of peers (60.2 percent).
- On the other hand, E-5–E-6 respondents exhibited the highest level of concerns related to being seen as weak (50.4 percent), peers thinking that respondents are faking mental health issues (49.9 percent), angering one's supervisor if time is taken off for treatment (38.0 percent), not trusting mental health professionals (39.6 percent), and not thinking that mental health care works (19.7 percent).

Key findings by mental health need were as follows:

- Significant differences by mental health need were found across all concerns that might affect respondents' decisions to receive military mental health counseling or treatment. The prevalence of concerns was significantly higher among respondents with mental health needs than peers with no mental health needs.
- The higher prevalence of concerns among respondents with mental health needs appeared to be driven by the even higher levels of concern exhibited by the subset of respondents with unmet mental health needs for the following: loss of confidence from unit members (71.6 percent), being seen as weak (63.6 percent), peers thinking they were faking their mental health problems (58.2 percent), and being embarrassed (52.1 percent).

Mental Health Issues for Which Service Members Would Delay or Avoid Treatment Because of Concerns About Damage to Military Careers

HCPM Survey respondents were asked to indicate whether they would delay or avoid military mental health treatment because it could damage their careers for each of the mental health–related issues listed in Table 2.9:

- More than half of the respondents indicated that they would delay or avoid mental health treatment for depression because it could damage their careers. More than four in ten respondents indicated that they would delay or avoid mental health treatment related to thoughts of self-harm (48.6 percent), anxiety or worries (48.5 percent), trouble adjusting after a stressful life event (47.5 percent), posttraumatic stress (46.0 percent), and thoughts of harming others (43.9 percent).

No notable service branch or pay grade group differences were observed (see Tables C.25 and C.26 in Appendix C).

With respect to differences by mental health need (see Table C.27 in Appendix C), key findings were as follows:

- Across all types of mental health issues presented, respondents with mental health needs were more likely to indicate that they would delay or avoid treatment because it might harm their military careers, compared with respondents with no mental health needs.

TABLE 2.9
Issues That Would Delay or Cause Avoidance of Mental Health Treatment Because It Could Damage Military Career

For each of the following issues, please indicate whether you would delay or avoid military mental health treatment because it could damage your military career.	Yes	95% confidence interval
Depression	52.6%	48.8–56.5
Thoughts about harming yourself	48.6%	44.7–52.4
Anxiety or worries	48.5%	44.6–52.4
Trouble adjusting after a stressful life event	47.5%	43.7–51.3
Posttraumatic stress	46.0%	42.1–49.8
Thoughts about harming others	43.9%	40.1–47.7
Marital relationship problems that do NOT involve physical violence	37.5%	33.8–41.3

NOTE: All data are weighted. Percentages are calculated using nonmissing values. The average number of respondents across items for the table is unweighted *n* = 1,373.

Moreover, respondents with unmet mental health needs were significantly more likely to indicate that they would delay or avoid treatment across all mental health issues, except for thoughts about harming others in comparison with those with met mental health needs.

- Differences between respondents with unmet mental health needs versus no mental health needs were notable for
  - depression (76.3 percent versus 38.1 percent)
  - thoughts of self-harm (69.7 percent versus 32.8 percent)
  - anxiety or worries (73.1 percent versus 35.0 percent)
  - trouble adjusting after a stressful life event (71.0 percent versus 35.1 percent)
  - posttraumatic stress (63.7 percent versus 32.9 percent)
  - marital problems not involving physical violence (56.6 percent versus 27.9 percent).

Perceived Effects on Mental Health Treatment and Treatment-Seeking Intentions

In this section, we present findings about how confidentiality concerns may affect mental health treatment and treatment-seeking intentions. The findings pertained to the following:

- concerns about military health providers
- how confidentiality concerns might influence mental health treatment-seeking intentions
- the perceived impact on mental health service use, individual readiness, and unit readiness if military health providers could release information only about service members' duty limitations to commanding officers.

Concerns Regarding Military Health Providers

HCPM respondents were asked to rate to what extent they would limit what they share if they were (hypothetically) receiving treatment for a mental health issue from a military health provider because of concerns about privacy and to what extent they would be concerned that the provider would use what is shared to determine respondents' fitness for duty (see Table 2.10).

Key findings were as follows:

- More than 88.2 percent of respondents asserted that they would limit what they share in mental health treatment because of privacy concerns.
- Approximately 40 percent of respondents indicated that they would limit by quite a bit or very much what they would share in treatment with a military mental health provider because of concerns about privacy.
- Similarly, 40.3 percent of respondents expressed that they would be quite a bit or very much concerned that, if they received mental health treatment, their providers would use what they share to determine their fitness for duty.

No significant group differences by service branch or pay grade were documented (see Tables C.28 and C.29 in Appendix C, respectively).

Differences by mental health need were exhibited (see Table C.30 in Appendix C) and included the following:

- The potential to limit what is shared with providers during mental health treatment because of concerns about privacy was significantly more prevalent as a concern among respondents with mental health needs, as 46.0 percent indicated that they would limit quite a bit or very much of what is shared with providers because of privacy concerns compared to those with no mental health needs (29.4 percent). Moreover, respondents with unmet mental health needs expressed even higher levels of privacy concerns (58.8 percent) that might limit what they share with military mental health providers.

TABLE 2.10

Concerns About Military Health Providers

If you were receiving treatment for a mental health issue from a military health provider:	Not at all	A little bit	Somewhat	Quite a bit	Very much
To what extent would you limit what you share because of concerns about your privacy?	11.8% (9.6–14.0)	22.2% (19.1–25.3)	26.6% (23.0–30.1)	21.8% (18.7–25.0)	17.6% (14.7–20.5)
To what extent would you be concerned that your provider would use what you share to determine your fitness for duty?	12.2% (9.8–14.5)	19.0% (16.1–21.8)	28.5% (24.8–32.2)	19.1% (16.0–22.3)	21.2% (18.3–24.2)

NOTE: All data are weighted. 95 percent confidence intervals are presented in parentheses. Percentages are calculated using nonmissing values. The average number of respondents across items for the table is unweighted n = 1,380 (73.7%).

- A similar pattern of findings was observed with respect to concerns about military providers using what is shared in treatment to make fitness-for-duty determinations, which was endorsed as quite a bit or very much a concern by 31.5 percent of respondents with no mental health needs, 46.6 percent of those with mental health needs, and 57.1 percent of those with unmet mental health needs.

Mental Health Treatment-Seeking Intentions

HCPM Survey respondents were asked a set of questions that investigated how their mental health treatment-seeking intentions might be affected by confidentiality concerns (see Table 2.11).

Key findings were as follows:

- Roughly 40 percent of respondents agreed or strongly agreed that they would delay or avoid treatment because of concerns about privacy.
- More than a third of respondents also agreed or strongly agreed that they would seek care only if their chains of command would not find out (35.6 percent).
- More than 40 percent agreed or strongly agreed that they would seek treatment outside the military so that the treatment would not be documented in military medical records (42.7 percent) and would find it helpful to get care after hours so their units would not find out (44.6 percent).

Service branch group differences were not observed (see Table C.31 in Appendix C). Significant differences by pay grade groups were observed (see Table C.32 in Appendix C):

TABLE 2.11
Mental Health Treatment-Seeking Intentions

Please indicate the extent to which you agree with each statement. If I had a mental health issue . . .	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
I would delay or avoid treatment because of concerns about privacy	18.0% (15.1–20.8)	22.5% (19.5–25.6)	26.3% (22.7–29.8)	23.2% (19.8–26.6)	10.1% (8.2–11.9)
I would only seek treatment if my chain of command would not find out	18.7% (15.7–21.6)	21.2% (18.0–24.4)	24.5% (21.1–27.9)	24.7% (21.3–28.2)	10.9% (9.0–12.8)
I would seek treatment outside the military health system so the care would not be documented in my military medical record	25.9% (22.5–29.3)	16.8% (14.3–19.4)	24.7% (21.3–28.1)	22.0% (18.6–25.5)	10.5% (8.5–12.5)
It would be helpful to get care after hours so that my unit would not find out	22.3% (19.1–25.6)	22.3% (19.3–25.2)	28.0% (24.6–31.5)	18.2% (14.9–21.4)	9.2% (7.2–11.2)

NOTE: All data are weighted. 95 percent confidence intervals are presented in parentheses. Percentages are calculated using nonmissing values. The average number of respondents across items for the table is unweighted n = 1,379 (73.6%).

- Interestingly, intentions to delay or avoid treatment because of concerns about privacy were highest among O-1–O-3 respondents (50.6 percent) and lowest among O-4–O-6 respondents (32.5 percent).
- In addition, O-1–O-3 respondents were the most likely to agree or strongly agree that they would seek treatment only outside the MHS (56.4 percent), and that getting care after hours would be helpful so that unit members would not find out (63.6 percent).

Differences by mental health need are displayed in Table C.33 in Appendix C. Key findings were the following:

- Intentions to delay or avoid treatment because of privacy concerns were highest among respondents with unmet mental health needs (57.2 percent) and lowest among those with no mental health needs (30.1 percent).
- Similarly, respondents with unmet mental health needs were the most likely and respondents with no mental health needs were the least likely to agree or strongly agree that they would seek treatment only if their chains of command would not find out (56.0 percent versus 31.9 percent), would seek treatment outside the MHS (62.6 percent versus 33.6 percent), and that getting care after hours would be helpful so that unit members would not find out (60.9 percent versus 34.8 percent).

Perceived Impact of Limiting the Release of Mental Health Information to Commanding Officers

HCPM Survey respondents were asked to indicate the perceived impact on mental health service use, individual readiness, and unit readiness if military health providers could release information only about service members' duty limitations to commanding officers (see Table 2.12).

Key findings were as follows:

- A majority of respondents thought that limiting information released to commanding officers to duty limitations would greatly or slightly improve the use of mental health services (68.1 percent), individual readiness (64.8 percent), and unit readiness (60.2 percent).
- Moreover, only a small proportion of respondents thought that restricting provider release of information to duty limitations would slightly or greatly worsen mental health service use (8.2 percent), individual readiness (10.8 percent), and unit readiness (11.6 percent).

Group differences by service branch and pay grade were not observed (see Tables C.34 and C.35 in Appendix C).

Group differences by mental health need were found (see Table C.36 in Appendix C). Specifically, respondents with mental health needs were more likely than respondents with no mental health needs to believe that restricting information released to commanding officers

TABLE 2.12
Perceived Impact of Releasing Information Only About Duty Limitations to Commanding Officers

If military health providers could only release information about service members duty limitations to commanding officers, how do you think it would affect . . .	Greatly improve	Slightly improve	No effect	Slightly worsen	Greatly worsen
Use of mental health services	28.6% (25.0–32.1)	39.5% (35.7–43.3)	23.6% (20.3–27.0)	6.6% (4.8–8.4)	1.6% (0.9–2.4)
Individual readiness	26.0% (22.7–29.3)	38.8% (34.9–42.6)	24.5% (21.1–28.0)	8.6% (6.6–10.5)	2.2% (1.4–3.0)
Unit readiness	23.0% (19.9–26.1)	37.2% (33.4–41.1)	28.2% (24.6–31.8)	9.1% (7.3–10.9)	2.5% (1.6–3.3)

NOTE: All data are weighted. 95 percent confidence intervals are presented in parentheses. Percentages are calculated using nonmissing values. The average number of respondents across items for the table is unweighted *n* =1,360 (72.6%).

to duty limitations would improve use of mental health services (73.5 percent versus 61.2 percent), individual readiness (69.6 percent versus 57.4 percent), and unit readiness (64.4 versus 53.8 percent).

Summary

We aimed to field a population-based survey that was representative of the active component military. As noted, *the survey results cannot be interpreted as fully representative of the knowledge and opinions of all service members due to evidence of substantial self-selection of respondents*. However, the service members who self-selected into the study represent a group of particular interest for military policies around mental health care. The purpose for treatment confidentiality is to encourage individuals who need care to get it without fear of discrimination. The HCPM Survey effectively overrepresents individuals who need treatment and who have mental health symptoms. These are precisely the individuals the policies were designed to reassure and encourage to get treatment. Although the survey is not fully representative of the military, it may still provide key insights into how the policies are working for those individuals who are most directly concerned with the confidentiality of treatment. To better focus on this group, many of the analyses included estimates and comparisons for the subset of respondents who had a need for mental health treatment in the past year.

Misunderstanding of Policies in the Military

The findings highlighted several areas in which misperceptions about command notification requirements prevail. For instance, although the majority of respondents recognized the serious risk of harm to others (85.3 percent), self-harm (84.3 percent), and interference with

duties (77.1 percent) as circumstances that require command notification, as outlined in DoDI 6490.08 (both the 2011 and 2023 versions), we found that 14.7 percent did not believe that serious risk of harm to others and 15.7 percent did not believe that serious risk of self-harm required provider disclosure to a commanding authority. Further, misperceptions regarding command notification being required *whenever* mental health treatment appointments are missed (56.2 percent), mental health medication is prescribed (31.7 percent), or mental health diagnoses are made (30.9 percent) are common, potentially hindering self-referral to treatment. Although these circumstances are not explicitly referenced in DoDI 6490.08, other issuances do touch on some of these issues.

For instance, with respect to prescription medications, in the Army, OTSG/MEDCOM Policy Memo 21-019, "Behavioral Health eProfiling Standardization Policy" (Headquarters, U.S. Army Medical Command, 2021), specifies that prescribing medication for a behavioral health condition does not always require a profile,[5] noting that "many psychotropic medications do not impair a Soldier's ability to function in the occupational setting, do not have duty-limiting side effects, or do not increase the risk of adverse outcomes." Marine Administrative Message (MARADMIN) 153/10, "Mental Health Counseling and Treatment and Security Clearances Within the U.S. Marine Corps," stipulates that personnel holding security clearances who are undergoing counseling or treatment must notify command if medications have been prescribed (U.S. Marine Corps, 2016). These issuances clarify that prescribed medication for mental health conditions do not always require command notification but may be required for special personnel or when there are duty limitations.

Regarding missed mental health treatment appointments, the Military Command Exception under HIPAA does allow for command authorities to require medical appointment notifications (e.g., treatment reminders, missed and canceled appointments) for "mission purposes" (Privacy and Civil Liberties Office, 2022). However, AFI 44-172 (2015), *Medical Operations Mental Health*, specifies that the mental health provider will contact command if failure to continue care incurs risk to the patient, others, or the military mission. AFI 44-172 also specifies that command notifications can include mental health no-shows as part of overall medical group no-shows but should not be differentiated from other medical group no-shows. MARADMIN 308/11 (U.S. Marine Corps, 2011), "Commander Access to Health Information," states that command authorities may require notification of medical appointments (which includes missed appointments) for fitness-for-duty determinations and proper execution of the military mission. However, medical appointment reminders should not include the "right to know" the specific clinic (e.g., mental health). DHA Procedures Manual 6025.1, *Primary Care Behavioral Health (PCBH) Standards*, stipulates that behavioral health consultants should notify command about missed appointments if the patient is active duty, at elevated risk for self-harm, and cannot be reached by phone (DHA, 2019). Both AFI 44-172 and MARADMIN 308/11 specify that command notifications for missed

[5] A profile is the Army's standard method of communicating about duty limitations due to medical conditions and associated treatments between medical providers and commanders.

appointments should not include information that would indicate that the appointments are mental health related. All of the policies reference risk to self, others, or mission as conditions that would necessitate command notification of missed appointments.

Perceptions Regarding the Implementation of Mental Health Treatment Confidentiality Policies and Practices

Regarding perceptions of service members' understanding of the nature of provider disclosures to command, nearly 58.0 percent of respondents thought that service members are often or always unsure of the types of mental health information that might be released to commanding officers. Further, an even greater proportion (80.3 percent) of respondents with unmet mental health needs held these views of service members as being unsure of what information might be involved in command disclosures, which also may be a reflection of their own uncertainty. Findings suggest that the intent of issuing DoDI 6490.08 (2011), which was to clarify command notification requirements "to dispel stigma in providing mental health care to service members," might not be reaching a substantial proportion of service members.

At least one in five respondents held perceptions about the management of service members' mental health information that could cause concerns. Approximately 22 percent of respondents thought that service members' mental health information is often or always shared with commanding officers and then spreads to other unit members. In addition, 20.0 percent of respondents thought that mental health information is often or always shared without service members' consent or knowledge.

Widespread concerns regarding the confidentiality of mental health treatment were endorsed among respondents with respect to the privacy of medical records, safeguards and control over access to medical records, and the entities who could access service members' mental health information. A substantial proportion of respondents expressed being somewhat or very concerned about the privacy of medical records if they were to receive mental health counseling (46.2 percent) or mental health medication (47.2 percent). Our findings suggest that only a minority of respondents felt very confident that safeguards were in place to protect the privacy of medical records (18.9 percent) and that they have some control over who accesses their personal mental health information (12.8 percent). Further, service members who may have more oversight over the management of mental health information (i.e., O-1–O-3 and O-4–O-6 respondents relative to enlisted) had the lowest levels of confidence about the confidentiality of mental health information compared with other pay grades.

Findings revealed substantial concerns about the confidentiality afforded to those who receive mental health services. Nearly half or more of respondents were concerned that, if they received mental health services, their information could be shared with entities who could have an impact on their careers (i.e., commanding officers in their direct chains of command, supervisors, promotion review boards, and potential future employers outside the military), as well as with entities within the health care system (i.e., future medical insurers,

military health providers not involved in service members' treatment, and the Veterans Disability Panel).

Perceived Impact of Limited Mental Health Confidentiality

Concerns about how commanding officers in the direct chain of command and immediate supervisors would respond if they found out that respondents were receiving mental health treatment were prevalent. The level of concern regarding actions that commanding officers and immediate supervisors might exact toward respondents (i.e., treating them differently, hindering careers, limiting work activities, and blaming them for getting treatment) versus actions related to handling service members' mental health information (i.e., telling others about mental health issue and asking providers for information respondents do not want shared) appeared comparable.

When queried about concerns related to receiving military mental health services that might affect respondents' decisions to obtain treatment, the most highly endorsed concerns (up to 60 percent of respondents) were related to factors that could affect respondents' careers (e.g., ability to deploy, security clearance, and military training or school entrance). Still, a substantial proportion of respondents reported that their decisions to receive mental health treatment might be affected by concerns related to negative reactions by their peers, who might have less confidence in them (53.8 percent) or think that they are faking it to get out of responsibilities (40.4 percent), as well as by supervisors, who might be angry about the time off for treatment (31.6 percent). Stigma-related concerns also figured prominently, with worries about being seen as weak (45.1 percent) or mental health treatment being too embarrassing (37.7 percent).

Additionally, concerns about damage to one's military career appeared to be a deterrent to obtaining mental health services for a wide variety of mental health issues. Approximately half of respondents reported that they would delay or avoid mental health treatment for such issues as depression (52.6 percent), thoughts of self-harm (48.6 percent), anxiety or worries (48.5 percent), trouble adjusting after a stressful life event (47.5 percent), and posttraumatic stress (46.0 percent). More than a third of respondents indicated that they would delay or avoid mental health treatment for such nonclinical issues as marital relationship problems (not involving violence) because it could damage their military careers.

The potential impact of confidentiality concerns on relationships with mental health providers and treatment seeking intentions was also evident. Nearly 90 percent of respondents indicated that they would limit what they would share with military mental health providers because of privacy concerns. More than 40 percent of respondents reported that they would seek treatment outside the MHS or that it would be helpful to get care after hours for privacy reasons despite existing regulations requiring members to report any outside care to their military primary care teams (e.g., Department of the Air Force Manual 48-123 [2020], *Medical Examinations and Standards*). More than a third of respondents asserted that they would seek treatment only if the chain of command would not find out. Correspondingly, the

majority of respondents (68.1 percent) thought that commanding officers being restricted to receiving information only about service members' duty limitations would improve the use of mental health services. A minority of respondents thought that releasing information only about duty limitations to commanding officers would negatively affect use of mental health services (8.2 percent), individual readiness (10.8 percent), and unit readiness (11.6 percent).

Implications

Altogether, the findings suggest that there are many concerns associated with receiving mental health services in the military when confidentiality cannot be assured. These concerns stem from the anticipation of negative repercussions from leaders, peers, and providers and even within service members themselves (with respect to internalized stigma). Concerns about leaders' access to service members' mental health information may be partly due to misperceptions about command notification requirements, including the circumstances under which commanding officers may release information to others in the chain of command and within the unit.

Improving understanding and knowledge of policies governing the confidentiality of service members' mental health information may assuage some of the documented concerns. Many of the concerns involved fears about career-related impacts. Leaders can rectify any misconceptions about how receiving mental health treatment can adversely affect careers in the military but also need to be able to address when treatment involvement may in fact lead to career setbacks (e.g., not being able to deploy). Leaders can also play a role in addressing concerns about leaders and peers responding negatively to service members receiving mental health treatment by fostering a climate that is supportive of mental health care, which may also help to counter any personal stigma that service members may harbor about receiving mental health treatment. Leaders can also enforce confidentiality protections by stringently applying the need-to-know requirement to include as few individuals as possible.

With respect to service members potentially holding back information from military health care providers because of confidentiality concerns, it is unclear whether this can ever be fully remedied. Providers can dispel unfounded concerns but may be limited in instances in which service members accurately understand that the mental health challenges that they are experiencing (e.g., serious risk of self-harm) require command notification. Service members who are knowledgeable about the command exceptions and would like to avoid having their commanding officers notified about their mental health conditions may resort to limiting what is shared with providers. This may drive the reporting of such conditions as self-harm or harm to others underground and outside the purview of providers. Our findings indicated that restricting the information that is released to commanding officers to be solely about duty limitations was seen by a majority of respondents as a way to improve mental health service use. For example, per DoDI 6490.08 (2011, 2023), "minimum amount of information to satisfy the purpose of the disclosure" includes diagnosis, treatment plan, and "ways the command can support or assist the service member's treatment." It is unclear whether

providing commanding officers clinical information, such as diagnosis and treatment plans, improves readiness as opposed to limiting information to duty limitations and any needed accommodations to support medical care. Information related to how the command can support service members can be released with service members' consent instead of falling under the umbrella of command-notification requirements. Further, our findings suggested that enhancing privacy by providing treatment after hours or outside the military may facilitate mental health treatment-seeking for a portion of service members.

Finally, confidentiality concerns were more prevalent among respondents with mental health needs than respondents with no mental health needs—and even more acutely so among the subset with unmet mental health needs. For instance, respondents with unmet mental health needs relative to those with no mental health needs were more likely to report being concerned about the privacy of medical records if they were receiving mental health medication (60.7 percent versus 38.3 percent), about information being shared with commanding officers if respondents were receiving mental health treatment (70.1 percent versus 47.5 percent), and delaying or avoiding treatment because of privacy concerns (57.2 percent versus 30.1 percent). Although DoDI 6490.08 (2011) "provides guidance for balance between patient confidentiality rights and the commander's right to know for operation and risk management decisions,"[6] concerns about confidentiality may be impeding mental health treatment use among those in need of care.

[6] Reissued DoDI 6490.08 (2023) contains the following language: "Promotes reducing stigma in obtaining mental health care services by balancing patient confidentiality with a commander's need to know certain information for military operational and risk management decisions, ensuring, except in a case in which there is an exigent circumstance, the confidentiality of mental health care services provided to members who voluntarily seek such services."

CHAPTER 3

Stakeholder Interviews

In this chapter, we report the methods and results of the interviews we conducted with three stakeholder groups: commissioned officers (in the O-1 to O-5 pay grades and who all held command roles), mental health providers (psychologists, social workers, and psychiatrists), and enlisted service members (pay grades E-3 to E-9). We limited our interview scope to focus specifically on mental health treatment policies and practices. We did not analyze stakeholder perspectives on alcohol and substance use, as they are covered under a separate set of policies with different bearings for confidentiality beliefs and practices.

Methods

We collected and analyzed qualitative data from stakeholder interviews conducted from December 2020 through March 2022. A group of experts developed the content for interview protocols with three stakeholder groups—commissioned officers, military mental health providers, and enlisted service members. We recruited participants across each service branch (except the Coast Guard) and among varying ranks within the three stakeholder groups. A total of 46 in-depth interviews were conducted (16 with commissioned officers, 13 with providers, and 17 with enlisted service members). The interview protocols are included in Appendix E. Data collection was approved by RAND's institutional review board (known as the Human Research Protection Committee), the Office of People Analytics, and the DHA's Human Research Protection Office. Materials are registered under Report Control Symbol DD-HA-2714 (Washington Headquarters Service).

Participant Recruitment

For enlisted service members, we recruited from the active component by obtaining a random sample from the Defense Manpower Data Center containing name, contact information, and basic demographic information (e.g., service branch, pay grade). We included enlisted service members (E-3 to E-9) and excluded those below the pay grade of E-3. Potential interviewees were contacted via email, with follow-up messages to nonresponders. Enlisted service members were provided a $50 gift card for study participation. A total of 395 enlisted service members were invited to participate in an interview during nonduty work hours.

To recruit providers and commissioned officers, we relied on support from specific military installations to identify appropriate personnel who fit our established inclusion criteria. We selected two large installations per service branch (i.e., the Army, Marine Corps, Navy, and Air Force), for a total of eight installations. A task services memo was sent in the DHA Tasker System to each installation requesting that installation commands identify a point of contact who would assist with coordinating individual, 45- to 60-minute telephone interviews with nonmedical officers who are in command of between 50 and 250 service members. The identified point of contact supplied the RAND team with contact information to interview up to four officers (two in grades O-1–O3 and two in grades O-4–O5). The Behavioral Health Clinical Community identified a point of contact at each installation who could assist the RAND team with identifying three potential providers (one psychiatrist, one psychologist, and one social worker) to participate in the interviews. We do not disclose the installations that were sampled to protect participant privacy.

As shown in Table 3.1, a total of 47 interviews were completed (17 enlisted service members, 16 commissioned officers, and 13 providers). Given other competing demands, the selected Army installations were unable to recruit commissioned officers. We were also unable to recruit psychologists or psychiatrists stationed at Navy installations or psychiatrists who were stationed at Marine Corps installations. Of the 22 commissioned officers who were invited to participate, one declined and five did not respond. Of the 16 providers who were invited to participate, three did not respond.

All 16 commissioned officers we interviewed had a command role (e.g., squadron commander, battalion commander, company commander). Two commissioned officers had never interacted with or received mental health information from a provider. However, one of these two commissioned officers described receiving service members' mental health information from their first sergeant. From here on out, we refer to the commissioned officers who participated in the stakeholder interviews as *commanding officers* or *commanders* (the term more commonly used in policy documents related to medical privacy and confidentiality).

TABLE 3.1
Stakeholder Sample

Stakeholder type	Army	Air Force	Navy	Marine Corps	Total
Enlisted service members (E-3–E-9)	4	3	6	4	17
Commissioned officers	0	7	3	6	16
Mental health providers					
Psychologist	1	2	0	1	4
Social worker	1	3	1	1	6
Psychiatrist	1	2	0	0	3

NOTE: Providers were sorted based on the service branch of installation from where they were recruited.

Data Collection

Interviews were conducted by the study principal investigators from 2020 to 2022. Specifically, interviews with enlisted service members were held between December 2020 and July 2021, interviews with commanding officers were held between June and December 2021, and interviews with providers were conducted between November 2021 and March 2022. Two additional project staff were trained by the principal investigators to conduct the interviews and understand topics to probe. The semistructured interviews lasted approximately one hour. Interviewers received training from an expert in qualitative methods on conducting interviews. Interviews assessed participants' experiences with the U.S. military behavioral health system and their perceptions and understanding of confidentiality policies and practices.

Specifically, we focused on the circumstances surrounding the disclosure of behavioral health information and the perceptions of conditions or circumstances that would trigger a behavioral health provider to notify a service member's commander. We also probed on mental and behavioral health treatment confidentiality perspectives, the nature of interactions among and between our stakeholder groups (e.g., provider-officer dynamics), and stakeholder suggestions for practice and policy improvements. The semistructured interviews followed the interview protocols with varied questions and probes for each stakeholder group. We attempted to achieve thematic saturation to the extent possible with our select sample of interviewees and acknowledge that perspectives from Army commanding officers and Navy mental health providers are limited. Following verbal informed consent, interviews were captured via notetaker, who transcribed the dialogue of each interview. Those transcript-style written notes were used for coding and subsequent analysis. In the quotes that follow, brackets are sometimes used to fill in words or phrases to provide the reader with the relevant context or to specify references made by the stakeholder. Enlisted service members participated during off-duty hours and received Amazon gift cards valued at $50 each.

Coding and Analysis

Two researchers analyzed the interview transcripts. Data were coded using a standardized codebook, developed over multiple iterations based on the interview protocol and emergent themes. Codes were developed and sorted into parent and child codes to capture broad and specific dimensions. Interview transcripts were coded using applied thematic analysis in Dedoose, a qualitative data analysis software program that supports collaborative and team-based coding. All interview data were deidentified and stored on the RAND project team's password-protected shared folder hosted on RAND's government cloud. During initial coding, we identified emergent themes and incorporated new codes into our codebook. We evaluated interrater reliability, adjudicated differences in code application and interpretation, and regularly held meetings to discuss areas of uncertainty or anomalies. Such discrepancies were resolved via discussion and consensus. We finalized our codebook and continued this

process until we independently attained 0.92 kappa agreement on an interrater reliability test. Once interrater reliability was established, we completed coding all interviews.

We analyzed the coded data by exporting parent and child codes from Dedoose and examining coded interview excerpts by stakeholder group in Microsoft Excel. For each excerpt within a given code, constructs were summarized and grouped by common themes, and unique perspectives were drawn out. We identified illustrative quotes and examples of important concepts. Given the small sample size of commanding officers and providers, we do not disclose service branch information among these stakeholder types for the illustrative quotes included in this report to protect participant privacy and mitigate the potential for reidentification. For example, *marine* is replaced with *[service member]*, and any mentions of the Air Force, Army, Navy, Marine Corps are replaced with *[service branch]*.

Interview Results

We present our results in four main sections. First, we describe stakeholders' perceptions of mental health confidentiality in the military. We then describe stakeholders' perceptions of how these policies are implemented, perceptions of the impact of these policies and practices, and their ideas on how to improve these policies and practices. For each topic, we first describe stakeholders' perceptions; then we provide illustrative quotes to support our findings.

Perceptions of Mental Health Confidentiality Limits

Perceptions of mental health confidentiality in the military were centered on the following three aspects: circumstances under which military health care providers are required to notify commanding officers about service members under their care, the types of information shared about service members, and personnel with access to service members' mental health information.

Circumstances Perceived as Requiring Command Notification

All three stakeholder types described mental health–related circumstances that align with the command notification requirements outlined in DoDI 6490.08 (2011, 2023). Table 3.2 provides select quotes for each of the circumstances described: harm to self, harm to others, harm to mission, special personnel, inpatient care, duty interference, and command-directed evaluations.

Most participants described risk of harm to self, others, and mission as exceptions to confidentiality, as exemplified by one provider:

> But there's always exceptions—typically a service member can come into a mental health clinic and can be involved in care without a commander or first sergeant being notified, with the exception being, without posing risk of harm to themselves or others, or the mission itself.

TABLE 3.2

Circumstances Perceived as Requiring Command Notification

Circumstance	Quote
Harm to self	"From a readiness perspective, there are some things that I am allowed to ask. If someone goes and talks about a *suicidal ideation*, then the command hears about that." —commanding officer "If there are *suicidal ideations*, they would also be obligated to share to command." —service member
Harm to others	"Any concerns of *suicide ideation*, *homicide ideation*, we are also required to report any mental health issues that may impede with their [clients'] ability to do their job." —provider Also, *homicidal ideation*—that would have to be shared with your chain of command." —service member Anything that involves *homicidal ideation*, then yeah, the commander or the 1st Sergeant should be notified." —commanding officer
Harm to mission	"They can alert me of situations that may affect the units' ability to perform missions. I can find out if a member is undergoing mental health [treatment]." —commanding officer If there is a direct, imminent impact to the mission, I'm required to discuss that with the commander." —provider
Special personnel	"If they have clearance and work a Top Secret job and this person is not stable, then obviously that makes them a potential risk to mission. Then we have to notify their command or first sergeant and say, 'Hey, you may want to consider suspending their clearance.'" —provider "That's also true if a person is in a higher level of clearance—Top Secret or another classified information [level]. We make sure if they are protecting classified information that they are in a good space to do that. If there is concern over their judgment, reliability, or ability to make those decisions of holding that information, then we would break confidentiality to remove them from that status. That could be detrimental of course. Other jobs like flyers, flying aircraft or flight crew controllers, air traffic control, people in more special tactics settings that also hold clearance and weapons statuses. Anyone who does a specific job with specific requirements. If we have concerns that they can't fulfill the requirements based on a psychological reason, we are allowed to break confidentiality to make sure they are not a risk to safety of others or the mission." —provider So, for PRP [Personnel Reliability Program], we are required to let the point of contact know that the member might have what are called 'suitability factors.' They might become aware a patient is being seen by a medical provider so that part of confidentiality is compromised." —provider
Inpatient care	"There's only certain information they are allowed to tell commanders, like if the [service member] is admitted. They're not allowed to go into detail as to why the [service member] was admitted, just, 'Hey your [service member] will be in this health care facility for five days,' or 'your [service member] is having suicidal ideations or thoughts but we will take care of them.'" —service member "Unless they [service members] go to an inpatient or intensive outpatient program [notification is not required], in which case, it takes up a lot of duty time and then the command would need to be informed." —service member

Table 3.2—Continued

Circumstance	Quote
Duty interference	"For an intensive outpatient program, then the chain of command does know because you attend outpatient classes every day and that's your place of duty. You are not supposed to have any additional duties, like staff duty or anything like that, during that time and only focus on your treatment. So, the command would definitely know about that since you're on modified duty." —service member "Behavioral health confidentiality is ensuring that commanders know what they need to know and do and ensuring that concerns about fitness for duty or suicide ideation are properly reported." —provider "They are good about not sharing most things with me. I feel in the dark for the most part and I'm moderately okay with that. I want my [service branch members] to feel confident going there [mental health clinic] and knowing unless it's really bad—if they don't want me to know, I won't know if it's safe and they can do the job." —commanding officer
Command-directed evaluation	"If it is a command-directed evaluation, that's different. In those cases, we will reveal what the diagnosis is and what the recommendations are and whether we think the member is fit for continued service or not." —provider

Notably, the quotes for harm to self and harm to others presented in Table 3.2 illustrate how several stakeholders considered suicidal and homicidal ideations as constituting a risk requiring command notification. This contrasts with the viewpoint held by various stakeholders that ideations alone do not necessitate command notification. As one provider asserted: "I see a lot of folks with morbid ideations, with severe symptoms; that doesn't necessarily warrant command communication."

In addition, a commanding officer referenced having a plan as a requirement for command notification: "I understand it to be that I can share virtually anything I want with a provider granted I do not demonstrate I have a plan to harm myself or another person."

Participants also referred to child abuse and domestic violence as requiring command notification, which are referenced under "harm to others" in DoDI 6490.08 (2011, 2023). One provider advised that service members should hold off on treatment if they are not prepared to disclose any of the circumstances that require command notification, including domestic violence:

> If there were any concerns with alcohol, drugs, family maltreatment, suicidal ideation, or homicidal ideation, it would be in the best interest of the member to not get help until they are ready to disclose it because he would have to get referrals or let commanders know.

With respect to what constitutes harm to mission, one provider stated:

> It really depends, but very broadly if someone has to do a job where it could be unsafe for them to go back and try to do it due to their mental health challenges. Typically related to those who have weapons as part of their job. . . . In theory, if someone has Top Secret clear-

> ance and they are demonstrating something that shows me their judgment is not there and they are a threat to national security.

Several providers discussed how harm to mission is highly dependent on a service member's job type, as jobs performed by service members with mental health conditions vary in their level of risk. One provider explained:

> With any patient, we are getting as much as we can about their symptoms but also what their job actually is, because one person's job—they do data entry by themselves—that might not be a harm to mission but if they are a provider who performs surgery, then there may be something about their symptoms that could cause harm.

Another provider relayed that harm to mission is determined by the nature of the organization:

> [Harm to mission] is driven by the makeup of the organization. If you have an infantry company, guys and gals pulling triggers and shooting off explosives—if there is something that would impact the ability to perform that in a safe way, then that confidentiality of what we discuss is important to notify commanders because there may be a recommendation to put the guy or gal on sleep meds because they have insomnia, mild depression, or anxiety.

Another provider discussed balancing the need to protect the mission and service members' information:

> As it relates to other limits of confidentiality, it does truly depend on the job and the information that is disclosed, because we are always trying to find the balance between our alliance to the patient and to the mission.

Although most participants did not specifically use the term *special personnel*, some providers referred to service members in jobs that are Top Secret, related to classified information, require flight status, or part of the Personnel Reliability Program and the potential for command notification if there are concerns regarding the member's judgment or reliability (see Table 3.2). *Inpatient care* was mentioned as a circumstance that requires notification to command, as inpatient care typically involves service members being away from their duty stations to receive this type of care. For acute medical conditions interfering with duty (i.e., duty interference), a service member explained that an intensive outpatient program may also warrant notifying command because the treatment can take up significant duty time (see Table 3.2). Lastly, command-directed evaluations were identified by stakeholders as a condition for notification of mental health information to command as the evaluations are initiated by commanders and used to determine a service member's suitability for duty.

Command notification is also required in *other special circumstances* when "the military mission outweighs the interests served by avoiding notification, as determined on a case-by-case basis" as specified in DoDI 6490.08 (2011, 2023). Though none of the participants

referred specifically to the *other special circumstances* exception included in DoDI 6490.08, participants across stakeholder groups mentioned the following circumstances as requiring command notification: placement on medications, deployment, sexual assault, and Uniform Code of Military Justice (UCMJ) violations. Although not explicitly mentioned in DoDI 6490.08, prescribed medications or preparations for deployment could fall under command notifications related to *duty interference*. Sexual assault and UCMJ violations are also not listed in DoDI 6490.08 as circumstances requiring command notification. However, MHS providers are required to report experiences of sexual assault disclosed by patients to a sexual assault response coordinator or victim advocate or to the Family Advocacy Program if perpetrated by an intimate partner pursuant to DoDI 6310.09 (2019), *Health Care Management for Patients Associated with a Sexual Assault*. In the Manual for Courts-Martial (Joint Service Committee on Military Justice, 2019),[1] the Military Rules of Evidence 513, "Psychotherapist—Patient Privilege," is cited in Army Regulation 608.18 (2011), *The Army Family Advocacy Program*, and AFI 44-172 (2015), *Medical Operations*, as protecting confidential communications between a patient and a psychotherapist (or an assistant to a psychotherapist) from unauthorized disclosure in a case arising under the UCMJ if the communication was made for the purpose of facilitating diagnosis or treatment of the patient's mental or emotional condition.

Information Disclosed About Service Members

DoDI 6490.08 (2011) specifies that "health care providers shall provide the minimum amount of information to satisfy the purpose of the disclosure" for all circumstances requiring notification to command authorities. DoDI 6490.08 specifies that the minimum amount of information shall generally consist of the following:

- diagnosis
- description of treatment (prescribed or planned)
- impact on duty or mission
- recommended duty restrictions
- prognosis
- any applicable duty limitations
- implications for the safety of self or others
- ways the command can support or assist the service member's treatment.[2]

All stakeholder groups mentioned the kinds of *minimum amount of information* outlined in DoDI 6490.08. We heard from several stakeholders that the ways in which a command aims

[1] This study was completed before the latest edition of the manual was published, in September 2023. Some of the policies mentioned in this report might have been revised or updated since then. See Joint Service Committee on Military Justice, 2023.

[2] The DoDI 6490.08 (2023) reissuance qualifies that it is the health care provider who determines how command can provide support (i.e., "ways the disclosing health care provider determines that command can support or assist the service member's treatment").

to support or assist a service member's treatment appears to open the door to a potentially broad array of information that could be conveyed from providers to commanding officers. For example, one commanding officer noted that all types of information would be beneficial for commanders to know:

> I can't think of any type of information that wouldn't be useful for commanders if the intent is to help the [service member]. Even if it's something that's prior to joining the [service branch], it would be helpful for the commander to know if it's helping that [service member] cope or be better at his or her job. I think it should be full disclosure.

Another commanding officer alluded to a wide latitude of information supplied by providers and how childhood trauma is infrequently discussed but could be helpful:

> Often, providers will tell you just about everything they know because they are under no obligation not to in that forum. As a commander, if I wanted to find out certain things, I have authority to do so. . . . I personally think that childhood trauma has a lot of impact on how [service members] behave during enlistment. If we did a better job holistically understanding a [service member] and their upbringing and ask questions about family and seeing if there is a past trauma, that often helps explain behaviors. This is coming from a dude with zero clinical experience, but I have read as many books on the subject as a therapist if not more.

One provider admitted to potentially giving too much information when commanding officers have asked how to support service members:

> As I'm thinking, if command asks—the way the question is asked, "Are there any ways I can support the person?" I have to hint at things going on in their life to give a real answer. There sometimes might be too much information. If I say someone is having family problems, I do think that's a bit of an invasion of confidentiality. It's probably more information than the command actually needs, but at the same time, if there's a way I can help support this service member, maybe there's a way I can talk without giving too much information. I think sometimes in the past it may have crossed a little bit of a line.

One commanding officer noted receiving too much information in their command role:

> I get too much information almost. We have one or two doctors that help our units. I don't have too many probing questions. They [providers] will give me [service members'] medical history on the spot or email it to me.

Another provider commented on how interpretation of *minimum amount of information* can vary: "*Minimum necessary* is a subjective term. It means something different to my peers, the command, and the patient." Finally, an enlisted service member speculated that commanders and providers likely determine between themselves what types of information are shared and that there is probably variation across units:

> There very well could be variation on what is shared based on each individual commander and their respective medical officers. Each unit commander works out with the provider what criteria or circumstances constitute "need to know," and there may be variation between commanders, but [service members] may not be aware of what goes on in other units.

There were other providers and commanding officers who considered the types of information that can be disclosed as more circumscribed. For example, one provider stated:

> I always fall back on these three things supported by instruction: diagnosis, prognosis, and treatment plan. . . . If they [command] push for details, I refer them to the member. It's not my place to disclose details in their life.

A commanding officer remarked that providers should not share "anything that does not relate to the mission. I need to know the minimum. I just need to know if someone is safe and trustworthy. If there's more than that, then it gets back to the stigma."

Our interviews highlight the variety in the amount and type of information disclosed to commanding officers despite the policy specifying that only the minimal amounts of information be disclosed. It is evident that the policy needs further clarification to reduce the ambiguity regarding what information may be disclosed about an individual service member.

Personnel with Access to Service Members' Mental Health Information

Under DoDI 6490.08 (2011), guidance is directed at commanders regarding the protection of privacy, including to whom they can disclose service members' mental health information. DoDI 6490.08 specifically states: "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."[3] Our interviews suggested that the interpretations of *need to know* and those personnel who should be given access to service members' mental health information vary widely.

One enlisted service member described personnel designated as having need to know as those who filled out privacy policy–related forms:

> I think commanders are allowed to know because you have to fill out all these forms, like the HIPAA waiver. Senior enlisted and commanders are allowed to because they have the need to know. But unless there is a need to, I don't think the medical providers brief up every medical health issue; I think they have more important things to do. I know for myself, the CO [commanding officer], and the XO [executive officer], we fill out these forms on privacy policy, so we are allowed to receive that information.

[3] In the DoDI 6490.08 (2023) reissuance, the guidance to commanders no longer references to whom service members' information shall be restricted.

Another enlisted service member identified the "triad" as personnel with need-to-know access, including the commanding officer and their chief and first sergeant, and also noted that a service member's supervisor may be informed:

> I think the only way that [disclosure] normally happens is if the commander shares it. From my understanding the only two people that he usually brings in would be his chief and his first sergeant about this. Usually when something's going on, medical or disciplinary, it's always those three that make the decisions. It's called the triad, then they would make the decision together, so I guess those would be the only two other people, and in some cases, they talk to the service member's supervisor to keep him or her in the loop.

A commanding officer explained that need to know involves specific individuals within the chain of command:

> For me, it would be anyone that can get any kind of information. . . . Me, my first sergeant, and my section commander, we need to make sure that we can have that free communication with each other. They both need to have access.

In contrast, another commanding officer relayed that need to know can vary from situation to situation:

> Confidentiality is keeping information to people who need to know. That's determined on a case-by-case basis about who is involved, but generally commanders. So, an O-5 level commander or a [service branch] commander generally has complete knowledge of what's going on from the individual and medical care side. Below that, the information is parsed out as needed, so someone in their chain of command who needs to be involved, they'll be let in on the situation.

And yet another commanding officer clarified that the commander could designate personnel with need-to-know access, which can include personnel who are trusted by the service member experiencing a mental health issue:

> It's usually the [service branch] commander who decides to let them know, or the company commander decides, hey, this person is in a risky situation. They trust this other staff sergeant, so I'm going to let them know what's going on because I think they can help manage the situation and talk to them. The person is trusted by the individual. I'm going to let them know so they can better handle the situation.

It is clear that the need-to-know clause directing commanders' disclosures of mental health information is at the core of confidentiality policies aimed to limit the number of personnel with access to service members' mental health information. However, our interviews highlighted the ambiguity and diverse interpretation of *need to know*, effectively leaving decisions about access to information to the discretion of individual leaders.

Implementation of Mental Health Confidentiality Policies

We sought to learn from providers and commanding officers how mental health confidentiality policies and practices are implemented. We queried service members about their perceptions of how confidentiality policies and practices are implemented to identify how they are viewed and understood by enlisted members. Stakeholders' perspectives regarding the implementation of mental health confidentiality policies were categorized into the following three themes: education and understanding of policies, implementation processes, and monitoring and enforcement of policies.

Education and Understanding of Policies

Stakeholders were asked about their awareness of policies that set the rules for what information providers can share with commanders and where they learn about policies related to mental health confidentiality. Stakeholders' responses are described in this section and organized according to the following three domains: sources of information about mental health confidentiality, awareness and understanding of the policies, and how training or job experiences affect adherence to the policies.

Sources of Information Regarding Mental Health Confidentiality Policies

We asked participants where and how they source information about mental health confidentiality policies, regulations, and practices. Understanding how leaders, providers, and service members access information when questions arise regarding mental health confidentiality is essential to ensuring compliance with the policies. The following perspectives elucidate the extent to which stakeholders think that they know where to access accurate information about what confidentiality protections are in place for those deciding whether to obtain mental health services.

Providers detailed the sources they rely on for information about mental health confidentiality policies. Many providers reported seeking guidance from their networks, including supervisors, their department heads, or someone in their chains of command, as well as colleagues or peers. Other providers referenced their clinical internships or residencies as their primary source of mental health policy information, while others consulted the mental health portal in the Knowledge Exchange, a centralized portal for health care providers to access information, forms, and key contact information. We also heard that some providers confer with medical legal consultants and HIPAA privacy officers regarding confidentiality questions. One provider, however, described not receiving information about military confidentiality during their residency training and emphasized that training on confidentiality policies may vary:

> It wasn't part of my residency training or information that is sent out regularly. That would be information that would be rotated often, but I have not seen it. I mean, I think that is an issue—that some people might have that information while others don't. We don't all have the same type of understanding of what the potential impact might be or

> what should be disclosed. I mean, we are also trying to protect our license. There is communication amongst ourselves about what has been disclosed.

One provider described the need to rely on various sources of information to decide whether to disclose information related to a waiver for a service member's deployment:

> I did a [service branch] internship or residency. Most of us active duty providers get all of our training on making these decisions there. We always can consult. It came up a couple weeks ago, where I had a question about HIPAA. Can I release this information for this purpose related to a waiver for someone to deploy, despite their borderline status history? Like, it might be disqualifying but I think we can waive it. I called the medical legal consultant assigned to us, who is a lawyer on retainer, to be able to ask those questions. . . . In the med groups, we have a HIPAA privacy officer we consult with regularly . . . and our colleagues as well. Much of the time we can get guidance from the DoD and [service branch] instructions on medical privacy and then we have consultation. Those are the main things we'd fall back on.

Another provider shared how updates to the regulations are shared within a circle of close friends:

> I was introduced in residency and during military residency, I had to learn as I went. I was doing command meetings in my first week, . . . and I was exposed to health regulations and how they were applied. They've been pretty consistent in the places that I've been. . . . I have a close group of friends and we push updated lists to each other. We have these open discussions, and it forces us to go back to these regulations. When a regulation gets pushed, I get it from somebody and then push it out to others. . . . It is very piecemeal. That is how the federal government works.

The majority of **commanding officers** we interviewed shared that they rely on providers for policy guidance. Some also reported receiving policy guidance from a variety of other sources, including commanders' and first sergeants' courses, supplemented by mentorship, mental health clinics, annual HIPAA training, townhalls and presentations, consultations with legal and flight surgeons, and "Google" (i.e., internet searches). For example, one commanding officer stated:

> So, in certain positions, if you're a commander you have to do annual HIPAA training and that's it. Unfortunately, each year if you passed it, you could take like a quiz at the beginning and, if you pass, you don't have to take the course again. Some of the answers are on Google, so a lot of people just pull the test up, Google answers, and take the quiz, which is two hours shorter than taking the class.

Some commanding officers admitted to being unsure of sources of information for mental health confidentiality policies, and one commanding officer said that they did not have sufficient training and that the policies are complex. For example, one commanding

officer shared: "No one knows the policies and no one knows where to go, or practices to get through this. I would say it has hindered our ability. No one knows. It is unclear where to find policies or what the policies say."

Enlisted service members appeared to have less awareness of and clarity about the sources of information for policy guidance on mental health confidentiality than commanding officers or providers. Service members described policies as not being readily available and relayed that they would refer to the following sources for information about mental health confidentiality: medical or mental health clinics, command, and peers.

For example, one enlisted service member remarked that, in contrast to other types of policies, mental health confidentiality policies were not widely published:

> Outside of a medical facility, I don't think it's published anywhere. They publish other things [policies], like sexual harassment, equal opportunity, suicide prevention. It should be published, though. Confidentiality information is only available at a medical facility; I don't think it's published anywhere.

Several enlisted service members noted that information about confidentiality could be obtained by reaching out to mental health clinics for information or at the point of care when confidentiality agreements are signed. One service member relayed being told that they could "learn about confidentiality when you go to the mental health clinic and sign the form." Another service member corroborated the notion that information about privacy protections is provided on the confidentiality form when you see a provider but not published elsewhere:

> You have to sign a confidentiality form when you go into a provider that they won't share information with anyone. But outside of that, I don't think it's published anywhere. So, at different installations where leaders are focusing on other things, that behavioral health is not shown in a positive light—I don't know. It's not published anywhere that patients have privacy. In a normal workspace you wouldn't be seeing that.

Informed consent forms describing the limits of confidentiality have been issued across the services, such as DA Form 8001 ("Limits of Confidentiality," March 2019; see Army Regulation 40-66, 2010, for more information about the form), the U.S. Naval Academy's Form NDW-USNA-AAD-5211/08 (10/07) ("U.S. Naval Academy Midshipmen Development Center Informed Consent and Limits of Confidentiality," March 5, 2018), and the Air Force's "Mental Health Clinic Confidentiality/Informed Consent Sheet" (AFI 44-172, 2015, Attachment 3).

Another enlisted service member remarked about being unfamiliar with the regulations despite serving in the military for an extensive period and that they would likely inform command and turn to the behavioral health clinic for information:

> I'd have to do a whole lot of digging around. I would have to let command know I was looking for it. I would probably just call the behavioral health clinic and speak to someone there and have them tell me the regulations. No, I don't know off the top of my head, and I've been in the military for 15 years, so it's not something that's spread widely.

In addition to describing regulations as inaccessible, numerous, and unclear, one enlisted service member shared that they could seek information about mental health confidentiality from command or ask a peer about their experiences:

> I don't know even how to access them [service branch regulations]. There's two trillion of those and they aren't worded clearly. They could go to the command team and ask for confidentiality clauses. Or if they have a service member friend who is knowledgeable in that area, they can ask them what their experience has been.

One provider corroborated that service members are learning about confidentiality limits by "word of mouth" through the experiences of their peers:

> When instances come up, I end my informed consent speech with, "If I'm ever going to break confidentiality and share your care with someone else, you will know first." That quells the concerns, and usually people talk to someone in the past about stuff that was disclosed. They might have a good sense, like if I tell them I'm going to kill myself, you'll probably tell someone. Most is common sense. The people with flying status, mobility requirements, etc., they get . . . well, maybe not trained. . . . They are well versed in what they want to say in a medical setting based on word of mouth.

Last, some enlisted service members mentioned the following as additional sources of information on mental health confidentiality policies: support people assigned to units (e.g., nonmedical counselors), providers who do outreach to units, patient advocates, patient administrators, and HIPAA compliance officers in medical clinics and hospitals. However, not all service members are aware of or have access to these types of sources of information.

Our findings indicate that there is limited awareness of any single or consistent source of information for commanding officers, providers, or enlisted service members to learn about mental health confidentiality policies, given the multitudinous issuances from DoD and the services related to the release of service members' mental health information. Although DoDI 6490.08 (2011) contains most information pertaining to confidentiality policy and mental health treatment, results from our interviews suggest that few service members are aware of this regulation or other information sources and perceive that the information is fragmented or inaccessible. Our interviews highlight vast inconsistencies in how leaders learn and are trained on mental health confidentiality policies and regulations and how leaders approach implementing the policies or making determinations affecting confidentiality. Although some enlisted service members pointed to several sources of information, it is clear that many service members perceived the policies as being not readily accessible.

Understanding of Mental Health Confidentiality Policies

We asked stakeholders about their awareness and understanding of military mental health confidentiality policies to assess the extent to which providers, commanding officers, and service members reference and comprehend the policies or are confused about what is stipulated in the policies. Below, we describe each stakeholder group's familiarity with the policies

and provide illustrative quotes to illuminate where participants thought that the policies are ambiguous.

During our interviews, **providers** expanded on their knowledge of mental health confidentiality policies and pointed to gray areas in which policies may be unclear or are subject to clinical discretion or interpretation. As one provider noted:

> I'd say roughly 50 percent at best [of decisions affecting confidentiality] are explained in the policies, and 50 percent is up to clinical discretion. So, there are certain disorders that may meet criteria that someone may not be fit to do a job. We do have some standards on those. But even with those there is room for clinical discretion.

Another provider emphasized that, although there may be specific guidance in the policies, there is still some ambiguity and room for interpretation: "It's still always open to interpretation, so you consult with your supervisors, coworkers, about what's the most appropriate step for this situation. So we have standards, but also use discretion." Some providers shared about the challenges with learning and staying up to date on evolving policies and having insufficient time to review them. For example, one provider explained:

> It would take significant effort I think to do that [familiarize myself with all the policies]. Because I found find myself so busy all the time, I would have to do that [research the policies] on the weekends, so very rarely. If something comes up, I'd look for it but I can't say I do it often.

One provider described the intensive time needed to locate additional instructions to resolve a conflict between guidance coming from command and another specific instruction:

> I spent, I would say, a week trying to figure that out and track down the instruction. My chain of command is saying don't go to the CO [commanding officer] directly versus what the instruction says is contradictory. I spent a week trying to find instructions saying otherwise before doing something to piss off my command or go to the CO with something he didn't want. It's this whole big thing—it took forever, and no one knew the answer.

Another provider reported using the enlisted and officer directories to help figure out mission requirements and underscored the importance of going into the field with the unit to better understand potential duty limitations associated with treatment:

> We encourage officers to get out and go to the unit to get an understanding of jobs and duties. It's relevant if I'm doing treatment what treatment is feasible in the field and at home. And what modalities of treatment would stop you doing your job that I have to communicate to the commander.

Commanding officers' understanding of the policies varied widely, from grasping what military health care providers are not permitted to disclose pertaining to mental health infor-

mation to understanding HIPAA policies and their own personal interpretation of them. One commanding officer described the policies as "pretty common, pretty standard," but did not go into details.

Although the majority of commanding officers we spoke with were aware of the existence of policies, several shared that they did not have extensive knowledge of mental health confidentiality policies. For example, one officer (who reported receiving mental health information from a first sergeant but not from a provider) noted that they were not aware of the policies as they pertain to medications because that topic has "never been briefed." Other commanding officers were unable to recall specific policies. One stated, "I'm aware they exist, but I couldn't quote you the numbers," and another commanding officer said, "I'm 1,000 percent sure they exist but I haven't seen it."

Knowledge of mental health confidentiality policies may vary due to rank, billet, or commander (Office of the Chairman of the Joint Chiefs of Staff, 2021). As highlighted above regarding sources of information regarding confidentiality policies, a handful of commanding officers indicated that they rely on providers for guidance, which shapes their understanding and application of the policies. For example, one commanding officer noted deferring to providers about disclosure: "I don't know specifically what they [providers] can and cannot share. I just know if they can't share it, they won't. I trust that the providers are abiding by those policies." Similarly, other commanding officers defer to providers on confidentiality and disclosure policies. One officer stated: "I'm not super familiar [with the policies]. I just go to docs and ask them. I don't know individual policies." Another said: "I couldn't quote you the policy. . . . I use my experience and exposure. I'm more in touch with the actual providers. I trust that they know it [the policies] better than I."

Although multiple commanding officers stated that they were knowledgeable about the confidentiality policies, some also acknowledged that their familiarity may wane over time because they are not required to take courses until their training requires renewal. Another commanding officer also reported challenges with retaining their knowledge of mental health confidentiality policies and needing to refresh their knowledge as needed.

Most **enlisted service members** who participated in our interviews were aware of mental health policies, with only a few participants stating they had no awareness of the policies. Some service members indicated they had a basic understanding of military mental health policies but did not describe the extent of their knowledge. One service member stated that their knowledge is based on their experiences and observations of how policies are implemented at their installation and by their leadership, highlighting the possible variation in how policies are practiced and applied across the services.

In general, service members shared that they did not frequently reference the military mental health confidentiality policies. Those who referenced the policies tended to be higher-ranking enlisted service members (E-7–E-9), although they did not specify whether they referenced the policies for personal reasons or to support a junior service member.

Overall, the mental health providers we interviewed were most knowledgeable of military mental health confidentiality policies, followed by commanding officers, and then enlisted

service members. Across all stakeholder groups, awareness and comprehension of the policies varied widely, with several participants pointing to ambiguity in the policies that requires discretion in the interpretation and implementation of the policies.

Training and Experience with Mental Health Confidentiality Policies

Participants described how training and experience can influence adherence to confidentiality policies in a variety of ways. For instance, with respect to *minimum necessary information*, less experienced providers may find it difficult to refuse unlawful requests for information from officers, and providers may disclose unnecessary information in the absence of ongoing peer consultation. We also heard how varying levels of training among providers can result in failures to implement the policies as intended. Stakeholders also shared that, although more-experienced officers are well-versed in federal laws and standards on the protection of PHI, lower pay grades or officers with fewer interactions with mental health providers might not be as knowledgeable about allowable PHI disclosures.

Several providers pointed to the need for improvements in confidentiality policy training to prevent the sharing of patient health information that goes beyond required disclosure circumstances or minimum amount necessary. One provider remarked that "the biggest room for improvement is the implementation of the guidelines, the way they're meant to be followed" and noted that "everyone's training levels are different." Another provider emphasized the value of experience:

> I think errors are made, revealing too much or not enough, when you're a less experienced provider. At this point in my career, I'm confident talking about confidentiality to people and leaders, which is why I feel I don't have problems with commanders asking too much. I can toe the line and not get intimidated and tell only what they need. I wonder if there are some differences based on level of comfort and where they are in trainings.

One provider highlighted the role of mentoring in ensuring that providers do not violate confidentiality protections:

> More often than not, the providers don't cross the line unless they feel coerced. That's mentorship—don't break confidentiality. You can tell your boss no, and you have the law to back you up. But if you break that [confidentiality], you are subjecting yourself to muddy waters.

Another provider pointed out how gaps in the timing of officers' training can be an issue for policy compliance, highlighting the importance of timely training for commanding officers:

> You go through these formal stages of training as an officer. When you're presented with a problem, here's how you go about finding a solution because not every problem is the same. . . . There is a gap is the timing of this. I know people who have been in command for a whole year before going to the course. So, they go off what they think is right

> based on what someone told them and through the experience of being in a different unit before they ever sit down for the course. It's not a mandatory sequence of events. It's fluid because you don't know if you have the time to step away to be in the course and not be available for the unit.

An enlisted service member noted the lack of training on mental health care privacy in contrast to sexual assault:

> I can't say that they do any sort of training. I can't say that anybody knows the exact process. Unless you ask, I don't think anybody knows. The military takes a lot of time to stress sexual assault stuff, but nobody ever talks about the mental health thing, like it's OK to get help and your stuff is private. We have quarterly trainings on sexual assault, but never once in six years has anyone done a briefing on the services that mental health provides, and how it operates. There is not sufficient training in how mental health services operate.

Implementation Processes

We asked stakeholders to describe their experiences with the implementation of mental health confidentiality policies to get a better sense of the effectiveness of these processes and whether there are areas for improvement. We learned that approaches for command notification of service members' health information vary widely and that commanding officers largely depend on providers for education and enforcement of the policies. We also learned about how indirect disclosures can occur within units, given certain aspects of seeking mental health care within the military, and about lapses in confidentiality policy compliance between providers and command, as well as within the chain of command.

Forms of Command Notification

Stakeholders described exchanging mental health information about service members during more-structured (e.g., scheduled meetings) and impromptu interactions. Participants' descriptions revealed wide variation in how both structured and impromptu interactions occur.

Types of structured interactions in which service members' mental health information is disclosed included treatment team meetings, meetings about service members designated as *high interest* (e.g., service members whose risk is elevated), electronic communication, and discussions about service members with mental health conditions that occur through such programs such as the Force Preservation Council (U.S. Department of the Navy, 2016) and the Preservation of the Force and Family program (U.S. Special Operations Command, undated). Variations within and across these types of structured interactions were described. Specifically, participants discussed a variety of individuals who may participate in these interactions (e.g., commanding officers, first sergeants, providers of different types, service members experiencing mental health challenges), different criteria for determining when services members need to be tracked by such structures, and various types of information shared.

Impromptu interactions to discuss service members' mental health information were described as initiated by both providers and commanding officers. These impromptu interactions were depicted as sometimes occurring as one-offs or being more extensive and ongoing. Moreover, these impromptu discussions took place in different settings (e.g., offices, hallways, outside the workplace) and modes (e.g., in person, phone, email). For example, one commanding officer serving in a commander role described their interactions with a mental health provider: "Almost always in person. Walking down the hall, if her door is open, I'll stick my head in and chat. If it's urgent in nature, she'll pop into my office, and we'll talk in person behind closed doors." One provider explained how they would shut down impromptu interactions with commanding officers: "That happened when I was a commander and that was easier because I would say, 'We are not having this conversation right now.' I gave them tips on who to talk to."

Providers as Educators or Enforcers of Confidentiality Policies

A notable theme that surfaced throughout our interviews was that providers often serve as educators or enforcers of mental health confidentiality policies. Providers shared that having to support commanding officers by clarifying the difference between *prefer to know* and *need to know*, teaching the process for provider-commander exchanges of service members' mental health information, assisting with developing an understanding of what works best for service members (e.g., needed duty accommodations), and setting and enforcing limits on what information can be shared. Two providers described their experiences informing commanding officers about what information can be disclosed:

> I think a lot of the times, they [commanding officers] just need education to understand. A lot of the times they are asking questions about what they need to know because as commander they are privy to a lot of information. If I explain it, that it's not legally necessary to share, then they get it.

> A lot of times command misunderstands the difference with need to know and prefer to know. It takes description of professional ethics and laws and usually they realize there's a lot of red tape. Sometimes they still push, "Hey, I really need to know if this person is good." In that case, we help command understand emergency codes, and if doesn't meet that criteria and they can't articulate direct evidence of risk to self or others, then they have to at some level accept the ambiguity for privacy of a human being.

One commanding officer commented that providers sharing more than the minimal amount of necessary information can set up a troubling precedent:

> I've had providers giving out information that didn't need to be shared. They did end up sharing information that didn't need to be shared . . . but that was the guy [provider] reaching out to a commander. The commander didn't go seek it out. But now the commander knows if he wants that information, he can get it.

Indirect Disclosure of Mental Health Information

There are several ways that receipt of mental health care in the military can result in the indirect disclosure or inferring of service members' mental health information—for example, through passive sharing of information, deduction, or evidential observation. First, some participants reported believing that it is relatively easy to figure out that someone is seeing a mental health care provider if they are absent from their duty or if their behavior and work patterns change. Stakeholders shared that peers will often assume that a situation is related to mental health when someone is placed on modified duty. Participants explained that it is easy to notice when someone is missing a lot of work or absent for a few hours at a time, leading peers to become curious. Detecting a service member's absence may be particularly easy in certain circumstances. For example, if a service member is working a flight line, on a ship that is underway, in a career field where people hold Top Secret clearance, or in the Sensitive Compartmented Information Facility (SCIF, a secure location where sensitive government information is processed), privacy can be especially challenging, as absences may be more noticed.

We heard that most service members will not automatically infer that someone who is missing work is doing so due to mental health treatment, but it may cause peers to start asking why someone has so many appointments. Gossip within units may be the first step in others finding out that someone is seeking counseling. Service members may also ask questions if they are asked to pick up additional duties. As one member shared,

> If someone is pulled off from watch duty, someone [else] has to pick up their slack. They start asking questions—not necessarily at the chief level. But they could be talking to their [service branch E-4–E-6 supervisor]. Because they would demand, "Why am I standing this extra watch duty?"

A commanding officer shared that section chiefs can infer that someone is seeking counseling because "the section chiefs are pretty smart. . . . If you are going to medical at 1300, we know that nothing else, maybe besides physical therapy, would require a one-hour meeting, so I assume that's how my [service members] figure it out."

Finally, stakeholders shared how members use context clues to figure out that someone may be seeking mental health treatment. For example, one participant shared: "Just the fact they are asked to leave work for weekly appointments, their privacy will be compromised, even if someone isn't searching it out. That is a fair concern because if you come once a week, that's different than a dental cleaning." A participant also shared that mental health appointments may be referred to as *medical*, so other members of the unit could hear that term and be clued into why someone is missing work.

We also learned that indirect disclosures occur due to the visibility of keeping appointments. Some stakeholders shared how peers can observe service members physically entering medical facilities or mental health clinics. As one commanding officer put it, "The information behind treatment is very well-protected. I think that one is well protected, but you can't hide going to a mental health office." Service members talked about feeling embarrassed

when they are seen entering a mental health clinic or when placed on a new job because of mental health–related duty limitations and they are temporarily assigned a new duty (e.g., "mowing the lawn"). We heard that it becomes apparent to others why this change has happened. Stakeholders also shared that sometimes a service member's peer will walk them to the clinic to support them. However, we learned that another person accompanying a service member to an appointment increases the visibility of the service member receiving mental health treatment. Other times, we heard that information could spread when friends or commanding officers visit or see a service member in the mental health ward or hospital. As one service member shared about how indirect disclosures stem from this visibility:

> Sometimes it's a really small world, so someone always knows someone and sometimes information just gets out. Like, 'Hey, I saw you at the mental health clinic." I know a couple of people who reside in the dorms, and that's how some information got out as well. Yeah, either that or just gossip.

Although the issue of indirect disclosure through visibility and inference (e.g., consistently missing work) is difficult to avoid, some participants observed that this issue is less concerning for members who reside off base. One service member explained that off-base personnel are not as concerned about peers finding out indirectly because they have more control over the information they share with their peers. A commanding officer (who reported receiving mental health information from a first sergeant but not from a provider) also shared that they frequently move people around jobs, which tends to mitigate the issue of other members in the unit finding out that a service member is receiving mental health care because of a change in their job duties:

> [Why a service member is moved to different responsibilities] is usually not discussed [with other members in the unit]. We shuffle people around to give different experiences in shop. We go from building bombs to sitting behind the desk. We have ability to tweak where people go. We are moving people around constantly, so there's no questions asked.

Apart from deducing that a service member's absence is due to mental health reasons, service members told us that indirect disclosures occur because of the ease with which information can spread throughout a unit. Service members emphasized how ubiquitous gossip and rumors are within and across units, comparing the spread of information with "a game of telephone." Service members and commanding officers alike pointed to the proximity of individuals residing in the barracks and the camaraderie within service branches as contributing factors for such disclosures. Because of the nature of relationships and responsibilities of command and with fellow service members, information spreads easily according to stakeholders.

Stakeholders also discussed the obligation to inform a service member's chain of command if it becomes evident that a service member is at risk of hurting themselves, in an abusive situation, or abusing alcohol or substances. We also heard that peers may share non-

emergency information with command if they are concerned about a fellow service member. As one service member shared:

> The friendships you build in the [service branch] are not [as] trusting as you think. What is the threshold? I've had [service members] that go through divorce and the wife took all the money and all those kinds of things. He was staying up all night figuring that stuff out, and then he fell asleep on watch during the day—and that is very bad. They will go talk to the chain of command, but the chain of command might not do anything about it, but they can keep on top of them.

Providers discussed how paperwork, such as administrative forms, can reveal service members' mental health information. They explained how such paperwork could easily be mishandled, exposing sensitive health information. One provider recounted how they would hand deliver all paperwork containing sensitive information to prevent private information from being disclosed. Another provider explained how confidentiality of mental health information can be compromised through administrative paperwork, such as when service members are expected to share their profiles with supervisors to validate the need for modified duty:

> The biggest [way that confidentiality may be compromised] is in the processing of paperwork. . . . If someone is on profile or on separation or med board, . . . those administrative actions are in place to try to identify what's the disposition of a [service member]. When it has that tied to it, the level of confidentiality gets compromised. . . . For nondeployable [status], . . . it has this generic nomenclature, like it's "medical," but no detail. But the problem is if they are an important person to the unit with a key position. Sometimes the frequency of the topic coming up, like, "When is this person coming back"? Those discussions occur. . . . So people disclose stuff, and it's not nice and neat. . . . Junior [service members] are expected to carry their profile to validate to their supervisor they can't do certain things. For physical limitations, . . . the profile may say yes, they have back issues, but the profile could also say they have depression. Sometimes providers do it separately, but a lot don't. Now I learned all this stuff about you because you handed it [the paperwork or profile] over to me. But again, we train leaders to take care of people and be gatekeepers of sensitive issues like that, but they are human beings, so that doesn't always hold true.

Another way that the chain of command may have indirect access to this information is through appointment verification (e.g., confirming whether a service member attended a medical appointment). Although the chain of command would not necessarily know whether the appointment was mental health related, commanding officers could call the medical group to see whether a service member went in for an appointment. Medical can respond yes or no but cannot disclose information about why or what the service member discussed. In addition, some medical clinics share the number of no-shows to mental health appointments with the unit to help leaders figure out why a service member is not attending scheduled appointments. Furthermore, information can be indirectly disclosed through appointment

slips. One service member described how their chief asked for appointment slips following appointments, which contained information revealing the purpose of the appointment (e.g., "therapy"). A different enlisted service member said:

> If it's mental health related, you would have to get an appointment. And if they want it by the book, you have to show them your appointment slip. And if it says behavioral health on it, your command knows what you're doing. . . . If you tell the boss, "I have a mental health appointment," he would say bring me a slip, and then it says behavioral health. If you want to improve things, if the military just had general appointment slips, that could alleviate that concern.

Communications Within and Outside the Chain of Command

We solicited responses from stakeholders regarding how service members' mental health information is shared among leaders and learned how communication occurs within and outside chains of command. First, we heard how service members may confide in leaders about mental health challenges, who may in turn share that information with others in the unit. As one enlisted service member described: "Private issues aren't private. I've been in a lot of situations where I've told something to a leader, and it was spread through the shop like gossip. . . . They put my medical situation out there and discussed it with other leaders."

One commanding officer acknowledged that they share information about service members with the rest of their unit, with the intention that the service member's peers will help support them. An enlisted service member described a similar situation:

> I only shared it with my supervisor because I was working with him every day. He pointed out that I was acting different, that I seemed like I was having a tough time. So, I told him that I was having a rough time being away from family, the holidays were coming up, and I had never been away from my family before, so it was a big adjustment. . . . He shared that with everybody to see if, like, that could help me out or whatever, . . . but they definitely treated me differently.

A provider described how confidentiality of information can be discretionary between leaders—for example, when sergeants seek information from commanders:

> But for leaders, the confidentiality can be fluid in those interactions. If I'm a sergeant going to a commander and someone is asking for more information, especially if I'm not a provider, I'll spill the beans to you unless I have the intuitive sense that I'm sharing too much information.

Commanding officers shared that they may seek advice regarding how to manage a service member from other commanding officers outside their units. In other instances, commanding officers reported that they may share information with other commanding officers in cases of disciplinary problems (e.g., anger issues, violent tendencies). In these instances, commanding officers share this information so that other leaders can monitor the service

member and hold the service member accountable (e.g., ensure that the member attends their appointments). We also heard that commanding officers share mental health information with other commanding officers as part of a "warm handoff" for service members transferring to new units. However, one commanding officer noted that this information flow does not happen in a consistent manner. We heard that service members are unsure what information about mental health treatment is shared when transferring to a new duty station, and DoDI 6490.10 (2015), *Continuity of Behavioral Health Care for Transferring and Transitioning Service Members*, could be revised to better convey circumstances when information is shared and when it is not. DoDI 6490.10, Part 3(b), states, "When transitioning to another command, notification shall also be made to the gaining commander when adherence to the ongoing treatment plan is deemed necessary to ensure mission readiness and/or safety." *How* and *by whom* that determination is made is not specified. The DoDI indicates that "the behavioral health records of personnel identified for PCS [permanent change of station] shall be reviewed" for several reasons but does not specify *who* reviews those records. The policy explains how information from one health care provider to the other occurs with full transfer of medical records and case notes. The policy enclosure (Section a) states, "Service members, regardless of status, shall be given information on the possible need for transfer of information upon transition as part of their initial orientation to treatment." We did not hear from any providers we interviewed that this is an aspect of their informed consent process, although it is clear from a standard Army consent form that PCS is one reason to transfer PHI (DA Form 8001, "Limits of Confidentiality," March 2019).

The way that disclosures happen through the chain of command may be different for lower-ranking members. For those in lower pay grades, the disclosure of seeking mental health care may need to travel up the chain of command, often involving a greater number of individuals than service members in higher pay grades. An enlisted service member explained:

> I just talk to my CO [commanding officer], and it's pretty direct. So that would be an easy conversation for me to have. . . . But that's because of my time, experience, and exposure. I've been in [the military] for a while, and I understand . . . how simple the process is. I'm higher in the ranks. I am able to see the big picture, whereas [a] young lance corporal can't see the same perspective. I know it is easier for me to go through this process than the lance corporal who has a corporal wanting to know where they're at. And now every time they go to a medical health appointment, all their chain of command wants to know that information. I basically got only one guy I have to answer to. A lance corporal has like 15.

Monitoring and Enforcement of Mental Health Policies

We also captured participants' views on whether there is any monitoring of compliance with respect to military mental health confidentiality policies. Several commanding officers expressed being unaware of any monitoring of adherence to policies. For example, three different commanding officers shared their impressions of monitoring:

> I don't know of any monitoring. If someone is monitoring me, I have no idea to my knowledge. There is an expectation for commanders that we follow these policies.
>
> I'd say self-monitored. Other than a HIPAA statement on an email, . . . we do annual training on HIPAA, but there is no external entity looking to see how we are doing it.
>
> I'm not certain what the quality control mechanisms are.

One commanding officer conveyed that they rely on providers for awareness of accountability mechanisms and to ensure regulation compliance: "I guess I trust the medical professionals only sharing what they are allowed to. I know there are checks and balances through inspections and things. If someone said something they are not supposed to, an inquiry could be done."

Providers described a variety of processes for upholding adherence to policies, such as through officer evaluation reports or peer reviews. Examples of such processes for adhering to confidentiality policies discussed by participants are depicted in Table 3.3.

One provider was unaware of any monitoring but did mention avenues for recourse if violations occur:

> I don't think they [providers] are really monitored. If there is gross violation, the [service member] can contact JAG [Judge Advocate General], IG [inspector general], or there are other ways [service members] can complain about confidentiality violations. If someone kills themselves, then there is an investigation; otherwise, it is not close to being monitored. There is no direct, constant observation of the application of those regulations.

One service member questioned whether there is any monitoring in place while referencing a violation that occurred in the public health office:

> I'd say everybody, whether you go to that clinic or not, can look at your record if they were to wonder what was going on with me, not that they're supposed to do that because of HIPAA, but you know, who's actually monitoring that? Who's looking up whose record? Because there have been issues of people working in the public health office and they were looking up other people's STI [sexually transmitted infection] records and telling their friends, "Hey, maybe you shouldn't date this person because they have this STI." And that is an issue in the military overall, not specifically at this base. But you know, there's people that have the access and they want to know.

Perceived Impact of Mental Health Confidentiality Policies and Practices

Throughout our interviews with providers, commanding officers, and service members, we assessed the perceived impacts and implications of mental health confidentiality policies on military careers, duties and responsibilities, and mental health treatment. We learned how these perceptions affect military members' decisionmaking and experiences, such as how

TABLE 3.3
Monitoring and Accountability Processes for Adhering to Policies

Process	Provider quotes
Inspector general (IG)	"I think the biggest [way that regulations and policies are monitored] is the IG or within the medical element within the unit patterns and holding leadership positions super accountable. I don't know of any mechanisms, beside providers."
Officer evaluation report	"We use the officers evaluation report, which is basically how we communicate, how we meet different standards like integrity, like a HIPAA violation, then being held accountable for that."
Electronic medical record (EMR) notes and internal management control	"[Adherence to the policies is monitored], I guess really, just by our EMR notes. When we have a disclosure, that's documented. . . . So, long story short, when there's internal review . . . called internal management control, they will check a certain number of records to see if we're adhering to policies. So, when a person comes to outpatient care, we try to have a team treatment meeting within seven days, and we try to get it done before that. We always try to have that in person, and we document that. So, that's one way that we have quality assurance checks when we have our internal inspections. And then external inspections [happen] at least once a year."
Patient Safety Report and HIPAA privacy officer	"I'm frequently having these discussions, but not everybody is. The protection is in place, but people make mistakes. We have those avenues—two main reporting options. One is the patient safety report when unnecessary disclosure happens, accidental or not. And the other is the HIPAA privacy officer for discussions. Those are ideal fail-safes for accidental or purposeful disclosure."
Peer reviews	"I think they're monitored. We have peer reviews that we do. If someone was not—like if they were revealing too much or not enough, that would come out there. We have different kinds of inspections where processes are looked at. I think they are reasonably checked to make sure we follow them."
Inspections	"We do monthly peer reviews on everything, and everyone. Investigations of how command notifications are done is a component of that to ensure compliance."

seeking treatment and the associated limitations to confidentiality might have implications on career trajectories.

Providers

In general, most providers shared negative perspectives regarding how mental health confidentiality policies affect their ability to carry out their clinical work. First, providers suggested that mental health policies made it difficult for them to maintain confidentiality, particularly when commanding officers were asking a lot of questions. One provider pointed out a specific policy that requires providers to review seven years of a service member's medical history to determine whether they are eligible to deploy. This provider shared:

> I think that's overkill. Sometimes I don't necessarily think back seven years in someone's record to say if they can go to Afghanistan for six months. I think that one- to two-year charts does make sense, but I think that, you know, sometimes we go way too far in the other direction. I think that sometimes we're scrutinizing things too far back and they are nonissues.

Another provider mentioned that the policies present additional difficulties for certain job types, such as flyers. For example, a flyer who is placed on medication for a mental health condition is typically put on a profile and is restricted from flying for at least six months, according to the current policies on mental health (U.S. Air Force, 2023). Should the provider wish to try a new medication or change the prescription for the service member (i.e., if they do not observe improvement with the first medication), the six-month flying-restriction "clock" would restart each time a new medication is initiated. The provider stated, "If things weren't scrutinized so heavily on the operational side of the house, we would have freedom to switch over their medications to something that might work better." The provider added that this sometimes results in flyers being reticent to start medications and why flyers may report that they are doing better than they actually are.

Relatedly, we also heard from other providers that some service members likely withhold information about their mental health because they are worried about possible career repercussions and potential disclosure to their commanding officers. Another provider shared an experience with treating a security forces service member, who disclosed information following receipt of informed consent. Because of the information the service member shared, the provider referred them to another provider. The service member then "fired" the provider for disclosing their private information to the new provider. In this case, the mental health treatment of the member was disrupted because their confidentiality was perceived as betrayed. The provider commented, "I know we [mental health providers] are not popular because sometimes we recommend things, and it disrupts plans, and they [service members as patients] aren't happy." Another provider raised the issue that, although the confidentiality policies help guide providers' recommendations, ultimate decisions affecting duty modifications reside with commanding officers. Last, a few providers described challenges related to mandated disclosures. Several shared that some circumstances ought to be protected, while others described the policy on command exceptions as "vague" and "broad." Some characterized commanding officers' requests for information beyond the minimum necessary as bordering on "nosey and gossipy."

A few providers shared positive or indifferent attitudes toward military confidentiality policies. One provider indicated that mental health confidentiality policies did not affect how they document or disclose service members' diagnoses. Another provider stated, "[Policies] provide a clear framework to carry those out. They are supportive for my clinical work. They are helpful." Another provider described how the military mental health confidentiality policies made them "more thoughtful," and that despite gray areas, the policies provide solid guidance for making decisions and navigating ethical questions regarding individual privacy.

Overall, providers pointed to various circumstances in which the policies hinder their ability to carry out their clinical responsibilities. Although a few providers had positive perspectives to share, our interviews highlight the need to further explore how military mental health confidentiality policies affect the provision of care by mental health providers.

Providers discussed having mixed agency (Kennedy and Johnson, 2009)—supporting the best interests of the patient and the military—and explained the challenges associated with balancing these competing priorities. As one provider shared:

> Even in my role, I don't feel I'm working for the patient but for command, which isn't true. I am not just there to help support command but I'm also there for the patient. . . . If you are part of command, you spend more time with them. Maybe your friends are in the chain of command, and it can get a lot trickier, I think.

Another provider described how they navigate the tension:

> I keep the relationship open, and I discuss with them [service members] and validate. I mostly validate their concerns. . . . I help them understand where they [command] are coming from as well and what works best for the member. At the end of the day, both our alliances are for the member. Although we both have other alliances to the unit, to fitness, to duty, we both want to make sure that the person is taken care of.

Another provider explained how commanders are under pressure to prevent suicides. Therefore, they discussed how commanders occasionally push decisions about treatment on providers (e.g., urging inpatient treatment for a service member when providers think that it is unwarranted) and how this could affect service members' care and providers' careers:

> There is this expectation that there will be zero suicides. That means that someone has to take the blame if there are suicides. The commands would then say, "You should have sent the person to intake [for inpatient care]," but there is nowhere that says that. My [service branch] commander may be a pediatrician, so I have to explain to him why we are unable to have this patient go to this inpatient facility. I mean, I imagine as we evolve, there will be this expectation that we would do what the commander wants us to do. It would be better for promotions, you know. . . . There is still that tension and this belief, from the unit perspective, that they [commanders] have all the information they need, and we [providers] are just the pawn about sending this member to the inpatient program.

Commanding Officers

Commanding officers held a wide variety of perceptions about how mental health confidentiality policies affect their duties and leadership responsibilities. Some commanding officers described the weight of being held responsible for the well-being of service members and discussed how the policies affect this responsibility. One commanding officer expressed wanting greater access to service members' mental health information and discussed how increased transparency would help them make more-informed decisions: "We need more transparency instead of less." Another commanding officer discussed how their career was "derailed" when they called a distress line to talk to someone for support and provost marshal officers and emergency medical technicians responded. The commanding officer shared, "it

took me a long time to get over that resentment," and noted that they were able to use the experience to better connect with their service members:

> In retrospect, I will say some days I feel it was a blessing because now I feel the impact I can have on the [service branch] is higher on the individual level with [service members] who know I'm transparent about it. We need people who are [transparent]. I know a colonel who had been sober for years and never told anyone. I think there is an obligation to share hope with others so they can build on that. That's why they say "the shoulders of giants." I'd feel terrible if someone hurt themselves because I was too much of a wimp to share my story. The promotion train stopped at my door, so I have nothing to lose except being a positive influence on others.

Another commanding officer described the importance of "setting the example" to help offset junior members' apprehension with mental health care. For example, this commanding officer shared how they were initially hesitant about taking a prescribed antianxiety medication for fear of how the news might affect their career (e.g., ability to deploy) but proceeded with the prescribed treatment as an example to others. This commanding officer stated, "There was a hesitation. But I put money where my mouth is—if you want to be a leader you should go [to mental health treatment]."

Commanding officers also commented on the impact of mental health policies on their ability to lead. Some commanding officers said that mental health policies are "working for them" and did not impede their ability to lead effectively. Several commanding officers held positive views toward the policies, with one stating, "It makes it easier because we know how to help this person." This commanding officer also noted that the policies help facilitate connecting service members with resources. Another commanding officer acknowledged that the "restrictiveness of the information is necessary," but countered this sentiment, saying that "the commanding officer gets the information if he or she needs it." Another commanding officer shared that the amount of information typically disclosed is appropriate and sufficient for making informed decisions but admitted to potentially feeling differently if leading a much larger unit, where they might not have direct communication with the provider and would need to rely on subordinates to communicate with providers about service members' mental health. This commanding officer elaborated on the utility of granting access to information under such circumstances: "If I had a much larger unit, I could delegate at certain levels. In that situation, I would have to trust my subordinates to talk to the provider. And they would have to be granted those privileges." In contrast, a commanding officer cautioned: "Confidentiality could backfire. I want it [confidentiality], but it backfires because I can't make good decisions for who I'm sending on deployment until I have medical look [at the service member's mental health record]."

A sentiment shared by commanding officers was the perceived impact of policies on their relationships with providers. One commanding officer described having issues with physical health providers, who asserted that they were unable to give out any information because of their interpretation of HIPAA policies. Some commanding officers expressed that maintain-

ing connections with providers can facilitate a better understanding of their members. For instance, one commanding officer (who reported receiving mental health information from a first sergeant but not from a provider) stated:

> It's good for the commander to have a link with the behavioral health providers. I think it's good to have a sense of what's going on with your members. But in terms of intricate details, I don't think there's a need for that. It should be vague like, "Hey, they're going through a divorce. You don't need to know details." The member's private life is private.

Last, commanding officers noted that mental health confidentiality policies and practices can affect officers' ability to lead and manage personnel within their purview. For example, some commanding officers shared their desire for more information about potential drivers of service members' mental health issues within their units (e.g., toxic leaders exacerbating service members' mental health conditions). According to these commanding officers, such information would help them better manage leaders and support service members but is not information they are privy to under current regulations.

Service Members

Service members described the following perceptions of how confidentiality policies could affect them: negative career repercussions (e.g., promotions, military service), compromised confidentiality (e.g., members cannot trust providers to keep information confidential), withholding of information (e.g., members censoring information during clearance evaluations), stigma, and decisions around health care providers and care settings (e.g., military versus civilian).

Most service members indicated that concerns about confidentiality might affect their decision on whether to seek mental health care. A consequence of seeking mental health care perceived by service members is the negative impact on military career trajectories. We heard that many service members are afraid that obtaining mental health treatment could disqualify them from specialty jobs, particularly jobs in intelligence, security forces, law enforcement, and special operations. These service members thought that seeking care could result in the loss of security clearances or the ability to hold arms. Another service member gave the example of military police and how, once they get coded for mental health, they get pulled from duty and will "be stuck with other duties, like cleaning buildings and stuff."

Service members specifically mentioned that seeking care for anxiety, depression, bipolar disorder, schizophrenia, and PTSD could lead to a medical review board, depending on the severity of symptoms. One service member shared this view and added that the review board could result in dismissal from the military. Although dismissal from the military does not occur based on medication alone, our interviews suggested that this perception persists and affects whether service members seek mental health treatment. The following excerpt highlights these key misperceptions that taking medications, obtaining mental health services, and being diagnosed with certain mental health conditions are automatically disqualifying or sent for medical review:

> So, a lot of people do get medically released from the military if they develop depression and stuff like that, just for the psychological factor of, are they going to be able to perform their duties or are they going to be depressed too much? It's only like very, very mild cases where, as long as you're not taking medication or something, that you can stay in. But if you have severe depression or PTSD or anything like that, which pops up from having kids or going through loss or trauma or stuff. . . . The first thing they do is they send you to a medical review board because they think you're unfit for duty and can't perform your duties because you "need to get your mental health together." I know a lot of moms who don't seek help from what could be postpartum depression because they don't want to lose their career over it, even though they probably should get help, but it wouldn't look good.

Some senior enlisted service members expressed differing views; one did not think that promotion would be affected and that the military was promoting behavioral health in "all the right places." Another senior enlisted member also stated that mental health treatment should not affect service members because they would be able to make their own appointments. However, this senior enlisted member also posited: "People are afraid of not progressing in their careers. I've had senior people in the [service branch] tell me if you seek behavioral health, you're weak. I believed that for a long time."

For those who do seek care, service members described how concerns about confidentiality may affect their relationships with mental health providers and limit what information is shared. Several service members also asserted that there is a common belief that "providers tell command everything," so many service members are not willing to open up or trust providers. A few service members shared firsthand accounts of witnessing medical information being shared with command and imparted how this affected their future decisions regarding mental health care. For example, one service member observed a provider sharing private health information that did not meet the criteria for minimum amount necessary and shared how they no longer trusted the military medical community. In a different example, a service member was informed by peers that their chief attempted to solicit information from their therapist and shared how this affected them: "I became really selective about what I would disclose, and it definitely took an even bigger toll on my mental health because I felt that I didn't have an outlet to express what I was feeling." There is a perception that providers will "snitch" to command, which stops many from sharing information for fear of career repercussions. Additionally, we heard that active duty members are less likely to share information when they engage in mental health counseling because they believe that providers have ongoing conversations with leadership about their treatment.

Service members described several factors that affect the degree to which service members in general withhold information, including command climate, the desire to serve in the military, and concerns over potential diagnosis outcomes. First, willingness to disclose information depends on their command climate. Service members' concerns about their leadership learning about their medical information are tied to how much they trust their commands. Under a positive command climate, service members reported talking more openly with providers. Another service member explained that what is shared with providers

depends on whether help is wanted or whether they want to continue serving in the military. Some providers and service members shared that they believe some members will embellish what they discuss in counseling sessions (e.g., severity of symptoms) if they want to get out of the military. On the other hand, if a member wants to continue in the military, they may withhold information about their mental health during sessions. We also heard that some service members are reticent to share information with providers because they are fearful of receiving a diagnosis and undergoing the associated treatments necessary, as some treatments require time away from work and could result in indirect disclosure (e.g., peers notice absent service members and gossip).

Service members also pointed to the specific types of information that may be withheld from mental health providers. Participants observed that some service members would not want to tell providers if they are suicidal because that triggers command notification, and service members are afraid of losing their careers as a result. Participants shared that service members may hide other types of issues, such as assault, domestic violence, problematic behaviors, and addiction out of fear of retaliation or administrative separation. We also heard that service members who know they have a condition that could trigger a medical board might not be as forthcoming, as one provider described:

> However, there are some members I know who are not forthcoming because they have a condition they know could result in a limit to confidentiality or could trigger something for their career. Like, it could trigger a medical board down the road. That's usually not those who self-refer for treatment but usually someone being evaluated for something specific. If someone comes in being evaluated to go do some other challenging kind of job, they know if they have unresolved mental health issues, they won't be cleared. They don't have rapport with me and tell me they are fine and not stressed. That's not people getting treatment; it's a different kind of thing.

A key theme that emerged from our interviews was that service members will not be very forthcoming if they are ordered to go to mental health treatment. One provider shared that this is particularly salient when service members undergo security clearance evaluations or evaluations for special duty assignments. The provider explained: "Once we talk about those things, sometimes people are more hesitant to talk to me about things. It happened once where someone even said, 'I'll end it here.'" Another service member shared how members censor health information in these scenarios:

> They will mask certain issues if they know that's what they are going for. For example, if someone is going up for a TS/SCI [Top Secret/Sensitive Compartmented Information security clearance], they're not going to answer that they drink a 12 pack every day. There are no concerns. Everyone is a big girl and big boy, so they filter out what they disclose if they are up for a special duty. We are all pretty good at lying. We would self-screen.

Another perceived consequence of service members receiving mental health treatment is being treated negatively by peers and leaders, given that mental health conditions and treat-

ment are often highly stigmatized. Service members, commanding officers, and providers all identified pervasive stigma as a major barrier to seeking mental health care in the military. Many service members expressed that they would feel embarrassed about seeking help and that they were afraid of others knowing their personal business. Service members also shared that they are afraid of peers seeing them differently or judging them. We heard from stakeholders that there is a prevailing belief that mental health struggles should be handled independently, and that seeking mental or behavioral health care is a sign of weakness and an inability to live up to military standards. One service member explained how some social circles are supportive of mental health, which can facilitate seeking care, but "if you have friends deep in the military mentality," this can be a barrier to seeking mental health support. Some service members shared the sentiment that seeking behavioral health treatment signifies they are a "disappointment and failure." One service member expressed that they would not seek out military mental health care due to their concern that the provider would view them as "crazy." Lastly, we heard from several participants that the stigma around seeking mental health care stems from the presumption that service members seek mental health care to get out of work duties and shift their responsibilities onto peers. One service member described their experience with stigma while underway:

> When I was underway, and one guy was experiencing pretty bad depression, he went to a counselor and got removed from the ship and got sent back stateside. Pretty much everyone that found out about that said he pulled the "b---- card" just to get off the ship. I knew of some other [people] that wanted to do the same thing, but they knew that they'd be looked down upon by others, for the same thing, pulling the "b---- card," like I said. So, there's definitely some negative stigma attached to that in terms of getting out of things early, I suppose.

Next, stakeholders described negative reactions from leadership as a perceived consequence of seeking mental health care. Service members mentioned that some senior leadership discourage soldiers from seeking care and are not supportive of mental health. One service member shared their experience with different command teams: "I've had a few [commands] that are open and if you need anything, you should "go to behavioral health." I've had some that say, "You're fine, drink water, get over it." There are more barriers to behavioral health than doors that lead to it in my experience." Several service members described having to approach their chains of command to approve time to seek mental health care, with lower-ranking service members needing approval from several leaders in their chains of command.

A few service members shared how confidentiality concerns affect their selection of a health care provider. Participants observed that some members would prefer not to see a miliary provider because they believe that everything will be reported to command and others will learn their business. We heard how these members would prefer to see a civilian provider because they believe that confidentiality is more reliable outside the military. Service members also relayed how many rely on chaplains because they are not considered mandatory

reporters. A provider shared that they advise service members to speak to chaplains about specific issues service members do not want reported:

> There are—at times the patient may not share things they want to because they know I'd have to report it. I tell them to speak to the chaplain because they have 100 percent confidentiality—unrestricted. I haven't found it too often but at times a patient may say, "Well, I can't go into that because of the repercussions." I encourage them to share as much as they can and, if not, they can share with the chaplain who is sometimes trained in mental health, but I think sometimes there is an impediment to the patient.

Service members expressed that many seek care outside the military because they do not trust military providers. One participant said that many service members do not want to see military health care providers but that civilian providers are not an option: "A lot of people refuse to see military doctors, but we're also not allowed to see a civilian doctor off base if we can get help with whatever clinic we have on base. Having that option would be good." Although receipt of health care off base from civilian providers is appropriate in some circumstances, an important takeaway from our interviews is that many service members believe that is not permissible.

Another challenge that some members noted is specific to care within medical units. We heard that service members who work in medical units prefer not to be seen by their peers and colleagues who are the mental and behavioral health providers. We also heard that senior enlisted service members working in medical units do not want to see mental and behavioral health specialists because these providers are their leaders.

In general, most participants held strong views on the impacts of confidentiality policies. Although some commanding officers stated that the policies were beneficial to overall force readiness and supporting the safety and confidentiality of their service members, a few participants held opposing sentiments. Several commanding officers acknowledged the rationale for limiting who can access mental health information, but a few pointed to the usefulness of expanding provider communications with commanders and need-to-know access with more members in the chain of command. Similarly, although some providers stated that military mental health confidentiality policies provide a clear framework for carrying out their clinical responsibilities, other providers were concerned that the policies hindered their ability to effectively care for patients. Finally, service members shared their perceptions about military confidentiality policies and their views of how those policies affect their decisions around mental health care. We learned that concerns about confidentiality limits heavily influence whether some members seek mental health care, accurately depict their mental health to providers, perpetuate stigmas around mental health, or seek support from civilian providers.

Strategies to Improve Mental Health Confidentiality in the Military

To generate ideas for improving mental health confidentiality in the military, including perceptions and understanding of policies, implementation and adherence, sources of informa-

tion, and perceived impacts, we asked participants about strategies employed and potential solutions for addressing the ambiguities and shortfalls described above.

Strategies Employed by Stakeholders

Interviewees described some solutions that have been implemented to increase mental health treatment-seeking and to clarify mental health confidentiality policies so that service members know exactly what can and cannot be shared and under what circumstances.

First, providers described their approaches to addressing service members' privacy concerns. Many providers shared that they discuss informed consent with patients in the first mental health treatment session and review the policy in subsequent sessions. One provider described their approach to addressing service members concerns: "Straightforward, I give the limitations. When instances come up, I end my informed consent speech with, 'If I'm ever going to break confidentiality and share your care with someone else, you will know first.' That quells the concerns." Another provider also shared about the informed consent process: "So, when they [service members] come in for their initial visit, I explain informed consent and what my limits to confidentiality are. I try to make it a good safe space so that they can be open and transparent and vulnerable."

Some providers acknowledged they can only address the concerns of those who present to the clinic and presume that some service members do not present because they believe that their problems might not be kept confidential. For example, one provider shared:

> Most of time, if they come in the door, fill out the form, I address concerns. That usually allows them to reveal private info. However, there are some members I know who are not forthcoming because they have a condition they know could result in a limit to confidentiality or could trigger something for their career, like it could trigger a medical board down the road. That's usually not those who self-refer for treatment but usually someone being evaluated for something specific.

Another provider explained how they respond to concerns related to certain careers stating:

> [C]ertain fields, like intel, security forces, law enforcement guys because they carry weapons, of course, the special operations guys—because these guys, they're the tip of the spear, and it's hard to come to us in the first place, and like the guys that work in intel, they also tend to have TS [Top Secret] clearance. . . . There's the fear if I come to mental health, my clearance is at risk of being suspended. But what I try to tell people, if you come to treatment and you're doing well and responding to treatment well, I'm not going to recommend that your clearance be revoked. . . . But we tell people, coming to mental health is really no different from the family practice clinic to be seen for diabetes or high blood pressure or whatever, you're being seen and you're taking care of yourself, and that's what matters. But again, there are circumstances where we have to notify command and we may have to make a recommendation because it's about you, your colleagues, and the mission. And that's helpful too when you are straightforward with your patients and they

> understand that, but it might prevent some people from getting care they need because of the fear.

One provider noted that experience level may affect how discussions about confidentiality are handled: "The seasoned providers like myself will have different ways of conveying confidentiality than a brand-new provider still trying to figure that out. I think errors are made revealing too much or not enough when you're a less experienced provider."

Some providers talked about using certain strategies to afford greater confidentiality to service members. One strategy is to place them under the Limited Privilege Suicide Prevention (LPSP) Program. Participating providers clarified that, under the LPSP, notes cannot be disclosed without proving a need for the information to be shared.[4] This provides an additional layer of protection because of potential risk of suicide when service members are under investigation for possible UCMJ violations. Although service members are enrolled in LPSP, information disclosed to providers is protected and afforded a greater level of confidentiality, but the protection ends once the provider determines that there is no longer a risk of suicide. Another provider shared that one way of offering a higher level of protection is to write brief, vague notes; for instance, providers might not document an extramarital affair in the medical record. Some providers indicated that they shared their medical notes with the service member "for transparency."

Some providers noted that they encourage their patients to tell their commanding officers that they are receiving mental health services without offering details. Many providers reported that when they must disclose information to a commanding officer, they ideally have the service member in the room with them and do not speak with the commanding officer without first informing the service member. Providers also discussed needing to balance commanding officers' expectations with needing to protect health information. One provider explained how they brief commanders on the confidentiality guidelines:

> For those [commanders] who aren't comfortable, I'll have an office call with them and sit them down. I have a one pager basically a commander's HIPAA guide. You bring in the HIPAA guideline—OK, for the military as a commander you can know this. You are privileged to know accountability—so if a soldier said they went to the behavioral health clinic and you have a question, you are allowed to know if they showed up to the appointment and went when they said they did. Then you also have a right to know diagnosis, prognosis, and duty-limited medications. If a solider has major depressive disorder and are taking three or four meds, you need to know. But everything behind that with intricacies with that patient is not a need to know. Unless there is an immediate safety concern

[4] AFI 44-172 (2015), *Medical Operations, Mental Health*, states: "Notes written when a member is on LPSP status must be labeled with 'Limited Privilege Suicide Privilege Suicide Prevention (LPSP) Program. LPSP notes are restricted from disclosure unless determined to be releasable after consultation with the medical-legal consultant. Do not release without specific patient authorization or as specifically authorized by DOD or AF [Air Force] policy.'"

> that some piece of historical private information is necessary to disclose, you won't get that because you don't need to know that.

One service member shared having no concerns about confidentiality following receipt of informed consent from a provider: "I don't think there is any fear of confidentially. I have sat down and spoken with our psychologist, and they said that they have permission of releasing only a certain part of information." Another service member remarked that concerns about confidentiality may dissipate throughout the course of treatment:

> But normally, during the course of treatment, as people can see, "OK, I'm talking with mental health and there really hasn't been repercussions to my career; things are actually going very well." It's normally something like that. It gets dispelled the longer in treatment.

Next, commanding officers offered several examples of how they convey information to their units about mental health confidentiality policies. We heard from a commanding officer that they sit down and review the HIPAA policies with any service member who asks what mental health information can and cannot be shared. Another commanding officer reported addressing these questions at formation. A few other commanding officers spoke about the Force Preservation Council, which is designed to ensure that important health information is shared among trusted leaders.

One interviewee shared that the Marine Corps implemented a secure mobile application (i.e., accessed with a Common Access Card) called the Command Individual Risk and Resiliency Assessment System (CIRRAS) to inform inbound commanding officers of at-risk marines based on indicators that could affect performance or welfare, including mental health, relationship, or alcohol- or drug-related issues (Gonzales, 2021). The goal of the application is for commanding officers to maintain awareness of readiness concerns using a single portal (Gonzales, 2021). This approach stemmed from the need to secure marines' personal information discussed during the monthly commanding officer review during the Force Preservation Council (Marine Corps Order 1500.60, 2016). The interviewee expressed belief that such a program could be expanded across DoD. Another solution we heard from commanding officers was senior leaders sharing their own stories of seeking mental or behavioral health treatment with their units and demonstrating their approval of seeking support by "walking the walk." One of these commanding officers shared that if leaders are going to encourage service members to seek mental health treatment successfully, they need to be supportive of treatment-seeking.

Lastly, we learned about a new system that tracks no-shows to medical appointments as another strategy to improve accountability and facilitate care. The stakeholder who discussed this strategy clarified that the system tracking is not intended to identify specific individuals who missed appointments but rather to illustrate to command the number of missed appointments. This stakeholder added that the overall aim is to alert command of potential barriers to care, such as the need to provide sufficient time to attend medical appointments.

Solutions Proposed by Stakeholders

When asked about recommendations for improving current mental health confidentiality policies and practices, there was no shortage of ideas from interviewees. For example, stakeholders proposed the following solutions:

- Address limits of confidentiality during unit functions (i.e., by commanders during formation).
- Establish a mental health stand-down day, in which typical duties are preempted by training across the installation.
- Post clear, visible, accessible guidance on the limits of confidentiality.
- Discuss limits of confidentiality with units (by providers).
- Train health care providers (particularly less experienced providers) on briefing informed consent procedures to new patients.
- Clarify policies and ensure common understanding.
- Track the implementation of policies.
- Apply the limits of confidentiality uniformly across military (e.g., treat all positions the same, regardless of sensitive positions).

Providers mentioned more training and education for commanding officers and clearer policies as potential solutions. Providers also recommended that commanding officers find alternate ways to share information about duty limitations with their non-commissioned officers without sharing PHI, such as using nonspecific language that does not reveal the nature of the limitation. Providers said that the vagueness of the policies need clarity. One provider suggested having digital and hard-copy documentation of information exchanged between providers and commanding officers to ensure adherence and proper implementation of confidentiality policies.

Commanding officers also made several recommendations to improve confidentiality policies. For example, some commanding officers want more information about service members to make better life-affecting decisions. One commanding officer shared that they want a more holistic view of their service members to be able to give them the support they need. It is important to note that this sentiment for expanding disclosure of health information was not shared by providers or service members. We also heard from a commanding officer in a commanding role that they wanted more in-person training and resources on mental health confidentiality policies. Another commanding officer suggested that medical and physical appointments be treated the same. They suggested that appointment windows be offered in the middle of the day, enabling service members to attend appointments without disclosing the purpose and without having to miss unit formation or other activities in which service members would be noticeably absent. Next, we heard from commanding officers that having an embedded medical officer or mental health liaison could be useful, as could educating commanding officers on basic mental health when having an embedded provider is not an option. Last, we heard that standardizing processes for PCS orders and transfer loca-

tions, including better communication between commands, could ensure more-uniform and more-consistent practices around sharing service members' mental health information.

Service members recommended that DoD advertise confidentiality, post visible regulations, and have a public health campaign to educate service members on policies and raise awareness of mental health treatment options. In addition, we heard suggestions from service members to institute a mental health stand-down day devoted to training about policies and how they are implemented, make mental health clinic phone numbers more accessible, and generally make it easier and more convenient to get mental health appointments. Specifically, service members recommended the following to improve confidentiality policies:

- Expand confidential programs, such as the Military and Family Life Counseling Program (confidential, nonmedical counseling for service members and family members).
- Rate commanding officers on how they handle personal information.
- Provide clear information about confidentiality policies at in-processing briefings.
- Train noncommissioned officers to better support someone who gets help.
- Ensure that there are multiple channels and resources for people to learn where and how to get help.

Summary

Perceptions of Limits to Mental Health Confidentiality in the Military

Perceptions of what constituted *harm to self* and *harm to others* (two circumstances requiring command notification) varied, with participants from each stakeholder group thinking that suicidal or homicidal ideation satisfied the requirement for disclosure, whereas other participants thought that reference to a plan was necessary. Themes from the interviews also included the following:

- Interviewees mentioned wide-ranging types of information they perceived to fall under the minimum amount of information that providers can disclose to command about ways commanders can support or assist the service members' treatment.
- Determinations of who constitutes *personnel with a specific need to know*—meaning, individuals whom commanding officers can share information with—also varied. Some commanding officers shared that they had a predetermined set of individuals assigned with need-to-know authorization, whereas other commanding officers decided on a case-by-case basis who would have access to service members' mental health information.

The documented variations in how these domains within DoDI 6490.08 (2011) are interpreted illustrate how challenging it can be for service members to reliably anticipate what circumstances might require command notification and what types of information might be disclosed and to whom. These uncertainties could feed into hesitancies to seek mental health treatment.

Implementation of Mental Health Confidentiality Policies

Implementation of mental health confidentiality policies in the military were examined along three dimensions: education and understanding of policies, implementation processes, and monitoring and enforcement of policies.

Education and Understanding of Policies

Both providers and commanding officers referred to trainings (e.g., residency and internship, annual HIPAA training) as providing foundational knowledge of policies. However, both stakeholder types described shortcomings and challenges associated with trainings, mechanisms for staying informed about policies, and sources of information about policies.

Providers mentioned several barriers to remaining knowledgeable about policies—specifically, not all received training that addressed mental health confidentiality policies in the military, policy updates are pushed out in a piecemeal fashion, there is insufficient time to gain familiarity with the large number of policies, and it can be difficult and time intensive to locate needed policies. Among commanding officers, they reported that not all of them had received training on policies, that existing trainings were insufficient or occurred too late into the assumption of a command position, and that their knowledge of policies and sources of information about policies were lacking.

Most enlisted service members were unaware of formal trainings or of sources of information about mental health treatment confidentiality. In light of the knowledge gaps, service members described relying on the experiences of peers either by "word of mouth" or directly observing how policies were implemented at their installations to piece together their understanding of what mental health treatment confidentiality entails. Service members referred to clinics and informed consent processes at the point of initiating treatment as a source of information for confidentiality policies. As described earlier, informed consent forms describing the limits of confidentiality have been issued across the services, such as DA Form 8001 ("Limits of Confidentiality," March 2019; see Army Regulation 40-66, 2010); "the U.S. Naval Academy's Form NDW-USNA-AAD-5211/08 (10/07) ("U.S. Naval Academy Midshipmen Development Center Informed Consent and Limits of Confidentiality," March 5, 2018), and the Air Force's "Mental Health Clinic Confidentiality/Informed Consent Sheet" (AFI 44-172, 2015, Attachment 3). Current informed consent forms do exhibit variations. For example, the "Mental Health Clinic Confidentiality/Informed Consent Sheet" contained in AFI 144-172 specifies that one of the common exceptions that may require mental health providers to disclose information to appropriate authorities without service members' authorization is when there is "any threat to commit crimes or fraud." In contrast, DA Form 8001 refers only to legal circumstances related to the limited psychotherapist-patient privilege under the UCMJ. Informed consent forms can be a source for disseminating standardized information about confidentiality policies.

Effective trainings for providers and commanding officers may play an important role in enhancing adherence to mental health confidentiality policies. Providers referenced mentoring and peer consultation as particularly important tools for guarding against breaches

in confidentiality. Moreover, our findings indicated that commanding officers often rely on providers as the main educators and enforcers of confidentiality policies, a reliance that can have its drawbacks when providers violate policies (unintentionally or intentionally) or differentially execute policies because of gray areas that are subject to interpretation, situation, or clinical discretion. Perhaps, timely joint trainings with providers and commanders may ensure mutual understanding of policies and guard against commanders asking for information beyond what is the minimum amount necessary to satisfy the purposes of a disclosure. This may also mitigate tensions that may arise between commanders wanting more information and service members and providers who are not comfortable with sharing more information. Further, trainings for service members at large may also be warranted based on our findings. Even though policies, such as DoDI 6490.08 (2011), are intended to dispel the stigma associated with mental health care by clarifying command notification requirements, service members described knowledge gaps and misperceptions regarding mental health confidentiality that may undermine DoD's goals to encourage treatment-seeking. Training would be beneficial to service members to enhance their understanding of the policies, increase awareness of information sources, and strengthen their confidence in how mental health information is protected and the circumstances surrounding necessary disclosures.

Implementation Processes That May Compromise Confidentiality

Our findings identified several implementation processes that may compromise mental health confidentiality, which included providers' different means of notifying commanders, indirect disclosures that are associated with receiving mental health care in the military (e.g., provision of treatment during business hours in locations visible to peers and leaders, appointment slips and verification by chain of command), and disclosure of mental health information through the chain of command.

Differing means of command notification can occur through impromptu interactions (e.g., in the hallway), which may increase the risk of oversharing service members' mental health–related information. Standardized, structured communication processes may minimize breaches of confidentiality with respect to providers communicating minimum necessary information to commanders.

Aspects of receiving mental health care in the military may compromise confidentiality. Privacy may be impinged on when others can infer use of mental health services because service members are seen going into a mental health clinic, are missing from work at the same time every week, or have modified duty. Accountability processes (e.g., appointment slips submitted to supervisors, commanding officers calling the medical department to verify attendance to appointment) create avenues to learn about service members' mental health service use. Documentation of service members' mental health care can be a source of compromised confidentiality when junior service members or service members not trained in HIPAA may be handling paperwork with sensitive patient mental health information.

Communications about service members' mental health information throughout the chain of command were also described as a mechanism through which mental health confi-

dentiality could be compromised. That is, commanders communicate beyond need to know, or those with need-to-know access disclose information to others.

Monitoring and Enforcement of Mental Health Confidentiality Policies

Providers pointed to more monitoring and enforcement processes for mental health confidentiality policies than commanding officers. It is unclear from our interview data what kind of oversight is in place to monitor communications about service members' mental health information that occur throughout the chain of command to ensure compliance with policies. Current policies primarily address the monitoring and compliance of DoD-covered entities (e.g., all DoD health plans, institutional health care providers, MTFs). For instance, Department of Defense Manual 6025.18 (2019), *Implementation of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule in DoD Health Care Programs*, stipulates that DoD-covered entities must establish standard operating procedures for uses and disclosures of PHI, along with policies and procedures for ensuring compliance. DoD-covered entities are also required to maintain records of uses and disclosures of PHI and submit compliance reports to assess compliance with HIPAA rules. A covered entity may also be subject to compliance reviews by the Secretary of Health and Human Services to determine compliance.

DoDI 6040.45 (2015), *DoD Health Record Life Cycle Management*, provides guidance on electronic health record information sharing and disclosure and states:

> Each MTF will establish a mechanism that tracks disclosures of PHI within the guidance outlined in DHA- and Service-level policies as required by law. Military Services will use a standardized tracking mechanism for accountable HIPAA disclosures at their MTFs. When technically feasible, this disclosure tracking data must be centralized, and the tool used capable of accounting for disclosures made throughout the MHS, conforming to all privacy and security safeguards. The tracking mechanism will allow qualified individuals to generate and review a report on disclosure activity in accordance with [DoD Manual 6025.18-R, 2003].

AFI 41-200 (2017), *Health Insurance Portability and Accountability Act (HIPAA)*, specifies that the medical group commander or MTF commander is responsible for designating an MTF primary HIPAA privacy officer who ensures "continues assessment, implementation, monitoring, and revision of the MTF HIPAA Privacy programs," which includes conducting HIPAA compliance assessments and audits using approved compliance-monitoring tools (e.g., the DHA HIPAA Privacy Rule Assessment Tool).

Although DoDI 6490.08 (2011) does instruct commanders to protect the privacy of mental health care information as specified in DoD Directive 5400.11 (2007), *DoD Privacy Program*, absent from this and other instruction and policy documents is guidance about monitoring,

enforcement, and evaluation of how commanders and personnel designated with a specific need to know are held accountable for protecting PHI.[5]

Perceived Impact of Mental Health Confidentiality Policies and Practices

Providers noted several areas in which they disagreed with current policy, such as requiring a review of seven years of a service member's mental health history to decide whether they can deploy to Africa (e.g., U.S. Africa Command Instruction 4200.09A [2019], *Force Health Protection Requirements and Medical Guidance for Entry into the U.S. Africa Command Theater*). In addition, providers described how policies could compromise the quality of care (e.g., service members withholding information). Last, even though providers are called on for their expertise and to provide recommendations for the well-being of service members, they can be overruled; ultimate decisions (e.g., to limit duties, to deploy members) lie with commanding officers.

Although some commanding officers viewed confidentiality policies as yielding positive impacts, they described challenges, such as providers with differing views about whether and what types of health information can be released and the level of care warranted for at-risk service members. One of the factors described as driving commanding officers' desire for greater access to service members' mental health information and more-intensive treatment for at-risk service members (e.g., inpatient hospitalization) was the weight of being held responsible for the well-being of service members and the pressure of having 0 percent suicides.

Among enlisted service members, most remarked that policies may affect their decisions on whether to get mental health treatment. Worries about the negative fallout that might ensue with respect to their career if they obtained mental health treatment were pervasive among our sample of interviewees. Feared consequences included being "flagged in the system" "whenever you are seen by mental health," being pulled from duties, and being "treated differently" by unit leaders or peers because "getting therapy is super negative in the military." Because of these fears, some service members reported that they would withhold information from providers to avoid inappropriate disclosure and potential career impacts.

[5] DoDI 6490.08 (2023) specifies that military departments, DHA, and the Office of the Deputy Assistant Secretary of Defense for Health Readiness Policy and Oversight will evaluate the effectiveness and compliance with this instruction and will recommend improvements to the Office of the Assistant Secretary of Defense for Health Affairs. A reporting template containing the metrics that will be used for assessments and recommendations is provided.

CHAPTER 4

Key Findings and Recommendations

In this chapter, we summarize key findings from the HCPM Survey and key stakeholder interviews and outline recommendations based on these findings. Next, we describe the study limitations and final conclusions.

Key Findings from the HCPM Survey and Stakeholder Interviews

Our key findings are supported by data from both the survey and interviews. To track the data source supporting our key findings, we refer to survey *respondents* when presenting survey results and to *stakeholders* when presenting interview findings. Here, we bring them together to describe the most-important results in our three content areas: perceptions of limits to mental health confidentiality, implementation of mental health confidentiality policies and practices, and the impact of limited mental health confidentiality in the military.

Perceptions of Limits to Mental Health Confidentiality in the Military

Perceptions regarding limits to mental health treatment confidentiality in the military varied widely across the following domains: mental health–related circumstances requiring command notification, the types of information that providers might release to commanding officers, and the entities who may have access to service members' mental health treatment information.

Mental health–related circumstances perceived as requiring command notification were subject to varying interpretations. For example, in the stakeholder interviews, there were providers, commanding officers, and enlisted service members who viewed suicidal and homicidal ideations as constituting serious risk of *harm to self* and *harm to others*, whereas others thought that additional criteria (e.g., having a suicide plan) are required to rise to level of necessitating command notification. *Harm to mission* determinations were also described as varying mainly depending on the service member's job, with specific references to jobs involving access to weapons or national security. Harm to mission has previously been criticized as overly broad and lacking clear criteria, which can lead to inconsistent reporting by providers and create a wide latitude for commanders to access service members' mental

health information under the premise of ensuring the proper execution of the mission (Engel, 2014; King and Snowden, 2020; Neuhauser, 2011; Orme and Doerman, 2001).

Findings from the survey revealed substantial misperceptions about command-notification requirements related to mental health treatment. Specifically, more than half of survey respondents (56.2 percent) thought that command notification is required whenever a service member misses a mental health treatment appointment, nearly a third thought this to be the case whenever a service member is prescribed mental health medication (31.7 percent) or receives a mental health diagnosis (30.9 percent), and 23.3 percent thought that providers will notify command whenever service members receive mental health services for any reason. Notably, 20.3 percent respondents assumed that providers will notify command whenever a service member is undergoing a marital separation.

Perceptions regarding what types of information can be shared with command varied based on stakeholder interviews, variation that appeared to be due in part to differing interpretations of what constitutes *minimum amount of information* that can be disclosed to advise the command on how to support or assist the service member's treatment (as specified in DoDI 6490.08 [2011]). Correspondingly, findings indicated that 58.0 percent of respondents and 80.3 percent of respondents with unmet mental health needs viewed service members as being often or always unsure of what information might be released to commanding officers.

Perceptions related to which personnel or entities could access service members' mental health information diverged. According to stakeholder interviews, some commanding officers used a more consistent approach in their interpretation of *personnel with a specific need to know* (e.g., the leadership triad of commanding officer, executive officer, and first sergeant), whereas others determined who needed to know on a case-by-case basis. Survey findings shed additional light on other entities perceived as being able to access service members' mental health information. A substantial proportion of survey respondents were concerned that, if they were to receive mental health treatment, their information would be shared with future nonmilitary employers (55.0 percent), promotion review boards (54.9 percent), future medical insurers (52.7 percent), other providers not involved in the service member's treatment (51.9 percent), and the Veterans Disability Panel (45.5 percent), all of which are prohibited by HIPAA unless the service member provides consent, including via HIPAA authorizations (e.g., U.S. Department of Veterans Affairs disability evaluations).

Perceptions Regarding the Implementation of Mental Health Treatment Confidentiality Policies and Practices

Components essential to effective policy implementation include ensuring that stakeholders are educated and have a clear understanding of the policies, developing processes that support implementation, and monitoring and enforcing policy compliance (Centers for Disease Control and Prevention, 2021; Mthethwa, 2012). Findings related to these three components are summarized in this section.

Lack of or insufficient training and education about mental health care confidentiality policies was a common theme among interviews with providers, commanding officers, and enlisted service members. Not all providers or commanders receive training, and many characterized the training as insufficient. Most enlisted service members were not aware of any formal trainings on mental health confidentiality and mentioned only mental health providers and clinics as sources of information for mental health confidentiality practices. Providers shared that, without effective training, less knowledgeable or experienced providers and commanding officers may be more likely to deviate from policy guidance or differentially execute policies because of gray areas that are subject to interpretation.

Implementation processes may compromise confidentiality. Means that providers used to notify commanders and strategies that commanding officers use to communication to others in the chain of command with a need to know are mechanisms through which mental health confidentiality could be compromised. Standardized, structured communication processes may minimize breaches of confidentiality with respect to minimum necessary information by providers and need to know by commanders. Processes involved with unit accountability when receiving mental health care in the military may compromise confidentiality. Interviewees shared how privacy may be impinged in any number of ways, such as if service members are seen going into a clinic, when appointment slips are submitted to supervisors, or if paperwork is handled inappropriately. Ensuring the highest levels of confidentiality protections for service members may be challenging for military providers who have dual responsibilities to clients and the military mission.

In terms of *monitoring and enforcement of mental health confidentiality policies*, providers were able to point to more monitoring and enforcement processes for mental health confidentiality policies in the medical system, compared with commanding officers. It is unclear what kind of oversight is in place to monitor communications about service members' mental health information that occur throughout the chain of command to ensure compliance with need-to-know policies.[1]

Perceived Impact of Limited Mental Health Treatment Confidentiality in the Military

Most enlisted service members that we interviewed held perceptions of policies that may affect their decisions on whether to get mental health treatment—echoing the findings from our survey. Worries about negative career impacts were pervasive, and those who had not obtained treatment talked about withholding information that they believed could have a negative impact on their careers. Several service members also recounted experiencing, first-

[1] The DoDI 6490.08 (2023) reissuance added Section 3.4, "Reports and Assessments," which requires "reports and metrics to evaluate the effectiveness of, and compliance with this instruction," to be submitted by military departments and the DHA to the Office of the Deputy Assistant Secretary of Defense for Health Service Policy and Oversight.

hand or through their peers, instances of providers sharing information with commanding officers that they had viewed as inappropriate disclosures.

Findings suggest that there are a host of concerns associated with receiving mental health services in the military when confidentiality cannot be assured. These concerns stem from the anticipation of negative repercussions from leaders, peers, providers, and even from service members themselves (in the form of internalized stigma). The most common concern expressed by survey respondents, should their commanding officer or supervisor obtain information about their mental health care, was career related, such as the potential impact on their ability to deploy, maintain their security clearance, or be approved to attend military training or school opportunities.

Moreover, about half of survey respondents reported that these concerns were a deterrent to obtaining mental health services for a wide variety of mental health issues. These confidentiality concerns also affected the information they shared and their relationship with mental health providers. Nearly 90 percent of respondents indicated that they would limit what they would share with military mental health providers because of privacy concerns. A substantial proportion of respondents reported that they would seek treatment outside the MHS (42.7 percent) or that it would be helpful to get care after hours (44.6 percent) for privacy reasons. Finally, compared with service members with no mental health needs, confidentiality concerns were even more prevalent among service members with mental health needs and even more acutely so among the subset with unmet mental health needs.

Recommendations

Drawing on our findings, we recommend several steps for improvement. These recommendations are addressed to the multiple DoD entities responsible mental health information privacy:

- the Office of the Under Secretary of Defense for Personnel and Readiness, which established the HIPAA-related DoDI 6025.18 (2019), and the assistant secretary of defense for health affairs, who is responsible for ensuring that HIPAA policies comply with federal laws governing the privacy of health information
- DHA, which is responsible for the covered entities and business associates and coordination between the DHA Privacy Office and the DHA chief information officer (J-6)
- the DoD Privacy, Civil Liberties, and Freedom of Information Directorate, which provides advice, monitoring, official reporting, and training to implement the Privacy Act (Pub. L. 93-579, 1974)
- the Under Secretary of Defense for Personnel and Readiness, who is responsible for personnel health and readiness and is the role in which this trade-off between patient confidentiality and mission readiness in DoDI 6490.08 (2011) needs to be better defined and implemented.

Coordination among the staff in these DoD offices will be necessary when acting on these recommendations. Recommendations based on our study's findings are organized for DoD's consideration by the following potential targets for intervention: improving the understanding of confidentiality policies surrounding mental health treatment, strengthening supports and accountability measures to ensure that policies are implemented as intended, and mitigating the consequences associated with limited confidentiality around mental health treatment in the military.

Improve the Understanding of Confidentiality Policies Surrounding Mental Health Treatment

Clarify Aspects of Policies That Are Unclear and Susceptible to Provider and Commander Discretion and Variability in Implementation

Efforts to eliminate language in DoD issuances that stigmatize mental health conditions or treatment have illuminated the lack of clarity that characterizes many mental health–related policies, regulations, instructions. In recent guidance related to a review to ensure DoD issuances are not fueling or perpetuating stigmatizing views, Deputy Secretary of Defense Kathleen Hicks stated, "Policies should be precise in language in order to maximize clarity and minimize confusion" (Deputy Secretary of Defense, 2022; quoted in Kime, 2022). Relatedly, in a response to a 2016 U.S. Government Accountability Office report recommendation, the DHA's PHCoE conducted a review of DoD and military service-specific policies on mental health and substance misuse for stigmatizing language and found that 34.9 percent of mental health policies and 42.1 percent of substance misuse policies contained imprecise language (e.g., "mental disease or defect") (Campbell et al., 2023; Gomez-Cano et al., 2021). The study authors assert that unintended stigma could result from policies that are "ambiguous" or "leave too much discretion in interpretation" with respect to the duty status of individuals who have received mental health treatment (U.S. Government Accountability Office, 2016). Further, unclear policies were depicted as possibly befuddling gatekeepers (i.e., leaders whom service members turn to for help with mental health challenges) and care providers when considering the negative career impact that may be associated with receiving mental health treatment.

This current study similarly identified aspects of policies related to the confidentiality of mental health treatment that seemed unclear and subject to interpretation across commanding officers, providers, and service members at large. Stakeholder interviews and surveys documented differing views regarding the circumstances that require command notification, the kinds of information that can be disclosed, and to whom disclosures should be released. For instance, findings indicated differences in what is considered *harm to self*, *harm to others*, and *harm to mission* (command notification circumstances specified in DoDI 6490.08, 2011).[2] These topics are important fundamentals of DoD policy, and how they are

[2] DoDI 6490.08 (2023) provides additional guidance for these three circumstances. See Appendix F.

interpreted directly affects sharing versus protecting a service member's personal mental health information.

The documented variations in how policy is interpreted illustrate how challenging it can be for service members to reliably anticipate what circumstances might require command notification and what types of information might be disclosed and to whom. These uncertainties could feed into hesitancies to seek mental health treatment. According to the interview and survey responses, these uncertainties likely deter help-seeking. It is noteworthy that providers, who arguably have the most-extensive training and experience with respect to health care–related policies, described command exceptions as "vague" and "broad" and asserted that *minimum amount of information* necessary is a "subjective term" that "means something different" to peers, command, and patients.

We heard that service members are unsure what information about mental health treatment is shared when transferring to a new duty station. Just 34 percent of survey participants were correct in reporting that policies dictate that, when transferring to a new duty station, mental health information is shared with the gaining command. Indeed, DoDI 6490.10 (2015), *Continuity of Behavioral Health Care for Transferring and Transitioning Service Members*, indicates that sharing typically occurs, although the policy could be revised to better convey circumstances when information is shared and when it is not. DoDI 6490.10, Part 3(b), states, "When transitioning to another command, notification shall also be made to the gaining commander when adherence to the ongoing treatment plan is deemed necessary to ensure mission readiness and/or safety." *How* and *by whom* that determination is made is not specified.

DoDI 6490.10 (2015) indicates that "the behavioral health records of personnel identified for PCS shall be reviewed" for several reasons but does not specify *who* reviews those records. The policy explains how information passed from one health care provider to another occurs with full transfer of medical records and case notes. The policy enclosure (Section a) states, "Service members, regardless of status, shall be given information on the possible need for transfer of information upon transition as part of their initial orientation to treatment." We did not hear from any providers we interviewed that this is an aspect of their informed consent process, although it is clear from a standard Army consent form (DA Form 8001, "Limits of Confidentiality," March 2019) that PCS is one reason to transfer PHI. Although command notifications are integral components to ensuring the safety and care of service members, establishing clear and consistent policies are also critical to minimizing confidentiality concerns and maximizing privacy protections.

DHA, Installation Commands, and Line Supervisors Should Ensure That Policies, Manuals, Forms, and Informational Resources Are Clear, Consistent, and Widely Accessible

Our findings indicated that there is no single or consistent source of information for commanding officers, providers, or enlisted service members to learn about mental health confidentiality policies. Providers and commanding officers alike expressed challenges with

knowing where to locate policies. One provider described taking a week to locate relevant policies that were needed to reconcile a conflict between guidance from command and a specific instruction. Another provider relayed having to rely on a network of friends to distribute policy information and updates to one another. Commanding officers most often described relying on providers for policy guidance, along with other disparate sources (e.g., consultations with legal and flights surgeons, internet searches). Both providers and commanding officers also described the policies as difficult to access because they are complex, numerous, and hard to understand. Given the large number of issuances and fragmented guidance, creating a single source that is inclusive of all disclosure requirements may help to increase transparency, accessibility, and understanding of mental health confidentiality policies.

Enlisted service members cited mental health clinics or providers most frequently as sources of information for mental health confidentiality (e.g., one interviewee said, "Outside of a medical facility, I don't think it's published anywhere"). In light of a knowledge or information gap, some service members described filling that gap by extrapolating from the experiences of peers either by "word of mouth" or directly observing how the policies and practices are carried out at their installations, which could lead to misunderstandings about confidentiality limits and protections. For instance, if a service member witnesses command being notified after their peer misses a mental health treatment appointment, they may mistakenly assume that any missed appointments require command notification, but their peer might have been at risk for self-harm and could not be reached by the provider, circumstances that do necessitate command notification.

DoDI 6000.14 (2020), *DoD Patient Bill of Rights and Responsibilities in the Military Health System (MHS)*, provides guidelines for information sharing: "Each MTF/DTF [dental treatment facility] shall provide patients with accurate, easily understood information and assistance in making informed healthcare decisions about their health plans, providers, and facilities." DoD 6000.14 further specifies: "It is DoD policy that MHS patients have explicit rights about information disclosure; choice of providers[,] . . . privacy and security of personally identifiable information (PII)." Findings from our interviews highlight the role of the informed consent process during the initiation of treatment and ongoing treatment as an important vehicle to educate and increase service members' awareness regarding confidentiality limits and policies. Examples of current informed consent forms exhibit variability in the descriptions of confidentiality exceptions (e.g., DA Form 8001 ["Limits of Confidentiality," March 2019; see Army Regulation 40-66, 2010], the U.S. Naval Academy's Form NDW-USNA-AAD-5211/08 (10/07) ["U.S. Naval Academy Midshipmen Development Center Informed Consent and Limits of Confidentiality," March 5, 2018], and the Air Force's "Mental Health Clinic Confidentiality/Informed Consent Sheet" [AFI 44-172, 2015, Attachment 3]). Informed consent forms used by the services and MTFs should be reviewed for inconsistencies, and relevant modifications to forms and associated policies should be made to ensure that clear and consistent information related to confidentiality limits and protections is disseminated during the informed consent process.

Although DoD 6000.14 (2020) addresses the provision of accessible treatment information at the point of care, to address treatment concerns or questions that may be serving as barriers to care, information needs to be more specific and broadly disseminated. For instance, the Navy Medicine Female Force Readiness Clinical Community created a resource document, *Normalizing Military Mental Health Care: Myth vs. Fact*, to dispel misperceptions about mental health care, including disclosures of treatment to command (Navy Medicine, 2022). The resource instructs readers to consult with the chain of command or their provider for details about what information may be disclosed to the commanding officer or others who are designated on a *need-to-know* basis. However, if service members have concerns or questions about treatment confidentiality, referencing command or providers as sources of information might not be a viable option.

The DHA Privacy and Civil Liberties Office and DHA PHCoE have been developing brief information sheets to provide guidance on the disclosure of personnel PHI (Privacy and Civil Liberties Office, 2022) and to address mental health confidentiality concerns (PHCoE, 2020b). Broad dissemination of informational materials beyond medical settings may increase awareness and understanding of the limits of mental health treatment confidentiality.

Through our stakeholder interviews, we identified several recommendations to improve the accessibility of mental health confidentiality policies and informational resources:

- Post clear, visible, accessible guidance on the limits to confidentiality.
- Discuss limits of confidentiality with units (by providers).
- Address limits of confidentiality in formation (by commanders).
- Conduct public health campaigns to educate service members on mental health treatment confidentiality policies.

Strengthen Supports and Accountability Measures to Ensure That Mental Health Confidentiality Policies Are Implemented as Intended

Enforce Mandatory Education and Training for All Military Personnel on Mental Health Confidentiality Policies and Practices

Enforcing mandatory education and training on mental health confidentiality policies and practices requires some level of standardization of training materials across services, installations, and provider and commander training programs. Given the number of stakeholders and training settings, specific offices or organizations within DoD should be tasked with the development of standardized materials.

Providers delineated several areas of improvement for training and education on mental health confidentiality policies and practices. First, providers reported varying levels of training on confidentiality policies and practices in the military. For instance, some providers reported receiving much of their training on confidentiality policies in the military during their clinical internship or residency, whereas others did not. This difference might have been related to whether providers completed their training in a military versus civilian setting.

Second, providers discussed the importance of mentoring to guard against violations of confidentiality protections, particularly with less experienced providers who may find it difficult to refuse unlawful requests for information from commanding officers. Third, ongoing, continuous peer consultation was described as essential to ensuring adherence to confidentiality policies. Training should ensure that providers are operating from the same knowledge base and understanding of confidentiality policies and practices. As one provider noted, "We don't all have the same type of understanding of what the potential impact might be or what should be disclosed."

Commanding officers referred to formal types of training, such as annual HIPAA training, commanders' and first sergeants' courses, townhalls, and presentations. However, some commanding officers reported challenges with retaining their familiarity and knowledge of mental health confidentiality policies even with such training. In addition, one provider pointed out that the timing of commanders' training can be an issue, noting that some officers can be in command for a whole year before going through the requisite training. Some commanding officers indicated that they were not required to know the policies as part of their assigned duties. However, leaders (including supervisors and senior enlisted leaders) often serve as gatekeepers (i.e., those who have primary contact with individuals experiencing mental health concerns and are in a position to facilitate treatment-seeking) (Britt, Wright, and Moore, 2012; Isaac, Lee, and Carnes, 2009; Mann et al., 2005). As gatekeepers, it is important for leaders to have an accurate understanding of confidentiality limits and protections to address service members' concerns about mental health care and facilitate access to treatment.

Although commanding officers or those designated by commanding officers to receive command notifications may receive HIPAA training, it is unclear whether those who are granted access to service members' mental health information based on a *specific need to know for the conduct of official duties* are also subject to training. DoDI 6490.08 (2011) specifies that only personnel with a specific need to know "shall also be accountable for protecting the information."[3] Ensuring that anyone who has access to service members' mental health information receives training is one way to bolster the confidentiality protections.

Incorporating education about mental health confidentiality limits and protections into existing DoD-wide trainings may be warranted, considering the significant misperceptions surrounding command notification requirements. For instance, 56.2 percent of survey respondents thought that command notification is required whenever service members miss mental health treatment appointments. One in five survey respondents thought that providers are required to notify commanding officers whenever a service member is undergoing a marital separation. Further, 58.0 percent of survey respondents perceived service members as

[3] DoDI 6490.08 (2023) removed the "specific need to know" reference and does not specify which personnel, including which "other person(s) specifically designated in writing by the commander" can be provided access to service member's information, nor does it stipulate whether such personnel are required to receive HIPAA training.

being often or always unsure of the types of mental health information that might be released to commanding officers; among respondents with unmet mental health needs, 80.3 percent held this perception. Such misperceptions and uncertainty about confidentiality limits and protections could significantly deter use of mental health services.

The standardization of trainings and materials will likely require a collaborative effort across offices within the medical department (e.g., Assistant Secretary of Defense for Health Affairs, DHA's Behavioral Health Clinical Management Team, Behavioral Health Clinical Community) and operations (including professional military education and training programs for providers and all levels of technical training, such as Basic Military Training and military academies).

Use Structured Documentation to Facilitate Provider-Commanding Officer Communications to Limit Open-Ended Dialogue and Increase the Transparency of the Nature of Communications So That Service Members Understand What Is Shared and What Is Not Shared

Health care providers are required to maintain an accounting of disclosures per DoDM 6025.18 (2019), *Implementation of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule in DoD Health Care Programs*. Existing structured forms of communication have been established to facilitate health care provider disclosures to commanding officers. OTSG/MEDCOM Policy Memo 21-019, "Behavioral Health eProfiling Standardization Policy" (Headquarters, U.S. Army Medical Command, 2021) notes the variability in Army providers' communication of duty limitations and other critical information related to soldiers' behavioral health conditions, which "may contribute to confusion and serve as a barrier to care." Per the memo: "Behavioral health providers use the DA Form 3349 in eProfile to communicate with Commanders about medical conditions and associated treatments that may interfere with execution of duties." Providers are also instructed to inform soldiers when they are placed on profiles and to provide a description (a hard copy, if necessary) of recommended duty restrictions. In addition, guidance on minimal profiling is provided (e.g., mental health condition, duty limitation recommendations), and a provider must document the rationale for any deviation from the minimum profiling guidance in the electronic health record. Although OTSG/MEDCOM Policy Memo 21-019 provides a structured form of communication between providers and commanders within the Army, this may not be consistent across DoD and is an area that can be addressed by DHA.

Providers described challenges related to commanding officers who ask for information beyond the minimum necessary that "borders on nosey and gossipy" and dual-role conflicts (e.g., provider obligation to serve the best interests of their patients and the military). For instance, with the intent of better supporting service members, the types of information commanding officers reported wanting was wide ranging, from information about childhood trauma to drivers of mental health issues within units (e.g., whether toxic leaders are contributing to service members' mental health challenges). Commanding officers and providers described holding discrepant views about whether and what types of PHI can be released,

which some providers attributed to being driven by the weight of commanding officers' felt responsibility for ensuring the well-being of service members in their command and 0 percent suicide rates. Using structured documentation and forms of communication to facilitate provider-commanding officer interactions (such as those described in OTSG/MEDCOM Policy Memo 21-019) could provide important guardrails against breaches of confidentiality (Headquarters, U.S. Army Medical Command, 2021).

Use Structured, Standardized Documentation to Facilitate and Limit Communications Within the Chain of Command

The provisions under DoDI 6490.08 (2011) allow commanders to provide access to service members' PHI to *personnel with a specific need to know* for the necessary *conduct of official duties*. This opens the channels for service members' PHI to be communicated throughout the chain of command. Correspondingly, roughly one-fifth (21.8 percent) of survey respondents thought that when mental health information is shared with commanding officers it often or always spreads to other unit members. Just over half (55 percent) of service members said that they would be concerned that, if they received mental health treatment, their mental health information would be shared with commanding officers in the chain of command, and 48.6 percent expressed concern that their information would be shared with direct supervisors.

Structured forms of communication, such as like those outlined in OTSG/MEDCOM Policy Memo 21-019 (Headquarters, U.S. Army Medical Command, 2021), for disclosures from provider to commanding officer could be similarly applied to communications throughout the chain of command to ensure that only minimal necessary information is shared. Guardrails for communications throughout the chain of command about service members' mental health information may be particularly important for safeguarding service members' mental health information, given that it is unclear how these communications are monitored and regulated.

Ensure That Policy Is Revised to Include Guidance, Monitoring, Enforcement, Accountability, and Evaluation of Policy Compliance When Service Members' Mental Health Information Is Disclosed Throughout the Chain of Command

Although DoDI 6490.08 (2011) stipulates those personnel with need-to-know access to service members' information "shall also be accountable for protecting the information," no further guidance on accountability measures or enforcement is provided for communications within the chain of command.[4] From our stakeholder interviews, providers more

[4] The DoDI 6490.08 (2023) reissuance no longer references "need-to-know" access but does not provide guidance on commanders sharing service members' information with others in the chain of command. Section 3.4, "Reports and Assessments," has been added to the 2023 reissuance, which stipulates that military departments and DHA "will evaluate the effectiveness of, and compliance," with the instruction and make recommendations for improvements to the Office of the Assistant Secretary of Defense for Health Affairs "as requested or at least every 2 years." See Appendix F.

readily identified monitoring and enforcement processes for mental health confidentiality policies (e.g., officer evaluations, electronic medical record reviews by the Internal Management Control Program, peer reviews) in comparison with commanding officers. Such issuances as DoD Manual 6025.18 (2019), *Implementation of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule in DoD Health Care Programs*, and DoDI 6040.45 (2015), *DoD Health Record Life Cycle Management*, provide guidance for the compliance and enforcement of privacy protections for PHI by covered entities (i.e., the health plan or health care provider that transmits any health information in connection with a HIPAA standard transaction). Similar policy, guidance, monitoring, enforcement, accountability, and evaluation of privacy protections by personnel in the chain of command who have access to service members' medical information should be established. Officer evaluation systems could include evaluations of the handling of PHI within the unit and enforcing privacy policies among those designated to receive PHI (including those determined have a need to know) within the chain of command. Guidance for officer evaluation systems could be revised to underscore this aspect of leadership.

Mitigate the Consequences Associated with Limited Confidentiality Around Mental Health Treatment in the Military

DHA Should Explore the Feasibility of Expanding Treatment Options That Afford Greater Service Member Privacy

Standard mental health care as delivered in military treatment settings may compromise privacy. Privacy may be impinged on when others can infer use of mental health services when service members are seen entering mental health clinics located in distinct venues (e.g., a specific wing within a medical facility, a particular building), are missing from work at the same time every week, or having modified duty. Increasing the availability of telehealth and services during nonwork hours could allow for treatment options with greater privacy.

Accountability processes (e.g., appointment slips submitted to supervisors, commanding officers calling the medical department to verify attendance to appointment) create avenues to learn about service members' mental health service use. Ensuring that accountability processes involving appointment reminders do not reveal service members' receipt of mental health care (e.g., referencing only general medical appointments) could be codified in DHA policy. Correspondingly, 40.5 percent respondents agreed or strongly agreed that they would delay or avoid treatment because of concerns about privacy. A substantial proportion of respondents agreed or strongly agreed that they would seek treatment outside the military so that it would not be documented in military medical records (42.7 percent) and would find it helpful to get care after hours so their units would not find out (44.6 percent). Respondents with unmet mental health needs were even more likely to express wanting to seek treatment outside the military (62.6 percent) or after hours (60.9 percent) because of privacy concerns.

Military OneSource and the Military and Family Life Counseling Program provide nonmedical counseling that can be delivered by phone, online, and off base, which are not

recorded in service members' medical records. Military OneSource and the Military and Family Life Counseling Program are subject to fewer privacy exceptions (which include harm to self or others, suspected family maltreatment, and illegal activity) in comparison to the command notification requirements specified in DoDI 6490.08 (2011, 2023). Examining whether offering Military OneSource, the Military and Family Life Counseling Program, and similar treatment options for clinical conditions could improve treatment access while maintaining mission readiness could build toward an empirical evidence base that points toward optimal and effective options for balancing the risks versus benefits of current military policies.

Modify Policies to Increase Confidentiality Protections and Minimize Adverse Consequences Associated with Limited Confidentiality While Protecting the Needs of the Warfighting Mission of DoD

The majority of survey respondents indicated that providers being allowed to release information only about service members' duty limitations to commanding officers would greatly or significantly improve mental health service use by service members (68 percent), individual readiness (65 percent), and unit readiness (60 percent). Apart from circumstances involving serious risk of harm to self or others, findings suggest that revising policies to restrict the disclosures of a minimum amount of information to include information only about duty limitations may be worth examining as a potential means to increase confidentiality protections.

Further, under DoDI 6490.08 (2011), *minimum amount of information* also includes diagnosis, treatment plan, prognosis, and ways command can support or assist service members' treatment.[5] It is unclear whether commanders' access to and use of clinical information—such as diagnosis, treatment plan, and prognosis—are associated with improved outcomes for service members' mental health, military readiness, or mission success. Similarly, whether command involvement in supporting service members' treatment is beneficial should also be subject to empirical examination. Command involvement could allow for better coordination, accountability, and reinforcement of treatment plans. As an alternative to the current instruction in DoDI 6490.08, commander involvement in supporting service members' treatment can be facilitated by providers but as part of service members consenting to and authorizing the release of information to leaders as opposed to as part of required command notification disclosures.

Empirical support for the effectiveness of confidentiality policies around military mental health is currently lacking (Engel, 2014). The evidence base on how to best balance service members' privacy with commanders' need to access mental health information for operational and risk management purposes may be expanded by evaluating whether the following policy modifications could improve mental health service use while ensuring the effective execution of military missions: restricting disclosures to information solely about duty limi-

[5] DoDI 6490.08 (2023) specifies that the "disclosing health care provider determines" the ways that command can support or assist service members' treatment.

tations, instituting civilian standards of mental health confidentiality (i.e., exceptions limited to harm to self or others), or obtaining service members' consent to enlist commanders' involvement in treatment.

Our findings indicated that a plethora of career-related concerns deter receipt of mental health care, particularly among those service members with unmet mental health needs. For instance, among survey respondents with demonstrated mental health needs in the past year but who did not obtain treatment in the same time frame, a high proportion agreed or strongly agreed that their decision to receive mental health treatment might be affected by concerns about negative impacts on their ability to deploy (71 percent), security clearances (70 percent), careers (73 percent), and chances for military training or school (66 percent). A high proportion of survey respondents with unmet need also asserted that they would delay or avoid treatment across a wide variety of mental health–related conditions, such as depression (76 percent), thoughts of self-harm (70 percent), anxiety or worries (73 percent), stressful life events (71 percent), posttraumatic stress (64 percent), and marital problems (57 percent) because of military career concerns.

In a review of military policies on mental health (Acosta et al., 2014), the authors identified several policies that limited specific job opportunities for service members who had a mental health disorder or received treatment. The review noted the lack of specificity characterizing many of these policies. For instance, it was unclear whether job restrictions applied to service members who ever had a mental disorder (even if they were in remission or effectively managing their symptoms) and whether all mental health conditions equally limited career opportunities (e.g., schizophrenia versus depression). Further, DoD is currently conducting its own review of internal policies that may stigmatize mental health conditions or service use, including examining policies that restrict the use of firearms or career promotions strictly because a service member has a diagnosis (Kime, 2022). Clarifying duty-status implications associated with mental health conditions or receipt of treatment may help to mitigate confidentiality concerns for some service members (King and Snowden, 2020).

Study Limitations

We note several study limitations, beginning with our low survey response rate and self-selected sample. The survey was designed as a probability sample of the active component force, with survey weights that account for the sample design and survey nonresponse. The resulting service member sample was diverse and broadly representative of the sampled population on most military and demographic characteristics. *However, high rates of survey nonresponse and survey drop-off suggest that the service member sample is substantially self-selected and should not be treated as fully representative of the entire active component force*. In particular, the sample likely overrepresents individuals who have a personal interest in mental health care and in the confidentiality of such care; we believe that individuals not interested in these topics were less likely to start the survey and were more likely to drop

out once the survey started. Service members who are concerned about DoD confidentiality protections might have been apprehensive about participating in the survey and might be underrepresented. The individuals in the population who are not included in the survey's service member sample might have systematically different knowledge and opinions about the confidentiality of mental health care than the service members who responded. This type of service member self-selection cannot be fully corrected with survey weights, and the reader should interpret the findings with this limitation in mind.

Thus, the survey results presented in this report should not be interpreted as fully representative of the knowledge and opinions of all service members due to evidence of substantial self-selection of service members. However, the service members who self-selected into the study may represent a group of particular interest for military policies around mental health care. The purpose for treatment confidentiality is to encourage individuals who need care to get it without fear of discrimination or stigma. The existing survey effectively overrepresents individuals who need treatment and who have mental health symptoms. These are precisely the individuals the policies were designed to reassure and to encourage to get treatment.

Second, a preponderance of our measures were novel, and we were therefore unable to assess their psychometric properties prior to survey distribution. We attempted to avoid ceiling and floor effects by selecting ordinal scales that are typical within the literature, and we performed pretesting to improve clarity. However, it is conceivable that one or more of the items lacked robust psychometric properties, producing measurement error within our analysis.

Third, as is the case with all self-reported surveys, responses may be influenced by social desirability bias and participant fatigue. We attempted to minimize these effects by stating in clear terms that all responses were confidential and by limiting the total duration of time required to complete the survey.

Any future efforts to survey service members about mental health confidentiality policies and practices may consider further shortening the survey duration by assessing knowledge versus perceptions and opinions in separate surveys. For instance, under the DHA Procedural Instruction 6025.10 (2018), *Standard Processes, Guidelines, and Responsibilities of the DoD Patient Bill of Rights and Responsibilities in the Military Health System (MHS) Military Medical Treatment Facilities (MTFs)*, the Patient Experience Working Group is tasked with the responsibility of monitoring patient awareness of the DoD Bill of Patient Rights and Responsibilities through DHA survey processes at least annually. A similar type of monitoring and evaluation of service members' knowledge of mental health confidentiality limits and protections could be established outside human subjects research. Moreover, to the extent that this study's nonresponse was largely due to a lack of interest in health care privacy issues, enlisting high-level encouragement from DoD officials that convey the value and importance of the topic may improve survey response rates. In addition, future survey efforts could be strengthened by obtaining more information about the characteristics of respondents and nonrespondents (e.g., mental health need, mental health service use), which could improve survey weights. Lastly, evaluations of different methods to increase survey participation rates

can assist in identifying effective strategies to counter nonresponse (Miller and Aharoni, 2015; Sammut, Griscti, and Norman, 2021).

Findings from the stakeholder interviews should also be considered in light of certain study limitations. Our interview findings come from individual anecdotes and experiences and cannot be generalized. We identified large installations for the purposive recruitment of providers (O-3–O-6) and commanding officers. Lower-ranking providers and processes at smaller installations may differ. We did not have representation of Army commanding officers and some provider types that provide care to service members in the Navy and Marine Corps. Nonetheless, the interview findings identified several areas related to the understanding, implementation, and consequences of mental health confidentiality policies and practices that could be improved and that are likely to be widely applicable across DoD.

Finally, this study focused primarily on mental health and was unable to fully address the extent to which confidentiality concerns and issues are unique to mental health or part of a broader military medicine issue. For instance, the Military Command Exception under HIPAA, which allows providers to disclose the PHI of armed forces personnel to military command authorities for proper execution of the military mission, covers both physical and mental health conditions. Although we did not assess the degree to which concerns about the disclosure of PHI regarding physical health conditions affect medical care seeking and engagement, our survey findings suggest that respondents' perceptions of military health providers sharing information without service members' knowledge or consent were just as prevalent for physical health conditions as they were for mental health conditions.

Conclusions

Our findings suggest that concerns about confidentiality continue to be a factor in service members' considerations about whether to obtain mental health treatment. Our findings point to several areas that can be targeted to mitigate confidentiality concerns if DoD does not modify current policies to increase service members' mental health treatment confidentiality within the military. These areas include ensuring compliance with policies, expanding treatment options that afford greater privacy, and minimizing adverse consequences associated with limited confidentiality (e.g., curtailing negative career impacts and responses from leaders and peers due to receipt of mental health services). One goal of DoDI 6490.08 (2011, 2023) is to promote treatment-seeking by assuring service members that the necessary guardrails are in place to limit mental health–related disclosures between military providers and commanding authorities, and within units, while also guaranteeing the effective execution of the military mission. DoD needs to ensure that clear guardrails are established, enforced, and widely understood and known. The HCPM Survey findings may serve as a baseline for future efforts to measure the impact of new strategies to facilitate access to confidential mental health treatment, such as those required by the Brandon Act (Pub. L. 117-81, 2021).

Abbreviations

AFI	Air Force instruction
AR	Army regulation
DHA	Defense Health Agency
DoD	U.S. Department of Defense
DoDI	Department of Defense instruction
HCPM	Health Care Privacy in the Military
HIPAA	Health Insurance Portability and Accountability Act of 1996
MARADMIN	Marine Administrative Message
MHS	Military Health System
MTF	military treatment facility
OTSG/MEDCOM	Office of the Surgeon General/U.S. Army Medical Command
PCS	permanent change of station
PHCoE	Psychological Health Center of Excellence
PHI	protected health information
PTSD	posttraumatic stress disorder
SD	standard deviation
UCMJ	Uniform Code of Military Justice

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High rates of mental health issues among service members and a reluctance to access mental health services together represent one of the greatest ongoing threats to U.S. military readiness. Concerns about the confidentiality of mental health services received within the military have been documented as a significant barrier to service members obtaining needed treatment. At times, disclosing mental health information to commanding officers may be necessary so that informed decisions can be made about duty assignments, needed accommodations, unit resources, or deployments. The challenge the U.S. military faces is how to optimally protect service members' confidentiality so that mental health services are sought and needs are not driven underground—while also ensuring the successful execution of the military mission.

In this report, the authors examine the potential impact of existing U.S. military mental health confidentiality policies on service members seeking assistance for mental health issues. The authors conducted a multimethod investigation involving key-stakeholder interviews with military mental health providers, commanding officers, and enlisted service members and a survey of the active component regarding knowledge, understanding, and practices associated with mental health confidentiality policies.

Findings shed light on the perceptions held by service members on the limits to mental health confidentiality and how policy implementation influences service members' decisions regarding mental health care. The authors recommend steps that the U.S. Department of Defense could take to improve military personnel's understanding of confidentiality policies, strengthen processes to ensure that policies are implemented as intended, and mitigate the consequences associated with the limited confidentiality afforded to mental health services within the military.

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