RECORD OF PROCEEDINGS

IN THE MATTER OF: **DOCKET NUMBER:** BC-2023-01112

COUNSEL: NONE

HEARING REQUESTED: YES

APPLICANT'S REQUEST

His entry level separation with an uncharacterized character of service and reentry code 2C[1] be changed to allow him to reenter the United States Air Force (USAF).

APPLICANT'S CONTENTIONS

He has successfully graduated basic military training, completed every task the USAF has put before him, and has proven a number of times his mental health concerns are not valid. A licensed mental health provider has indicated he has no mental health concerns and contradicts the Air Force Discharge Review Board's (AFDRB) medical provider's conclusion indicating he has an unresolved medical issue preventing him from reentering the military. All he wants to do is serve in the USAF. In his initial medical waiver request the mental health provider stated, "This individual may reapply to return to USAF training or duties at some future time after treatment and resolution of the condition (if desired)." Recently he was evaluated by a credentialed mental health provider who stated he does not have any of the conditions the waiver authority used to deny his medical waiver by indicating, "based on client's report, observations during the appointment, and collateral information from the client 's father, the client does not meet criteria for any mental health disorders."

While in Basic Military Training (BMT) he was identified as having mental health issues through a medical record screen. On 9 Sep 21, he was screened by a military mental health provider who stated he was seen in the emergency room (ER) due to "emotional upset in 2019." During this time, he was dealing with the death of a fellow military dependent, by apparent suicide, that he had known since he was in kindergarten. The provider also noted he was dealing with the breakup of a relationship at that same time. During this screening, the mental health provider did not have all his medical documentation and only had the diagnosis in his medical records. His family managed to obtain the documentation from 2019. Upon the provider's review she noted it appeared the applicant had a suicide attempt by overdose and came to this conclusion based on the heading of the forms the hospital uses to document what they believe are mental health cases. Unfortunately, at that time his family, nor he noticed that detail. The military mental health provider then diagnosed him with personal history of a mental or other behavioral disorder based on the documentation. However, the diagnosis cannot be accurate as the provider stated in her own words there was no indication medical documentation supported these diagnoses.

The actual reason he was in the ER in 2019 was because he needed to talk to someone. He did not know the doctor diagnosed him with acute stress reaction and major depressive disorder. Based on the review of the medical documentation and diagnostic criteria for those two conditions he does not feel he meets either of these diagnoses. Two hours after BMT graduation he found out he was to be separated. He met with the mental health provider, and she noted several diagnoses in his medical records came from his 2019 ER visit and some were diagnosed in 2015. Neither he nor his family recalled a visit in 2015 where he might have been diagnosed with a mental health

[1] Involuntarily separated with an honorable discharge, or entry level separation without characterization of service.

disorder. His family obtained medical records from the local hospital and discovered he had been given a mental health diagnosis after a 2015 ER encounter. It also noted the medical documentation had the heading of suicide attempt by overdose which was again incorrect. His family obtained a letter from the hospital that stated the documentation was a generic template used for all visits for what they consider mental health in nature and not that it directly identifies what the patient is being seen for in the ER. There is no indication the military mental health provider ever saw this documentation or that it was ever given any weight in the decision. His request for a waiver was denied.

In 2015 he was seen in the ER as a 15-year-old after failing to make the baseball team. He had just moved to a new town and hoped by making the baseball team he would also make friends. After finding out he did not make the team, he made a comment to a fellow friend (also 15 years old) to the effect of, "I'm done with all that. I found out I didn't make the baseball team. The saying hard work pays off is not true for me." The friend then contacted the local Police Department, and they went to his house. He and his parents told the police he was not suicidal and just upset, but he still needed to be cleared by the local hospital. This was an overreaction by a 15-year-old, and he was never, nor have has he ever been suicidal. During this ER encounter he was screened by a social worker from the local mental health clinic. He did not know at the time she was a mental health professional. The ER doctor diagnosed him with suicidal ideation and acute stress reaction. The mental health professional did not diagnose him with the same conditions so therefore he should not be held to a mental health diagnosis from a non-mental health provider.

When he joined the USAF in 2021, he did not recall at the time the ER encounters. He never had any counseling, therapy, medication management or hospitalization. He was told by the recruiter to identify any medical issues that he had since the age of 15 which meant anything before the age of 15, he did not have to identify, including his asthma diagnosis and a broken arm. He marked no to everything except for wearing glasses on his enlistment paperwork as he truly believed this to be the case.

In support of his request the applicant provided copies of an adult diagnostic assessment, dated 6 Mar 23, entry level separation medical waiver decision, dated 21 Sep 21, and a mental health waiver request for military service, dated 17 Sep 21.

The applicant's complete submission is at Exhibit A.

STATEMENT OF FACTS

The applicant is a former Air Force airman basic (E-1).

On 3 Aug 21, according to DD Form 4, *Enlistment/Reenlistment – Document Armed Forces of the United States*, the applicant enlisted in the Regular Air Force.

On 17 Sep 21, the applicant was seen at the mental health clinic for a follow-up visit and to submit a mental health waiver request for continued military service. The provider deferred to the waiver authority due to conflicting information. The applicant denied history of mental health conditions and suicidal ideation, and records obtained and submitted with the waiver suggested a suicide attempt by overdose. .

On 21 Sep 21, the waiver authority did not grant a medical waiver for accession and determined the applicant's condition did not meet medical waiver criteria for entry. The waiver authority also indicated it was very likely the applicant's condition existed prior to service (EPTS) and it was noted the applicant did not disclose his medical history or condition at the Military Entry Processing Station (MEPS).

On 20 Oct 21, the applicant's commander recommended the applicant be discharged from the Air Force, under the provisions of AFPD 36-32, *Military Retirements and Separations, Concerning Voluntary and Involuntary Separations*, and AFI 36-3208, *Administrative Separation of Airmen, for Fraudulent Enlistment* for either fraudulent enlistment or erroneous enlistment. The specific reasons for the action were based on a mental health evaluation summary on 21 Sep 21 finding the applicant did not meet minimum medical standards to enlist and he should not have been allowed to join the Air Force because he had a pre-service history of mental or behavioral disorder. Furthermore, he failed to document this on his paperwork and the medical staff found him unqualified for military service, rendering him ineligible for a disability separation.

On 1 Nov 21, the applicant provided a rebuttal to the discharge action denying the reasons for separation based on misdiagnosis and inaccurate medical documentation and requested he be retained in the Air Force, and if not allowed to return to duty, he be separated with an entry level separation based on erroneous enlistment.

On 24 Nov 21, the Chief, Administrative Discharges (Judge Advocate) found the discharge action legally sufficient.

On 12 Jan 22, the discharge authority directed the applicant be discharged with an entry level separation for fraudulent enlistment.

On 12 Jan 22, the applicant received an entry level separation with an uncharacterized character of service. His narrative reason for separation is "Fraudulent Entry" and reentry code is 2C.

On 10 May 22, the applicant submitted a request to the Air Force Discharge Review Board (AFDRB) for an upgrade of his discharge characterization, a change to the discharge narrative reason, and a change to the reenlistment eligibility code.

On 30 Sep 22, the AFDRB concluded the applicant's medical records show he has an unresolved medical issue that prevent him from reentering the military and found no basis of an inequity or impropriety to upgrade his discharge. The AFDRB found liberal consideration was not appropriate to be applied to his request because the condition or event that caused his condition had occurred prior to service, his condition did not occur during service, and there was no evidence of service aggravation.

For more information, see the excerpt of the applicant's record at Exhibit B and the advisory at Exhibit C.

APPLICABLE AUTHORITY/GUIDANCE

DoDI 1336.01, *Certificate of Release or Discharge from Active Duty (DD Form 214/5 Series)*. The Department of Defense (DoD) authorizes six characterizations of service for military service members to receive on discharge: (1) Honorable; (2) Under Honorable Conditions (General); (3) Under Other than Honorable Conditions; (4) Bad Conduct; (5) Dishonorable, and (6) Uncharacterized.

DODI 1332.14, *Enlisted Administrative Separations*. A separation will be described as an entry-level separation if separation processing is initiated while an enlisted service member is in entry level status (180 days continuous active duty) except when: (1) Characterization under other than honorable is authorized under the reason for separation and is warranted by the circumstances or (2) The Secretary concerned on a case by case basis determined the characterization of service as honorable is warranted. The characterization is authorized due to reason of selected changes in

service obligation, convenience of the government, disability, secretarial plenary authority or an approved reason established by the Military Department.

Entry level separations, which are accompanied by an uncharacterized discharge, are given to individuals who separate prior to completing 180 days of military service or when discharge action was initiated prior to 180 days of service. This type of discharge does not attempt to characterize service as good or bad. Rather, an uncharacterized discharge is the absence of a characterization of service, as the individual being discharged does not have sufficient time in service in order to fairly characterize the individual's service.

On 3 Sep 14, the Secretary of Defense issued a memorandum providing guidance to the Military Department Boards for Correction of Military/Naval Records as they carefully consider each petition regarding discharge upgrade requests by veterans claiming PTSD. In addition, time limits to reconsider decisions will be liberally waived for applications covered by this guidance.

On 25 Aug 17, the Under Secretary of Defense for Personnel and Readiness (USD P&R) issued clarifying guidance to Discharge Review Boards and Boards for Correction of Military/Naval Records considering requests by veterans for modification of their discharges due in whole or in part to mental health conditions [PTSD, Traumatic Brain Injury (TBI), sexual assault, or sexual harassment]. Liberal consideration will be given to veterans petitioning for discharge relief when the application for relief is based in whole or in part on the aforementioned conditions. Liberal consideration is not required for cases involving pre-existing conditions which are determined to have been aggravated by military service.

Under Consideration of Mitigating Factors, it is noted that PTSD is not a likely cause of premeditated misconduct. Correction Boards will exercise caution in weighing evidence of mitigation in all cases of misconduct by carefully considering the likely causal relationship of symptoms to the misconduct. Liberal consideration does not mandate an upgrade. Relief may be appropriate, however, for minor misconduct commonly associated with the aforementioned mental health conditions and some significant misconduct sufficiently justified or outweighed by the facts and circumstances.

Boards are directed to consider the following main questions when assessing requests due to mental health conditions including PTSD, TBI, sexual assault, or sexual harassment:

a. Did the veteran have a condition or experience that may excuse or mitigate the discharge?
b. Did that condition exist/experience occur during military service?
c. Does that condition or experience actually excuse or mitigate the discharge?
d. Does that condition or experience outweigh the discharge?

On 25 Jul 18, the Under Secretary of Defense issued supplemental guidance to military corrections boards in determining whether relief is warranted based on equity, injustice, or clemency. These standards authorize the board to grant relief in order to ensure fundamental fairness. Clemency refers to relief specifically granted from a criminal sentence and is a part of the broad authority Boards have to ensure fundamental fairness. This guidance applies to more than clemency from sentencing in a court-martial; it also applies to any other corrections, including changes in a discharge, which may be warranted on equity or relief from injustice grounds. This guidance does not mandate relief, but rather provides standards and principles to guide Boards in application of their equitable relief authority. Each case will be assessed on its own merits. The relative weight of each principle and whether the principle supports relief in a particular case, are within the sound discretion of each Board. In determining whether to grant relief on the basis of equity, an injustice, or clemency grounds, the Board should refer to the supplemental guidance, paragraphs 6 and 7.

On 17 Aug 23, the Board staff provided the applicant a copy of the liberal consideration guidance (Exhibit F).

AIR FORCE EVALUATION

The AFRBA Psychological Advisor completed a review of all available records and concurs with the AFDRB's decision and rationale and finds insufficient evidence to support the applicant's request for the desired changes to his record. The applicant had repeatedly denied he had any suicidal thoughts during his two ER visits in the past but yet, at least four different providers/medical professionals, two ER physicians, an ER nurse, and a licensed clinical marriage and family therapist (LCMFT), at different points in time had documented he had expressed albeit vague suicidal ideation or gestures. Both of his ER records devoted considerable attention to assess and address his suicidal and safety risk. It is acknowledged both of his ER physicians' notes were vague and did not provide any clarifying information about his suicidal ideation or depression; however, his reported symptoms of suicidal ideation were consistently identified by each ER physician and their observations were consistent to the reports of the LCMFT and nurse during each respective visit. The military mental health provider recognized discrepancies in these records but found the majority of the records indicated suicidal ideation as the presenting illness for his ER visits. The LCMFT's notes from his first ER visit in 2016 provided detailed information about his suicidal ideation/gesture and stressors. There is no justifiable reason to doubt the validity of this provider's report and opinion especially since this provider was a licensed and duly qualified mental health professional performing duties within the parameters of the provider's duties, knowledge, expertise, training, experience, and credentials. The military mental health provider also noted discrepancies in the applicant's explanation and so his reports were not observed to be credible. The psychological advisor concurs the applicant's reporting had also been inconsistent particularly pertaining to his reports of suicidal ideation or gesture. There were also times he reported his second ER visit was caused by the stress of his friend's death by suspected suicide causing problems in his personal relationship but on the BAS Intake Survey and during his second ER visit, he omitted his friend's death as a stressor.

The applicant had repeatedly disputed the accuracy of his records, but he did not submit any substantive evidence to support his claim. He submitted an assessment performed in Feb 23 by a licensed master social worker (LMSW) and this provider found he did not meet criteria for any mental health disorder. This opinion was applicable and valid at the time that evaluation had taken place, which was in Feb 23. The LMSW could not confirm the applicant did not have any mental disorders at the time of his two ER visits occurring several years prior to that evaluation because she did not assess him at those times in the past. The LMSW did not speak to or obtained any collateral information directly from any of the providers at the ER in 2016 or 2019 and the assessment results was based on the applicant's subjective self-report, his father's reports, and the records he submitted for review. Again, the LMSW's assessment was relevant to the applicant's functioning at the time of the more current evaluation in 2023 and not of the past as it would be impossible to retroactively assess someone's functioning from the prior years. The ER physicians were qualified to make such assessments in an acute setting like the ER and are entitled to form their clinical judgments of the applicant as they deemed appropriate based on their education, experience, training, and credentials.

The applicant disputed diagnoses given to him at the ER. Based on review of the available ER records, the clinical impressions that were circled or endorsed by both ER physicians from each visit was "acute stress reaction". This is not a disorder. If he had a disorder, he would have been given a diagnosis of Acute Stress Disorder. Acute stress reaction is a short-term response to a traumatic event. The psychological advisor concurs with the applicant's explanation in his statement at the time of service that he did not experience or was exposed to actual or threatened death, serious injury, or sexual violation as outlined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) for Acute Stress Disorder, but it appeared the context of his reported

acute stress reaction was in response to his psychosocial stressors. His stressors and symptoms were considered acute and serious enough to him that he needed to seek crisis intervention or emergency care. His acute stress reaction produced symptoms of depression and caused distress and impairment to his functioning (safety concerns) that were similar to symptoms of Acute Stress Disorder. There is no evidence he was given a diagnosis or met diagnostic criteria for Acute Stress Disorder but was identified to have symptoms or condition of acute stress reaction. The applicant reported he was given a diagnosis of Major Depressive Disorder. His ER notes do not reflect this diagnosis. Under the "Clinical Impression" section during his ER visit in 2019, his ER physician circled "Depression" and "mild". There was nowhere in this record a diagnosis of Major Depressive Disorder was recorded. The impression formulated was that he had mild form/severity of depression. There are several variations of a depressive disorder which may include Major Depressive Disorder, but his ER records did not specify a specific depressive disorder. It is possible he may have met diagnostic criteria for another depressive disorder, but no information was available to confirm this potential diagnosis. Despite the vague or lack of a clear depressive disorder diagnosis, he did report to his ER physician and the triage nurse having depression caused by the demise of his long-term relationship that led him to seek emergency care. The applicant reported he was given a diagnosis of suicidal ideation and this report is erroneous. Suicidal ideation is not a diagnosis. His ER physician from 2016 designated/circled "Suicidal ideation" under the category of "SIGNS / SYMPTOMS" and this is because suicidal ideation is a symptom of a mental disorder (suicidal ideation is a symptom of various mental disorders). His ER physician's note acknowledged he had suicidal ideation, and this endorsement was supported by the evaluation from the LCMFT on the same visit based on his own reporting. Lastly, the applicant was given a diagnosis of Adjustment Disorder, Unspecified by the LCMFT in 2016 in response to his difficulties adjusting to recently moving from California to Kansas and was informed he did not make the baseball team causing him to experience emotional distress. The applicant conceded this was an appropriate diagnosis in his response to his discharge notification during service and this psychological advisor also finds this diagnosis was valid and appropriate to his situational stressor and clinical presentation at the time of evaluation.

The applicant claimed he was briefly seen each time in the ER and his providers could not make an appropriate clinical impression of his functioning or condition. His providers, physician, nurse, and LCMFT, during each ER visit had independently and consistently reported similar symptoms and assessment of his functioning at the time, which made it highly unlikely their assessments were inappropriate or erroneous. Furthermore, it does not matter how long an evaluation may take to form a clinical impression, but it is about the adequate information that was gathered during the time spent with the individual that matters. Some evaluations may take longer or shorter than others and some clinical presentations or symptoms are not as complicated to assess. The situation may vary among different individuals and in the applicant's situation, as it appeared from his ER records, he was cooperative and engaged in his evaluations and so the time spent on each evaluation did not need to be prolonged. There was enough information gathered to form an informed clinical impression, risk assessment, and disposition. It is reminded that he was evaluated in the ER and due to the fast-paced nature of the ER environment and its purpose, evaluations tend to be quick and follow-up care is typically established to address the presenting problems in more depth or for the longer term if necessary.

He did not seek or receive a formal mental health evaluation around the time of any of his ER visits to rule out any mental disorders causing his ER visits, to determine his mood was stable, and to demonstrate he no longer had safety concerns to himself. His maladaptive behavioral patterns of being unable to cope with stressful situations causing decompensation of his mood and requiring a higher level of care made him disqualified for military service. Military service is highly stressful and so his past demonstrated behaviors of not being able to cope with stressful situations without any mitigation of the concern made him incompatible with service.

The applicant claimed he did not know his visits were mental health related and this notion is difficult to fathom. The reasons he went to the ER both times were because he was stressed, had difficulties adjusting to his new environment, was experiencing depressed mood, and/or had suicidal thoughts/gestures. All of these concerns were mental health related. He did not go to the ER for any physical issues complaints or any other reasons other than for his mental health concerns and was even seen by a mental health professional during one of the visits. It was clear and apparent these visits were mental health related. While the applicant has his own definition of what counseling is, there are other definitions of counseling. Counseling may consist of a series of visits or encounters, but counseling could be a one-time or short-term event. He discussed speaking with the ER physician during his second visit and felt better afterwards and informed the military mental health provider "his difficulties continued to resolve after talking w/ the hospital provider". This is a form of counseling. In addition to counseling, his MEPS paperwork for question #139 asks: *Been evaluated or treated, either with medication or counseling, for a mental condition, depression or excessive worry*. He endorsed "No" to this question because he did not believe he was evaluated at the ER. His ER records disputes his contention and belief. To reiterate, the applicant was evaluated by two ER physicians and an LCMFT and was assessed for suicide risk by an ER nurse for his suicidal ideation/gesture and depression. His evaluation especially with the LCMFT yielded a valid and appropriate diagnosis of Adjustment Disorder, Unspecified, a safety plan was developed, and aftercare/follow-up treatment was planned. The method and process employed by the LCMFT is the very definition of an evaluation in spite of the amount spent with him. He was evaluated and diagnosed with a mental health condition in the ER and so his answer on the MEPS paperwork for question #139 was not accurate.

The applicant contends he was not evaluated to determine his fitness for duty by the military mental health provider and all she did was review paperwork and did not give any weight to the person in front of her. The purpose of the encounters was to assess his prior service potentially disqualifying mental health condition to determine if he could remain in the military and to assist with submitting a waiver because this was an issue that was flagged by Flight Medicine. However, the provider did assess him for his mental health condition and reported on the waiver application, "*PSYCHOLOGICAL TESTING PERFORMED: Symptom screening completed at intake which did not indicate significant mental/behavioral health symptomology in the present appointment*." His past suicidal ideation/gesture behaviors were one of the main concerns that was further made complex by his inconsistent and non-reporting noted in the application. He also did not satisfactorily demonstrate his past maladaptive behaviors and safety concerns had been mitigated or resolved. His waiver was denied according to the Chief of Accession Medical Waiver Division because he very likely had a mental health condition that was EPTS, which was verified by his ER records particularly from the evaluation from the LCMFT in 2016, he did not disclose his mental health history or condition and the condition was not listed on his MEPS which was confirmed by his MEPS paperwork dated 21 Apr 21, and he did not meet medical waiver for entry to the USAF per applicable DoD and AF instructions. His waiver denial for these reasons were the basis of his ELS discharge. Based on these reasons which were corroborated by his objective records, there is no error or injustice identified with his ELS discharge.

Finally, the AFDRB discussed liberal consideration is not appropriate to be applied to the applicant's petition because his mental health condition did not occur during service and no evidence his prior service mental health condition was aggravated by his military service (Kurta memorandum #15). The psychological advisor concurs liberal consideration is [not] appropriate to be applied to the applicant's petition for these reasons.

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 20 Jun 23 for comment (Exhibit D), and the applicant replied on 17 Jul 23. In his response, the applicant reiterates his contentions, disagrees with the psychological advisor's opinion, and argues he is fit for duty and qualified to be an airman. He has obtained a copy of the police narrative from the encounter when he was 15 years old, and it proves he was not suicidal at any time, and he denied being suicidal from the beginning. In further support of his request, the applicant provided additional evidence to include 1) Narrative report from the police department, dated 1 Mar 16, and 2) email from the Defense Health Agency Senior Enlisted Leader, dated 30 May 23.

The applicant's complete response is at Exhibit E.

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 response to the advisory opinion, the Board concludes the applicant is not the victim of an error or injustice. It appears the discharge was consistent with the substantive requirements of the discharge regulation and was within the commander's discretion. Specifically, the applicant's ELS with an uncharacterized character of service was appropriately determined in accordance with DoD policy since the applicant did not complete the required amount of time to be issued a character of service. Based on a totality of the evidence, the applicant's failure to disclose his prior service ER visits for his mental health condition, his narrative reason for separation of "fraudulent entry" is warranted. Furthermore, the Board finds the evidence submitted by the applicant, including the assessment conducted by a LMSW, not persuasive to change his RE code to allow reentry into the Air Force. While the Board considered the applicant's request under liberal consideration due to his documented mental health condition, the Board finds liberal consideration is not applicable based on the applicant's mental health condition did not occur during service and there is no evidence his prior service mental health condition was aggravated by his military service. 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-2023-01112 in Executive Session on 31 Aug 23:

Panel Chair
Panel Member
Panel Member

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

Exhibit A: Application, DD Form 149, w/atchs, dated 3 Apr 23.
Exhibit B: Documentary evidence, including relevant excerpts from official records.
Exhibit C: Advisory Opinion, AFRBA Psychological Advisory, dated 15 Jun 23.
Exhibit D: Notification of Advisory, SAF/MRBC to Applicant, dated 20 Jun 23.
Exhibit E: Applicant's Response, w/atchs, dated 17 Jul 23.
Exhibit F: Letter, SAF/MRBC, w/atchs (Consolidated Clarifying Guidance), dated 17 Aug 23.

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.

X

Board Operations Manager, AFBCMR