This summary was reviewed by the Policy Subcommittee of the Defense Advisory Committee on Investigation, Prosecution, and Defense of Sexual Assault in the Armed Forces (DAC-IPAD) but has not been reviewed by the DAC-IPAD.

Staff-Prepared Summary of Information on the Scope of the Psychotherapist-Patient Privilege in the Military Justice System

I. INTRODUCTION

In the 2022 decision *United States v. Mellette*, the Court of Appeals for the Armed Forces (CAAF) held that Military Rule of Evidence (M.R.E.) 513, the psychotherapist-patient privilege, covers only communications between the patient and mental health provider and does not extend to all evidence of a patient's diagnosis and treatment.[1] This decision created concern among victims and their counsel that a victim's personal, confidential mental health diagnosis and treatment information may become publicly available. It also created uncertainty regarding how mental health records containing diagnosis and treatment information may be provided to the defense and under what circumstances.

Because of these concerns, the Defense Advisory Committee on Investigation, Prosecution, and Defense of Sexual Assault in the Armed Forces (DAC-IPAD) elected to study M.R.E. 513 to determine whether the privilege should be expanded to include evidence of diagnosis and treatment.[2] After learning that military primary care health practitioners frequently provide mental health services, the DAC-IPAD broadened its review to also consider whether the privilege should be expanded to encompass communications between a patient and their primary care health provider in the course of seeking mental health treatment.

In reviewing these issues, the Committee heard testimony from

- Victims' counsel, prosecutors, defense counsel, and government and defense appellate counsel from the Military Services;
- A military psychiatrist and a military primary care physician; and
- Mr. Ryan Guilds, who provides pro bono representation of civilian and military victims and who spoke as a representative of victim advocacy organizations.

II. BACKGROUND

A. Establishment of the Privilege

The U.S. Supreme Court recognized a federal psychotherapist-patient privilege in the 1996 civil case *Jaffe v. Redmond*.[3] The Supreme Court noted that effective therapy "depends upon an

[1] *United States v. Mellette*, 82 M.J. 374, 378 (C.A.A.F. 2022).

[2] Congress, in the National Defense Authorization Act for Fiscal Year 2025, directed the Secretary of Defense to provide a report to the House and Senate Armed Services Committees analyzing the advisability of modifying M.R.E.513 to include records of diagnosis and treatment within the psychotherapist-patient privilege. The DAC-IPAD's report and recommendations may also help inform this study. National Defense Authorization Act for Fiscal Year 2025, Pub. L. No. 118-159, §569E, 138 Stat. 1773 (2024).

[3] *See Jaffe v. Redmond*, 518 U.S. 1 (1996). Federal Rule of Evidence 501 provides that "[t]he common law—as interpreted by United States courts in the light of reason and experience—governs a claim of privilege unless any of the following provides otherwise: the United States Constitution; a federal statute; or rules prescribed by the Supreme Court."

atmosphere of confidence and trust" and that "the mere possibility of disclosure may impede development of the confidential relationship necessary for successful treatment."[4]

In 1999, the President extended the psychotherapist-patient privilege to military practice with the establishment of M.R.E. 513,[5] which states:

> A patient has a privilege to refuse to disclose and to prevent any other person from disclosing a confidential communication made between the patient and a psychotherapist or an assistant to the psychotherapist, in a case arising under the Uniform Code of Military Justice, if such communication was made for the purpose of facilitating diagnosis or treatment of the patient's mental or emotional condition.[6]

There are seven exceptions to the privilege, including a requirement that the treating psychotherapist disclose information "when necessary to ensure the safety and security of military personnel, military dependents, military property, classified information, or the accomplishment of a military mission."[7]

B. Constitutionally Required Exception

M.R.E. 513, as initially enacted, contained an eighth exception to the privilege, which provided that the privilege may be pierced "when admission or disclosure of a communication is constitutionally required."[8] In the National Defense Authorization Act for Fiscal Year 2015, Congress directed removal of the "constitutionally required" exception,[9] and the President removed it in a June 2015 executive order.[10]

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[4] *Jaffe v. Redmond*, 518 U.S. 1, 10 (1996).

[5] *See* Exec. Order No. 13,140, 64 Fed. Reg. 55,115 (Oct. 12, 1999).

[6] MANUAL FOR COURTS-MARTIAL, UNITED STATES (2024 ed.) [2024 MCM], Military Rule of Evidence [M.R.E.] 513(a).

[7] *Id.*, M.R.E. 513(d)(6). The other exceptions are (1) when the patient is dead; (2) when the communication is evidence of child abuse or of neglect, or in a proceeding in which one spouse is charged with a crime against a child of either spouse; (3) when federal law, state law, or service regulation imposes a duty to report information contained in a communication; (4) when a psychotherapist or assistant to a psychotherapist believes that a patient's mental or emotional condition makes the patient a danger to any person, including the patient; (5) if the communication clearly contemplated the future commission of a fraud or crime or if the services of the psychotherapist are sought or obtained to enable or aid anyone to commit or plan to commit what the patient knew or reasonably should have known to be a crime or fraud; or (7) when an accused offers statements or other evidence concerning his mental condition in defense, extenuation, or mitigation, under circumstances not covered by Rule for Courts-Martial [R.C.M.] 706 or M.R.E. 302. In such situations, the military judge may, upon motion, order disclosure of any statement made by the accused to a psychotherapist as may be necessary in the interests of justice.

[8] Exec. Order No. 13,140, 64 Fed. Reg. 55,115 (Oct. 12, 1999).

[9] National Defense Authorization Act for Fiscal Year 2015, Pub. L. No. 113-291, §537, 128 Stat. 3292 (2014).

[10] Exec. Order No. 13696, 80 Fed. Reg. 119, 35819 (June 22, 2015).

The removal of the "constitutionally required" exception to M.R.E. 513 was not the end of the debate, however. A split developed among the Courts of Criminal Appeals (CCAs), with the Navy-Marine Corps Court of Criminal Appeals (NMCCA) taking the position that constitutional issues must be considered when raised, and the Army Court of Criminal Appeals (ACCA) taking the opposite position.[11] CAAF has yet to resolve this disagreement.[12]

III. The Scope of the Privilege

A. Background

1. United States v. Mellette

Prior to CAAF's 2022 decision in *United States v. Mellette*, there was a split among the CCAs regarding whether diagnosis and treatment, including prescription medication, were included within the psychotherapist-patient privilege. The Coast Guard and Navy CCAs held that diagnosis, treatment, and prescription medications were included in the privilege,[13] while the Army CCA held that they were not within the privilege.[14]

In *United States v. Mellette*, CAAF held that the plain reading of M.R.E. 513(a) protects confidential communications between patient and therapist, including communications involving diagnoses and treatments, but does not extend the privilege to all evidence of a mental health patient's diagnoses and treatments.[15] The Court stated that if the President had intended M.R.E. 513 to apply more broadly to include a patient's medical records, he could have used language

[11] *See J.M. v. Payton-O'Brien*, 76 M.J. 782, 783 (N-M. Ct. Crim. App. 2017) (The court established a procedure under which a military judge who determined that the accused's constitutional right to privileged mental health records outweigh the patient's privacy interests could ask the patient to waive the privilege so the material can be disclosed to the defense. If the victim declined to waive the privilege, the military judge might craft a remedy, such as abating the proceedings, to protect the accused's constitutional rights. Under this procedure, the military judge may not pierce the privilege on constitutional grounds without the consent of the patient.). *See also United States v. Tinsley*, 81 M.J. 836, 847 (A. Ct. Crim. App. 2021).

[12] CAAF reviewed the issue of whether there is still a constitutional exception to M.R.E. 513 in *B.M. v. United States*, 2024 CAAF LEXIS 201, 84 M.J. 314 (C.A.A.F. 2024). However, in its April 2024 opinion, CAAF determined that it could not resolve this issue in this case as it would amount to an advisory opinion because it could not provide the victim's requested relief—lifting the military judge's abatement order.

[13] *See United States v. Mellette*, 81 M.J. 681, 697 (N-M. Ct. Crim. App. 2021), *overturned by United States v. Mellette*, 82 M.J. 374 (C.A.A.F. 2022) ("To interpret the privilege as covering only the patient's description of her symptoms, but not the psychotherapist's diagnosis and treatment of her condition, would deter patients from seeking mental health treatment in precisely the way *Jaffee* sought to avoid.") ("Revealing what psychiatric medication a patient has been prescribed to treat a diagnosed condition would in many circumstances suggest, if not reveal, the diagnosis itself."); *See also H.V. v. Kitchen*, 75 M.J. 717 (C.G. Ct. Crim. App. 2016).

[14] *See United States v. Rodriguez*, 2019 CCA LEXIS 387 (A. Ct. Crim. App. 2019) ("Had the President wished to broaden the category of information that would be privileged under Mil. R. Evid. 513, he could have included diagnosis and treatment in the plain language of the rule.").

[15] *United States v. Mellette*, 82 M.J. 374, 378 (C.A.A.F. 2022).

which would have "unambiguously expressed that intent."[16] The Court pointed to the Florida psychotherapist-patient privilege statute as an example of a privilege that encompasses a patient's records of diagnosis and treatment.[17]

Two judges dissented in the *Mellette* opinion, stating they would hold that "a record of a patient's diagnosis is privileged to the extent that its disclosure would reveal what the patient confidentially told the psychotherapist or what the psychotherapist confidentially told the patient for the purpose of diagnosing or treating the patient's mental condition."[18] The dissenting judges provided the following rationale: "Disclosing a diagnosis or a treatment may reveal what the patient said to the psychotherapist or what the psychotherapist said to the patient for the purpose of facilitating treatment of the patient's mental condition."[19] Further, "[a] party armed with knowledge of a patient's diagnosis will be able to make an educated guess about the substance of the communications that gave rise to the diagnosis."[20]

2. Diagnosis and Treatment

At issue is whether the military's psychotherapist-patient privilege should encompass mental health diagnosis and treatment. As it examined the interplay between communications, diagnosis, and treatment, the Committee heard the perspectives of a military psychiatrist and a military primary care physician who also provides mental health treatment.[21] In addition, the Committee received responses from the Department of Defense (DoD) Defense Health Agency (DHA) to a request for information (RFI).

Both doctors agreed that they could not easily separate communications with patients from the diagnosis and treatment of those patients.[22] The primary care physician stated that diagnosis and treatment are "inextricably" tied to his communications with a patient.[23] In its RFI response,

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[16] *Id.* at 378.

[17] *Id.*, citing Fla. Stat. Ann. § 90.503(2) (West 2018), which states within its text: "This privilege includes any diagnosis made, and advice given, by the psychotherapist in the course of that relationship."

[18] *Mellette*, 82 M.J. at 385 (Judge Maggs, joined by Judge Sparks, dissenting).

[19] *Id.*

[20] *Id.*, citing *United States v. White*, Criminal Action No. 2:12-cr-00221, 2013 U.S. Dist. LEXIS 49426, at *23, 2013 WL 1404877, at *7 (S.D. W.Va. Apr. 5, 2013), *rev'd sub nom. Kinder v. White*, 609 F. App'x 126, 131 (4th Cir. 2015).

[21] *See Transcript of DAC-IPAD Public Meeting* (Dec. 3, 2024) (testimony of Lieutenant Commander (Dr.) Johnathan Heller, U.S. Navy, and Captain (Dr.) Adam Saperstein, U.S. Navy). Dr. Heller is a military psychiatrist who serves as the Program Director of DoD's forensic psychiatry fellowship training program at Walter Reed National Military Medical Center and Dr. Saperstein is a military primary care physician who serves as Associate Professor and the Vice Chair of Medical Education in the Department of Family Medicine at the Uniformed Services University of the Health Sciences in Bethesda, MD. Transcripts of all DAC-IPAD public meetings are available at https://dacipad.whs.mil.

[22] *Transcript of DAC-IPAD Public Meeting* 72 (Dec. 3, 2024) (testimony of CAPT Saperstein); 72 (testimony of LCDR Heller).

[23] *Transcript of DAC-IPAD Public Meeting* 91 (Dec. 3, 2024) (testimony of CAPT Saperstein).

DHA observed that unlike medical tests, such as lab tests or imaging studies, a mental health diagnosis "stems from a patient's communication of their experiences, thoughts, emotions, and behaviors" and also includes behavioral observations and reviews of the patient's medical history, among other factors.[24] DHA further noted that "[t]he quality and completeness of information required to accurately render a diagnosis depends on establishing a trusting and collaborative professional relationship" with the patient.[25] DHA pointed out that sometimes the confidential communications from the patient to the provider are itself the diagnosis,[26] treatment plans are derived in collaboration with the patient and through a discussion of the patient's diagnosis, and assessment of treatment options involves clinical observations and the patient's self-assessment.[27] The psychiatrist who spoke to the Committee added that following the *Mellette* decision, he now informs his patients that diagnosis and treatment may be subject to disclosure in certain circumstances so that they know of the possibility up front and can choose whether to continue with treatment.[28]

Both witnesses agreed that they are required to disclose information to the patient's command that may affect a patient's fitness for duty, such as drug abuse.[29] The psychiatrist explained that as much as he may try to protect the confidentiality of patient diagnosis and treatment, the codes he is required to provide for patient encounters in the military medical computer system may reveal some of that information.[30]

3. Rules of Production for and Victim Standing to Object to the Production of Non-privileged Diagnosis and Treatment Records

As a result of the *Mellette* decision, there was inconsistency among and within the Military Service judiciaries regarding the rules of production for non-privileged mental health information, as well as the question of whether victims had standing to object at the trial court to its production. In a July 18, 2024, decision, CAAF held that the military judge did not clearly and indisputably err by granting the defense request for production of a victim's medical records, including non-privileged mental health records, after concluding that the military medical treatment facility at issue was a military authority for the purposes of R.C.M. 701(a)(2)(A).[31] R.C.M. 701(a)(2)(A) and 701(a)(2)(A)(i) require the government to provide the defense access to

[24] Request for Information (RFI) to DoD Defense Health Agency (DHA) (Nov. 8, 2024) and DHA response (Jan. 10, 2025) [RFI to DHA], response to question 6. RFIs and responses can be found on the DAC-IPAD website at https://dacipad.whs.mil/.

[25] *Id.*

[26] *Id.*

[27] *Id.*, response to question 7.

[28] *Transcript of DAC-IPAD Public Meeting* 42 (Dec. 3, 2024) (testimony of LCDR Heller).

[29] *Transcript of DAC-IPAD Public Meeting* 57 (Dec. 3, 2024) (testimony of CAPT Saperstein); 59 (testimony of LCDR Heller).

[30] *Transcript of DAC-IPAD Public Meeting* 84 (Dec. 3, 2024) (testimony of LCDR Heller).

[31] *H.V.Z. v. United States*, 85 M.J. 8 (C.A.A.F. 2024).

any "books, papers, documents, data, [or] photographs . . . if the item is within the possession, custody, or control of military authorities" and "the item is relevant to defense preparation."[32]

CAAF further clarified that under M.R.E. 513(e)(2), prior to ordering production of a victim's mental health records—including non-privileged diagnosis and treatment information—the military judge must conduct a closed hearing and the patient must be afforded a reasonable opportunity to attend the hearing and be heard.[33]

4. Extracting Non-privileged Diagnosis and Treatment Information from Mental Health Records

Following the *Mellette* decision, defense counsel began requesting victims' non-privileged mental health diagnosis and treatment information as part of their routine discovery requests. Defense counsel seek this information primarily to ascertain whether the victim had a mental health diagnosis or was taking medication at the time of the reported sexual assault so that they can argue that the medication or diagnosis affected the victim's ability to accurately perceive and recall the reported assault. Defense counsel also seek information regarding the victim's medications and diagnosis following the reported assault to argue that the victim is not able to accurately recall the reported assault, is being untruthful, or is not competent to testify at the accused's court-martial.

Non-privileged diagnosis and treatment information is often contained within records that also contain privileged information. While CAAF clarified that victims may be heard at the trial court as to whether this non-privileged information should be produced, there is still confusion about how this non-privileged information should be extracted from otherwise privileged records.

The Military Services have used different methods for producing this non-privileged information, including the following:

- The military judge orders the mental health treatment facilities to extract the non-privileged diagnosis and treatment information and provide it to the court. This approach has not always been successful, as treatment facilities do not always have sufficient personnel or time to perform this task and have sometimes just sent the patient's entire record—including privileged information—to the military judge.
- The military judge orders that the patient's mental health records be provided to a medical law attorney or another attorney who is not part of the prosecution team to review the records and extract the requested information.
- The judge allows the victims' counsel to review and extract the information.
- Victims' counsel stipulates to the non-privileged information.
- The military judge sends an interrogatory to the mental health treatment provider to provide the information.

[32] 2024 MCM, *supra* note 6, R.C.M. 701(a)(2)(A)(i).

[33] *H.V.Z. v. United States*, 85 M.J. 8, 20 (C.A.A.F. 2024).

All of these methods have proven useful, but each has pitfalls. There is no one method that has emerged as a universally accepted procedure.[34]

B. Release of Privileged Information

Under M.R.E. 513, the patient is the holder of the privilege and may refuse to disclose or may prevent any other person from disclosing a confidential communication between the patient and therapist for the purpose of facilitating diagnosis or treatment of the patient's mental condition.[35] There are, however, a number of ways that otherwise-privileged information may be released to third parties, either purposefully, such as through an exception to the privilege under M.R.E. 513, or unintentionally. For example, if a mental health professional is aware that a patient who is a military member has a mental health condition or has been prescribed medication that may affect the safety and security of military personnel or adversely affect the mission, the psychotherapist is required to inform the patient's command.[36] While mild symptoms of depression or anxiety—or medication to treat those conditions—would not necessarily require command notification, such notification may be required if the condition or treatment renders the patient nondeployable.[37]

In addition, the patient waives the privilege if they voluntarily disclose or consent to disclosure of any "significant part" of the communication under circumstances in which it would be inappropriate to allow the claim of privilege.[38] This may become an issue if the patient discloses privileged information to friends, to family, or on social media. Because only mental health medical providers are covered by the psychotherapist-patient privilege, a patient's disclosure of information to any other provider could waive the privilege. Such information would include diagnosis and treatment, if the rule is expanded to encompass them within the privilege. For example, this type of release might occur when an emergency room provider or sexual assault nurse examiner (SANE) requests a list of a patient's medications or diagnoses. Once released, that information might then be provided to prosecutors and defense attorneys should an alleged sexual assault result in prosecution.

Military mental health providers are required to insert in the patient's medical records medical codes that could indicate the patient's diagnosis or medications prescribed. Such information

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[34] In a concurring opinion in the case of *B.M. v. United States*, 2024 CAAF LEXIS 201, 84 M.J. 314 (C.A.A.F. 2024), Chief Judge Ohlson of CAAF wrote separately to express how military judges may resolve M.R.E. 513 issues post-*Mellette* in the future. Advising that having a military judge conduct an *in camera* review to separate privileged from non-privileged material is not an optimal solution, the Chief Judge suggested that the victim, defense, and government should be encouraged to enter into a stipulation of fact regarding the victim's diagnosis and treatment, if they are willing. Alternatively, he suggested that the military judge order the treating therapist to submit an affidavit to the court containing the diagnosis and treatment.

[35] 2024 MCM, *supra* note 6, M.R.E. 513(a).

[36] *Id.*, M.R.E. 513(d)(6).

[37] Assistant Secretary of Defense for Health Affairs, memorandum, "Clinical Practice Guidance for Deployment-Limiting Mental Disorders and Psychotropic Medications" (Oct. 7, 2013).

[38] 2024 MCM, *supra* note 6, M.R.E. 510(a).

may also be available to professionals other than mental health providers through the military's online health record, MHS Genesis, which contains the medical records of patients who receive care in military treatment facilities.[39]

C. Psychotherapist-Patient Privilege in Federal and State Courts

1. Jaffee v. Redmond

Noting that all 50 states recognize a psychotherapist-patient privilege, in 1996 the Supreme Court recognized a federal psychotherapist-patient privilege in the case of *Jaffee v. Redmond*, stating that the mental health of the public is a "public good of transcendent importance."[40] The Court found that the privilege "serves the public interest by facilitating the provision of appropriate treatment for individuals suffering the effects of a mental or emotional problem."[41] The Court further stated:

> Effective psychotherapy . . . depends upon an atmosphere of confidence and trust in which the patient is willing to make a frank and complete disclosure of facts, emotions, memories, and fears. Because of the sensitive nature of the problems for which individuals consult psychotherapists, disclosure of confidential communications made during counseling sessions may cause embarrassment or disgrace. For this reason, the mere possibility of disclosure may impede development of the confidential relationship necessary for successful treatment.[42]

The Court rejected the use of a balancing test implemented by some courts, because "making the promise of confidentiality contingent upon a trial judge's later evaluation of the relative importance of the patient's interest in privacy and the evidentiary need for disclosure would eviscerate the effectiveness of the privilege."[43] For "if the purpose of the privilege is to be served, the participants in the confidential conversation 'must be able to predict with some degree of certainty whether particular discussions will be protected.'"[44]

Because *Jaffee* was a civil case, the decision did not discuss whether the privilege applied in criminal proceedings. The Court stated that it was "neither necessary nor feasible to delineate its

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[39] *Transcript of DAC-IPAD Public Meeting* 84 (Dec. 3, 2024) (testimony of LCDR Heller); *Transcript of DAC-IPAD Public Meeting* 41, 43–44 (June 11, 2024) (testimony of Mr. Ted Fowles, U.S. Coast Guard).

[40] *See Jaffee v. Redmond*, 518 U.S. 1, 15–17 (1996). Rule 501 of the Federal Rules of Evidence provides that the common law—as interpreted by U.S. courts in the light of reason and experience—governs a claim of privilege unless the U.S. Constitution, federal statute, or rules prescribed by the Supreme Court provide otherwise.

[41] *Id.* at 17–18.

[42] *Id.* at 15–17 (1996).

[43] *Id.* at 17.

[44] *Id.* at 18 (quoting *Upjohn Co. v. United States*, 449 U.S. 383, 393 (1981)).

full contours in a way that would 'govern all conceivable future questions in this area.'"[45] Federal courts now apply the privilege in both civil and criminal proceedings.[46]

2. Other Federal and State Court Opinions

The *Jaffee* opinion does not discuss whether the psychotherapist-patient privilege extends to diagnosis and treatment. There are few federal court opinions on this issue, and those opinions are split: some have found the privilege covers diagnosis and treatment, and others have found it does not. Similarly, the states are divided regarding whether the privilege covers diagnosis and treatment: some but not all states explicitly cover diagnosis and treatment through their psychotherapist-patient privilege statutes or rules.[47] Those courts that have found the privilege covers diagnosis, treatment, or both have provided the following rationales:

- Diagnosis and treatment are born of the communications between the patient and therapist. One court noted: "A party armed with knowledge of a patient's diagnosis will be able to make an educated guess about the substance of the communications that gave rise to the diagnosis."[48]
- Limiting the privilege to only communications would undermine the privilege or could dissuade a person from seeking treatment.[49]
- The privilege would be "gutted" if it did not encompass diagnosis and treatment: "A person's mental health diagnoses and the nature of his or her treatment inherently reveal something of the private, sensitive concerns that led him or her to seek treatment and necessarily reflect, at least in part, his or her confidential communications to the psychotherapist."[50]

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[45] *Id*. (quoting *Upjohn*, 449 U.S. at 386).

[46] *See Kinder v. White*, 609 Fed. Appx. 126 *; 2015 U.S. App. LEXIS 6681 **; 2015 WL 1812942 (4th Cir. 2015) (applying the privilege in a criminal case); *United States v. Glass*, 133 F.3d 1356, 1356 (10th Cir. 1998) (deciding that *Jaffee* extended to the criminal prosecution at issue); *United States v. Sheppard*, 541 F. Supp. 3d 793, 800 (W.D. Ky. 2021).

[47] *See* Fla. Stat. § 90.503; Cal. Evid. Code § 1012; Utah R. Evid. Rule 506.

[48] *United States v. White*, No. 2:12-cr-00221, 2013 U.S. Dist. LEXIS 49426, 2013 WL 1404877, at *7 (S.D. W.Va. Apr. 5, 2013), *rev'd on other grounds*, 609 F.App'x 126 (4th Cir. 2015)).

[49] *See United States v. Sheppard*, 541 F. Supp. 3d 793, 800 (W.D. Ky. 2021) (drawing a distinction between communications and medications would "undermine the point of the privilege in the first place."); *Stark v. Hartt Transp. Sys.*, 937 F. Supp. 2d 88, 91 (D. Me. 2013); *United States v. White*, U.S. Dist. LEXIS 49426, 2013 WL 1404877, at *7 (S.D. W.Va. Apr. 5, 2013) ("psychiatric diagnosis is born of and inseparably connected to private communications between a therapist and his or her patient."); *N.G. v. Superior Court*, 291 P.3d 328, 332 (Alaska Ct. App. Dec. 14, 2012); *United States v. Landrom*, 2024 U.S. Dist. LEXIS 75357 *; 2024 WL 1774824 (E.D. Va. 2024) (the court determined that therapy in which a therapist sits behind a one-way mirror observing and occasionally providing instruction to the patients is covered by the privilege, ruling that this therapy requires the same "atmosphere of confidence and trust" as traditional talk therapy).

[49] *Stark v. Hartt Transp. Sys.*, 937 F. Supp. 2d 88, 91 (D. Me. 2013).

[50] *Id*. at 91.

In holding that Alaska's psychotherapist-patient privilege protects not only confidential communications but also test results and diagnostic perceptions, theories, and conclusions, the Alaska Court of Appeals noted that while states such as California explicitly include diagnosis within the psychotherapist-patient privilege, many other states interpret the privilege more broadly than just "communications."[51] The court cited *McCormick on Evidence* in stating that the majority of jurisdictions extend the privilege not only to communications between the patient and physician but also to "any information acquired in attending the patient," such as "data acquired by examination and testing."[52]

Those jurisdictions that have held that diagnosis or treatment are not covered by the privilege adopt a stricter interpretation of the privilege, adhering to the philosophy that privileges should be narrowly tailored.[53]

D. Comparison with Other Privileges

In its *Jaffee* opinion, the Supreme Court likened the psychotherapist-patient privilege to the attorney-client and spousal privileges.

Several trial practitioners who spoke to the Committee suggested that the psychotherapist-patient privilege in the military be given the same protections from release as the lawyer-client privilege or the communications to clergy privilege, both of which are considered to be nearly inviolable.[54] Both of these privileges involve communications between the parties, much as the psychotherapist-patient privilege does. As practitioners have pointed out, diagnosis and treatment of a patient's mental health condition stem from the communications between the patient and the therapist. They could be analogized to legal advice provided by an attorney to a client based on the client's communications to the attorney.

E. Stakeholder Perspectives

1. Barriers to Mental Health Treatment and Participation in the Courts-Martial Process

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[51] *N.G. v. Superior Court*, 291 P.3d 328, 332 (Alaska Ct. App. Dec. 14, 2012) (the court also noted that this privilege is modeled on Alaska's attorney-client privilege).

[52] *Id*. at 333, citing KENNETH S. BROUN ET AL., MCCORMICK ON EVIDENCE § 100, Vol. 1, pp. 455–56 (6th ed. 2006).

[53] *See United States v. Ray*, 585 F. Supp. 3d 445 *; 2022 U.S. Dist. LEXIS 22540 **; 2022 WL 374367 (S.D. N.Y. 2022) (holding that medications prescribed by the therapist are not covered by the privilege except in rare cases in which the prescription would reveal the communications between the therapist and patient); *Behar v. PA DoT*, 791 F. Supp. 2d 383 *; 2011 U.S. Dist. LEXIS 34615 ** (M.D. Pa. 2011) (Pennsylvania privilege does not include diagnosis).

[54] *See* 2024 MCM, *supra* note 6, M.R.E. 502 and M.R.E. 503. *Transcript of DAC-IPAD Policy Subcommittee Meeting* (June 11, 2024) 62 (testimony of Mr. Paul Markland, U.S. Coast Guard); *Transcript of DAC-IPAD Public Meeting* (Mar. 12, 2024) 31 (testimony of Lieutenant Colonel Stacy Allen, U.S. Marine Corps).

During the Committee's 2024 military installation site visits, junior and senior enlisted members, as well as Service Academy students, discussed mental health treatment issues with Committee members. Some site visit participants mentioned long wait times to get mental health treatment or being too busy to take time off work. Some participants said that there is still social and professional stigma attached to seeking mental health treatment or that it could harm career prospects, such as disqualifying someone from pilot training. Medical and mental health practitioners on a panel at the December 2024 DAC-IPAD public meeting confirmed that stigma associated with mental health is a significant barrier to receiving treatment.[55]

Victims' counsel and others who spoke to the Committee also described the *Mellette* decision as a barrier to victims' seeking mental health treatment.[56] This view was echoed by a primary care physician, who stated that that a patient who was told that records containing diagnosis and treatment might be disclosed if they testified as a witness in a court-martial might be reluctant to seek treatment.[57] In addition, he expressed concern that if a patient's records were disclosed in the course of testifying at a court-martial, that patient might tell other people about the disclosure, which might deter them from seeking mental health care in the future.[58] He emphasized that this effect might be amplified in "a cohesive community such as the military."[59] A military psychiatrist told the Committee that being able to tell his patients that their diagnosis and treatment have special protections would enhance his ability to put his patients at ease and encourage an honest and open conversation.[60]

A special trial counsel (STC) noted that some victims are hesitant to participate in the court-martial process because they know that someone who is not their mental health provider may be reading through their mental health records to extract diagnosis and treatment information.[61] She also pointed out that the diagnosis and treatment of an individual are often based on the privileged communications between the patient and the provider.[62] A government appellate counsel similarly stated that the purpose of the privilege is to encourage people to receive the treatment they need without fear of their confidential information being released. He further declared that he could not draw a distinction between diagnosis and communications.[63]

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[55] *Transcript of DAC-IPAD Public Meeting* 46, 88 (Dec. 3, 2024) (testimony of CAPT Saperstein); 88 (testimony of LCDR Heller).

[56] *Transcript of DAC-IPAD Policy Subcommittee Meeting* (June 11, 2024) 56–57 (testimony of Commander Sara DeGroot, U.S. Navy); 60–61 (testimony of Colonel Iain Pedden, U.S. Marine Corps); 63 (testimony of Mr. Markland).

[57] *Transcript of DAC-IPAD Public Meeting* 43 (Dec. 3, 2024) (testimony of CAPT Saperstein).

[58] *Id.* at 70–71.

[59] *Id.*

[60] *Id.* at 92 (testimony of LCDR Heller).

[61] *Id.* at 202–03 (testimony of Major Alexis Brown, U.S. Air Force).

[62] *Id.*

[63] *Transcript of DAC-IPAD Public Meeting* (June 11, 2024) 52 (testimony of Colonel Matt Talcott, U.S. Air Force).

2. Confusion and Trial Delays

Victims' counsel stated that victims have continued to experience the negative effects of the *Mellette* decision and that confusion and inconsistency continue regarding who should conduct the review of the victim's mental health records to extract non-privileged diagnosis and treatment information from otherwise privileged records.[64] Government appellate counsel concurred that the *Mellette* decision has created a great deal of confusion and litigation and that they could use more clarity from CAAF.[65] By contrast, several STCs who spoke to the Committee viewed *Mellette* as providing needed clarity regarding what was and was not covered by the M.R.E. 513 privilege,[66] and defense counsel argued that the decision has been positive for the defense community.[67]

3. Discovery

One defense counsel mentioned that they try to identify *Mellette* information early in the pretrial process to avoid unnecessary delays and that access to non-privileged diagnosis and treatment information has made the trial process more efficient.[68] They stated that they now seek diagnosis and treatment information as part of their initial discovery requests and then add more specificity to the request after some initial investigation.[69]

Victims' counsel confirmed that defense counsel ask for diagnosis and treatment information in every case and military judges are ordering production of the victim's mental health records in almost every case in which they are requested.[70] One victims' counsel noted that prosecutors and defense counsel have become much more "cavalier" in the way they treat a victim's mental health records.[71] One STC told the Committee that when responding to discovery requests for

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[64] *See Transcript of DAC-IPAD Public Meeting* (Mar. 12, 2024) 12–13 (testimony of CDR DeGroot); 13–14 (testimony of Lieutenant Colonel Allen); 15–16 (testimony of Major Alexandria McCrary-Dennis, U.S. Air Force); 17 (testimony of Commander Rebecca Shults, U.S. Coast Guard). *See also Transcript of DAC-IPAD Policy Subcommittee Meeting* 52 (June 11, 2024) (testimony of Colonel Evah McGinley, U.S. Army); 52 (testimony of Lieutenant Colonel Seth Dilworth, U.S. Air Force); 56 (testimony of CDR DeGroot).

[65] *Transcript of DAC-IPAD Public Meeting* 41 (June 11, 2024) (testimony of Colonel Joseph Jennings, U.S. Marine Corps); 41–42 (testimony of Colonel Christopher Burgess, U.S. Army); 42–43 (testimony of Col Talcott); 29 (testimony of Mr. Fowles).

[66] *See Transcript of DAC-IPAD Public Meeting* 198 (Mar. 12, 2024) (testimony of Major Alexandria Altimas, U.S. Army); 198–99 (testimony of Captain R. J. Stormer, U.S. Navy); 199–200 (testimony of Lieutenant Colonel Nicholas Henry, U.S. Marine Corps).

[67] *Id*. at 106–07 (testimony of Major Ira Gallagher, U.S. Army); 107 (testimony of Captain Hayes Larsen, U.S. Navy); 107–08 (testimony of Lieutenant Colonel Cory Carver, U.S. Marine Corps); 108 (testimony of Major Matthew Leal, U.S. Air Force); 108 (testimony of Commander David Rehfuss, U.S. Coast Guard).

[68] *Id*. at 107–08 (testimony of LtCol Carver); 108 (testimony of CDR Rehfuss).

[69] *Id*. at 110 (testimony of CDR Rehfuss); 110–11 (testimony of MAJ Gallagher); 112 (testimony of LtCol Carver).

[70] *Transcript of DAC-IPAD Public Meeting* (Mar. 12, 2024) 12–13 (testimony of CDR DeGroot); *Transcript of DAC-IPAD Policy Subcommittee Meeting* 53 (June 11, 2024) (testimony of Lt Col Dilworth).

[71] *Transcript of DAC-IPAD Public Meeting* 12–13 (Mar. 12, 2024) (testimony of CDR DeGroot).

this information, they demand some specificity, requiring the defense counsel to provide some information that records exist and that they are relevant and necessary for the defense.[72]

One victims' counsel stated that even if diagnosis and treatment were covered under the M.R.E. 513 privilege, often that information would be disclosed to trial counsel in interviews with the victim or another witness, which would then have to be provided to the defense as part of trial counsel's *Brady/Giglio* obligation.[73] An STC raised the concern that sometimes as part of an investigation, the investigator obtains the victim's mental health records from the treatment facility; as a result, the government is already in possession of those records when the defense makes a discovery request.[74]

Defense counsel stated that if M.R.E. 513 were amended to include diagnosis and treatment information within the privilege, the defense would conceivably be deprived of constitutionally required information, adding that defense counsel are seeing cases in which diagnosis and treatment information from the victim has made a difference in the outcome.[75] One defense counsel noted that expanding privilege would also delay courts-martial proceedings while defense counsel attempt to obtain this information through investigation and interviews of the victim's friends.[76] Several defense appellate counsel said they support the narrow reading of M.R.E. 513 in the *Mellette* decision as being more fair for the defense.[77] One counsel observed that the diagnosis and treatment information sought is usually fairly narrow and that the defense must demonstrate that the information requested is relevant.[78]

Mr. Ryan Guilds expressed concern that following the *Mellette* decision, military judges are routinely ordering the production of victims' diagnosis and treatment information in a way that threatens victims' dignity and privacy.[79] He told the Committee that he is therefore trying to find the least intrusive way of providing his clients' diagnosis and treatment information to the defense—often through affidavit—because he knows that the military judge will likely issue an order for the information.[80]

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[72] *Id*. at 209–10 (testimony of LtCol Henry).

[73] *Id*. at 218 (testimony of Maj Brown).

[74] *Id*. at 221–22 (testimony of LtCol Henry).

[75] *Id*. at 117 (testimony of CAPT Larsen); 119–20 (testimony of CDR Rehfuss); 122 (testimony of Maj Leal); 123–24 (testimony of MAJ Gallagher).

[76] *Id*. at 118 (testimony of LtCol Carver).

[77] *Transcript of DAC-IPAD Public Meeting* 106 (June 11, 2024) (testimony of Mr. Tom Cook, U.S. Coast Guard); 109 (testimony of Ms. Rebecca Snyder, U.S. Navy).

[78] *Id*. at 109 (testimony of Ms. Snyder); 110 (testimony of Ms. Megan Marinos, U.S. Air Force).

[79] *Id*. at 126–27 (testimony of Mr. Ryan Guilds, Protect Our Defenders and Survivors United).

[80] *Id*. at 133.

IV. Scope of M.R.E. 513 Privilege: Treatment Providers

A. Application of M.R.E. 513 to Communications between a Patient and Psychotherapist

M.R.E. 513 provides that communications between a patient and their therapist or other mental health provider are privileged. M.R.E. 513(a) states:

> A patient has a privilege to refuse to disclose and to prevent any other person from disclosing a confidential communication made between the patient and a psychotherapist or an assistant to the psychotherapist, in a case arising under the Uniform Code of Military Justice, if such communication was made for the purpose of facilitating diagnosis or treatment of the patient's mental or emotional condition.[81]

The rule provides the following definitions:

> "Patient" means a person who consults with or is examined or interviewed by a psychotherapist for purposes of advice, diagnosis, or treatment of a mental or emotional condition.[82]
>
> "Psychotherapist" means a psychiatrist, clinical psychologist, clinical social worker, or other mental health professional who is licensed in any State, territory, possession, the District of Columbia, or Puerto Rico to perform professional services as such, or who holds credentials to provide such services as such, or who holds credentials to provide such services from any military health care facility, or is a person reasonably believed by the patient to have such license or credentials.[83]
>
> "Assistant to a psychotherapist" means a person directed by or assigned to assist a psychotherapist in providing professional services or is reasonably believed by the patient to be such.[84]

B. Provision of Mental Health Treatment and Prescriptions by Medical Professionals Not Specializing in Mental Health

[81] 2024 MCM, *supra* note 6, M.R.E. 513(a).

[82] *Id.*, M.R.E. 513(b)(1).

[83] *Id.*, M.R.E. 513(b)(2).

[84] *Id.*, M.R.E. 513(b)(3).

1. Studies of Providers of Mental Health Treatment

Studies conducted since the onset of the COVID-19 pandemic in 2020 have found increased levels of depression and anxiety in patients and anticipate that this elevation will continue for the foreseeable future.[85] It corresponds with an increase in the number of prescriptions for antianxiety and antidepression medication. The rise in mental health concerns has overburdened mental health providers, leading to increased wait times—often lasting several months—for patients to receive mental health treatment.[86]

Given this shortage of mental health providers, many patients first seek treatment and medications from their primary care providers. A study conducted using data from patient visits from 2016 to 2018 found that more patients received treatment of depression and anxiety from their primary care provider than from a psychiatrist or other mental health provider (38% vs. 32%).[87] In such cases, 50% of the prescriptions for anxiety and depression medication were written by primary care providers, versus 40% by mental health providers, and 10% by other specialists.[88] Primary care providers also wrote more prescriptions for other mental illnesses than did mental health providers.[89]

Military members have also reported difficulty in gaining access to mental health providers. Consequently, many receive at least initial treatment, including prescription medications, for anxiety, depression, post-traumatic stress disorder (PTSD), and other mental health disorders from their primary care providers or from physicians in an emergency room.[90]

2. Request for Information

In response to the Committee's RFI, DHA provided information regarding mental health treatment of military members and their families.[91] Its data show that

- From October 2021 through December 2023, the number of Service members seeking mental health treatment who were seen in military treatment facilities

[85] *See* Anuradha Jetty, Stephen Petterson, John M. Westfall, & Yalda Jabbarpour, *Assessing Primary Care Contributions to Behavioral Health: A Cross-sectional Study Using Medical Expenditure Panel Survey*, 12 J. PRIMARY CARE & CMTY. HEALTH 1, 2 (2021).

[86] *Id*. at 2.

[87] *Id*. at 3.

[88] *Id*.

[89] *Id*.

[90] *Transcript of DAC-IPAD Public Meeting* 44 (June 11, 2024) (testimony of Mr. Fowles).

[91] *See* FRI to DHA, *supra* note 24.

decreased from 100,000 to 80,000 per month, while Service member referrals to civilian mental health providers increased from 20,000 to 40,000 per month.[92]

- From January 2022 through December 2023, about 64% of Service members and their families who received mental health treatment had at least one mental health encounter with a primary care provider.[93]

DHA noted that demand for mental health services has outpaced supply and the military is responding with targeted care—referring patients to clinical or nonclinical care as needed and providing earlier interventions.[94]

DHA stated that primary care providers prescribe medications for patients' mental health conditions, but often refer patients to mental health providers for counseling, though some primary care providers are trained to provide counseling.[95]

3. Military Primary Care Provider Perspective

A military physician who spoke to the DAC-IPAD informed the Committee that he frequently provides mental health treatment to patients and frequently prescribes medications to treat mental health issues. He stated that primary care providers may engage in "brief therapeutic interventions" with patients who require mental health care but will refer patients to a mental health provider or a counselor if they require therapy.[96] Noting that "there's a substantial amount of mental healthcare that's being delivered in primary healthcare spaces in America in general and in the DoD in particular," he observed that a primary care practitioner may work closely with a psychologist or counselor to provide the best treatment for the patient.[97] He expressed concern that if he sends a message regarding a patient's care to a psychologist, his message may not be covered by the privilege, because primary care practitioners do not fall within M.R.E. 513's definition of psychotherapist.[98]

C. Communications Between Patients and Primary Care Providers Under M.R.E. 513

While most states have a doctor-patient privilege, there is no such privilege in the federal system or the military justice system. The M.R.E. 513 privilege does not cover

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[92] *Id.*, response to question 2b (the number of Service member encounters showed a similar trend; decreasing in military treatment facilities from 250,000 to 190,000 per month and increasing in the civilian system from 50,000 to 90,000 encounters per month).

[93] *Id.*, response to question 5.

[94] *Id.*, response to question 3.

[95] *Id.*, response to question 8.

[96] *Transcript of DAC-IPAD Public Meeting* 35 (Dec. 3, 2024) (testimony of CAPT Saperstein).

[97] *Id.* at 41, 78–79.

[98] *Id.* at 82.

communications between patients and primary care providers as it does between patients and mental health providers.

D. Communications Between Patients and Physicians in Civilian Jurisdictions

Federal courts have held that the psychotherapist-patient privilege does not extend to physicians or other medical professionals, such as nurse practitioners;[99] however, the Supreme Court in the *Jaffee* decision ruled that the psychotherapist-patient privilege should be extended to licensed social workers. The Court stated that the reasons for the privilege's applying to psychologists and psychiatrists also apply to licensed social workers—namely, that social workers provide a significant amount of mental health treatment.[100] The Supreme Court suggested that future cases would further shape this new privilege: "Because this is the first case in which we have recognized a psychotherapist privilege, it is neither necessary nor feasible to delineate its full contours in a way that would 'govern all conceivable future questions in this area.'"[101]

Many states cover communications between medical professionals and patients through the psychotherapist-patient privilege. Some states explicitly include communications between medical professionals and patients within their psychotherapist-patient privilege rules or statutes, often defining "psychotherapist" as including a person who is authorized to practice medicine, who the patient believes is authorized to practice medicine, or who is engaged in the diagnosis or treatment of a mental or an emotional condition, using this or similar wording.[102]

Most states cover communications between physicians and patients under a physician-patient privilege, though not all jurisdictions recognize a physician-patient privilege in criminal proceedings. Some states also cover communications between patients and nurse practitioners and other medical professionals.

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[99] *See Stark v. Hartt Transp. Sys.*, 937 F. Supp. 2d 88, 92–93 (D.Me. 2013); *United States v. Ghane*, 673 F.3d 771, 783 (8th Cir. 2012); *EEOC v. Nichols Gas & Oil, Inc.*, 256 F.R.D. 114, 120 (W.D.N.Y. 2009).

[100] *Jaffee v. Redmond*, 518 U.S. 1, 15 (1996).

[101] *Id*. at 18 (quoting *Upjohn Co. v. United States*, 449 U.S. 383, 386 (1981)).

[102] *See* Fla. Stat. § 90.503; Cal Evid Code § 1010; Ala. R. Evid. Rule 503; Alaska R. Evid. 504; Ark. R. Evid. 503; Conn. Gen. Stat. § 52-146d; ALM GL ch. 233, § 20B; Tex. Health & Safety Code § 611.001.