Work-Product

UNITED STATES AIR FORCE
BOARD FOR CORRECTION OF MILITARY RECORDS

RECORD OF PROCEEDINGS

IN THE MATTER OF: Work-Product

DOCKET NUMBER: BC-2021-03558

COUNSEL: Work-Product

HEARING REQUESTED: YES

APPLICANT'S REQUEST

His official military personnel record be amended to reflect:

a. Additional 10 months active duty service credit to achieve a 20-year retirement; or

b. Reinstatement to active duty to complete 20 years of service; or

c. Full retirement under the Temporary Early Retirement Authority (TERA); or

d. Placement on the Temporary Disability Retired List (TDRL) vice the Permanent Disability Retired List (PDRL) with reevaluation by a Medical Evaluation Board (MEB) for possible return to active duty.

APPLICANT'S CONTENTIONS

Per applicant's counsel, the Air Force's abnormal medical treatment and ill-timed MEB[1] proceedings resulted in the erroneous determination the applicant was unfit for duty. The applicant was mis-prescribed drugs which exacerbated otherwise treatable mental health problems. His psychological issues were directly correlated with his being erroneously prescribed amphetamine salts. As such, it is fundamentally unjust for the Air Force to have provided a course of treatment to the applicant contrary to Food and Drug Administration (FDA) guidance and sound medical advice, then effectively punish him for the temporary side-effects of that erroneous treatment by forcing him to retire less than 10 months before reaching his 20-year full retirement threshold because of the mistakes the Air Force made.

Furthermore, the MEB should have ordered the applicant be placed on TDRL status and scheduled a reevaluation once the withdrawal symptoms were alleviated. If the Air Force Board for Correction of Military Records (AFBCMR) is not convinced the applicant should be automatically reinstated, he should at the very least be transferred from the PDRL to the TDRL, where he should have been originally placed, to determine his capability for reenlistment for the remainder of his term after he had stabilized the effects of the prescribed drugs.

[1] Counsel, throughout her brief, utilizes the term "Medical Evaluation Board (MEB)" when she is actually referring to the "Physical Evaluation Board (PEB)."

The applicant's medical retirement was both an error and an injustice. His medical retirement was an error because (1) the medical problems which led to his retirement were directly caused by medications his Air Force doctor incorrectly prescribed; (2) the problems he experienced had been resolved at the time of his retirement, as proved by the fact he was elevated to a squad-level [sic] position after his MEB, but before being discharged, indicating there was no need for him to be prematurely retired; and (3) the applicant was assessed for his MEB as he was still being weaned off a highly addictive medication which had been incorrectly prescribed by his doctor, consequently, he should have been placed on the TDRL until he had fully recovered.

The applicant's medical retirement was an injustice because (1) it deprived him of the right to retire with full benefits only 10 months prior to reaching his 20-year term; (2) it effectively punished him for trusting his doctor's judgment, and (3) given his high level of functionality and success in his current job, it appears whatever underlying condition the applicant may have suffered from, it is highly manageable with the proper medications. The applicant's duties in cyber operations were not impacted by his condition and were he reinstated, there is no reason he would not be able to continue to serve at a high level in his assigned role for the Air Force.

The applicant was first diagnosed with Persistent Depressive Disorder in 2006, but was only referred to an MEB in 2017, after 11 years of successful service in the Air Force while managing his condition. He initially encountered increased psychological stress in 2015, as he was transitioning to a new career in Cyber Security while experiencing severe problems in his marriage, exacerbated further by having to care for his four children for extended periods while his wife traveled for work. The applicant was initially prescribed Lorazepam, which was effective and allowed his depression to fully resolve, though he continued to experience some insomnia. In Nov 16, the applicant relapsed into a depressive state and was diagnosed with Major Depressive Disorder (MDD). His Air Force doctor prescribed the applicant Lexapro and amphetamine salts in the form of Adderall. Subsequent review by a forensic psychiatrist at the University of Virginia found this decision to be highly abnormal because Adderall is only FDA-approved to treat attention deficit hyperactivity disorder (ADHD) or narcolepsy. The applicant had never been diagnosed with ADHD and had been diagnosed with chronic insomnia for many years when he was prescribed Adderall, the exact opposite of narcolepsy.

In Feb 17, the applicant presented himself to a walk-in clinic anxious and tearful. Specifically, he was concerned about the effects Adderall was having on him. As a result, it was recommended the applicant take his Adderall once every other day for a week and then stop completely. The one-week taper period was unusually short for such an addictive drug and 36 hours later, the applicant arrived at the emergency department emotionally disturbed. On 17 Feb 17, the applicant was described by his doctor as being agitated and potentially going through psychological problems brought about by alcohol and other substance disorders. In late Mar17, he was prescribed additional drugs to help him sleep and his Adderall prescription was formally discontinued. During this period of withdrawal from Adderall, the applicant experienced psychiatric instability and resumed drinking alcohol. Once his Adderall prescription was discontinued and his withdrawal symptoms resolved, he was selected by his commander for a squadron-level position.

The applicant underwent his initial MEB on 25 May 17. The MEB found he was not specifically impaired in any meaningful way, though his condition had degraded his effectiveness as a leader. The applicant's commander recommended he not be retained; however, he clearly stated if the applicant could show long-term success from treatment, he would retain him but discussions with the applicant's provider made him think this success was not achievable. The commander also recommended medical retirement or allowing the applicant to stay until reaching 20 years and then retiring. Once the applicant was prescribed medicine which properly addressed his underlying conditions, instead of exacerbating them, his mental health quickly improved and stabilized. Upon

review, the applicant's mental health history clearly indicated his 25 May 17 MEB occurred at the tail-end of the acute psychological distress caused by the Adderall prescription and subsequent withdrawal symptoms. On 22 Oct 18[2], just 9 months and 19 days away from a 20-year threshold for full retirement, the applicant was honorably separated from the Air Force due to permanent disability. The applicant now works for a Department of Veterans Affairs (DVA) hospital and is sufficiently stable that he only needs to meet with a psychiatrist once a quarter.

The applicant later hired a forensic psychiatrist and professor at the University of Virginia to review his medical records. On 4 Apr 21, the forensic psychiatrist published his report regarding the applicant's medical treatment finding that although only a few months in duration, the consequences of the applicant being prescribed amphetamine salts was quite profound. The psychiatrist also found the FDA explicitly advised doctors not to prescribe amphetamine salts to patients with the applicant's medical history, even if he had a condition which amphetamine salts could theoretically have treated, such as adult ADHD or narcolepsy. Once prescribed, his doctors also failed to provide the amount of monitoring recommended by the medical literature. The forensic psychiatrist stated he was also confused by the decision to attempt such a non-traditional treatment plan when the applicant had successfully responded to single doses of approved antidepressants in the past. As a result of all these concurrent factors, the psychiatrist stated it was his professional opinion the applicant's prescription of amphetamine salts and the management of that prescribed regimen resulted in the MEB's finding of permanent disability. He also stated had the applicant received more standard and acceptable medication and treatment for his condition, it would have resulted in his retention on active duty until his retirement.

In support of his contentions, counsel references the following: Title 10, United States Code § 1552(3)(A) (10 USC § 1552(3)(A)); Title 32, Code of Federal Regulations § 865.2; 10 USC § 1210(a); 10 USC § 1210(b); Department of Defense Manual (DoDM) 1332.18, *Disability Evaluation System*, Volume 2; Air Force Instruction (AFI) 36-3212, *Physical Evaluations for Retention, Retirement, and Separation*; and AFI 36-2603, *Air Force Board for Correction of Military Records (AFBCMR).*

In discussion, counsel contended service members submit themselves to the care of military physicians on the good faith assumption the doctors will address the medical problems they are experiencing and do no harm. Here, the applicant was successfully managing mild, but chronic, depression and insomnia until his doctor prescribed him amphetamine salts, in the form of Adderall, a drug not recommended for off-label use. The applicant's depression and insomnia were not helped and were in many ways exacerbated by the prescription and his doctor's subsequent unconventional order that he rapidly withdraw from it, which led to a further deterioration of his state. This culminated in the applicant being evaluated by the MEB at the height of the problems brought on by this improper and addictive prescription, a state which clearly did not meet the definition of a stable condition.

The AFBCMR should address three clear errors. First, the applicant was erroneously prescribed Adderall to treat conditions which were contrary to the types of conditions Adderall is intended to treat. Second, after erroneously prescribing Adderall, his physician had him stop taking it within a week, which was extremely fast for such a highly addictive stimulant, and then the Air Force subjected the applicant to an MEB while he was still experiencing adverse side effects of withdrawal. The applicant performed his job without issue in the remaining six months he was in the Air Force and continues to hold a steady job today. He was assessed at the end of his worst series of hospitalization and there is a clear correlation between his mis-prescription of amphetamine salts. Third, the Air Force placed the applicant on the PDRL instead of the TDRL

[2] The applicant was discharged from the Air Force on 28 Oct 18.

while the applicant was still experiencing withdrawal which is precisely the type of scenario that the TDRL was intended to manage.

The applicant's performance at his work between the MEB and his formal retirement date made clear he was fully competent and fit for duty when he was separated. The MEB erred in ruling his disability was permanent. Importantly, the test focuses on whether a preponderance of the medical evidence indicates the condition is unlikely to change, and not based on the opinion of the evaluating physician. Permanent disability retirement is clearly reserved for instances wherein the condition is stable and permanent, and the total disability rating is 30 percent or greater. The applicant's record makes clear there was no rational expectation for the condition to persist for the three years necessary to deem the condition to be stable and permanent. This clearly suggest that placing the applicant on the TDRL for a few weeks or months while his body stabilized after having an adverse reaction to the Adderall would be well within the timeframe for reevaluation which the TDRL was designed to permit.

In addition to being an error, the Air Force's treatment of the applicant was also unjust. His irremediable psychological issues were directly correlated with his being erroneously prescribed amphetamine salts as, prior to that point, he had been successfully treated for common mental health challenges in the Air Force without issue. Additionally, it is unjust to evaluate a person for a permanent disability while they are still experiencing the side effects of a highly addictive drug whose side effects clearly resolved with time. The MEB should have ordered the applicant be placed on TDRL status and scheduled a reevaluation once the withdrawal symptoms were alleviated. This would have allowed the MEB to determine whether the problems the applicant was facing were in fact chronic or if they were temporary.

Finally, the applicant also experienced an injustice in that the Air Force failed to offer him the opportunity to work on Limited Assignment Status (LAS) which would have allowed the Air Force to retain his much-needed expertise in cyber systems. The applicant's specific situation clearly meets all considerations for keeping someone in the Air Force through the LAS program. Specifically, he had a clearly manageable condition; very little medical support was needed to sustain him in his role when not being given the wrong medication; as a Cyber Systems Surety Craftsman, his physicality was not meaningfully impacted; he had completed 19 years, 2 months, and 11 days of service at his retirement; cyber security is an ever-growing threat and the Air Force, as any large enterprise, is in need of as many qualified cyber security personnel as they can muster. Permitting the applicant to be reevaluated would cost the Air Force almost nothing, and if he were found fit to serve, it would be a tremendous benefit to the Air Force for him to share his knowledge and expertise with junior airmen as well as executing his assignments with a high level of competence. The above errors and the MEB's decision to place the applicant on the PDRL unjustly deprived him of the opportunity to serve to full retirement.

The applicant's complete submission is at Exhibit A.

STATEMENT OF FACTS

The applicant is a retired Air Force master sergeant (E-7).

On 13 Apr 17, according to AF Form 469, *Duty Limiting Condition Report*, the applicant had the following duty/mobility restrictions: not worldwide qualified, not deployable, not clear for temporary duty (TDY), not clear for permanent change of station (PCS), and no weapons bearing. His condition required MEB processing.

On 15 May 17, according to the *Commander's Memo to Medical Evaluation Board (MEB)/Physical Evaluation Board (PEB)*, the applicant's commander recommended "Do Not Retain."

On 11 Aug 17, according to AF IMT 618, *Medical Board Report*, the applicant was diagnosed with Persistent Depressive Disorder and referred to an Informal Physical Evaluation Board (IPEB).

On 15 Aug 17, according to an *Impartial Review Election*, the applicant did not elect an impartial review of his MEB and did not wish to submit a rebuttal letter.

On 22 Aug 17, according to AF Form 356, *Findings and Recommended Disposition of USAF Physical Evaluation Board (Informal),* the applicant was found unfit because of physical disability and diagnosed with:

- Category I – Unfitting Conditions:
  - Persistent Depressive Disorder; Incurred While Entitled to Receive Basic Pay: Yes; Line of Duty: Yes; Combat Related: No. Condition is Permanent and Stable: Yes.

Recommended Disposition: Unfit – IDES [Integrated Disability Evaluation System] Awaiting DVA Ratings.

On 31 Aug 17, according to a DVA Disability Evaluation System Proposed Rating letter, for purposes of entitlement to DVA benefits, it is proposed to establish service-connection for Persistent Depressive Disorder (also claimed as anxiety – training and deployments, insomnia, depressive disorder and PTSD [Post-Traumatic Stress Disorder] Jan 08) as directly related to military service with a 50 percent evaluation.

On 1 Nov 17, according to AF Form 356, *Findings and Recommended Disposition of USAF Physical Evaluation Board (Formal)*, the applicant was found unfit because of physical disability and diagnosed with:

- Category I – Unfitting Conditions:
  - Persistent Depressive Disorder; Incurred While Entitled to Receive Basic Pay: Yes; Line of Duty: Yes; Disability Compensation Rating: 50; Veterans Administration Schedule for Rating Disabilities Code: 9434; Combat Related: No. Condition is Permanent and Stable: Yes.

Recommended Disposition: Permanent Retirement with a combined compensable percentage of 50 percent.

On 3 Nov 17, according to AF Form 1180, *Action on Physical Evaluation Board Findings and Recommended Disposition*, the applicant did not agree with the findings and recommended disposition of the Formal PEB (FPEB) and requested a one-time reconsideration.

On 14 Nov 17, according to applicant memorandum, Subject: Appeal of the Findings of the Formal Physical Evaluation Board (FPEB), the applicant requested the Secretary of the Air Force Personnel Council (SAFPC) find him fit for duty.

On 16 Nov 17, according to an AFPC/DPFDD memorandum, Subject: Review of Physical Evaluation Board Proceedings, the applicant's appeal of his PEB case was forwarded to SAFPC for consideration. The applicant contended he was fit and should be returned to duty and requested a DVA reconsideration.

On 12 Apr 18, according to a SAF/MRBP memorandum, Subject: *Physical Evaluation*, the Secretary of the Air Force directed the applicant be permanently retired with a disability rating of 50 percent under the provisions of 10 USC § 1201.

On 26 Apr 18, according to an Office of Airmen's Counsel (OAC) memorandum, Subject: *Request for Reconsideration of the SAF Personnel Council Findings*, dated 19 Apr, the applicant requested reconsideration of the findings and recommendations of the SAFPC.

On 12 Jun 18, according to SAF/MRBP memorandum, Subject: *Request for Reconsideration*, there was not sufficient additional evidence to support reconsideration; therefore, the request for reconsideration is disapproved, and the memorandum dated 12 Apr 18 remains valid.

On 22 Jun 18, according to applicant's email, Subject: *Findings from SAFPC*, he no longer wished for a one-time reconsideration.

On 27 Jun 18, according to Special Order Number Work-Product, effective 28 Oct 18, the applicant is relieved from active duty, organization and station of assignment. Effective 29 Oct 18, he is permanently disability retired in the grade of master sergeant (E-7) with a compensable percentage for physical disability of 50 percent.

On 28 Oct 18, the applicant was furnished an honorable discharge, with Narrative Reason for Separation of Disability, Permanent IDES, and credited with 19 years, 2 months, and 11 days active service.

For more information, see the excerpt of the applicant's record at Exhibit B and the advisories at Exhibits C, F and G.

AIR FORCE EVALUATION

The AFRBA Psychological Advisor finds insufficient evidence to support the applicant's request for a change in his retirement via return to duty to meet the criteria for active duty retirement, or to be granted the additional time to complete the criteria for a full active duty retirement.

This Psychiatry Consultant has reviewed all available military and service treatment records (STR) and finds the applicant's contentions were partially corroborated by his records. There was no evidence in his military records the use of the stimulant medication, Adderall, directly led to his medical retirement. It is correct his condition had resolved at the time of his retirement; however, evidence that links the discontinuation of Adderall to the resolution of his mental health condition is at best, loosely associated, and speculative. The treatment record shows the applicant first sought mental health and alcohol treatment in 2006 and was diagnosed with alcohol abuse and depression. He was prescribed an antidepressant medication, Celexa, and quetiapine for insomnia. In Sep 06, his diagnosed Major Depression, recurrent, went into full remission, the Celexa was discontinued in Nov, but the quetiapine continued with the diagnosis of persistent insomnia. Quetiapine is a medication that has been used off-label by many medical professionals to treat sleep and anxiety complaints. The applicant deployed in the summer of 2007. Treatment records related to mental health fell silent after Mar 07 until 8 Dec 13 when he presented voluntarily to the Mental Health (MH) clinic accompanied by his wife requesting family therapy to address recent family conflicts relating to child rearing practices. The applicant was not assessed with depression or alcohol abuse at the time. However, in Oct 15, he was seen again by a psychiatrist who assessed him with dysthymia and prescribed antidepressant medication, and restarted lorazepam to target sleep initiation.

Once again, the applicant's condition went into remission in late spring 2016, but the insomnia continued. At this point, the antidepressant medication was discontinued, and the anti-anxiety medication lorazepam was continued, at least through Sep 16. In Nov 16, the psychiatrist prescribed a new antidepressant (Lexapro), and continued lorazepam, for the diagnosis of MDD with seasonal onset. Also prescribed was 15mg of Adderall XR (extended release), a significantly high dose for a stimulant naïve patient. At the time, the applicant complained of lack of energy, decreased concentration, and lack of pleasure (all consistent with depression-related symptoms). He denied depressed mood, appetite or weight changes. He denied suicidal ideation. This psychiatry advisor finds this medication combination curious, acknowledging a stimulant medication is not FDA-approved for treating depression; however, acknowledging it is not uncommon for stimulant use in the elderly patient with poor energy and depressed mood; however, typically, not generally, Adderall and usually low-dose methylphenidate due to its short, immediate acting property. Furthermore, given the history of alcohol abuse, both Adderall and lorazepam would not be logical treatment options in such individuals. Another reason for not combining lorazepam and Adderall is the fact that Adderall worsens insomnia, which had been present in this patient for several years. To further complicate the picture was his described overuse of over-the-counter Nyquil that possibly further contributed to insomnia and irritability. Nonetheless, these medications were continued through the first week of Feb 17, and his diagnosis was changed to dysthymia. The applicant reportedly stated the Adderall was working well, keeping him motivated during the short days.

On 7 Feb 17, the applicant met with a therapist and reported he "is currently experiencing increased anxiety and depression symptoms since his wife left for TDY on 10 Jan 17." While she was away, he was the primary parent for their four kids. He also reported his medication was not a good fit for him and would like to make some changes. The applicant reported that during previous sessions, he had under-reported his symptoms so it would have minimal impact on his career. He reported fleeting thoughts of "not being here" but was able to quickly dismiss them. The therapist contacted the psychiatrist to inform them of the applicant's concern about Adderall. The psychiatrist reportedly recommended to slowly decrease to one dose every other day for one week and then discontinue.

Then, on 8 Feb 17, the applicant presented to the emergency room (ER) with suicidal ideations and hours later, was seen by MH for complaints of chronic depression and recently escalating anxiety and irritability. During the mental health assessment, he reported he had been fighting with his wife prior to coming to the hospital. He attributed his deterioration in mood to Adderall. In addition to anxiety and irritability, the applicant also endorsed mood instability, increased anger, and decreased sleep. He reported taking over-the-counter sleep aids "every night for 20 years." At the time, he was using three bottles of Nyquil a week for sleep, and two Benadryl in addition to 2mg of lorazepam. This writer notes that when polypharmacy is involved, it is difficult, if not impossible, to determine which drug is responsible for side effects, especially when the reported symptoms could be attributed to the combination of medication, or a natural state of being, given the circumstances. The use of three bottles of NyQuil a week describes overuse, which can cause nervousness and excitability, fast, pounding, or uneven heartbeats, confusion, tremors, insomnia, trouble concentrating, headache, and other symptoms, and thus, Nyquil cannot be ruled out as the cause for irritability. The applicant was not admitted to the hospital, and apparently not considered to be in withdrawal from any substance. He was referred to the partial hospital program (PHP). There was no indication he was being treated in the ER for any type of withdrawal symptoms, and he did not complain of any symptoms that could not be explained by a state of acute anxiety related to interpersonal and emotional struggles documented throughout the STR.

On 9 Feb 17, he was added to the High Interest Log (HIL) and referred to the PHP program. On 13 Feb 17, he was evaluated at the MH clinic and referred to the ER for MDD, suicidal ideations

and homicidal ideations, and was admitted to the hospital (inpatient treatment record not available). His wife, who also met with the MH clinic provider, reportedly stated she [wife] told the applicant she wanted a divorce and his anger had gotten worse since. The applicant reported binge drinking. He quit attending the PHP due to not having freedom to take smoke breaks. He continued to endorse suicide-related ideation with thoughts about death and dying. The applicant's mental status examination noted he presented with "anxiety," psychomotor agitation, and reported using medications other than as prescribed and continued drinking alcohol. He reported he was trying to cut down on his drinking and complained of sweating all the time. The examiner noted his presentation suggested alcohol withdrawal or withdrawal from some other substance. This writer concluded, based on the available evidence, his prescribed medications may have contributed to the exacerbation of his symptoms, especially when used inappropriately; however, it is not likely they were the sole cause of his deterioration, given the circumstances of chronic use and overuse of the over-the-counter Nyquil, which can cause the same symptoms, marital difficulties he was experiencing, and having difficulties accepting the separation and imminent divorce, and binge drinking. It is important to note, the applicant was cleared medically and was not considered in withdrawal from any substance, which allowed his admission to the behavior health inpatient unit.

Of note, in less than 30 days, the applicant experienced in the following order: a discharge from acute hospitalization after spending several days endorsing daily suicide-related thoughts two weeks after discharge; binge drinking; denying continued use of alcohol, four weeks after discharge; deemed no longer clinically significant suicide risk; having inappropriate behaviors at work and during the Alcohol and Drug Abuse Prevention and Treatment (ADAPT) sessions; and consideration of an MEB. Additionally, four days after the MEB examination, he was seen for "anxiety, loss of control, anger, depression, sleep," at MH. He was told his first sergeant called with concerns about his inappropriate behaviors at work, his change in mood, and the report that he "stopped taking his medication" 10 days prior to the irritability incident. Weeks later, the applicant appeared stable and was fit for continued military service until 19 May 17 when his psychiatrist profiled the member as not cleared for mobility, PCS, TDY, and deployment and he has shown no instability but is not suitable/fit for continued military service. The psychiatrist noted there had not been significant improvement, and the applicant was unwilling to discuss changing medication, but agreed to augment his treatment by adding Wellbutrin. The applicant still reported episodic insomnia that had a "large behavioral component," and he reported a lack of interest in therapy. The applicant's commander recommended he not be retained but acknowledged the case was extremely difficult to evaluate because he was a good performer and squadron asset "when he does not experience any of these medical issues; however, member has a history of needing recurring services at unpredictable times and therefore, creates an overall unreliable situation in his office." The commander stated, "If member could show a long-term success from treatment I would absolutely retain." Five days later, the applicant presented to the ER with suicidal ideation, and would spend the month of June in the PHP and return to the HIL for suicidal ideation until his removal in mid-Jul 17. At the DVA, the applicant reported he has angry verbal outbursts, road rage, and he throws and breaks things. He also had moderate to severe difficulty with concentration. He had vague fleeting thoughts of suicide with no intent or plan.

The applicant continued with treatment, and there were no additional visits to the ER or inpatient care or partial hospitalization treatment. However, treatment records fell silent after 4 Oct at which time the applicant was not on the HIL and his risk for suicide was noted as not currently at clinically significant risk. There were appointment cancellations in Oct 17, but no evidence of any MH treatment beyond Oct. The applicant remained on a physical profile that restricted his ability to deploy, bear weapons, and he was not clear to TDY or PCS. The restrictions were set to expire on 18 May 18.

This writer opines the evidence in the record demonstrates the applicant showed stability for many years prior to 2015; however, the frequent episodes of instability demonstrated by the presence of passive suicidal thinking, unpredictable behaviors, difficult moods, and challenges in overall daily emotional functioning, significantly outweighed the potential risk of negative consequences for continued military service, even though he was approximately 10 months from retirement. The evidence supports a medical retirement.

The complete advisory opinion is at Exhibit C.

APPLICANT'S REVIEW OF AIR FORCE EVALUATION

The Board sent a copy of the advisory opinion to the applicant on 22 Jun 22 for comment (Exhibit D) but has received no response.

AIR FORCE EVALUATION

AFPC/DP3SA recommends denying the applicant's request for length of service or early retirement. This office can only address the eligibility requirements for a length of service or early retirement. Based on review of the Master Personnel Record and the applicant's request, there is no error or injustice that occurred relating to length of service or early retirement eligibility. The applicant did not complete the required active service to qualify for retirement under 10 USC § 8914 and no authority existed in 2018 to allow an early retirement under the TERA. Had the TERA been offered, the applicant would not have been eligible to apply based on the Office of the Secretary of Defense (OSD) criteria.

Legal requirements for a length of service retirement are outlined in 10 USC § 9314, *Twenty to thirty years; regular enlisted members.* The applicable version, then 10 USC § 8914, states: Under regulations to be prescribed by the Secretary of the Air Force, an enlisted member of the Air Force who has at least 20, but less than 30, years of service computed under section 8925 of this title may, upon his request, be retired. Based on the legal requirements established in 10 USC § 8914, the applicant did not meet the parameters for a length of service retirement.

In the National Defense Authorization Act for Fiscal Year 1993 (FY93 NDAA), Public Law (PL) 102-484, 23 Oct 92, Congress enacted the TERA, which permitted selected military members to be offered early retirement. Section 534 of that law gave the Secretary of Defense authority to allow the Service Secretaries to permit early retirement for selected military members having more than 15 but less than 20 years of active service. PL 107-314, FY03 NDAA, Section 554, extended the TERA to 1 Sep 02 at which time that TERA authority expired.

Section 504, PL 112-81, FY12 NDAA reinstated temporary retirement authorities contained in section 4403, PL 102-484, of the FY93 NDAA, which authorized the Military Departments to retire active service military members up to 5 years before completion of 20 years of service. Section 508, PL 114-328, of the FY17 NDAA extended this authority until 31 Dec 25.

On 12 Apr 12, the OSD issued procedural guidance to the services regarding the use of the TERA. This guidance outlines the TERA as a management tool available to the Military Departments through 31 Dec 18. It further indicates the TERA is not an entitlement and the OSD guidance clearly states the TERA may not be offered to individuals under evaluation for disability retirement under Title 10, Chapter 61. The Service Secretaries are also directed to prescribe regulations and policies for eligibility for early retirement, and the OSD guidance indicates the TERA should be used to retire members who are excess to service short-term and long-term needs, i.e., in overage specialties.

When the Service Secretary offers the TERA to airmen in overage specialties, the program is announced in a Personnel Services Delivery Memorandum made available via the Air Force Personnel Center myPers website. The program is also publicized via messaging to the commanders and individual announcements to eligible airmen. A specific list is also created to identify those overage specialties eligible for early retirement. During 2018, no force management programs were in place to reduce end-strength or overage specialties, and no programs were made available by the Service Secretary to offer the TERA to any airmen.

The complete advisory opinion is at Exhibit F.

In an amended advisory, the AFRBA Psychological Advisor finds insufficient evidence to support the applicant's request for a change in his retirement via return to duty to meet the criteria for active duty retirement, or to be granted the additional time to complete the criteria for a full active duty retirement.

The previous advisory is amended for clarification, as follows:

This writer opines the evidence in the record demonstrates the applicant showed stability for many years prior to 2015; however, the frequent episodes of instability demonstrated by the presence of passive suicidal thinking, unpredictable behaviors, difficult moods, and challenges in overall daily emotional functioning, significantly outweighed the potential risk of negative consequences for continued military service, even though he was approximately 10 months from retirement. The evidence supports *the medical retirement granted by the Service and does not support the applicant's request for a change in the decision made by the military*.

The complete advisory opinion is at Exhibit G.

APPLICANT'S REVIEW OF AIR FORCE EVALUATION

The Board sent copies of the advisory opinions to the applicant on 23 Aug 22 for comment (Exhibit H) and the applicant's counsel replied on 4 Dec 23. In her response, counsel presents the applicant's request that the Board find the advisory opinion unpersuasive for the following reasons: (1) the advisory opinion provides little to no analysis and is silent on injustice; and (2) the applicant's medical retirement was the result of the Air Force's own errors.

Counsel references 10 USC § 1552 citing as the Board's single objective to correct Air Force records where there is either error or injustice. Further, counsel cites Department of Defense Instruction (DoDI) 1332.46, *Temporary Early Retirement Authority (TERA) for Service Members*, stating, "TERA provides…[t]he DoD with a force management tool that can be used for force shaping through calendar year 2025" and "TERA should be used to retire Service members who are excess to Service short-term and long-term need and who, absent the availability of TERA, would have been expected to pursue and qualify for a 20-year retirement." (emphasis added). The language is permissive and does not prohibit the use of TERA authority by the Board to grant relief in order to correct an error or injustice.

The advisory opinion cites the policy in effect at the time and states the applicant's discharge aligned with the policy. The advisory opinion shirks it responsibility to provide an opinion on the injustice which took place in this matter. The advisory claims it cannot opine on whether the applicant's medical retirement or evaluation by the MEB was appropriate; however, the appropriateness of these procedures is crucial to, and cannot be divorced from, the applicant's injustice argument. The applicant's requested relief is based upon the Air Force's improper and inequitable decision to medically retire him. The primary basis for his medical retirement was the

temporary mental health episode he experienced in 2017 as a direct result of his Air Force psychiatrist prescribing him Adderall. This prescription was wholly improper given the applicant's diagnoses, symptoms, and medical history.

The advisory opinion contends per OSD's 2012 guidance, "TERA may not be offered to individuals under evaluation for disability retirement under Title 10, Chapter 16[3]." However, the applicant's medical retirement was erroneous and caused by medications incorrectly prescribed by his Air Force psychiatrist. Prior to 2015, the applicant was functioning well, without antidepressants for nearly a decade. The symptoms of depression coincided with his transition into a new career and marital issues. He was prescribed both mirtazapine and lorazepam for these symptoms and his symptoms resolved from 2015 through spring/summer of 2016. The applicant's prescription for mirtazapine was eventually discontinued and he still experienced symptoms of insomnia, with symptoms of depression once again in the fall of 2016.

The applicant's Air Force psychiatrist initially diagnosed him with MDD and prescribed Lexapro, then downgraded the diagnosis to a milder form of depression and prescribed Adderall. As opined by the forensic psychiatrist hired by the applicant, the prescription of Adderall was unsupported by medical literature and had detrimental impacts on the applicant's mental health in the months following. It is unclear why Adderall was prescribed to a patient with no history of ADHD. Although Adderall has been used off-label to treat treatment-resistant depression, the applicant's medical record clearly demonstrated his depression was not treatment-resistant. The applicant had no issues with depression for nearly a decade and the symptoms that began in 2015 were successfully treated by antidepressants. It is further unclear why a stimulant was prescribed to a patient that was struggling with insomnia. Finally, it is puzzling why Adderall was prescribed to a patient with a documented diagnosis of alcohol abuse disorder. Per the forensic psychiatrist's review, "[t]he FDA lists prior substance use disorder as a contraindication for treatment, even in cases that are FDA approved." As a result of the side effects, the applicant sought treatment and expressed his concerns. The Air Force psychiatrist instructed the applicant to take the Adderall every other day and to stop completely after one week.

The forensic psychiatrist found this recommendation to be unsupported by any medical literature. Unfortunately, the applicant followed these instructions and began to experience withdrawal symptoms. This led to the applicant seeking treatment at the ER where he again raised concerns regarding the Adderall. Although his hospital notes do not indicate withdrawal, the applicant's symptoms were consistent with withdrawal. Once these symptoms subsided, his mental state began to return to normal. Unfortunately, he was referred to the MEB in May 17, during and just subsequent to the time he was experiencing withdrawal symptoms. Counsel reiterates earlier arguments regarding the findings of the MEB and the commander's recommendation.

The observation that long-term success may be unachievable was in contradiction to the applicant's achievements after he stopped taking Adderall and the withdrawal symptoms subsided. He was promoted to master sergeant in Aug 17 and earned two degrees in criminal justice and information technology in Oct 17. Further, the applicant's commander strongly recommended he be retained to allow for retirement, whether that be medically or until he reached 20 years. This indicates the applicant's medical condition was not severe enough to require immediate separation. Indeed, the applicant remained on active duty until Oct 18, over one year after the MEB's findings.

The advisory opinion provided only minimal discussion of retirement authorities. Yet, it did not discuss the injustice, the AFBCMR's ability to award constructive service, or whether the

[3] Typographical error, correct cite is Title 10, Chapter 61.

AFBCMR was prohibited from approving the TERA for a service member who should not have been medically retired. But for the erroneous medical retirement, the applicant was expected to pursue and qualify for a 20-year retirement. The Air Force psychiatrist's negligent prescription of Adderall derailed the applicant's military career and ability to remain in service until the completion of his 20 years.

The applicant's complete response is at Exhibit I.

FINDINGS AND CONCLUSION

1. The application was timely filed.

2. The applicant exhausted all available non-judicial relief before applying to the Board.

3. After reviewing all Exhibits, to include the applicant's rebuttal, the Board concludes the applicant is not the victim of an error or injustice. The Board concurs with the rationale of the AFRBA Psychological Advisor and the rationale and recommendation of AFPC/DP3SA and finds a preponderance of the evidence does not substantiate the applicant's contentions.

The applicant's recorded history of alcohol abuse and depression began in 2006. While the applicant has since exhibited extended periods of stability, the Board agrees his frequent episodes of instability demonstrated by the presence of passive suicidal thinking, unpredictable behaviors, difficult moods, and challenges in overall daily emotional functioning, are incompatible with the requirements of continued military service. Considering the nature of the applicant's mental health condition and the findings of the multiple providers who treated the applicant via in-patient, individual, and group counseling, the applicant's condition was permanent and stable for the purposes of the FPEB; therefore, placement on the PDRL was appropriate. The applicant was afforded due process during the DES process and at no time during these proceedings did the applicant request retention via LAS in accordance with AFI 36-3212, *Physical Evaluations for Retention, Retirement and Separation*. Given the aforementioned facts, there is no justification to award the applicant unearned service credit or to reinstate him to active duty service.

Due to the multiple medications prescribed, the applicant's abuse of alcohol and over-the-counter Nyquil, compounded by personal and professional stressors, occurring concurrently, the Board is not persuaded it is possible to specifically single out the prescribed Adderall as the cause for the applicant's increased depressive episodes and deteriorating mental health.

Additionally, further complicating this issue, the applicant has communicated under-reporting his symptoms for fear of impact to his military career, binge drinking, not complying with sleep hygiene recommendations, and increasing dosages and/or completely stopping his prescribed medications without medical consultation. Further, according to treatment notes, the applicant's marital problems and subsequent divorce played a significant role in his increased anxiety and depression symptoms. To state his mental health condition was caused by any one circumstance would be purely speculative.

Regarding the applicant's request for retirement via the TERA, this program was not offered by the Air Force in 2018, and if it had been, the applicant was still not eligible to participate according to OSD guidance, as he was approved for disability retirement under Title 10, Chapter 61. Further, when offered, the TERA is used to retire members excess to the service's needs. As counsel noted in their contentions, qualified cyber security personnel, such as the applicant, would likely not fall into this category. Therefore, the Board recommends against correcting the applicant's records.

4. The applicant has not shown a personal appearance, with or without counsel, would materially add to the Board's understanding of the issues involved.

RECOMMENDATION

The Board recommends informing the applicant the evidence did not demonstrate material error or injustice, and the Board will reconsider the application only upon receipt of relevant evidence not already presented.

CERTIFICATION

The following quorum of the Board, as defined in Department of the Air Force Instruction (DAFI) 36-2603, *Air Force Board for Correction of Military Records (AFBCMR)*, paragraph 2.1, considered Docket Number BC-2021-03558 in Executive Session on 24 Sep 24:

[redacted] Panel Chair
Work-Product, Panel Member
Work-Product Panel Member

All members voted against correcting the record. The panel considered the following:

Exhibit A: Application, DD Form 149, w/atchs, dated 26 Oct 21.
Exhibit B: Documentary evidence, including relevant excerpts from official records.
Exhibit C: Advisory Opinion, AFRBA Psychological Advisor, dated 10 May 22.
Exhibit D: Notification of Advisory, SAF/MRBC to Counsel, dated 22 Jun 22.
Exhibit E: Letter, SAF/MRBC, w/atchs (Liberal Consideration Guidance), dated 8 Aug 22.
Exhibit F: Advisory Opinion, AFPC/DP3SA, dated 10 Aug 22.
Exhibit G: Amended Advisory Opinion, AFRBA Psychological Advisor, dated 10 May 22.
Exhibit H: Notification of Advisory, SAF/MRBC to Counsel, dated 23 Aug 22.
Exhibit I: Counsel's Response, w/atch, dated 4 Dec 23.
Exhibit J: Letter, SAF/MRBC, w/atchs (Liberal Consideration Supplemental Guidance), dated 29 May 24.

Taken together with all Exhibits, this document constitutes the true and complete Record of Proceedings, as required by DAFI 36-2603, paragraph 4.12.9.

11/1/2024

Work-Product