Report of the Expert Behavioral Analysis Panel

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Report of the Expert Behavioral Analysis Panel*

*Report contains mental health information the Panel was authorized to review pursuant to Court Order.

Amerithrax Case:

Expert Behavioral Analysis Panel

August 23, 2010

The Honorable Chief Judge Royce C. Lamberth
United States District Court for the District of Columbia
333 Constitution Ave N.W.
Washington, DC 20001

Dear Chief Judge Lamberth:

Pursuant to your Federal Court Order, the Amerithrax Expert Behavioral Analysis Panel is now submitting its Final Report. Panel Members remain cognizant that materials related to this report remain sealed at this time and therefore we have maintained strict confidentiality regarding their contents. This Report is submitted without dissent and represents a consensus of the views of all Panel Members.

We would like to acknowledge the tremendous guidance that we have received from leaders who have been responsible for serving on recent major independent panels and commissions. Former Secretary of the Army John O. Marsh, Jr., former U.S. Attorney General Edwin Meese III, and former U.S. Senator Charles S. Robb have all provided us with the benefits of their past experiences. Their guidance in assisting the Panel with their own "lessons learned" has been of inestimable value. As a consequence, the Panel remains in their debt.

Throughout this process, the Panel has also been fully aware of the tragic consequences of these attacks on victims and their families. As a tribute to them and with humility, we have consciously attempted to focus on recommendations we believe to be most important, and whose implementation can make the greatest difference toward preventing a similar attack in the future.

Respectfully yours,

Gregory Saathoff MD
Executive Director
Critical Incident Analysis Group
University of Virginia School of Medicine

Gerald DeFrancisco
President
Humanitarian Services
American National Red Cross

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II. Executive Summary

In September and October 2001, a series of letters containing *Bacillus anthracis* was mailed to targets in the media and Congress. As a result, 22 individuals became infected and five died.

Over the next eight years, the United States Department of Justice (DOJ) conducted one of the most complex, far-ranging and expensive investigations in the history of law enforcement. This investigation, code-named Amerithrax, eventually identified the mailer as Dr. Bruce Ivins, a microbiologist at the United States Army Medical Research Institute of Infectious Diseases (USAMRIID).

In July 2009, Chief Judge Royce C. Lamberth of the U.S. District Court for the District of Columbia authorized a report from the Expert Behavioral Analysis Panel. Chief Judge Lamberth authorized the Panel to examine "the mental health issues of Dr. Bruce Ivins and what lessons can be learned from that analysis that may be useful in preventing future bioterrorism attacks." The Panel was granted access to the Amerithrax investigative materials as well as the sealed psychiatric records of Dr. Ivins. The Panel was asked to provide insights into how the country can be better defended from such attacks and to provide a better understanding of Dr. Ivins himself. In particular, the Panel was asked to offer, based on the available materials, a better understanding of Dr. Ivins' mental state before and after the anthrax mailings, his possible motives — and the connections, if any, between his mental state and the commission of the crimes. The Panel was aware that it was not being asked to be the final arbiter of whether or not Dr. Ivins was responsible for the attacks, or to conduct a peer review of the doctors and therapists who provided care to Dr. Ivins over the years.

The Panel thus undertook its work with no predispositions regarding Dr. Ivins' guilt or innocence and in fact without even a focus on that issue. The Panel's review of the sealed psychiatric records, however, does support the Department of Justice's (DOJ's) determination that he was responsible. Dr. Ivins was psychologically disposed to

undertake the mailings; his behavioral history demonstrated his potential for carrying them out; and he had the motivation and the means. The psychiatric records offer considerable additional circumstantial evidence in support of the DOJ's finding.

MEANS AND OPPORTUNITY

Dr. Ivins acknowledged that he was the sole custodian of the "RMR-1029" flask that held the anthrax used in the attacks, and had unrestricted and unobserved access to the "hot suites" where work with anthrax could be conducted anytime day or night. From his own laboratory writings we know that the quality and spore concentration of the anthrax he produced matched that contained in the letters. In addition, he had the equipment necessary to produce the non-weaponized[1] dried spores found in the letters. Some of his colleagues have contended that USAMRIID, where he worked, lacked the sophisticated equipment capable of producing the dried spores within the short time period in which the evidence suggests they were produced; but he, notably, never made that case. In fact, he named many of his colleagues, including his two technicians, as possible anthrax mailers.

Dr. Ivins also had the opportunity to commit the crime. His extensive, unexplained weekend and nighttime hours in the hot suite coincided with the period prior to the mailing of the anthrax letters in September and October. These odd hours enabled him to evade whatever supervisory oversight and observation by colleagues might have occurred. His secretive behavior in the hot suite mirrored his long-established habit of making secret, night-time drives to faraway locations — many much more distant than Princeton University, the location from which the letters were mailed. Dr. Ivins could not account for his activities during the windows of time when the letters were mailed. A man like him, who had committed repeated acts of breaking and entering as well as burglary without having been caught,

would have little difficulty mailing the letters late at night or early in the morning without being seen.[2]

A TRAUMATIC, DAMAGING CHILDHOOD

To most of his colleagues and acquaintances, Dr. Ivins was an eccentric, socially awkward, harmless figure, an esteemed bacteriologist who juggled at parties, played the keyboard at church and wrote clever poems for departing colleagues. That is precisely how Dr. Ivins wanted them to see him. He cultivated a persona of benign eccentricity that masked his obsessions and criminal thoughts. That self, which he described in detail to his therapists, [redacted] Other evidence shows that Dr. Ivins was also exploitive and manipulative — clever in enlisting others in his schemes without their knowing, willing cooperation.

But Dr. Ivins, a meticulous scientist, was also very careful about the ways in which he shared information about himself. Only his doctors and therapists heard about [redacted] and, with one known exception, his criminal break-ins. And even with these mental health professionals, he could be skilled in his deceit. In his self-disclosures to his employer, too, he was canny — acknowledging some mental health issues but omitting and distorting others, in a manner that enabled him to evade real scrutiny. A lack of communication, in general, between the mental health professionals Dr. Ivins saw over the years and between them and his employer also played a role in his successful compartmentalization of his behavior.

Dr. Ivins thus managed to keep his obsessions and [redacted] thoughts, key aspects of his true self, hidden from public view for most of his life.

In the Panel's view, the previously sealed records afford significant insight into how that real self was formed. The record indicates that

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Dr. Ivins experienced a strange and traumatic childhood. Although his early experiences certainly do not exonerate him in any way, they do help explain the kind of character and worldview he developed. (Please see Case Narrative and Behavioral Analysis sections for a more thorough discussion of this subject.)

Dr. Ivins grew up in a family in which, there is ample evidence, his mother assaulted and abused her husband — stabbing him, beating him, and threatening to kill him with a loaded gun. It also appears that she physically abused Dr. Ivins as a boy, and that his father mocked him publicly as well. For these and other reasons, Dr. Ivins grew up with the deeply felt sense that he had not been wanted by his parents. This was later confirmed by a family member who described Dr. Ivins' mother's attempt to injure herself to end the pregnancy and his parents stated preference for a girl rather than another son.

[redacted]

Throughout almost his whole life, Dr. Ivins avoided confrontation. Instead, he learned to compartmentalize and conceal his behavior. As early as college, he was interested in "clandestine-type things," a classmate recalled. And as Dr. Ivins himself later reported, [redacted] Yet at the same time, he performed well enough academically to gain admission to graduate school.

II. Executive Summary

A LIFELONG OBSESSION

While an undergraduate at the University of Cincinnati, Dr. Ivins was turned down for a date by a student (referred to in this document as KKG Sister #1) who was a member of the Kappa Kappa Gamma (KKG) sorority. Although this woman has no memory of the incident or Dr. Ivins, the rebuff to his fragile self image appears to have triggered a lifelong obsession. It primed him to be hypersensitive to any future rebuffs from the same source — KKG.

As events unfolded, Dr. Ivins moved several years later to the University of North Carolina to do post-doctoral research, and met there a graduate student who had been a member of KKG, a woman referred to in this document as KKG Sister #2. Strongly drawn to her, he later told his psychiatrist that [redacted] too much or too quickly — or both — for her comfort, prompting her to withdraw.

In that rebuff, Dr. Ivins [redacted] as he told a psychiatrist years later. [redacted]

Dr. Ivins engaged in a series of criminal acts against KKG Sister #2, including stealing her irreplaceable research notebooks and breaking her car window. He also broke into and trespassed onto a number of KKG sorority houses and offices, and stole various documents.

As the Narrative section of this report describes in greater detail, Dr. Ivins' obsession with the sorority and with KKG Sister #2 continued for three decades — it was still driving his behavior shortly before he died. It was characteristic of him that he declared in an Internet posting in 2007 that the sorority had declared a "fatwa" against him. Dr. Ivins routinely depicted himself as a victim — not only of KKG, not

only of his parents, but also of colleagues, Congress, the media, the FBI, USAMRIID Security and the Frederick Police Department. He often succeeded in persuading others that this view was accurate. In reality, however, he was more often than not the victimizer.

Dr. Ivins' attachment to KKG Sister #2 was so intense that shortly after leaving the University of North Carolina in 1978 [redacted]

As already noted, Dr. Ivins was often candid, albeit sometimes selectively so, with his psychiatrists and therapists. To his psychiatrist in 1978, [redacted] The impression he left in his one year of meeting with this psychiatrist was so powerful that when she first heard about the anthrax mailings in 2001, she immediately "worried" that he might be the perpetrator.

WORK AT USAMRIID

Dr. Ivins joined USAMRIID in December 1980, and became one of the institute's top authorities on the anthrax vaccine, which was mandated for U.S. Armed Forces. His job entailed producing large batches of *Bacillus anthracis* that were tested on vaccinated laboratory animals, to see whether the vaccination would protect them. He was an expert in the bacteria's growth, purification, and spore-producing process.

In the early 1980s, KKG Sister #2 unknowingly moved into Dr. Ivins' neighborhood in Gaithersburg, Md. He quickly discovered her presence. Among various other acts of harassment, he wrote and signed her name to a letter to the editor of the local newspaper, defending the practice of fraternity/sorority hazing. After the letter was published, he sent a copy of it, as it appeared in the newspaper, to the mother of a student who had died during a hazing. The mother, who had become an anti-hazing activist, then furnished the letter to an

author writing a book on the subject. The entire chain of events not only led to great embarrassment for KKG Sister #2, but demonstrated Dr. Ivins' deviousness and willingness to use others, as well as the United States Postal Service, to accomplish his stealthy retribution.

In the 1990s Dr. Ivins developed intense emotional attachments to two technicians who worked in his laboratory, women known in this document as Technicians #1 and #2. In 1999, Technician #2 left the lab to pursue medical studies at a university in New York State. Her departure [redacted]

Once again Dr. Ivins was candid to his psychiatrist. [redacted]

Switching soon to another therapist, [redacted] His therapist became so alarmed that she sought legal advice from her practice's malpractice insurance carrier and made tentative inquiries with the local police department. She later quit the practice because the physician in charge, referred to as Dr. #3 in this report, did not share her concerns about Dr. Ivins' dangerousness.

Besides coping with his separation from Technician #2, Dr. Ivins was also dealing in 1999, 2000 and 2001 with various threats to the anthrax vaccine program. *Vanity Fair* magazine published a report linking the vaccine to Gulf War Syndrome, a condition with a wide range of acute and chronic symptoms that developed in veterans of the conflict. In August 1999, the Food and Drug Administration (FDA) shut down production of the vaccine by the one company licensed to produce it, after the company failed its FDA inspection. In February

2000, the House Government Reform Committee's national security subcommittee urged the Defense Department to suspend the anthrax program, and in May 2000, 35 members of Congress signed a letter asking the Secretary of Defense to stop it until a long-term study could be done regarding its safety. In June 2001, Senator Daschle, the Senate majority leader, sent a letter to the Department of Defense that heightened concerns about the safety of the vaccine. Also in June, the Department of Defense announced it was curtailing its vaccination program — the vaccine was beginning to run out.

As his own emails show, Dr. Ivins became concerned that his vaccine program was in jeopardy. On September 7, 2001, he wrote that he had just received his own anthrax vaccine injection but that supplies were dwindling "and when it's gone, there's nothing to replace it with. I don't know what will happen to the research programs and hot suite work until we get a new lot. … Everything is in limbo."

DR. IVINS' MOTIVES FOR THE ATTACKS

Investigators determined that the first anthrax letters were mailed on September 17 or 18, in the wake of the 9-11 attacks. It was not until October 4, however, that the first case of anthrax exposure was reported, and there was no immediate reference in that case to the victims' having received a letter. A second set of letters was mailed sometime between October 6 and October 9.

As the Analysis section of this report explains in greater detail, Dr. Ivins had multiple motives in launching what he later called [redacted] through the mail. The key themes were revenge, a desperate need for personal validation, career preservation and professional redemption, and loss. These themes guided him not only in making the attacks, but in choosing his targets and shaping his methods.

- *Revenge*

  The attacks above all enabled Dr. Ivins to gain retribution against his various perceived enemies. Some of those enemies, like Senators Daschle and Leahy, had directly incurred his wrath; others, like the *New York Post*, which to him represented the media and New York City, appeared to have been symbolic stand-ins for broader targets. But in each case Dr. Ivins achieved one of his lifelong preoccupations — revenge. In 2000, he had told his therapist that [redacted] With the anthrax attacks, [redacted]

- *Personal validation*

  The attacks also represented a way for Dr. Ivins to elevate his own significance. One day his program was under scrutiny and his career as an anthrax researcher imperiled. The next day his program and his skills could not have been more crucial to national security.

  Dr. Ivins was also trying to impress KKG Sister #2. After an approximately 18-year hiatus, he wrote her an email "after the anthrax attacks" "to refresh his acquaintance," as he later put it, on September 21, 2001 — shortly after the first set of anthrax letters were mailed but before they were discovered. With its references to biowarfare and anxiety, the email would soon cast him in her eyes, he appears to have hoped, as a prophet and as a defender of the nation. He joined the American Red Cross the next day, positioning himself with the greatest possible significance by referring — as he never had previously — to his expertise in "anthrax research" on the volunteer application.

- *Career preservation and professional redemption*

  By launching the attacks, Dr. Ivins showed that anthrax was a threat and the vaccine he helped manage was necessary to protect the public. The attacks in this sense achieved their goal.

- *Loss*

  In part, launching the anthrax attacks appears to have been an effort to inflate his importance with Technician #2 and potentially attract her back into his laboratory. In the aftermath of the attacks, physicians with research backgrounds in anthrax were in demand. Technician #2 conceivably could have returned to the laboratory — embraced by her peers as an authority and with only Dr. Ivins, her mentor, to thank.

THE MAIL AS VEHICLE

Dr. Ivins had used the mail for decades as a means of harassment. The U.S. Postal Service provided him the opportunity to carry out his schemes anonymously, consistent with his longstanding preference.

When he decided to engineer his anthrax attacks, therefore, it was perhaps predictable that he would choose the mail as his vehicle.

In retrospect, it was also not surprising that he would choose anthrax as his weapon. Not only was he expert in its production and purification, but he referred to it with a morbid intimacy. On numerous occasions, including some prior to the attacks, Dr. Ivins suggested to various therapists that [redacted]

Finally, given Dr. Ivins' obsessions and proclivity for careful planning, it was also like him to give very careful consideration to the specific site for the mailings.

All four of the recovered letters were sent on two separate occasions from the same mailbox, at 10 Nassau Street, Princeton, N.J., investigators determined. That box is nearly 200 miles from Dr. Ivins' home in Frederick, Md., but just 175 feet from 20 Nassau Street, the address of the KKG office at Princeton University.

The box thus appears to have represented to him the two key reservoirs of his obsession and rage. Dr. Ivins' statements to therapists and the FBI suggest that KKG represented authority and all the successful, talented, attractive people who had rejected him and inspired his rage. Princeton represented his father and perhaps his unmet college aspirations and the humiliation and rage wrapped up in these concepts for him. For him, dropping anthrax in this box appears to have represented both a conquest and a desecration — in short, payback.

The return address on the letters to Senators Daschle and Leahy was also significant. As discussed in greater detail in the analysis, the ZIP Code Dr. Ivins selected likely was related to his passion for codes and laden with associations for him.

SUICIDE

Through a combination of good luck and his own fabrications and deflections, Dr. Ivins was able to avoid the focus of investigators in the first few years after the attacks. But by 2004, the tide was beginning to turn against him, especially as scientists developed new, more refined techniques for analyzing the genetic material in the *Bacillus anthracis* that was mailed. As the scrutiny of investigators ratcheted up and at last, the Federal Government prepared to indict him for the mailings, Dr. Ivins finally revealed his rage in a remarkable rant. At a group therapy session in July 2008, he bragged that he was procuring a gun and threatened to kill others and then be killed by police.

Reports indicate he was extremely dangerous and required involuntary treatment on a psychiatric ward at that time. In obtaining his involuntary commitment, Dr. Ivins' mental health professionals likely prevented a mass shooting and fulfillment of his promise to go out in a "blaze of glory." Dr. Ivins was not only homicidal, he had a specific plan, which there is no reason to think he would not have carried out.

He was thwarted, however, by his involuntary psychiatric hospitalization and the FBI's ensuing search and confiscation of his ammunition, body armor and a bulletproof vest.

At the time of his hospitalization, Dr. Ivins said he actually agreed that he presented a danger to himself and others. But he believed that because he had been involuntarily hospitalized, his full medical records would be provided to investigators. He believed, in other words, that his decades-long effort to conceal the truth about himself had reached a tipping point and was about to be shattered. This recognition, groundless as it may have been, likely contributed to his decision to commit suicide.

To make his suicide possible, he engaged in a final deception, persuading a psychiatrist that he was no longer dangerous to others or himself and that he was qualified for discharge from the hospital. Within a few hours of his discharge, he had purchased the additional acetaminophen he needed to kill himself. He swallowed it a few days later, dying before investigators could further assess the mental state and motives that led him to commit his unprecedented acts of bioterrorism.

SECURITY ISSUES

Despite criminal behavior and sabotage of his colleague's research, Dr. Ivins was hired by USAMRIID and received a security clearance, allowing him to work with potential weapons of mass destruction. Moreover, he was permitted to remain in the hot suite with anthrax — in position to potentially carry out more attacks — for nearly seven years thereafter.

These developments took place in large part because his medical records, which contained highly relevant information that likely would have disqualified him from employment, were not obtained and his treating clinicians never interviewed.

The failure to obtain them apparently resulted from these main causes:

- Dr. Ivins' self-disclosures featured key medical and psychiatric omissions;
- Investigatory follow-through was lacking;
- Information requested was not always provided;
- Dr. Ivins' treating psychiatrist lacked both an awareness of the full contents of the medical record and an appreciation of the stakes involved in assessment.

The Panel believes that part of the explanation for these failures may lie in the shifting security landscape. Beginning in 2001, the rules governing security at USAMRIID began to change, with Biological Personnel Reliability Program (BPRP) procedures slowly supplementing those established under Army security programs. The evolutionary nature of this shift may have delayed discovery of problematic information.

But familiarity, the Panel believes, played a much greater role in the failure of the systems to operate. Over the decades, Dr. Ivins' tenure at USAMRIID, combined with respect for him as a scientist, appears to have led to a degree of complacency toward him. His co-workers and supervisors had long since become accustomed to him and his eccentricities. Near the end, a threatened co-worker's expressions of fear led only to a supervisor's instruction to "hide in the hot suite" — and no other intervention. Familiarity may explain why those involved in the medical surveillance system did not follow through when information they requested: 1) either was not provided at all; or 2) was provided and suggested the need for additional inquiry.

RECOMMENDATIONS

As a result of this review, the Panel has offered 10 findings and 14 recommendations. They are listed and explained in the following section.

End Notes for Executive Summary

[1]Greenemeier, L. (2008). Seven Years Later: Electrons Unlocked Post-9/11 Anthrax Mail Mystery. *Scientific American*. Retrieved from http://www.scientificamerican.com/article.cfm?id=sandia-anthrax-mailing-investigation.

[2]Former CIA counterintelligence officer and convicted spy Aldrich Ames repeatedly used a mailbox in Georgetown to provide information to enemy agents without being detected at the site of the box — in this case a postal collection box located at 37th and R Streets, NW that was essentially identical to the Princeton N.J. collection box used by the anthrax mailer. In order to request meetings with the KGB, Ames would leave horizontal chalk marks above the USPS logo.

III. Findings

1. Dr. Ivins had a significant and lengthy history of psychological disturbance and diagnosable mental illness at the time he began working for USAMRIID in 1980. [redacted] that would have disqualified him from a Secret level security clearance had they been known. Such disqualification would have prevented him from having access to anthrax prior to and after 2001.

2. Information regarding his disqualifying behaviors was readily available in the medical record and accessible to personnel had it been pursued under mechanisms that existed prior to and after 2001.

3. Relevant information in the medical record, including pertinent psychiatric history, did not become available during the security clearance process as a result of a several factors:

    - Dr. Ivins made critical omissions in his self-reports;
    - Background medical record investigators did not pursue inconsistencies in Dr. Ivins' reporting;
    - Background medical record investigators did not request and review available medical records;
    - Background medical record investigators did not follow up on incomplete responses by treating clinicians;
    - Background medical record investigators did not clarify information through direct interview;
    - Treating clinicians did not report significant information known directly to them or available to them through ancillary therapist notes in the medical record.

4. It was not privacy law that prevented the flow of healthcare information between Dr. Ivins' private psychiatrist and

USAMRIID — information that would have disqualified Dr. Ivins from a security clearance and access to select agents prior to the mailings or afterwards. Dr. Ivins had signed multiple waivers of his right to health information privacy. It is possible, however, that healthcare providers *viewed* privacy law as a barrier to disclosing information of concern about Dr. Ivins.

5. The Department of Justice (DOJ) did not seek or obtain authorization and therefore did not review or have access to comprehensive psychiatric records during the course of the investigation of Dr. Ivins. Federal investigators requested access to medical records, but the U.S. Attorney's Office within the DOJ viewed privacy law and its relationship to mental health and medical records as a significant legal barrier to obtaining them during the course of the investigation.

6. While he was employed at USAMRIID, routine drug and alcohol testing was not performed on civilians, like Dr. Ivins, who worked within secure USAMRIID laboratories.

7. Dr. Ivins' [redacted] contributed to numerous episodes of impaired behavior within the work setting. The impairment and its cause were not detected or formally evaluated because [redacted] were not performed.

8. Despite Dr. Ivins' long-term involvement in psychiatric treatment and work-related monitoring of his psychiatric issues, treatment and management interventions fell short of directly addressing his risk of harm to others until July of 2008. Even at that time, risk assessment with regard to self and others did not appear to adequately take into consideration the potential significance and imminence of his legal situation.

III. Findings

9. Many of the civilian mental health professionals who treated Dr. Ivins prior to 2001 (Dr. #1, Dr. #2 and Therapist #1) did not know that he had a security clearance and would have advised against it had they been consulted. However, even after recommending involuntary hospitalization for Dr. Ivins because of his suicidality and homicidality, the psychiatrist who treated Dr. Ivins from 2000-2008 continued to take the position that Dr. Ivins should have full access to agents such as anthrax.

10. Failures in supervision, documentation, and communication allowed Dr. Ivins to avoid scrutiny before and after the anthrax mailings.

IV. Recommendations[2a]

1. Personnel Reliability Program measures that allow for requisition of medical records should be utilized. Consent to release of the employee's complete records should be made a condition of continued access and security clearance.

2. All possible measures should be taken to ensure the privacy of medical information, with information disclosed only on a "need to know" basis and with strict penalties for inappropriate disclosure.

3. Serious deficits in judgment, cognition, and behavior can occur with a variety of medical and psychiatric diagnoses and also in the absence of diagnoses; the vast majority of violence and other criminal behavior occurs in the absence of a major mental illness. Medical records may contain documentation of deficits in judgment and cognition as well as of disqualifying behaviors. Therefore, where security procedures call for review of medical records, review of those records should occur in all cases and not be predicated on the reported presence or absence of specific symptoms or diagnoses.

4. For those to be newly enrolled in Personnel Reliability Programs, requests for records and their reviews should be all-inclusive. Subsequent requests and reviews for records should extend to all available records for the previous five years or the entire period since the last complete record review, whichever is longer. Subsequent to detailed review of the records, the treating clinician providing these records should be interviewed to determine the completeness of the records. If additional notes and materials exist, and if there have been contacts with additional clinicians, these notes and materials should also be reviewed, and clinicians contacted.

IV. Recommendations

5. The Personnel Reliability Program process should include a longitudinal review of all medical questionnaires to detect discrepancies and inconsistencies. Any that are detected should be followed up.

6. Because institutions that deal with Biological Select Agents and Toxins (BSAT) evolve in their response to national security imperatives, the need for additional inventory control and other security measures within facilities should be evaluated on an ongoing basis.

7. Routine drug screening should continue to be mandated for all persons working within BSAT laboratories. The types of drugs screened in such programs should be reevaluated each year by an expert advisory board.

8. Background investigators should be trained thoroughly to recognize red flags that relate both to counterintelligence and mental health issues and to respond to those indicators with thorough investigations.

9. Information from treating clinicians should be regarded as important but not dispositive when questions of security clearance and fitness-for-duty are considered. All fitness-for-duty evaluations and medical reviews should be conducted by clinicians who have had no treatment or other relationship with the subject of the investigation. These clinicians should also receive specific training in conducting fitness for duty evaluations in high security settings.

10. Requests for information from treating clinicians should include a detailed written and verbal description of the significance of the information requested and the potential consequences to national security of inaccurate and incomplete information. A clinician providing this information should be asked to sign a form acknowledging this discussion and certifying the accuracy and

completeness of the information provided. The treating clinician should be given the option of recusing himself or herself from making the assessment, deferring to an independent evaluator. Release-of-information forms signed by the employee should contain a waiver indemnifying the clinician from civil actions resulting from passing on appropriate concerns in good faith.

11. Requests for reports recommending return to the workplace should be accompanied by a description of the person's essential job duties as well as potential security risks. The healthcare provider completing the report should sign an acknowledgment that he or she has reviewed that information and that his or her recommendations regarding job performance are based on that review.

12. Every facility in which work is done with high-risk materials or in which security issues are otherwise implicated should have an employee wellness program. The program should facilitate and encourage assistance for any employee demonstrating high levels of stress, signs of substance abuse, or other indicators of distress. Support for these programs — and their success — should be a core measure of job performance for supervisory personnel, including laboratory directors and principal investigators.

13. Steps should be considered to promote the flow of protected healthcare information between military and civilian care providers when indicated.

14. Facilities working with high-risk materials must ensure that supervision, documentation, and communications within and between agencies are given the priority that they deserve.

End Note for Recommendations

[2a]Recommendations for Personnel Reliability and Biosurety Programs are covered in greater detail in Appendix II.