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Medical Operations

MENTAL HEALTH

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This instruction implements Air Force Policy Directive (AFPD) 44-1, *Medical Operations* and establishes guidance for United States Air Force (USAF) Mental Health (MH) services. This instruction provides guidance for the operation of the MH services [as distinguished from the Combat Stress Center, Traumatic Stress Response (TSR) operations, and Exceptional Family Member Program (EFMP)] and the assessment and treatment of USAF personnel and beneficiaries with MH problems. This instruction applies to all active duty (AD) Air Force (AF) members and to members of the AF Reserve (AFR) and Air National Guard (ANG) whenever eligible for DoD medical services. The AFR does not have a separate system to provide behavioral health treatment. Clarification about AFR-specific policies, processes, and/or procedures should be directed to HQ AFR/SG's MH Consultant at Robins AFB, GA. The ANG provides psychosocial assessment and referral services for its members. Referrals are made to civilian providers for treatment. Clarification about ANG-specific policies, processes, and/or procedures should be directed to the ANG/SG office at ANGRC Andrews JFB, MD. The Privacy Act of 1974 applies to this instruction. This AF Instruction (AFI) may be supplemented at any level, but all supplements must be routed to Air Force Medical Operations Agency (AFMOA)/SGHW, 3515 S. General McMullen, San Antonio, TX 78226, for coordination prior to certification and approval. Refer recommended changes and questions about this publication to the Office of Primary Responsibility using the AF Form 847, *Recommendation for Change of Publication*; route AF Form 847s from the field through appropriate chain of command. Ensure that all records created as a result of processes prescribed in this publication are maintained in accordance with AFMAN 33-363, *Management of Records*, and disposed of in accordance with the AF Records Disposition Schedule (RDS) located at **https://www.my.af.mil/afrims/afrims/afrims/rims.cfm**.

Chapter 1

RESPONSIBILITY

1.1. Assistant Secretary of the Air Force for Manpower and Reserve Affairs (SAF/MR): serves as an agent of the Secretary and provides guidance, direction, and oversight for all matters pertaining to the formulation, review, and execution of plans, policies, programs and budgets within the Air Force Medical Service.

1.2. Air Force Surgeon General (AF/SG). AF/SG agencies and personnel support MH as described below:

1.2.1. Maintains management responsibility for all MH programs and processes. Implements policy, advocates for MH processes, supports personnel and resource requirements and directs strategic planning of MH programs.

1.2.2. Directs AFMOA to implement AF policies in record keeping, reporting, research, training, operational oversight and program evaluation.

1.2.3. Promotes total force MH by coordinating policy, management of programs and processes with the AFR/SG and ANG/SG, respectively.

1.3. Commander, AFMOA.

1.3.1. Appoints AFMOA MH Division Chief.

1.3.2. Provides personnel and resources for the MH Division.

1.4. MH Division Chief, AFMOA.

1.4.1. Leads development and implementation of AF MH services and initiatives.

1.4.2. Appoints and supervises Alcohol and Drug Abuse Prevention and Treatment (ADAPT)/Drug Demand Reduction (DDR), MH, Resiliency and Family Advocacy branch chiefs.

1.4.3. As required and in coordination with the AFMOA Commander, designates the program manager for AF programs for which the AFMOA MH Division is primarily responsible.

1.4.4. Ensures timely support of requests for information, briefings and other requirements related to MH.

1.4.5. Oversees branch chiefs and MH technician career field manager to ensure integrated, effective and efficient MH for beneficiaries.

1.4.6. Coordinates the activities of the Consultants to the AF/SG for Clinical Psychology, Psychiatry, Social Work, Psychiatric Nursing and the 4C0X1 Career Field Manager to ensure a coordinated approach to MH issues.

1.4.7. Coordinates MH programs and initiatives with Major Command (MAJCOM) MH staff officers, enlisted members and/or consultants.

1.4.8. Collaborates with the AF Inspection Agency to develop inspection criteria and processes to assess compliance of MH with official policy and guidance.

1.4.9. Collaborates with other AFMOA Divisions to ensure integrated, efficient and effective healthcare.

1.5. Judge Advocate General, USAF (AF/JA). Provides legal opinions, instructions, guidance and assistance regarding MH programs and policies.

1.6. AF Director of Psychological Health (DPH), Air Force Medical Support Agency (AFMSA).

1.6.1. Directs DPH staff to provide AF senior leader support on the full range of MH issues.

1.6.2. Coordinates with Chief, AFMOA MH Division on MH policy and operational issues.

1.6.3. Coordinates with HQ AFR/SG's Chief MH Consultant on MH policy, procedural and operational issues.

1.7. MAJCOM/Direct Reporting Unit (DRU) SG or Equivalent.

1.7.1. Implements and ensures compliance with MH policies and programs at the MAJCOM/DRU level.

1.7.2. Appoints a point of contact for all MH concerns within the command. This position may be a senior MH officer serving fulltime in this capacity or may be any clinical officer or civilian equivalent providing liaison on MH issues for the command.

1.7.3. Identifies and corrects MH service delivery issues that cannot be resolved at the installation level.

1.7.4. Develops prevention programs that encourage responsible behavior and enhance organizational wellness.

1.7.5. Coordinates with AFMOA MH Division on MH-related complaints and inquiries.

1.7.6. Provides assistance and guidance to base-level MH.

1.7.7. Develops MAJCOM specific MH initiatives to address MAJCOM specific requirements.

1.8. Installation Commander.

1.8.1. Ensures allocation of sufficient resources for MH programs.

1.8.2. Promotes cooperation among installation organizations to build healthy resilient communities.

1.9. Military Treatment Facility (MTF) Commander and Reserve Medical Commanders (where applicable).

1.9.1. Ensures the availability of adequate resources for the effective and efficient implementation of MH.

1.9.2. Ensures a safe physical environment for MH staff and patients. Implements safety requirements to include duress systems, controlled access to provider offices and other measures to support safety.

1.9.3. Establishes MTF guidance for emergency MH evaluations both during and after duty hours. Ensures MH Providers (MHPs) assess patients in appropriate clinical settings only,

specifically prohibiting MH evaluations at non-medical locations (this does not prohibit MH outreach, prevention and/or TSR services from being provided outside medical locations).

1.9.4. Provides medical support for MH. Ensures effective patient care coordination between MH, primary care and other medical services. Coordination of care for high interest (HI) patients is especially critical and will, at a minimum, include consultation between the patient's MHP, primary care manager (PCM) and emergency department (ED) providers (where available).

1.9.5. Ensures a network of MH specialty services to provide services unavailable in the MTF (e.g., inpatient psychiatric care, substance abuse services, etc.).

1.9.6. Appoints an installation DPH. This may be an additional duty for a senior MHP.

1.9.7. Limited Scope MTFs (LSMTF): LSMTFs may not have sufficient MH personnel to provide all MH services or meet all requirements described in this AFI. All MH services provided must be done in a safe manner that ensures high quality care. Some required services/requirements may be provided by a supporting MTF or through civilian services.

1.9.7.1. If the LSMTF Commander identifies requirements in this AFI that cannot be met by the LSMTF but can be met by another MTF or civilian medical service, a Memoranda of Agreement (MOA) will be established with the supporting facility.

1.9.7.2. If the LSMTF Commander identifies requirements in this AFI that cannot be met by the LSMTF, nor another supporting facility, a request for waiver will be submitted through the MAJCOM/SG, to AFMOA, and then to AF/SG3 as the final waiver approval authority. Waivers will be revalidated every three years by the LSMTF by sending an updated request through the MAJCOM/SG for concurrence by AF/SG3.

1.9.8. Establishes MOA with local protective services, law enforcement and other outside non-TRICARE network agencies as needed.

1.10. Chief of Medical Staff (SGH).

1.10.1. Ensures required MH training is provided to all MTF professional staff. Training on the following topics will be conducted annually and preferably in person:

1.10.1.1. Substance abuse identification, referral process and treatment resources.

1.10.1.2. Family maltreatment prevention, identification, referral process and treatment resources.

1.10.1.3. MH problem identification, referral process and treatment resources.

1.10.2. Ensures privileging is consistent with MHP training and assigned clinical practice.

1.11. Squadron Commander Responsible for MH.

1.11.1. Ensures MH personnel provide annual training on MH issues as required by AFI or other AF/SG guidance.

1.11.2. Provides MH personnel for consultation to an installation hostage negotiation team, TSR team, safety human factors consultant and other specialized duties as local mission requires.

1.11.3. Ensures MH operates in a facility that is safe from physical hazards and that minimizes the risk of assault or physical injury of both staff and patients.

1.12. MH Flight Commander or Equivalent.

1.12.1. Leads base MH programs.

1.12.2. Assists commanders in identifying and referring members to MH.

1.12.3. Conducts flight self-inspection using MTF sanctioned inspection criteria (i.e., HSI) within 60 days of arrival.

1.12.4. Supports geographically separated units and personnel IAW Memoranda of Understanding (MOU).

1.12.5. Requests at least annually a security/threat assessment of MH facilities and security procedures from Security Forces Squadron (SFS).

1.12.6. Monitors the appropriateness of clinical services delivered to MH patients in collaboration with the MTF Executive Committee of the Medical Staff.

1.12.7. Oversees documentation of MH, ADAPT and Family Advocacy Program (FAP) treatment that is created or maintained by MH. Meets required information protection standards and release of protected information IAW established DoD and AF guidance.

1.12.8. Supervises all elements of MH.

1.12.9. Ensures that MH flight business practices comply with the current version of the AFMOA's produced Air Force Medical Services (AFMS) Guide to MH Business Practices. Monitors productivity to ensure business practice standards and access standards are met.

1.12.10. Must be a privileged provider.

1.12.11. Ensures MHPs and other staff as needed participate in Multidisciplinary Clinical Case Conference (MCCC) IAW paragraph 5.2.3. of this instruction.

1.12.12. Coordinates with the SGH to ensure implementation of MH related Notice to Airmen (NOTAM).

1.13. Installation Director of Psychological Health (DPH).

1.13.1. The installation DPH, appointed by the MTF commander, is the Wing Commander's primary MH consultant on all MH issues. Typically the MH Flight commander will serve as the DPH. When the duties of MH Flight commander and DPH are held by different individuals, the MH Flight commander is senior in terms of MH flight leadership.

1.13.2. Advises leadership on psychological health matters and coordinates the delivery of MH services.

1.13.3. Serves as the MH representative to Community Action Information Board (CAIB) and Integrated Delivery System (IDS).

1.13.4. Collaborates with Air Reserve Component (ARC) DPHs and AFR's regional Psychological Health Advocacy Program (PHAP) teams as needed to promote a culture of psychological health for the Total Force.

1.13.5. ANG Wing DPHs will coordinate with regional supervisors to promote a culture of psychological health for the Total Force.

1.14. Family Advocacy Officer (FAO). Oversees FAP IAW AFI 40-301, *Family Advocacy* and FAP Standards.

1.14.1. The FAO provides technical consultation and support to FAP staff assigned to the Resiliency Element (RE).

1.14.2. The FAO ensures FAP resources centrally provided for prevention and outreach initiatives are available to FAP staff regardless of flight organizational alignment.

1.14.3. Ensures Family Advocacy Nurse (FAN), Family Advocacy Intervention Specialists (FAIS) and Family Advocacy Outreach Manager (FAOM) participate in clinical case staffing or other clinical care coordination functions as specified in FAP Standards.

1.15. Alcohol and Drug Abuse Prevention and Treatment Program Manager (ADAPTPM). The duties of the ADAPTPM are listed in AFI 44-121, *Alcohol and Drug Abuse Prevention and Treatment Program.*

1.15.1. The ADAPTPM provides technical consultation and support to ADAPT staff assigned to the RE.

1.15.2. The ADAPTPM ensures ADAPT resources centrally provided for prevention and outreach initiatives are available to ADAPT staff regardless of flight organizational alignment.

1.16. MH Flight or Equivalent NonCommissioned Officer in Charge (NCOIC).

1.16.1. Develops, mentors and manages enlisted personnel in the MH Flight.

1.16.2. Establishes, maintains and evaluates enlisted MH, FAP and ADAPT training programs.

1.16.3. Oversees in-service flight training.

1.16.4. Conducts flight self-inspection in cooperation with the MH Flight commander using HSI criteria within 60 days of arrival.

1.16.5. Manages MH treatment records.

1.16.6. Collects and updates administrative and statistical data at the request of flight, squadron, group, wing, MAJCOM and AF agencies using AF sanctioned databases.

1.16.7. Oversees enlisted evaluation, feedback, recognition processes and monitors all upgrade training for enlisted personnel in MH.

1.16.8. Ensures enlisted involvement in clinical care activities as appropriate for training level and experience.

1.17. MH Technician.

1.17.1. Screens patients under the oversight of a privileged MHP. Schedules appointments or referrals to other agencies, as appropriate.

1.17.2. Performs emergency triage and initial basic assessment procedures. Administers standardized psychological testing, conducts clinical interviews, mental status examinations,

substance abuse evaluations and bio-psycho-social assessments. All of these patient care functions will be performed under the oversight of a privileged MHP and IAW training level.

1.17.3. Assists in MH diagnosis, treatment, patient education and discharge planning under the oversight of a privileged MHP.

1.17.4. Conducts or assists in providing treatment for MH, FAP and ADAPT patients. (Refer to AFI 44-121 for guidance on use of MH technicians in ADAPT). MH Technicians cannot provide FAP treatment but can co-facilitate groups. They cannot conduct FAP interviews or intakes.

1.17.5. Participates in multidisciplinary team meetings.

1.17.6. Observes, monitors, reports and records patients' treatment progress using Subjective, Objective, Assessment, Plan (SOAP) format (See Chapter 4), obtaining co-signature by a privileged MHP.

1.17.7. Conducts or assists in group therapy under supervision of a privileged MHP.

1.17.8. Provides prevention education and outreach such as substance abuse, suicide prevention and Family Advocacy briefings.

1.17.9. Assists in or arranges patient referral to public, private or military community agencies.

1.17.10. Performs MH medical attendant duties IAW AFI 41-307, *Aeromedical Evacuation Patient Considerations and Standards of Care.*

1.17.11. Provides TSR support and pre-exposure preparation IAW AFI 44-153.

Chapter 2

MH FLIGHT STRUCTURE

2.1. The MH Flight (or equivalent): ¨ consists of four elements: MH, FAP, ADAPT and Resiliency. Some installations will not have the manning for elements/element chiefs so dual responsibilities may be required. Rotating element chiefs is encouraged to maximize experience in all areas of the MH Flight. The ANG does not have a MH Flight or equivalent capabilities.

2.2. MH Element. The MH element enhances the health and readiness of the community by providing MH assessment, education, consultation, and treatment services to the beneficiary population through a variety of evidence-based therapeutic modalities. The MH element:

2.2.1. Provides inpatient (if available) and outpatient MH services at the installation.

2.2.2. Performs biopsychosocial assessments, psychological testing, diagnosis and treatment of MH conditions.

2.2.3. Performs special duty assessments and screenings as requested [Personnel Reliability Program (PRP)/Presidential Support Program (PSP), Military Training Instructor (MTI)/Military Training Leader (MTL), security clearances, etc.].

2.2.4. Conducts commander-directed evaluations (CDEs).

2.2.5. Refers patients for specialized and/or higher level of care.

2.2.6. Provides TSR and pre-exposure preparation in coordination with the RE staff.

2.2.7. Completes medical evaluation board (MEB)/profile/duty limiting condition (DLC) processes for psychiatric conditions when indicated.

2.2.8. Performs sanity board and forensic evaluations if appropriately trained provider is available.

2.2.9. Consults with commanders on MH issues.

2.2.10. Administers neurocognitive testing required by the AF for pre-deployment and post-injury.

2.2.11. Monitors and reports MH data as required by the MTF, MAJCOM or AFMOA.

2.2.12. Accomplishes other duties falling under the scope of MH care.

2.3. ADAPT Element. ADAPT promotes readiness, health and wellness through the prevention, evaluation and treatment of substance abuse. ADAPT:

2.3.1. Performs comprehensive substance abuse assessments.

2.3.2. Delivers Alcohol Brief Counseling (ABC) for all referrals.

2.3.3. Performs outpatient treatment of diagnosed patients when appropriate.

2.3.4. Facilitates and coordinates referrals to higher level care, when required.

2.3.5. Provides an aftercare program for patients completing treatment.

2.3.6. Conducts treatment team meetings that include unit representatives.

2.3.7. Monitors and reports substance use data, as required.

2.3.8. Provides, or arranges for, medical monitoring of substance abuse patients, as required.

2.3.9. Provides active drug use deterrence through the DDR program.

2.3.10. Provides commander consultation regarding ADAPT cases.

2.3.11. Performs profile/DLC processes for substance abuse conditions.

2.3.12. Accomplishes other duties falling under the scope of substance abuse prevention, evaluation and treatment.

2.3.13. For additional information, see AFI 44-121.

2.4. Family Advocacy Element. The Family Advocacy Element is led by the FAO and provides services to prevent and treat family maltreatment and to promote community health and resiliency. It is part of the FAP, which also includes personnel from the RE.

2.4.1. Assesses maltreatment referrals and engages protective services and/or law enforcement as needed to ensure family safety.

2.4.2. Provides interventions for maltreatment cases and implements Central Registry Board (CRB) recommendations.

2.4.3. Consults with commanders and first sergeants on maltreatment issues.

2.4.4. Delivers secondary prevention services through Family Advocacy Strength Training (FAST).

2.4.5. For additional information, See AFI 40-301.

2.5. Resiliency Element (RE). The RE collaborates with key community leaders, IDS, and other helping agencies to provide services that enhance the resilience of AF communities and reduce the incidence of family maltreatment and alcohol/drug misuse. Staff members assigned to the RE are responsible for prevention in their area of expertise but will work in collaboration and partnership on all efforts to maximize impact. The FAOM and FAN work directly for the RE Chief; however, they also participate in the appropriate FAP staff meetings to maximize coordination. Outreach and prevention efforts focus on the range of available MH services with utilization of resiliency principals including the 12 Targets (see Attachment 2). The RE has limited clinical care responsibilities so caution should be taken to ensure the element chief, if a provider, engages in sufficient patient care in another element to maintain clinical currency and IAW current business plan directions. The RE integrates evidence informed practices for the base community to build protective factors and to minimize risk factors. RE:

2.5.1. Provides suicide prevention training and outreach.

2.5.2. Conducts MH and wellness classes.

2.5.3. Provides family maltreatment prevention education.

2.5.4. Provides pre- and post- deployment resiliency briefings/classes.

2.5.5. Conducts parenting education classes.

2.5.6. Oversees the New Parent Support Program (NPSP).

2.5.7. Provides substance abuse prevention and outreach programs (excluding drug testing).

2.5.8. Provides briefings for Newcomer's Orientation, First Term Airman Center and Airman Leadership School, as requested.

2.5.9. Conducts all MH mandatory training requirements.

2.5.10. Promotes theme month activities (e.g., Child Abuse, Depression, Alcohol Awareness Month, etc.).

2.5.11. Assists with Wingman Day activities.

2.5.12. Provides classes for skill improvement [e.g., Dads 101, Prevention Relationship Enhancement (PREP), etc].

2.5.13. Conducts Psycho-educational classes [non-Relative Value Unit (RVU) generating].

2.5.14. Participates in the Population Health Working Group.

2.5.15. Collaborates with professional/community agencies.

2.5.16. Maintains outreach database and reporting.

2.5.17. Conducts visits to base units, preferably on at least a monthly basis. Units with a heavy operational tempo and/or with missions creating elevated unit demands/stressors as identified by unit leadership and the base CAIB/IDS will be targeted for more frequent visits and additional support programs to the maximum extent possible. The DPH will determine the best use of installation outreach services based on availability of assets.

2.5.18. Provides TSR and pre-exposure preparation in coordination with the RE staff.

2.5.19. RE Composition.

2.5.19.1. For installations with at least four assigned privileged providers, the element should include an MHP, at least one MH technician, and where assigned a FAOM, FAN and at least a half-time Family Advocacy Program Assistant (FAPA).

2.5.19.2. For installations with three assigned privileged providers, the element should include a half-time element leader, at least one MH technician, and where assigned a FAOM, FAN and at least a half-time FAPA.

2.5.19.3. For installations with two or less assigned providers, the RE is not required, but MH members will address resiliency requirements.

2.5.19.4. FAIS will work under the Family Advocacy Element.

2.5.19.5. Family Advocacy Treatment Managers and FAISs do not count as assigned providers in the calculation for the RE composition.

2.5.19.6. Neither the FAOM nor FAN will provide prevention services outside the scope of family maltreatment prevention and treatment. Within this scope, they will collaborate with other RE members on prevention activities to maximize effect.

2.5.19.7. The FAOM or FAN will not serve as the RE Chief.

2.6. MH Case Management Function. Case management is a collaborative process of assessment, planning, facilitation and advocacy for services to meet an individual's MH needs. These functions are performed by the MH staff. If staffing level permits, care coordination can

be optimized by assigning a single MH staff member to manage these functions. MH case management:

2.6.1. Tracks admissions and discharges of all MH patients.

2.6.2. Provides HI case management/monitoring for MH.

2.6.3. Coordinates psychiatric medication refills.

2.6.4. Arranges and follows internal/external referrals for MH.

2.6.5. Monitors no-shows and follow-up for MH patients.

2.6.6. Tracks patients during hospitalization, intensive outpatient and partial hospitalization.

2.6.7. Coordinates and consolidates internal/external MH care.

2.6.8. Oversees transfer of patients and records upon permanent change of station (PCS).

2.6.9. Identifies local community/network resources.

2.6.10. Documents case management in patient charts.

2.6.11. Collects and tracks documentation of external MH care for patients.

2.6.12. Participates in MCCC discussions whenever they occur.

2.6.13. Collaborates with ARC medical personnel in all matters dealing with ARC personnel.

Chapter 3

MH SAFETY

3.1. MTF Commander and Facility Manager.

3.1.1. Ensures MH operates in a clinic safe from physical hazards.

3.1.2. Provides a patient care setting that minimizes the risk of assault while preserving patient and staff dignity.

3.1.3. Prohibits unauthorized entry into patient care areas.

3.1.4. Ensures MH staff is trained in safety procedures including fire safety, equipment safety, bomb threat procedures and medical emergencies.

3.2. Duress Procedures.

3.2.1. MH Flight Commanders or equivalent will establish a clinic duress response plan to respond to threats of violence and will train the staff on this plan.

3.2.2. MH facilities will have an internal and external electronic duress alarm notification system. Internal duress alarms will notify the front desk or other location in MH that is continually manned during patient care duty hours. External duress alarms will automatically notify SFS or other equivalent security personnel of the emergency and will be activated simultaneously with the internal duress system. Both systems will be tested quarterly.

3.2.3. MH staff will be trained on duress procedures during initial in-processing. Duress exercises will be conducted by the MH Flight at least semi-annually. SFS personnel will participate in these duress exercises annually. **Note:** The duress exercises involving SFS personnel will be coordinated through Wing/IG office prior to execution.

3.2.4. The MH duress action plan will be maintained on file with documentation of training, attendance and practice.

3.3. On-Call Procedures.

3.3.1. MH will provide consultation to commanders after established duty hours. MHPs offer recommendations on managing crisis situations to commanders, law enforcement agencies, first sergeants and other helping agencies.

3.3.2. Occasionally, MHPs may be asked to meet a commander at the crisis scene. On-call providers and/or MH personnel may recommend response options but will not conduct patient assessment or provide intervention at the scene and will not be directed to engage with individuals exhibiting threatening behaviors. Personnel requiring evaluation must be taken to the ED by law enforcement, emergency response personnel or by member's command, as appropriate.

3.3.3. MTFs without an ED.

3.3.3.1. If a commander determines an emergency MH assessment is warranted, the patient will be taken to a civilian ED for the assessment by law enforcement or other

emergency response personnel. Unless privileged at the civilian facility, AF MHPs will not evaluate or treat the patient until released.

3.3.4. MTFs with an ED.

3.3.4.1. An MHP will be on-call to conduct emergency evaluations and interventions within the MTF ED when requested by ED providers.

3.3.4.2. If a commander, in consultation with a doctoral-level MHP, determines that an emergency MH assessment is warranted, the patient will be taken to the ED for the assessment. An MHP will conduct the evaluation IAW this AFI and other referenced AF and DoD guidance.

Chapter 4

MH RECORDS & RECORDS MANAGEMENT

4.1. MH Record.

4.1.1. A single integrated MH record will be established for each patient seen in MH. The MH record will contain all documentation created by ADAPT, FAP maltreatment services and MH. Use of a single MH record facilitates awareness and communication between treatment providers via a single integrated source for documentation of care. Attachment 3 provides a table of the rules for this record. **Note**: This guidance applies to all new MH records. All existing, active records will either be converted to an integrated record or closed within one year of publication of this instruction.

4.1.2. MH records are a separate category of record. A psychotherapy note recorded in any medium by an MH professional documenting or analyzing the contents of conversation during a private, group, joint or family counseling session is considered a MH record and will be maintained separate from the member's medical record(s). MH records are protected from release by 45 Code of Federal Regulations (CFR) Subpart E, *Privacy of Individually Identifiable Health Information*, DoD 6025.18-R, *DoD Health Information Privacy Regulation*, AFI 33-332, *Privacy Act Program*, and AFI 44-109, *Mental Health, Confidentiality, and Military Law*. Additionally, MH records that contain details of a patient's substance abuse treatment are protected by the federal confidentiality of substance abuse patient records statute, section 543 of the Public Health Service Act, 42 U.S.C. 290dd-2 and its implementing regulation, 42 CFR part 2. All patient care provided in MH including ADAPT and FAP elements will be documented in the integrated MH record. (**Note:** The protection afforded the MH record by 45 CFR Subpart E and AFI 44-109 excludes the documentation of medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis and progress to date).

4.1.3. Each patient will have a single, integrated MH record with the following exceptions:

4.1.3.1. Minor children seen for FAP evaluation only. If a minor child is seen for a FAP initial evaluation only and no MH record exists for the child, a separate record will not be created. The evaluation will be filed in the sponsor's MH record. Documentation will be filed in the appropriate section and clearly labeled with the child's identifying information. If the child is seen subsequently for FAP treatment, a separate MH record will be created and a copy of the FAP intake moved to their individual record.

4.1.3.2. Geographically separated MH elements. At locations where a patient is being seen during the same timeframe in geographically separate clinics (i.e., ADAPT, FAP, MH), separate records may be temporarily created if transfer between clinics of a single MH record is problematic. Geographic separation is defined as clinics in separate facilities. Consideration of the importance and sensitivity of tracking duplicate records will be used to ensure close communication between the clinics using temporary separate records to coordinate services provided. When care ends at one of the geographically

separated clinics, the documentation will be re-filed chronologically into a single MH record.

4.1.3.3. TSR psycho-educational counseling. No record is required if a member is seen for TSR psycho-educational counseling (up to four meetings by any member of the TSR team) following a potentially traumatic event. These meetings must be for the purpose of education and consultation and not for medical assessment and treatment IAW AFI 44-153, *Traumatic Stress Response*.

4.1.3.4. Educational, non-count patient activities. These contacts cannot involve assessment or treatment that results in diagnosis or documentation of communications as part of medical care.

4.1.3.5. Non-military intimate partner services. Documentation of assessment, safety planning and referrals of non-military beneficiaries who are intimate partners seen as part of a FAP evaluation will go into their AD intimate partner's record as a collateral contact.

4.1.3.6. NPSP and FAST prevention records. These records are maintained separately IAW AF FAP Standard P-10 and P-12 as required by AFI 40-301.

4.1.4. MH documentation will be in a six-part folder. The highest top right corner of the record will be labeled with:

4.1.4.1. Patient's last name, first name, middle initial and pay-grade (if applicable).

4.1.4.2. AD family member prefix and sponsor's Social Security Number IAW AFI 41-210, *TRICARE Operations and Patient Administration Functions*.

4.1.5. Place AF Form 745, *Sensitive Duties Program Record Identifier,* on the top right side in the MH record of any individual involved with a sensitive duty.

4.1.6. For all records of patients seen by the Family Advocacy Element, assigned incident numbers and victim names will be placed on the top left corner of the record.

4.2. MH Record Organization.

4.2.1. The six-part record will be organized in the following order and contain the listed administrative documentation. Each section will be clearly marked. Additional guidance for FAP documentation is described in FAP Standard M-8. Additional guidance for ADAPT documentation is provided in AFI 44-121.

4.2.2. SECTION A: ADMINISTRATION.

4.2.2.1. Privacy Act Form.

4.2.2.2. Written Informed Consent/Patient Information Sheet. There will be a standardized format approved for all MH Outpatient, FAP and ADAPT services. FAP clients must complete the approved AF Form 4405, *Family Advocacy Program (FAP) Client Information Form Maltreatment Intervention Services.* This form will describe services offered, hours of operation, rights and responsibilities of the patient, including the voluntary nature of services (unless commander-directed), privacy information, limits to confidentiality and mandated reporting requirements, after-hours emergency contact procedures and record transfer process upon PCS, separation and/or retirement. Patients sign and date the form (see Attachment 4 for an example).

4.2.2.3. Patient information forms. FAP intake forms [AF Form 2522, *Family Advocacy Program Intake* and FAP Client Questionnaire printed from Family Advocacy System of Records (FASOR)], ADAPT Substance Use Assessment Tool (SUAT) generated patient information forms, or locally developed MH element forms capturing patient demographics, contact information, reasons for seeking care, presenting complaints, prior history of treatment, current medications and other information as needed.

4.2.2.3.1. The patient information form will ask if the patient is requesting services voluntarily. If the patient was directed by command for an MH evaluation, procedures described in AFI 44-109 must be followed. Involuntary FAP and ADAPT patients will be managed according to relevant AFIs.

4.2.2.4. Release of Information Requests.

4.2.3. SECTION B: PSYCHOLOGICAL TESTS AND OTHER DATA COLLECTION INSTRUMENTS.

4.2.3.1. Raw psychological test data or other objective measures (e.g. OQ-45, BDI, PCL-M, etc).

4.2.3.2. FAP Child/Spouse Incident Report (FASOR 2486) and any other completed inventories that are required or selected by FAP staff.

4.2.3.3. Assessment printouts from SUAT.

4.2.4. SECTION C: MEDICAL DOCUMENTATION FROM OUTSIDE MH. Documentation from other MTFs and civilian clinics.

4.2.5. SECTION D: NON-MEDICAL DOCUMENTATION. Documentation including investigative reports, photographs, official state and city agency correspondence, etc.

4.2.6. SECTION E: MH DOCUMENTATION NOT INCLUDING TREATMENT NOTES.

4.2.6.1. Treatment/intervention plans, contracts, behavior logs, safety plans, suicide assessment tools and related information. Current treatment plans must be maintained on top of this section.

4.2.6.2. Medication Reconciliation Documentation.

4.2.6.3. CDE documentation. The request from the commander for the CDE, copy of the commander's notice of CDE to the member, copy of the final CDE report and other relevant documents. Evaluation notes by the provider will be placed in Section F.

4.2.6.4. FAP Referral Form.

4.2.6.5. Clinical tools (e.g., handouts, genograms).

4.2.6.6. MEB Narrative Summaries.

4.2.6.7. Sanity Board Reports.

4.2.6.8. Civilian Fitness for Duty Reports.

4.2.7. SECTION F: CHRONOLOGICAL DOCUMENTATION.

4.2.7.1. Initial assessment note completed by provider/technician. (**Not**e: Documentation filled out by patients will not be a part of the initial assessment note. Information forms filled out by the patient will be filed in Section A.)

4.2.7.2. Documentation of patient care such as psychotherapy, group therapy, medication management, ADAPT treatment team meetings and other meetings.

4.2.7.3. Psychological testing interpretation reports.

4.2.7.4. HI [MCCC notes, High Risk for Violence Response Team (HRVRT), Child Sexual Maltreatment Response Team (CSMRT)] clinical and multidisciplinary case staffing notes.

4.2.7.5. Termination/transfer notes.

4.2.7.6. Administrative documentation such as patient no-shows, rescheduling of appointments, telephonic contact, etc.

4.2.8. Documentation of assessments, interventions and/or treatment will be in SOAP format:

4.2.8.1. Subjective (S): Includes information obtained from patient report, description of therapeutic encounter and other collateral information.

4.2.8.2. Objective (O): Includes mental status information (e.g., affect, mood, cognition, etc.), testing results and other information observed or obtained regarding the patient. Suicidal and homicidal assessment must be documented at each session.

4.2.8.3. Assessment (A): Includes American Psychiatric Association Diagnostic and Statistical Manual (DSM) assessment (All five Axes for initial assessment and termination notes; at least first three Axes for other notes), assessment of progress of treatment in relation to treatment goals and other appropriate assessment information. FAP providers will use this section to document assessment of risk for maltreatment. If diagnosable conditions are identified, they will also be documented.

4.2.8.4. Plan (P): Describes the plan for further care if indicated or decision to terminate care. The plan will be sufficiently detailed so another provider can assume care if required. Prevention counseling may be documented in this section. Scheduling information (e.g., "Return to clinic in one week") is not sufficient in and of itself.

4.3. MH Record Documentation Rules.

4.3.1. All documentation will be filed in chronological order with more recent documentation filed on top of older documentation. Two-sided documents will be printed head-to-toe, if possible, to allow ease of reading.

4.3.2. All handwritten entries will be printed or written legibly and signed.

4.3.3. Entries will be made on approved forms or overprints IAW AFI 41-210.

4.3.4. For each patient contact, a note will be accomplished for the MH record. All patient notes will be dated, have the clinic name at the top of the note and will have signature of the MHP with signature block below (name, rank, service, corps, duty title). Notes by non-privileged staff will be co-signed by a privileged provider. Refer to section 7.21. in AFI 44-

119, *Medical Quality Operations*, for guidance regarding Certified Alcohol and Drug Abuse Counselor co-signature requirements.

4.3.5. All collateral contacts, such as phone calls to commanders, first sergeants or family members, will be documented on an SF Form 600, *Medical Record – Chronological Record of Medical Care*, and filed in Section F of the MH record.

4.3.6. Additional documentation requirements can be found for FAP in AFI 40-301 and the FAP Standards; for ADAPT in AFI 44-121.

4.3.7. Provider corrections in hard copy notes will be made by lining through the incorrect data with one straight line, making the correction, initialing and dating the correction. Erasing, scratching-out, blotting, whiting-out or otherwise destroying the original data is prohibited. Enter the correct data next to the lined-through data. Amendments of erroneous data will be done by the originating provider. A brief explanation will be documented if that person is not available. When using electronic/computer formats for treatment notation, follow the appropriate procedures for amending the permanent electronic note (e.g., amend function for AHLTA).

4.3.8. MH record documentation will be sufficiently detailed and organized to:

4.3.8.1. Facilitate continuity of care, document patient safety or risk status and describe diagnostic and therapeutic procedures performed as well as the patient's response to treatment.

4.3.8.2. Enable another MHP (within the respective discipline) assuming care or providing adjunct care to clearly understand the rationale for diagnosis, treatment, care provided and treatment plan.

4.4. Treatment Planning Format. Documentation of patient care will detail, either in the progress notes or in conjunction with a separate treatment plan, a clear explanation of the goals, therapeutic modalities and outcome measures. Treatment planning will be an ongoing process and collaborative with the patient. FAP providers must use the FASOR-generated intervention plan.

4.5. Closure/Transfer Notes.

4.5.1. Closure notes will be accomplished upon completion of MH care. A transfer note will be completed prior to transfer of care. See Attachment 5.

4.5.2. In the MH Record, closure/transfer notes will contain the following information:

4.5.2.1. Identifying information (Specify name, FMP/SSAN, duty position).

4.5.2.2. Date case opened and date of last contact.

4.5.2.3. Initial diagnosis.

4.5.2.4. Brief description of the course of treatment, status and significant clinical presentation to include HI status and prognosis.

4.5.2.5. Final diagnoses (Specify all five Axes).

4.5.2.6. Impact on military duty performance. Comments will include profile changes and current profile; any duty impact and restrictions during course of treatment, currently,

and anticipated at next assignment; MEB actions if taken; information impacting security clearance [omit personal details]; duty position of patient at termination [this is to support profile decisions in the event the patient is transferring from one job where profile was not needed to another position where it might be], and summary of any CDE recommendations, if the member underwent a CDE.

4.5.2.7. Reason for termination or transfer (Specify whether completed treatment, no show/cancel, PCS, separation from the military, unknown, other).

4.5.2.8. Recommendation for follow-up, if any.

4.5.3. In the Medical or Health Record (HR), closure/transfer notes will contain the following information (see Attachment 6):

4.5.3.1. Identifying information (Specify name, FMP/SSAN, duty position).

4.5.3.2. Date case opened and date of last contact.

4.5.3.3. Brief description of the course of treatment, status and prognosis (omit sensitive personal information).

4.5.3.4. Final Diagnoses (Specify all five Axes).

4.5.3.5. Reason for termination or transfer (Specify whether completed treatment, no show/cancel, PCS, separation from the military, unknown, other).

4.5.3.6. Profile and duty restrictions.

4.5.3.7. Recommendation for follow-up, if any.

4.6. HR Documentation.

4.6.1. For each outpatient visit, an abbreviated entry will be made into the electronic medical record of the individual(s) seen, in sufficient detail to enable health care providers in other clinics to provide effective continuing care to the patient(s). Sensitive, personal information disclosed in therapy will not be entered into the HR. Documentation in the HR will include a brief description of treatment, medication prescription and monitoring, results of clinical tests, diagnosis, prognosis and progress to date.

4.6.2. For AFR patients, a copy of each entry in the individual(s) HR should be immediately forwarded to the member's Reserve Medical Unit (RMU) for placement into the member's physical medical record.

4.6.3. For MH and ADAPT, a brief SOAP note is required for:

4.6.3.1. Initial assessment.

4.6.3.2. Any treatment visit.

4.6.3.3. Changes in diagnosis, profile, and/or therapy.

4.6.3.4. When medication is prescribed, renewed, changed or discontinued.

4.6.3.5. Closure or transfer.

4.6.4. Other patient contacts (telephone, email, messages left at reception area) may be documented in the HR, but do not require a full SOAP note.

4.6.5. For FAP contacts:

4.6.5.1. Briefly document in-person visits and closure or transfer summaries.

4.6.5.2. If a child is engaged in treatment, then a separate record will be used.

4.6.6. Missed appointments will be documented in the HR.

4.7. MH Record Closure.

4.7.1. All open MH records must be reviewed at least every six months. Patients who have not had an appointment at the clinic for the past three months or longer and whose care has not been formally terminated should be referred to a MHP for further contact or for completion of a closure note IAW Section 4.5.

4.7.2. Voluntary patients at no significant risk for suicide/homicide who choose not to continue care may be considered low risk for purposes of case closure. The MH record may be closed without further contacts at the provider's discretion.

4.7.3. Patients determined to be at mild risk will be contacted prior to case closure if they failed to attend scheduled appointments or requested to discontinue care prematurely. The provider will express safety concerns and make recommendations to the patient within a week of the first missed appointment. This encounter must be recorded in the MH record. MH staff will make at least three contact attempts before closing the case.

4.7.4. Patients assessed to be at moderate or higher risk for suicide/homicide will be considered HI patients and will be rescheduled immediately in the event of a "no show" for a scheduled appointment.

4.7.4.1. The commander and/or first sergeant will be informed if contact cannot be established within one hour or the HI patient refuses follow-up.

4.7.4.2. Closure of HI cases requires documentation of the provider's rationale and safety or transfer plan.

4.7.4.3. The commander or first sergeant will be informed of the intent to close an HI case and the plan to maintain patient safety.

4.8. Securing MH Records.

4.8.1. MH records must be kept in a properly secured location in the clinic. Records will be stored under a double lock system (e.g., stored in a locked cabinet/file system in a locked room).

4.8.2. MH records will not be removed from the MH Flight without MH Flight Commander approval or be left overnight in staff offices.

4.9. MH Record Retirement. MH records will follow the procedures for physical record retirement IAW AFMAN, 33-363, *Management of Records*. The retirement schedule that requires the longest retention of the record will be used. MH records will not be destroyed.

4.10. Release of Information.

4.10.1. Patient's information will be released IAW AFI 33-332, AFI 41-210, AFI 44-109 and DoD 6025.18-R. If requested, a patient may be given a summary of their care by the patient's provider.

4.10.2. If disclosure of confidential communications is requested for the purpose of a criminal investigation or proceeding under the Uniform Code of Military Justice (UCMJ), the MHP must determine if an exception to the general rule of privilege applies to that disclosure. This will be done with consultation from the Staff Judge Advocate (SJA). This request for information will be handled IAW local MTF procedures for requesting information. Normally, the requesting agency must request information for investigative purposes in the form of questions directly to an MHP, not as a formal release of the entire record. Guidance on how to respond to subpoenas and court orders for MH records will be obtained from the installation SJA or medical-legal consultant.

4.10.2.1. When release of information is determined to be required, the primary provider, element officer in charge (OIC), and/or the MH Flight Commander will review the record and make recommendations for redactions.

4.10.2.2. Redactions are the act of blacking out information on copies of documents being provided that could be potentially harmful to the patient and/or others referenced in the documents. This information is determined through the provider's clinical judgment but will be reviewed by the local SJA or (when available) the Medical Legal Consultant for guidance and support.

4.10.2.3. Due to differing rules regarding confidentiality and release of information guidelines specific to FAP and ADAPT, refer to AFIs 40-301 and 44-121 for guidance.

4.10.3. MH will coordinate with the MTF Health Insurance Portability and Accountability Act (HIPAA) privacy officer to track disclosures of protected health information.

Chapter 5

MH TREATMENT PROCEDURES

5.1. Access to Care.

5.1.1. MH will optimize the availability of its services to meet the needs of the enrolled population. The MH Flight Commander is responsible to ensure access standards are met, i.e., same day for emergent appointments, seven days for routine appointments. (**Note:** The ANG does not have MH Flight Commanders or military or DoD civilian MHPs to provide MH assessment, referral or treatment. ANG MH assessment and referral needs will be provided by contract position DPHs. Referrals for MH treatment will be made to community providers).

5.1.2. MTF commanders will coordinate a plan for specialty care that is unavailable in the clinic (e.g., inpatient psychiatric care, child psychiatry, inpatient substance abuse treatment, etc.). If required, they will obtain memoranda of agreement with hospitals and other resources to facilitate care.

5.1.3. Guidelines will be established for provision of MH care to ADAPT and FAP clients (AFI 44-121 and AFI 40-301). When assessing a patient's need for treatment in ADAPT or FAP, MHPs will consider whether MH treatment would also benefit the patient.

5.2. High Interest (HI) Patient Procedures.

5.2.1. HI status reflects a provider's judgment that heightened monitoring is indicated and the threshold for proactive intervention is lower than that required for other patients. Therefore, any patient, including those seen in ADAPT and FAP, meeting these criteria can be categorized as HI. Patients who are judged to be a moderate or higher level of risk for psychological decompensation or significant maladaptive behavior will be categorized as HI.

5.2.1.1. Patients assessed by the provider to be at moderate or higher suicide risk by definition are categorized as HI.

5.2.1.2. Patients with homicidal ideation/intent or significant psychopathology rendering them unable to provide for their own wellbeing or their dependent children are other examples of HI patients.

5.2.1.3. Patients being discharged from higher levels of care (i.e., inpatient or partial hospitalization for MH or substance issues) are categorized as HI and will be monitored over a sufficient period of time until clinical stability is well established.

5.2.1.4. Any case that currently meets the criteria for the activation of the HRVRT, CSMRT or other teams as clinically indicated will be considered HI.

5.2.1.5. A Primary MHP (PMHP) will be identified for each HI patient. Typically, the PMHP will be the MHP with the most contact with the patient.

5.2.1.6. The PMHP will be responsible for ensuring coordination of care with other providers (e.g., MHPs, PCMs) and the patient's commander.

5.2.1.7. The PMHP will generally be responsible for entering and removing the patient from the high interest log (HIL). Patients will be placed on the HIL as soon as the

provider makes that determination. Notifications to the patient's PCM, the ED, the on-call MHP and the patient's commander (if military) will be made the same duty day (ideally immediately and NLT the next duty day if determination is made after duty hours).

5.2.1.8. When the patient or their immediate family member is placed on the HIL due to high risk and is on PRP/PSP status or holds a Top Secret or higher clearance, the MHP will ensure that appropriate notifications to the program monitors are made [refer to AFMAN 10-3902, *Nuclear Weapons Personnel Reliability Program (PRP)]*. Notifications must be documented in the MH record and updated as needed.

5.2.2. High Interest Log (HIL).

5.2.2.1. The term "high interest log" replaces the term "high risk log" as referenced in AFI 44-102, *Medical Care Management*.

5.2.2.2. MH will maintain a HIL.

5.2.2.3. At a minimum, the HIL will contain the name of the patient, PMHP responsible for the coordination of the patient's care, date entered onto HIL, diagnosis, nature of the risk (e.g., risk level, risk factors), PCM, command representative and the next scheduled follow-up appointment.

5.2.2.4. Patients and commanders or first sergeants (in cases of military patients) must be apprised of the purpose and procedures of the HIL. Specifically, patients will know the policies for "no shows" and their responsibility to contact MH if they are unable to attend a MH appointment.

5.2.3. Multidisciplinary Clinical Case Conference (MCCC).

5.2.3.1. An MCCC will be established for case management monitoring of patients on the HIL and other patients as needed. All MHPs will attend the MCCC on a weekly basis.

5.2.3.2. Information necessary to coordinate care and manage risk will be shared with all MHPs and documentation of this coordination/case discussion will be placed in the MH record in Section F.

5.2.4. Coordination and Continuity of Care.

5.2.4.1. The HIL will be shared at least weekly with PCMs or their designees as well as ED providers if the facility has an ED. Significant changes in the risk status, treatment plan or precautionary measures must be communicated to the patient's PCM or designee, the on-call MHP, the ED and the patient's command (in cases of military patients) immediately (NLT next duty day if determination is made after duty hours).

5.2.4.2. A designated MHP will discuss HI cases with MTF PCMs face-to-face at least monthly.

5.2.4.3. The on-call MHP will be accessible to patients who are on the HIL when the PMHP is not available. When the PMHP anticipates being unavailable, the PMHP will inform other providers who will be covering any HI patients from his or her caseload.

5.2.4.4. MH staff will work with inpatient staff to ensure continuity of care before, during and after psychiatric hospitalizations. MH staff members will communicate with inpatient providers upon admission and discharge and at appropriate intervals throughout the duration of hospitalization (at least weekly).

5.2.4.5. Following discharge from higher levels of care, such as inpatient psychiatric care, partial hospitalization programs or substance abuse rehabilitation, an MHP will assess military personnel for fitness for duty and safety the same day whenever possible, but NLT the next duty day after discharge. MHPs should strongly encourage civilian facilities to not discharge patients after duty hours and/or on non-duty days. If MHPs become aware of a discharge that occurs during non-duty hours, the MHP will collaborate with the patient's commander to ensure that an adequate safety plan is established until the patient can be evaluated and care resumed by MH.

5.2.4.5.1. MH staff will inform the member's commander when a military member is released from inpatient care or partial hospitalization. This communication will be made directly to the commander to ensure clear communication at this time of heightened risk.

5.2.4.5.2. MH staff will prepare a new outpatient safety plan based on the assessment conducted after the patient's discharge.

5.2.4.5.3. If the member declines this evaluation and there is an indication of elevated risk, an emergency CDE will be recommended to the commander to ensure adequate safety assessment of the member.

5.2.5. Documentation.

5.2.5.1. All intake notes in both the MH record and HR will document specific assessment of potential for harm to self and/or others and document level of risk. Where multiple members of the family are seen at intake, notes will document each individual's assessment for risk of maltreatment.

5.2.5.2. MH records of HI patients will be identified with a yellow-colored cover sheet labeled "High Interest" on the top of Section F until the patient is removed from HI status.

5.2.5.3. A statement indicating a patient's HI status will be placed in the HR to facilitate awareness by allied health providers of risk status. The first sentence of the subjective elements will state in capital letters "HIGH INTEREST".

5.2.6. Clinical Management of Suicidal Patients. MHPs will:

5.2.6.1. Specifically target suicidal symptoms and risk factors in the formal outpatient treatment plan.

5.2.6.2. Take steps to safeguard the environment, especially limiting access to means of self-harm such as weapons.

5.2.6.3. Strongly consider using written screening tools. Discrepancies between what patients state verbally versus written statements will be reconciled. The MHP must have a clear understanding of any conflicting information that suggests risk for suicide.

5.2.6.4. Use management strategies that are uniquely applicable to military members such as the Limited Privilege Suicide Prevention (LPSP) program, profiles, MEBs, administrative separation recommendations and communication with commanders.

5.2.6.5. Enter patients who are psychiatrically hospitalized for suicide risk or attempted suicide into the HIL for at least four weeks following discharge or the attempt, whichever is later.

5.2.6.6. Carefully evaluate every Airman with a recent suicide attempt for both ongoing care and fitness/suitability for continued duty. Following any military member suicide attempt, the MTF SGH will lead a meeting to review the case and determine the medical disposition of the individual. This meeting must include at least one MHP. An Airman with a potentially medically disqualifying diagnosis will meet an MEB. Those with a potential personality disorder or other unsuitable condition will be referred to his/her commander with a recommendation for a CDE. Notify HQ AFR/SGP at Robins AFB, GA about all suicide attempts by AFR personnel to ensure proper disposition.

5.2.6.7. Initiate a fitness for duty determination for suicide attempts by ARC members.

5.2.6.8. MH personnel will accomplish DoD Suicide Event Report (DoDSER) for all completed suicides and suicide attempts requiring hospitalization or evacuation from theater of military members.

5.2.6.9. As clinically appropriate, work with patients to use community support resources to complement MH treatment (e.g., friends, family, unit, Airman and Family Readiness Center, Chapel, Health and Wellness Center, Alcoholics Anonymous, community based support groups, etc.) in managing suicidal behavior.

5.2.7. Cancellations.

5.2.7.1. If a HI patient calls to cancel an appointment, the MH staff will obtain the number where the patient is calling from and transfer the patient's call directly to the PMHP.

5.2.7.2. If the PMHP is unavailable, the MH staff will contact the on-call provider or other available MHP.

5.2.7.3. The PMHP will speak directly with the HI patient. The unit commander will be informed immediately if the patient refuses follow up. A course of action will be recommended to the commander by the PMHP based on the patient's individual needs.

5.2.8. Failure to keep scheduled appointments ("no shows").

5.2.8.1. If the HI patient no shows, the MH staff will contact the PMHP immediately.

5.2.8.2. If the PMHP is unavailable, the MH staff will contact the on-call provider or other available MHP.

5.2.8.3. HI patients will be rescheduled immediately in the event of a no show for a scheduled appointment.

5.2.8.4. The unit commander will be informed immediately if contact cannot be established within one hour or the patient refuses follow up.

5.2.8.5. All attempts to contact the patient and contacts with commanders and first sergeants will be documented in the MH record, Section F.

5.3. Multi-Disciplinary Case Management (MCM).

5.3.1. MCM coordinates the care of patients who may be involved in multiple elements within MH. These cases are usually complex or involve administrative or legal action (but do not warrant HI status).

5.3.2. An MCM log will be maintained to facilitate clinical case coordination and consultation.

5.3.3. Cases on the MCM log will be discussed weekly at the MCCC.

5.3.4. Sufficient information necessary to coordinate care and manage risk will be shared with all MH clinic personnel and documentation of this coordination/case discussion will be placed in the MH record.

5.3.5. MCM log will not be shared outside MH. However, clinical coordination of care with other allied health care providers will occur as needed.

5.4. Transferring MH Records and Coordination of Care at the Time of Permanent Change of Station (PCS).

5.4.1. All patients will be briefed on the possible need for transfer of information upon PCS as part of the initial orientation to the MH Clinic, ADAPT Program, or FAP. This briefing will be provided verbally, documented in the clinic record, and will also be incorporated as part of the initial confidentiality/consent to treatment paperwork reviewed and signed by the patient (see Attachment 4).

5.4.2. The MH Flight will obtain, from the MPF, a monthly listing of individuals identified for PCS departure. MH Flight staff will check clinic files for records of transferring personnel. When clinic records are identified, each case will be reviewed to determine appropriate action as outlined below.

5.4.2.1. For AD patients consent to transfer MH record/care is not required. However, every effort shall be made to involve AD patients in the process.

5.4.2.2. For non-AD patients actively involved in treatment at the time of PCS, the provider will discuss any need to transfer care/records. However, transfer cannot be accomplished without written consent. Closed records on non-AD patients are also reviewed prior to PCS. If the reviewing provider has concerns about elevated risk, the provider may contact the patient for a status check and determination of any need to transfer the record. Again, this transfer cannot be accomplished without the individual's written consent.

5.4.3. Open Cases. For all open MH Flight cases, the provider will review the case to determine if the record should be closed or if the patient's care should be transferred to a MH Flight at patient's new duty station. The decision to close a case will be based on clinical indications and not simply due to a move or for administrative convenience. The MHP will document the decision to close a case with a termination note in the MH record and the outpatient medical record. See Attachments 5 and 6. If the MHP makes the determination

that the case should remain open, the MHP will contact the patient to discuss the recommendation for continuing care at the patient's new duty station.

5.4.3.1. For cases requiring transfer, the MHP shall contact a privileged MHP at the gaining base, communicating patient status and needs in transition, as well as establishing an appointment for follow-up to ensure continuity of care. Prior to departing for the new duty station, the patient will be informed of the transfer of information and shall be given the name of a MHP at the gaining base, contact information and an appointment.

5.4.3.1.1. Prior to the patient's PCS, the MHP at the losing base will also complete and forward to the gaining MHP a summary of treatment outlining the basis for initial contact, identified problems, diagnostic assessment, risk assessment, treatment plan (including medications and therapeutic interventions), progress in relation to identified goals, referrals (if any), and status at the time of transfer, see Attachment 5, *Sample Mental Health Record Transfer/Termination Summary*. An abbreviated version of this summary will be placed in the outpatient medical record, see Attachment 6, *Sample Outpatient Medical Record Transfer/Termination Summary*. Document both summaries on a SF Form 600.

5.4.3.1.2. The contact with gaining MHP and the patient, the provision of contact information and the transfer of information will be documented in both the MH record and the outpatient medical record.

5.4.3.1.3. In the event a patient fails to appear for the scheduled appointment at the gaining base, the identified MHP at the gaining base will follow up to determine the cause and to reschedule, if appropriate. If the patient is diverted in route, the provider scheduled to deliver follow-on services will notify the referring MHP at the losing base. MH personnel at the losing base retain responsibility for coordinating follow-on services if the patient is diverted in route. Communicating the minimum amount necessary, the MHP at the losing base will work with the MPF in tracking the patient and, once the new base of assignment has been determined, will contact the appropriate MH Flight to provide necessary information and ensure appropriate follow up.

5.4.3.2. If the patient refuses to continue treatment and/or to schedule a follow-up appointment as recommended by the MHP, the provider should document the encounter and the decision by the patient to refuse services. The MHP should complete a summary of treatment for the MH record (see Attachment 5) and for the medical record (see Attachment 6).

5.4.3.2.1. If, in the provider's judgment, the failure to transfer care will result in risk to the patient, others, or the military mission, the MHP will contact the patient's commander and communicate concerns regarding increased risk.

5.4.3.3. Patients involved in required treatment as part of the FAP and/or ADAPT will have their cases transferred to their new duty stations to continue treatment.

5.4.4. Closed Cases. The decision to close a case will be based on clinical indications and not simply due to a move or for administrative convenience. The MHP will document the decision to close a case with a termination note in the MH record and the outpatient medical record. See Attachments 5 and 6.

5.4.4.1. All closed cases of AD members will be reviewed to assess risk of adverse mission impact. Particular attention should be given to review of cases involving a diagnosis of substance dependence, substantiated (but closed as unresolved) cases of family maltreatment, or previous suicide attempt. Reviewing providers will apply operational and clinical judgment in assessing risk of adverse mission impact, basing their assessment on their understanding of the member, the member's potential response to pressures associated with PCS, and the demands likely to be encountered in the new working and living environment. When a reviewing MHP cannot adequately assess the stressors likely to be encountered in a new working or living environment, the MHP should query his/her counterpart at the gaining base in order to determine appropriate action. If it is determined the risk of adverse mission impact warrants MH intervention, the provider at the losing base will follow the same procedures noted above for transferring open cases.

5.4.5. During the review of either open or closed cases, if the current risk for adverse mission impact is deemed severe enough to warrant a potential cancellation of PCS, the MHP will notify the member and his/her current Commander.

5.4.6. The MHP at the gaining base may request a copy of the MH record from the losing base.

5.4.7. Release of information to the gaining command will be based on the gaining provider's assessment of the risk of adverse mission impact. Release of MH information to command shall occur IAW AFI 44-109. Disclosures to command authorities will be tracked IAW DoD 6025.18-R and AFI 41-210.

5.5. Other Continuity of Care Procedures.

5.5.1. The MH Flight must notify the referring provider whenever a referred patient fails to keep their initial MH appointment.

5.5.2. Continuity of Care - Civilian Facility or provider.

5.5.2.1. Military patients referred for civilian MH care by an MHP will have a follow-up appointment with an MHP in order to facilitate continuity of care, and will be tracked at least quarterly to document duty and readiness fitness.

5.5.2.2. Military patients referred for civilian MH care by a non-MH MTF provider will be tracked by their MTF PCM at least quarterly to document duty and readiness fitness.

5.5.3. Commanders will notify MH staff if they become aware of a military member being seen off-base for emergent MH services. Likewise, MH staff will notify commanders when a military member is seen for emergent MH services (see paragraph 5.9) in order to facilitate appropriate safety and operational planning.

5.6. Management of Patients in Crisis (during duty and after-duty hours).

5.6.1. During duty hours, an MHP will be available to conduct emergency evaluations and consultation to base personnel. If services cannot be delivered in MH by close of business, arrangements will be made for the patient to be seen at an emergency medical facility per established MTF procedures. In some cases, the MHP may determine that the need for services is not acute and may arrange for the patient to be seen later in MH.

5.6.1.1. In an outpatient setting, MH assessments will only be performed during regular duty hours when both security and medical support are available. MH evaluations will not be performed at such places as the duty section, residence or public venues. Mass-casualty procedures may take precedence when indicated by Medical Command Centers.

5.6.1.2. After-hours MH assessments will only be conducted in an ED. In MTFs without an ED, these emergencies will be handled similar to other acute medical emergencies using community medical resources. MH assessments may be performed at any time in MTFs where a 24-hour ED is in operation.

5.6.1.3. If an emergent evaluation is conducted at MH, the requesting commander will provide an escort for the patient.

5.6.1.4. Transportation of patients. The unit commander is responsible for taking precautions to ensure the safety of the service member and others and for making arrangements for transportation to an emergency evaluation. Transportation of emergency MH patients will occur in a manner similar to other acute medical emergencies. Escort policies will not task MH personnel with accompanying MH patients in ambulances or Government Owned Vehicles (GOV)/Privately Owned Vehicles (POV). The exception is use of MH technicians to aid in air evacuation of certain categories of MH patients on military airlift.

5.6.1.5. Appointments extending beyond duty hours may increase risk. MH staff will ensure there is adequate staffing to minimize or respond to these risks.

5.6.1.6. MH will establish after-hours consultation procedures for commanders or other medical resources.

5.6.1.6.1. If initial consultation is provided by an intern or resident provider in an AF residency/internship training program, a privileged MHP will be available to provide appropriate supervision.

5.6.1.6.2. If the initial consultation is provided by MH technicians, and involves patient assessment, then in all cases a privileged MHP will provide eyes on supervision. If the consultation is to command, then a privileged MHP will be available to provide supervision to the technician as indicated.

5.6.2. On intake for evaluation, mental health staff shall ask whether the member is there voluntarily or at the direction of his or her commander/supervisor. If the member responds with the latter and the commander has not initiated a commander-directed mental health evaluation (CDE) IAW DoDD 6490.1 and DoDI 6490.4 and AFI 44-109, the MHP shall contact the commander to determine if a CDE was intended.

5.6.3. Fitness and Suitability for Duty Determinations.

5.6.3.1. All military personnel must be fit and suitable for their assigned duty, both physically and psychologically. Personnel must be able to perform job-related duties, accomplish mission tasks and tolerate environmental stressors.

5.6.3.2. Certain duty statuses, such as PRP/PSP, weapons bearing status, security clearances and/or flight status, have specific requirements for medical fitness and suitability. MH will advise Flight Medicine anytime a patient on flight status is seen. Flight Medicine will clear the member prior to resuming flight duties (AFI 48-123,

Medical Examinations and Standards). Notifications are also required for Remotely Piloted Aircraft (RPA) crewmembers, air traffic controllers, weapons controllers/directors, combat controllers and Aerospace Control and Warning Systems, Tactical Air Control Party and Air Liaison Officer.

5.6.3.3. MHPs will determine whether personnel with MH disorders are fit and suitable for duty. Any condition resulting in impairment could render the member unfit or unsuitable for duty and preclude deployment (**Note:** ANG DPHs are not permitted to perform fitness for duty evaluations).

5.6.3.4. Conditions that result in persistent or recurrent duty impairment, preclude deployment, or require continuing treatment for adequate functioning may require an MEB or administrative separation.

5.6.3.5. Factors influencing determinations of fitness and deployability for patients with MH disorders include:

5.6.3.5.1. Severity of symptoms or medication side effects.

5.6.3.5.2. Likelihood of relapse.

5.6.3.5.3. Risk of recurrence or exacerbation if exposed to operational stress or trauma.

5.6.3.5.4. Severity of functional impairment.

5.6.3.5.5. The provider's estimation of the member's ability to tolerate the rigors of austere or hostile environments.

5.6.3.5.6. Risk for deterioration, early return, or other adverse outcomes.

5.7. Commander-Directed Evaluations (CDE) Procedures.

5.7.1. CDEs will be conducted IAW Department of Defense Directive (DoDD) 6490.1, *Mental Health Evaluations of Members of the Armed Forces*; Department of Defense Instruction (DoDI) 6490.4, *Requirements for Mental Health Evaluations of Members of the Armed Forces*; AFI 44-109 and this instruction.

5.7.2. Commanders on G-series orders may request a CDE for a variety of concerns including fitness for duty, safety concerns, or significant changes in performance or mental state. CDEs will be initiated any time a commander is seeking feedback on a member from MHPs. Only commanders can order a CDE.

5.7.3. MHPs will discuss the reason for the request with the commander. They will document this and all subsequent discussions with the commander. MHPs will also document the rationale for their recommendations to the commander regarding the appropriateness of a CDE versus other options.

5.7.4. To ensure that DoD and AF guidance regarding CDEs are followed, MH will use a CDE checklist (see Attachment 7).

5.7.5. The assigned MHP will determine the appropriateness of the requested CDE based on whether it will assist the commander in answering specific duty-related questions. The MHP will also determine whether the CDE is being requested properly IAW DoDD 6490.1, DoDI 6490.4 and AFI 44-109.

5.7.6. The basis of a CDE request is observed behaviors that may indicate that the member has an impaired mental state or functioning based on a mental condition.

5.7.7. Before the initial appointment, MHPs will obtain the proper CDE documentation IAW DoD and AFIs. They will ensure that the commander followed the proper process for initiating the CDE. On intake for evaluation, MH staff shall ensure the member understands they are being evaluated at the direction of the commander.

5.7.8. At the start of the initial appointment, the MHP will review the legal requirements, process, limits of confidentiality and potential career impact of the CDE with the member.

5.7.9. Information to be reviewed by the MHP as part of the CDE will usually include:

5.7.9.1. A form to be completed by the member's commander, first sergeant and/or supervisor regarding the member's duty performance, recent changes in performance or behavior, as well as data such as time on station and administrative actions taken by the unit to remediate behavior.

5.7.9.2. Copies of the member's recent performance reports and Personnel Information File.

5.7.9.3. Psychological testing if administered. When a personality disorder is suspected, psychological testing is strongly recommended.

5.7.9.4. Collateral interviews with supervisors and with appropriate consent, coworkers, family members and friends, as appropriate.

5.7.9.5. Previous medical and MH records.

5.7.9.6. Laboratory and radiological studies as appropriate.

5.7.10. The MHP will complete a formal written response to the commander within one duty day following completion of the CDE. Reports will be consistent with the template found in DoDI 6490.4, Enclosure 5.

5.7.11. Emergency CDEs.

5.7.11.1. Emergency CDEs are conducted to assess imminent safety concerns (i.e., danger to self or others). All other questions from commanders will be handled through the routine CDE process. MHPs will ensure that an emergency CDE is warranted and the commander is aware of the limitations of an emergency CDE.

5.7.11.2. MHPs will consult with the commander to maximize the safety of the member during the referral process.

5.7.11.3. MHPs will ensure the member understands the reason for the referral, the process of the emergency CDE and the limits of confidentiality. MHPs will clearly differentiate between emergency CDEs, which are not voluntary and voluntary treatment of members who have presented to MH at the suggestion/encouragement of their command. MHPs will ensure voluntary treatment at the suggestion/encouragement of command is not coercive in nature.

5.7.11.4. All emergency CDEs will be accomplished IAW DoDI 6490.4 and AFI 44-109. Verbal feedback will be provided to the referring commander as soon as possible after the evaluation (within 24 hours). A written report will be completed within one duty day.

5.8. Limited Privilege Suicide Prevention (LPSP) Program.

5.8.1. The objective of LPSP is to identify and treat those AF members, who because of the stress of impending disciplinary action under the UCMJ, pose a genuine threat of suicide (AFI 44-109).

5.8.2. MHPs should clarify the potential benefits and limitations of confidentiality provided by this program for at-risk patients who are under investigation.

5.8.3. MHPs should attempt to have at risk patients enrolled in this program IAW AFI 44-109.

5.9. Duty Limiting Conditions (DLC).

5.9.1. An AF Form 469, *Duty Limiting Conditions Report*, will be initiated by a privileged MHP when a patient's MH condition impairs his or her ability to deploy or perform military duties, or whenever a patient's military duties impair his or her ability to recover from a mental illness or condition.

5.9.2. DLC status will be addressed at each patient appointment and annotated on all progress notes. Any change in status must be accompanied by justification and rationale.

5.9.3. Members with diagnosed conditions that are not amenable to treatment and restoration to full functioning within one year of onset of treatment will generally be considered unfit or unsuitable for military duty and the patient will be referred for an MEB or recommended for administrative separation.

5.9.4. Privileged providers who conduct military medical readiness assessments for individuals with psychiatric disorders must consider the following criteria. These criteria will be applied across each assessment event in the military medical readiness life-cycle (periodic health assessment, pre-and post-deployment assessment and reassessments).

5.9.4.1. All patients with conditions that do not meet retention requirements or that render an individual unfit or unsuitable for military duty will be referred through appropriate fitness for duty or administrative processes.

5.9.4.2. Psychotic and Bipolar Disorders are considered disqualifying for deployment.

5.9.4.3. Members with a psychiatric disorder in remission or whose residual symptoms do not impair duty performance may be considered for deployment duties.

5.9.4.4. Members with psychiatric disorders not meeting the threshold for an MEB will demonstrate a pattern of stability without significant symptoms for at least three months prior to deployment.

5.9.4.5. The availability, accessibility and practicality of treatment in theater must be considered in clearing members for deployment.

5.9.4.6. Members cleared to deploy will demonstrate behavioral stability and low potential for deterioration or recurrence of symptoms in a deployed environment. The environmental conditions and mission demands of deployment will be considered [e.g., impact of sleep deprivation, rotating schedules, fatigue due to longer working hours and increased physical challenges (including heat stress) with regard to a given MH condition].

5.9.4.7. The occupational specialty in which the individual will function in a deployed environment will be considered; however, deployed individuals may be called upon to function outside their military training as well as outside their initially assigned deployed occupation specialties. The primary consideration must be the overall environmental conditions and mission demands of the deployed environment rather than a singular focus on anticipated occupation-specific demands.

5.9.5. Medications prescribed to treat psychiatric disorders vary in terms of their effects on cognition, judgment, decision making, reaction time, psychomotor functioning and coordination. Caution is warranted in beginning, changing, stopping and/or continuing psychotropic medication for deploying and deployed personnel. Throughout the medical readiness lifecycle, medication will be evaluated for potential limitations to deployment or continued service in a deployed environment.

5.9.6. Few medications are inherently disqualifying for deployment for all military occupational specialties, at all potential operational locations and at all times during the conduct of operations. Clinical care proximity, procedures availability, tempo and demands of operations must be considered when determining use of psychotropic medications prior to deployment as well as in the operational environment.

5.9.6.1. Medications disqualifying for deployment include:

5.9.6.1.1. Antipsychotics, lithium and anticonvulsants.

5.9.6.1.2. Medications that require special storage considerations such as refrigeration.

5.9.6.1.3. Medications that require laboratory monitoring or special assessments, including lithium, anticonvulsants and antipsychotics.

5.9.6.1.4. Providers are required to initiate a DLC or medical profile when managing care involving the disqualifying medications listed in paragraph 5.9.6.1.

5.9.6.2. Potentially problematic psychotropics during deployments include short half-life benzodiazepines and stimulants. Consider potential for withdrawal symptoms, ability to secure and procure medications and potential for medication abuse when determining appropriateness for use by deploying personnel.

5.9.6.3. Providers should exercise clinical judgment regarding initiation of a DLC or medical profile, utilizing operational risk management principles, when managing other clinical situations or medications that can be potentially disqualifying for deployment. Provider clinical rationale utilized in making the determination regarding duty limitations should be clearly documented in the MH and HR notes.

5.9.6.4. A deployment waiver is required where less than 90 days of stability has been demonstrated in the following situations: Personnel who are newly diagnosed with an MH condition, personnel who receive a new prescription of a psychotropic medication, or personnel whose prescription for psychotropic medication has recently changed. Waivers will be considered for treatment scenarios that have clear evidence of clinical stability with minimal likelihood of de-compensation in a deployed setting and have been shown to be both effective and free of impairing side effects.

5.9.6.5. The combatant command overseeing the theater of operations may issue additional restrictions/guidance for deploying personnel.

5.10. Confidentiality.

5.10.1. Confidentiality is essential to providing effective MH care. While MHPs have an obligation to make notifications to commanders in specific situations, they will operate from a presumption of non-notification. MHPs will presume that they are not to notify a member's commander when a member obtains MH services in MH, primary care facility, or other setting where such services are provided. This presumption is overcome by the following situations which require command notification:

5.10.1.1. Harm to Self. The provider believes there is a serious risk of self-harm by the member.

5.10.1.2. Harm to Others. The provider believes there is a serious risk of harm to others. This includes any disclosures concerning child abuse or domestic violence.

5.10.1.3. Harm to Mission. The provider believes there is a serious risk of harm to a specific military operational mission to include cognitive deficits that could result in inadequate judgment.

5.10.1.4. Special Personnel. The member is in the PRP/PSP or is in a position that has been pre-identified by Service regulation or the command as having mission responsibilities of such potential sensitivity or urgency that normal notification standards would significantly risk mission accomplishment IAW DoDI 5210.42, *Nuclear Weapon Personnel Reliability Program (PRP)* and AFMAN 10-3902.

5.10.1.5. Acute Medical Conditions Interfering With Duty. The member is experiencing an acute MH condition or acute medical regimen that impairs his or her ability to perform his or her duties.

5.10.1.6. Substance Abuse Treatment Program. The member has entered into a formal outpatient or inpatient treatment program consistent with DoDI 1010.6, *Rehabilitation and Referral Services for Alcohol and Drug Abusers*, [Reference (f)] and AFI 44-121 for the treatment of substance abuse or dependence. Those who seek alcohol-use education who have not had an alcohol related incident (such as arrest for driving under the influence) do not require command notification unless they are diagnosed with a substance abuse or dependence disorder.

5.10.1.7. Child or Partner Maltreatment. A referral will be made immediately to FAP. As part of the FAP notification process, FAP will notify the military member's commander, unless the adult victim has requested and met the conditions for a restricted report of domestic abuse IAW AFI 40-301.

5.10.1.8. Sexual Assault Victims. Follow restricted reporting guidance provided in DoDI 6495.02 *Sexual Assault Prevention and Response Program Procedures* and AFI 36-6001, *Sexual Assault Prevention and Response (SAPR) Program.*

5.10.1.9. CDE. Information obtained as a result of a CDE consistent with DoDI 6490.4 and this instruction.

5.10.1.10. Other special circumstances. The notification is based on other special circumstances in which proper execution of the military mission outweighs the interests served by avoiding notification as determined by the SGH or MTF commander at the O-6 level or above.

5.10.1.11. Other medical personnel will also follow these disclosure rules regarding MH information.

5.10.2. Minimum Necessary Disclosure. In making a disclosure pursuant to the notification standards, health care providers will provide the minimum amount of information to satisfy the purpose of the disclosure. In general, this will consist of the diagnosis, a description of the treatment prescribed or planned, recommended duty restrictions and the prognosis.

5.11. Quality Management and Process Improvement.

5.11.1. MH staff will remain vigilant for processes that can be improved or new programs that could be implemented to support the flight's overall mission. Those activities that are high volume, involve HI patients, or are problem-prone are prime targets for process improvement.

5.11.2. MH staff will utilize a variety of data to identify processes requiring improvement and to develop solutions, including (but not limited to) self inspection checklists, peer review data, record audits, clinical data, customer feedback, the flight monthly status report and electronic medical record.

5.12. Peer Review.

5.12.1. MHPs will have peer review monthly. Ideally, peer review will be accomplished by a fully privileged provider within the same profession. If a provider of the same profession is not available at the installation, a fully privileged provider from the MH clinic will perform the monthly peer review within the scope of their clinical privileges to ensure compliance with AF unique standards of care. Additionally, arrangements will be made for same profession peer review at least quarterly.

5.12.2. All cases on the HIL will be peer reviewed monthly.

5.12.3. A minimum of three patient cases seen in the last 30 days must be reviewed per provider per month. If the provider did not see three patients or three records are not available, then all available records will be reviewed. HI records reviewed IAW the previous paragraph count towards this requirement.

5.12.4. Peer review will evaluate the quality of the assessment, mental status exam, diagnostic conclusions, clinical decision-making, risk assessment, treatment planning, documentation, legibility and organization of the record.

5.12.5. The reviewing provider will annotate any identified discrepancies or concerns on a standardized peer review form. The reviewing provider will advise the treating provider of the identified discrepancies for peer support and process improvement.

5.12.6. Correctable documentation errors will be corrected by the provider being reviewed IAW section 4.3.7.

Chapter 6

CLEARANCES

6.1. Family Member Relocation Clearances (FMRCs).

6.1.1. MH supports the FMRC process as a clinical consultant where MH or substance abuse issues are identified, IAW AFI 40-701, *Special Needs Identification and Assignment Coordination*. MHPs advise as needed on either outbound or inbound Facility Determination Inquiries (FDIs). The FAO or designee supports the FMRC process where FAP services are identified.

6.1.2. When MH identifies conditions that meet criteria for Exceptional Family Member Program (EFMP) enrollment, MH supports the functions of EFMP enrollment through mandatory referral to the EFMP Medical (EFMP-M) office, IAW AFI 36-2110, *Assignments*, Attachment 25, and AFI 40-701.

6.1.3. MHPs ensure the delivery of needed documentation to the Special Needs Coordinator (SNC) upon request for outbound FDIs regarding MH or substance abuse services obtained by family members in the MTF, or regarding those family members known to the providers of the MTF as requiring special services. MHPs complete the DD 2792, *Exceptional Family Member Medical Summary*, upon request of the SNC to support outbound FDIs or for EFMP enrollment.

6.1.4. MHPs provide consultation to the SNC or SGH upon request for outgoing FDIs regarding information gained during the interview, medical records review or electronic data review (such as medication histories) in order to support thorough documentation of MH needs in family members.

6.1.5. MHPs review incoming FDIs in locations where MTF MH/substance abuse services are provided to family members and make recommendations regarding service availability. MHPs provide consultation to the SNC and/or SGH as needed regarding whether host nation or local network capabilities meet MH needs specified on incoming FDIs.

6.2. Family Child Care Applications.

6.2.1. AFI 34-276, *Family Child Care Programs* requires MH, FAP and ADAPT to assist the Family Child Care panel in their decisions on licensure for day care providers.

6.2.2. MH will develop procedures for record search/review for Family Child Care applicants. Applications may be reviewed by a 5-level or higher MH technician. If no Potentially Disqualifying Information (PDI) is found, then the technician can sign the form. If PDI is noted, the application will be referred to a privileged MHP for review/approval.

6.2.3. A signed release will be provided by the applicant prior to record review.

6.3. Deployment MH.

6.3.1. All members' MH records will be screened by MH prior to deployment.

6.3.2. Members will receive an appropriate pre-deployment briefing prior to deployment to a combat zone in IAW AFI 44-153.

6.3.3. A person-to-person MH assessment will be conducted with a medical provider within 60 days of deployment.

6.3.4. All members deploying for 30 days or more to an imminent danger pay area will receive a predeployment neurocognitive baseline assessment utilizing the Automated Neuropsychological Assessment Metrics (ANAM) within 12 months prior to deployment. If the deployer has received a baseline within the previous 12 months and is deploying for a second time, no additional testing is required. At each base, MH will have at least one trained test proctor to schedule, administer and manage the data from ANAM.

6.3.5. Members returning from deployment will complete a Post Deployment Health Assessment (PDHA) questionnaire. PCMs will evaluate and refer members as appropriate based on their PDHA responses.

6.3.6. All redeployed members will receive a post-deployment briefing in conjunction with the installation redeployment support process IAW AFI 10-403, *Deployment Planning and Execution* and Chapter 8, *Redeployment Support Process*.

6.3.7. Post deployers will have a person-to-person MH assessment with a medical provider between 90-180 days after return from deployment, not later than 12 months after return from deployment and 24 months after return from deployment.

6.4. Special Clearances. MH staff may be required to assist in clearances for special duties [such as MTI/MTL, Survival Evasion Resistance Escape (SERE), Sniper school, recruiting duty, etc.]. They will ensure there is a signed consent for the release of confidential information and comply with the requirements outlined in the clearance request. Requests for clearances are not considered MH evaluations, but a clinical note will be placed in the electronic medical record and a copy of the documents kept in a clearance file.

6.5. Personnel Reliability Program (PRP)/Presidential Support Program (PSP).

6.5.1. PRP/PSP determinations require a comprehensive assessment of behaviors (both on- and off- duty), history, reliability, cognitive abilities and emotional stability.

6.5.2. For personnel being certified, recertified or otherwise evaluated for PRP/PSP, all HR SF Form 600s must be reviewed in order to determine if PDI exists (e.g., FAP, MH, ADAPT, relevant medical problems, MH issues treated by a PCM). Ensure ED documentation and Personal Health Assessments (PHAs) documentation are thoroughly reviewed. In addition, review Part III of the SF Form 93, *Report of Medical History*, as well as DD Forms 2807-1, *Report of Medical History* and 2807-2, *Medical Prescreen of Report of Medical History* (reports of medical history) in order to screen for responses made of prior-to-service behaviors or events that indicate discrepancies or potential disqualification, such as marijuana use, drug/alcohol rehabilitation, loss of consciousness, dizziness/fainting spells, significant head injury, previous MH problems, hospitalizations or treatment.

6.5.3. Consult DoD 5210.42-R, *Nuclear Weapons Personnel Reliability Program (PRP*) and AFMAN 10-3902 for more information on selection, evaluation, treatment and reporting of PRP/PSP personnel.

Chapter 7

MH PREVENTION SERVICES

7.1. MH prevention strategies will: target individual and organizational risk factors and increase resiliency in populations served. The RE has primary responsibility for these efforts, but will coordinate with other MH elements.

7.2. Prevention services at the installation level are: a collaborative effort shared among various agencies to include MH, MTF, CAIB and IDS. The IDS will be the focal point for the development and implementation of programs geared towards increasing organizational and individual awareness of MH issues, trends and threats to mission readiness.

7.3. Prevention services for FAP/ADAPT/DDR/TSR and Suicide Prevention are: outlined in their respective AFI's (AFI 40-301; AFI 44-121; AFI 44-153; AFI 44-154, *Suicide and Violence Prevention Education and Training*; AFI 44-120, *Drug Abuse Testing Program).*

7.4. MH will: provide briefings to the installation and community as requested.

Chapter 8

MISCELLANEOUS ROLES

8.1. Forensic Consultation. MHPs may consult regarding forensic MH issues, conduct forensic evaluations of military members and testify as expert consultants in military courts-martial. MHPs will not accept forensic cases in which they have previously evaluated the lawyer's client in any ordinary clinical context. MHPs may consult with a patient's defense attorney when the patient authorizes disclosure in writing; however, providers should be aware of potential negative impact on provider-patient relationship resulting from compelled disclosure or testimony from prosecution discovery.

8.2. TSR/Combat Stress Control. The TSR team chief is a MHP appointed by the installation commander. The primary function of the team is to consult with unit leaders and provide initial response when groups or individuals expect to be or have been exposed to potentially traumatic stress. The primary goal of TSR teams is to foster resiliency through education, screening, psychological first aid and referral in those exposed to traumatic stress. Refer to AFI 44-153 for more information.

8.3. Behavioral Health Optimization Program (BHOP) Services.

8.3.1. MHPs providing BHOP services will be trained in the AF BHOP model either via internship or externship training IAW the BHOP Manual (**https://kx.afms.mil/bhop**).

8.3.2. MHPs working in BHOP will function in the role of a Behavioral Health Consultant (BHC) to the PCM team to address the psychosocial aspects of the patient's overall health.

8.3.2.1. Patients seen by the BHC are referred by their PCM or PCM team for this specific service. In cases in which patients self-refer or are referred to the BHC by sources other than the PCM, such as PDHRA assessment or other screening, the BHC will report back to the PCM to ensure the PCM is aware that the patient is being seen by the BHC. In all cases, the PCM retains primary responsibility for the patient's overall health and treatment.

8.3.2.2. Services provided by the BHC include assessment, brief intervention and psycho-education. Collaborative consultation with the PCM team, BHC and the patient ensure BHC interventions support the PCM's treatment goals for the patient.

8.3.2.3. Patients referred to the BHC are seen in the Primary Care clinic from which they are referred and the Primary Care clinic's Mission Essential Performance Requirements (MEPR) code is utilized.

8.3.2.4. BHC functions as a consultant to the PCM team. The BHC ensures documentation of the patient's visit is available to the PCM via the electronic medical record and that verbal feedback is also provided to the PCM whenever possible.

8.3.2.5. When or if the need for prolonged or more intensive MH care arises, the BHC coordinates referral for specialty MH services.

8.3.2.6. Peer review for the BHC is conducted by another MHP (i.e., psychologist, social worker or psychiatrist), preferably one that has also been trained in the AF BHOP model.

8.4. Clinical Hypnosis/Formal Sex Therapy. Refer to AFI 44-102, *Medical Care Management.*

8.5. Biofeedback. MHPs may be granted privileges to administer biofeedback if they have been certified by the Biofeedback Certification Institute of America or if they have met the AF training requirements, which include having completed 20 hours of didactic instruction and 20 hours of supervised clinical treatment by an MHP privileged to perform biofeedback.

8.6. Prescribed and Adopted Forms.

8.6.1. **Prescribed Forms.** No forms prescribed.

8.6.2. **Adopted Forms.** SF Form 600, *Medical Record – Chronological Record of Medical Care*

SF Form 93, *Report of Medical History*
DD 2792, *Exceptional Family Member Medical Summary*
DD Form 2807-1, *Report of Medical History*
DD 2807-2, *Medical Prescreen of Report of Medical History*
AF Form 2522, *Family Advocacy Program Intake*
AF Form 4405, *Family Advocacy Program (FAP) Client Information Form Maltreatment Intervention Services*
AF Form 469, *Duty Limiting Conditions Report*
AF Form 745, *Sensitive Duties Program Record Identifier*
AF Form 847, *Recommendation for Change of Publication*

CHARLES B. GREEN, Lieutenant General, USAF, MC, CFS
Surgeon General

Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

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Abbreviations and Acronyms

AAAHC—Accreditation Association for Ambulatory Health Care

ABC—Alcohol Brief Counseling

AD—Active Duty

ADAPT—Alcohol and Drug Abuse Prevention and Treatment

ADAPTPM—Alcohol and Drug Abuse Prevention and Treatment Program Manager

AF—Air Force

AFMAN—Air Force Manual

AFI—Air Force Instruction

AFMOA—Air Force Medical Operations Agency

AFMS—Air Force Medical Service

AFMSA—AF Medical Support Agency

AFPD—Air Force Policy Directive

AFR—Air Force Reserve

AFRIMS—Air Force Records Information Management System

ANAM—Automated Neuropsychological Assessment & Measurement

ANG—Air National Guard

ARC—Air Reserve Component

BHC—Behavioral Health Consultant

BHOP—Behavioral Health Optimization Program

CAIB—Community Action Information Board

CDE—Commander-Directed Evaluation

CFR—Code of Federal Regulations

CSMRT—Child Sexual Maltreatment Response Team

DDR—Drug Demand Reduction

DLC—Duty Limiting Condition

DOD—Department of Defense

DoDD—Department of Defense Directive

DoDI—Department of Defense Instruction

DPH—Director of Psychological Health

DRU—Direct Reporting Unit

DSM—Diagnostic and Statistical Manual

ED—Emergency Department

EFMP—Exceptional Family Member Program

FAIS—Family Advocacy Intervention Specialist

FAP—Family Advocacy Program

FAPA—Family Advocacy Program Assistant

FAO—Family Advocacy Officer

FAOM—Family Advocacy Officer Manager

FAN—Family Advocacy Nurse

FASOR—Family Advocacy System of Records

FAST—Family Advocacy Strength-based Therapy

FDI—Facility Determination Inquiries

FMRC—Family Member Relocation Clearance

FOA—Field Operating Agency

FOIA—Freedom of Information Act

GOV—Government Owned Vehicle

HI—High Interest

HIL—High Interest Log

HIPAA—Health Insurance Portability and Accountability Act

HR—Health Record

HRVRT—High Risk for Violence Response Team

HSI—Health Services Inspection

IAW—In Accordance With

IDS—Integrated Delivery System

IMT—Information Management Tool

JA—Judge Advocate

LOD—Line of Duty

LPSP—Limited Privilege Suicide Prevention

MAJCOM—Major Command

MCCC—Multidisciplinary Clinical Case Conference

MCM—Multi-Disciplinary Case Management

MDG—Medical Group

MEB—Medical Evaluation Board

MEPR—Mission Essential Performance Requirements

MH—Mental Health

MHP—Mental Health Provider

MOA—Memoranda of Agreement

MOU—Memoranda of Understanding

MTI—Military Training Instructor

MTL—Military Training Leader

MTF—Military Treatment Facility

NCOIC—NonCommissioned Officer in Charge

NLT—No Later Than

NOTAM— Notice to Airmen

NPSP—New Parent Support Program

OIC—Officer in Charge

PCM—Primary Care Manager

PDHA—Post Deployment Health Assessment

PDHRA—Post Deployment Health Reassessment

PDI—Potentially Disqualifying Information

PHA— Personal Health Assessment

PHAP—Psychological Health Advocacy Program

PHI—Protected Health Information

PMHP—Primary Mental Health Provider

POV—Privately Owned Vehicle

PREP—Prevention Relationship Enhancement Program

PRP—Personnel Reliability Program

PSC—Permanent Change of Station

PSP—Presidential Support Program

RDS—Records Disposition Schedule

RE—Resiliency Element

RMU—Reserve Medical Unit

RPA—Remotely Piloted Aircraft

SERE—Survival Evasion Resistance Escape

SFS—Special Forces Squadron

SG—Surgeon General

SJA—Staff Judge Advocate

SNC—Special Needs Coordinator

SNIAC—Special Needs Identification and Assignment Coordination

SUAT—Substance Use Assessment Tool

TSR—Traumatic Stress Response

UAS—Unmanned Aircraft System

UCMJ—Uniform Code of Military Justice

USAF—United States Air Force

Attachment 2

12-TARGETS TO ENHANCE RESILIENCE AND OPERATIONAL PERFORMANCE

A2.1. Extended periods of high ops tempo or brief periods of intense operations can degrade performance. If practiced regularly the behaviors and thoughts described below enhance operational performance and resiliency in the midst of combat or operational stressors.

A2.2. Physical Fitness: Exercise not only improves strength and stamina, it enhances the ability of the body and mind to function at peak performance level, and creates a sense of well-being.

A2.3. Nutrition: Healthy foods and plenty of water together form the optimal fuel to ensure the mind and body operate at peak performance. Eating well and staying hydrated are essential for being at your best.

A2.4. Recharge: Take control of how you use your energy and include time for your body to replenish before the next surge of energy use. Identify recreational activities you enjoy and things that help you relax. Try to get 7 or 8 hours sleep every 24 hours if the mission permits. Whenever possible, maintain a consistent sleep schedule and try to use the bed only for sleep.

A2.5. Strategic Thinking: You automatically evaluate every event in your life. Pay attention to how you think about things and identify the good and the bad of each situation. Keep your thoughts balanced and build confidence in yourself and your training by reminding yourself of other challenges you have overcome and what you are learning through each circumstance.

A2.6. Situational Awareness (SA): Be aware of what is going on around you and remind yourself of your role in the task or mission. By realistically assessing each situation and leveraging your thoughts using your awareness of the situation and your training, you will improve your performance under challenging situations.

A2.7. Problem-Solving: Effective problem-solving increases the probability of a good solution. Follow these steps: 1. Specifically define the problem; 2. Set a realistic goal; 3. Generate multiple solutions (don't skip this part); 4. Compare the solutions, select one, and implement; and 5. Evaluate the outcome and identify lessons learned.

A2.8. Purpose=Y: Keep your purpose and your role in the mission clear in your mind. Define your Y (Why). Remind yourself of the reasons you were selected for or chose the job and the value you can gain. Thinking about your contribution to the bigger mission can reground you to a sense of purpose in life.

A2.9. Tactical Breathing: Stress and adrenaline can cause physical responses that erode performance, but Tactical Breathing can bring you focus and attention. Control your breathing by simply taking slow, deep breaths. Inhale and exhale slowly, releasing muscle tension as you exhale and focus on the task at hand.

A2.10. Comm Check: Make sure you are receiving the information that the sender intended and that your message has been received as you intended. Ask the person what they heard you say. Do not respond until the receiver finishes retelling what you said. Clarify if your message has been misunderstood.

A2.11. Mental Rehearsal: Images are powerful so use them to build your mental fitness by practicing performance-building techniques. Practice a task or procedure in your mind by visualizing yourself doing it well before you actually attempt it. Imagine a successful outcome.

A2.12. Be a Wingman: A Wingman cares for himself, others and AF families. Signs of distress in others should not be dismissed and neither should senseless risks to life as a result of improper safety and irresponsible behavior. Make responsible choices and help others do the same.

A.13. Lead From the Front: Demonstrate good leadership by using these techniques yourself. Talk about them and hold Airmen accountable. A leader facilitates positive group "sense making" of an experience, seeks out meaningful and challenging group tasks, communicates a high level of respect and commitment to unit members and anticipates high-stress events

Attachment 3

MENTAL HEALTH RECORD CREATION

Table A3.1. Mental Health Record.

		ADAPT	**FAP**	**MH**
Target	Event	Applicability	Applicability	Applicability
Children:	Are children seen?	No	Yes – for initial evaluation only	Yes
Children:	Is a record created?	N/A	If a MH record already exists, documentation will be placed in that record. If no MH record exists, documentation will be filed in the sponsor's record.	Yes – if seen for treatment
Adult:	When is a temporary record created?	If the patient is seen for more than one service at the same time in clinics at separate locations, a temporary record is created. Record documentation will be combined chronologically in one MH record as treatment ends.	If the patient is seen for more than one service at the same time in clinics at separate locations, a temporary record is created. Record documentation will be combined chronologically in one MH record as treatment ends.	If the patient is seen for more than one service at the same time in clinics at separate locations, a temporary record is created. Record documentation will be combined chronologically in one MH record as treatment occurs.
Adult:	Traumatic Stress education and Consultation – up to 4 meetings of the Traumatic Stress Response Team	No record required	No record required	No record required
Adult:	Educational, non-pt count activities. Cannot involve assessment or treatment	No record required	No record required	No record required

Adult:	Intimate Partner	N/A	Documentation for assessment, safety planning & referrals as seen as part of the FAP record will go into the AD intimate partner's record as a collateral contact.	N/A
Adult:	NPSP/FAST Services	N/A	Record is maintained separately.	N/A
All:	Labels for 6 part MH folder	Top left corner of record will contain: Pt last name, first name, middle initial, pay grade.	Top left corner of record will contain: Pt last name, first name, middle initial, pay grade.	Top left corner of record will contain: Pt last name, first name, middle initial, pay grade.
		AD prefix or family member prefix; sponsor SSN.	AD prefix or family member prefix; sponsor SSN.	AD prefix or family member prefix; sponsor SSN.
		Member or sponsor's unit.	Member or sponsor's unit.	Member or sponsor's unit.
		Telephone contact numbers: Cellular, home, duty, command.	Telephone contact numbers: Cellular, home, duty, command.	Telephone contact numbers: Cellular, home, duty, command.
		Records of members on PRP, PSP or on flight status must be clearly marked and annotated.	Records of members on PRP, PSP or on flight status must be clearly marked and annotated.	Records of members on PRP, PSP or on flight status must be clearly marked and annotated.
			Incident number and victim name.	

Attachment 4

EXAMPLE PATIENT'S INFORMATION SHEET

Date

MEMORANDUM FOR Patients of the (base) Mental Health Clinic

FROM: xxth Medical Operations Squadron/(office symbol)
(address)

SUBJECT: **Patient's Information Sheet**

1. Patients are often unsure what to expect in a Mental Health Clinic (MHC). We strongly encourage you to consider the following points regarding mental health care and to discuss them with your provider if you wish. You can expect the attention, respect, and best professional efforts of your provider. Your provider will expect you to take an active part in setting goals, deciding on treatment options and engaging in treatment. Talk to your provider if you have any questions about your care. Before your evaluation or treatment begins, we want you to understand how things work in the MHC. With the exception of Commander-Directed Evaluations, and non-self-referred ADAPT and FAP treatment, services at the MHC are provided strictly on a voluntary basis. If you feel that you have been improperly directed or pressured in any way to come to the clinic, please discuss this with your provider at the earliest possible time.

2. **Records of Your Care**. Every patient visit to the MHC is documented in the outpatient medical record so providers in other clinics caring for you are aware of your care here. These entries are as brief as possible to protect your privacy. Detailed notes documenting your mental health care are maintained in your mental health record. The mental health record is secured in the MHC. If you have questions/concerns about what information might be shared please discuss this with your provider.

3. **Disclosure Policy for Active Duty (AD) and Non-Active Duty (non-AD) Patients**. The privacy of non-AD patients is protected by the Federal Privacy Act and is not generally governed by other military regulations, unless the individual is also a Department of Defense employee. Most information related to the treatment of non-AD patients is not releasable without the written consent of the patient. Excluded from consent requirements are such activities as quality assurance reviews by other MHC professionals and collection of information for medical research. Other releases generally require your written consent. Exceptions for AD and non-AD include:

   Child or Spouse Maltreatment. Providers must report suspected child abuse or neglect, and other incidents of family maltreatment to military agencies, local child protective authorities, or both.

   Crimes or Fraud. Providers must report any threat to commit crimes or fraud by non-AD as well as AD clients. In many instances, military providers are also required to

notify appropriate agencies when AD members report they have committed a crime or have been the victim of a crime.

Danger to Self or Others. Providers must take steps to protect individuals from harm when a client presents a serious threat to the life or safety of self or others.

High Interest Log (HIL). Any time a provider considers a patient to be a serious risk for harming themselves or others, the patient is placed on the MHC HIL. In order to better coordinate care and ensure safety, the cases of patients on the HIL are discussed at weekly MHC meetings and the names are shared with family practice providers and the xx MDG Emergency Department. This practice is in accordance with military and DoD policy. Your provider will inform you if/when you are placed on the HIL and when you are removed from it. Patients on the HIL will be required to speak with their provider for a brief status check when calling the clinic. If a patient on the HIL fails to arrive for a scheduled appointment, the provider will attempt to make phone contact. If the provider cannot locate or contact the patient within one hour, the provider may contact other persons or agents in order to ascertain the patient's location and status in order to ensure their safety. Other persons or agents the provider might contact include, but is not limited to, the patient's commander, first sergeant and Security Forces, as appropriate. Should a high risk patient decline to reschedule an appointment the member's commander will be notified. Commanders of AD members must be informed when one of their personnel is placed on or removed from the HIL.

Continuity of Care. Information may be released for purposes of official military processes such as a Medical Evaluation Boards or Commander Directed Evaluations. Information may also be shared between military and non-military providers in certain instances in order to facilitate medical care (e.g., when a patient is referred to a civilian provider or hospital).

Coordination of Care at the Time of Permanent Change of Station (PCS) and Transfer of Information. The care/records of any AD member requiring ongoing treatment at the time of PCS will be transferred to the MHC at the gaining base for follow-up to ensure continuity of care. This transfer will be discussed with the AD member, but does not require the AD member's consent. In cases of AD members who have terminated treatment, records are reviewed prior to PCS. If there are concerns, the member may be contacted by a provider for a status check, at which time the provider will make a determination if the record needs to be forwarded to the gaining base if follow-up is required in the future. For non-AD patients actively involved in treatment at the time of PCS, the provider will discuss any need to transfer care/records. However, transfer cannot be accomplished without written consent. Closed records on non-AD patients are also reviewed prior to PCS. If the reviewing provider has concerns about elevated risk, the provider may contact the patient for a status check and determination of any need to transfer the record. Again, this transfer cannot be accomplished without the individual's consent.

Exceptions for AD Only:

Access to Records by Commanders. Though infrequent, Commanders may obtain information about a patient's treatment at the MHC if that information is required to ensure fitness or suitability for duty or to ensure the accomplishment of a military mission. When information is released under this provision, the information will be limited to that required for the Commander to make decisions about fitness and readiness.

Profiles/Duty Limiting Conditions. MHC providers will consult with commanders and/or first sergeants any time they feel a member has a condition or circumstance that makes them not fit for duty, deployable or requires any changes in their normal duties.

Drug or Alcohol Abuse. Providers must report all suspected instances of drug/alcohol abuse by AD clients to rehabilitation programs (ADAPT) and commanders. Per AFI 44-121, an Air Force member may voluntarily disclose evidence of personal drug use or possession to the unit commander, first sergeant, substance abuse evaluator, or a military medical professional. Commanders will grant limited protection for Air Force members who reveal this information with the intention of entering treatment. Commanders may not use voluntary disclosure against a member in an action under the Uniform Code of Military Justice (UCMJ) or when weighing characterization of service in a separation.

4. **Appointment Cancellations/No-Shows**. We ask that you give us at least 24 hours notice if you will be unable to make an appointment you have scheduled so we may try to use that appointment for another person seeking assistance from our clinic. If you provide us with less than 24 hours notice we will designate the appointment as a "no-show". Your provider may speak to you about whether continuing treatment makes sense if you have too many "no-shows". If you do not reschedule at the time of cancellation, a staff member will contact you and offer a follow-up appointment.

5. **Ancillary Staff/Trainees Involved in Patient Care**. We operate the MHC under a team concept approach. The team includes mental health technicians or clinician trainees who may be involved in your care. You should address questions about this to your provider.

6. **Exceptional Family Member Program (EFMP)**. For family members of AD who receive care for mental health conditions, your provider must determine if your condition would require enrollment in the EFMP. This may entail disclosure of your condition to proper medical and command authorities in order to ensure adequate medical care is available at any projected new duty location. Enrollment in the EFMP is mandatory for the AD member once the special needs of the family have been identified. Not all mental health treatment will require this; ask your provider if you have any questions.

7. **Medications**. If medications are prescribed for you, it is imperative you plan accordingly. Ideally we ask that you call 7 days prior to running out of the medications as to not disrupt the medication treatment course. You may request a medication refill if you are actively under the provider's care and doing well. If not we ask that you schedule an appointment.

8. **Telephone Consultations**. Face-to-face treatment is always the preferred treatment modality but is not always possible for your needs or clinic availability. Telephone consultations are intended to assist in, not replace, the routine care you receive in our clinic. We encourage you to contact your provider in this way any time between scheduled appointments if you have questions or concerns about your condition or treatment. We ask that you not communicate with your provider by e-mail.

[Signature block of MH Flight Commander or equivalent]

I have read and understand the above Patient's Information Sheet.

Patient's Printed Name, Signature:_____ Date:_____

Witness' Printed Name, Signature:_____ Date:_____

Attachment 5

SAMPLE MENTAL HEALTH RECORD TERMINATION/TRANSFER OF CARE SUMMARY

MENTAL HEALTH RECORD

TERMINATION/TRANSFER OF CARE SUMMARY

(Purpose: To provide documentation for continuity of care and disability/suitability evaluation by subsequent mental health providers. It is important that the individual clinician use judgment in determining the "minimum data necessary" to be included in the termination/transfer summary.)

Identifying information (Specify name, FMP/SSN, duty position)

Date case opened and date of last interview

Brief description of course of treatment, status and prognosis (Basis for initial contact, presenting symptoms, diagnostic information, identified problems, abnormal physical findings, abnormal laboratory/imaging results, psychological testing results, referrals and consultations [including but not limited to those within mental health, e.g., ADAPT, FAP, Clinical Health Psychology], relevant information obtained from collateral sources, type of treatment, biological treatment [details of prior medication trials and current medication, duration, dose, response, side effects], psychological and social interventions, risk assessment and interventions taken to reduce risk, response to treatment/changes in patient's condition to include status at time of termination of care and prognosis).

Diagnoses (Specify all five Axes)

Impact on military (Profile changes and current profile, duty impact and restrictions during course of treatment, currently, and anticipated at next assignment, MEB actions taken, information impacting security clearance [omit personal details], duty position of patient at termination [this is to support profile decisions in the event the patient is transferring from one job where profile was not needed to another position where it might be], summary of Commander-directed evaluations)

Reason for termination or transfer (Specify whether completed treatment, "no-show," cancel, PCS, separation from the military, unknown, other)

Recommendation for follow-up (Specify details of recommendations including need for follow up [e.g., clinically indicated, at discretion of patient], type of follow up recommended, medication prescribed and special instructions, name/agency to whom patient's care is transferred, and indicate whether patient expressed understanding of the recommendations and accepted or declined recommendations.)

SIGNATURE BLOCK - Therapist's signature and date

Attachment 6

SAMPLE OUTPATIENT MEDICAL RECORD TERMINATION/TRANSFER OF CARE SUMMARY

OUTPATIENT MEDICAL RECORD

TERMINATION/TRANSFER OF CARE SUMMARY

(Purpose: To provide documentation for continuity of care and disability/suitability evaluation while maintaining psychotherapist-patient confidentiality. It is important that the individual clinician use judgment in determining the "minimum data necessary" to be included in the termination/transfer summary.)

Identifying information (including name, FMP/SSN, duty position)

Date case opened and date of last interview

Brief description of course of treatment, status and prognosis (Omit personal and psychological information. Briefly summarize evaluation and course of treatment. *E.g., Self referred for treatment of depression, which has been in remission on Prozac 20mg for eight months. Successfully completed Health Thinking and Depression Management. Iron-deficiency anemia identified with screening CBC was corrected with iron supplement prescribed by PCM. Excellent prognosis.*)

Diagnoses (Specify all five Axes)

Reason for termination or transfer (Specify whether completed treatment, "no-show," cancel, PCS, separation from the military, unknown, other)

Profile and duty restrictions

Recommendation for follow-up (Specify details of recommendations including need for follow up [e.g., clinically indicated, at discretion of patient], type of follow up recommended, medication prescribed and special instructions, name/agency to whom patient's care is transferred, and indicate whether patient expressed understanding of the recommendations and accepted or declined recommendations. *E.g., Requires medication management. Continue Prozac 20mg qd for additional 3-4 months. Since there is no psychiatrist at [gaining base], patient will follow up with PCM at [gaining base] for medication management. Patient expresses understanding of her mental illness and treatment plan and will schedule appointment upon arrival at gaining base.*)

SIGNATURE BLOCK - Therapist's signature and date

Attachment 7

COMMANDER-DIRECTED EVALUATION (CDE) CHECKLIST

Item	Action	Date
1	(unit) /CC, (rank/name) requested CDE. CC phone #:_____ Rank/name member to be evaluated:_____ Rank/name CCF:_____ CCF phone #:_____ Case assigned to: (name MHP)	
2	MHP discussed appropriateness of **EMERGENCY / NON-EMERGENCY** referral with CC & documented discussion/ rationale for decision/ recommendations. CDE considered: **APPROPRIATE / NOT APPROPRIATE**	
3	Copy of PIF/personnel records requested.	
4	Appointment for testing (if warranted) is: (date & time) (**Note:** 7.2 below) Following psychological tests ordered: (circle all that apply) PAI Shipley MMPI MCMI 16PF Other:	
5	Appointment for CDE clinical interview is: (date & time) (**Note:** 7.2 below)	
6	Written information from CC reviewed for completeness and correctness. Information demonstrates adequate documentation of member's inability to change their behavior after being counseled by unit leadership: **YES / NO**	
7	Required documentation from CC received: 1) Letter to MTF/CC requesting CDE. MTF/CC approved: **YES / NO** 2) Copy of notification letter to evaluee. Member had at least 2 full duty days between notification & initial evaluation (non-emergency CDE): **YES / NO** 3) Memorandum with evaluee information.	
8	Pt seen for initial evaluation and given "Information to Directed Evaluees" form, had CDE process explained, including limits of confidentiality, potential uses of information and potential consequences.	
9	Medical record reviewed.	
10	PIF/personnel records reviewed	
11	Psychological testing completed (**Note:** if given on different dates). SF 600s completed for testing(s).	
12	Psychological testing interpretation completed – summary on SF 600	
13	Pt interviewed, interview(s) documented on SF 600. List interview dates below: 1) _____ 2) _____ 3) _____	
14	Following collateral contact(s) made and documented on SF 600: (person/date) 1) _____ 2)_____	

	3)_____ 4)_____	
15	Evaluation completed (**Note**: Written report due to CC NLT 1 duty day)	
16	Pt given feedback. Feedback documented on SF 600. **The CDE recommendations have been reviewed with me and I understand them.** Evaluee Signature: _____	
17	If separation is recommended based on Axis II condition, member advised that condition does not qualify for disability. **I have been advised and understand that separation based on a Personality Disorder does not qualify for disability processing or benefits.** Evaluee Signature: _____	
18	CC given verbal evaluation results.	
19	CC notified report ready for pick up.	
20	Report forwarded to MTF/CC. If MHP recommends separation, the CDE Report *MUST BE* signed by MTF/CC.	
21	**If MHP recommends separation *BASED ON A PERSONALITY DISORDER DIAGNOSIS* for a member who has been deployed to an imminent danger pay zone, then MHP *MUST* complete remaining sections**	
21.a.	Report specifically addressed presence or absence of PTSD diagnosis	
21.b.	Report specifically addressed other MH conditions/co-morbidity	
21.c	Report reviewed by a peer/higher-level psychiatrist or psychologist. If initial Axis II diagnosis made in context of on-going therapy, peer review must be accomplished as a full CDE. Include documentation of concurrence with diagnosis/recommendations	
21.d.	For situational awareness, discharge package must be routed through MH Flight/CC, SGH and MTF/CC. Include Staff Summary Sheet/routing slip in materials sent to AFMOA/SGHW.	
21.e.	Report and all documents used to make recommendation mailed to: AFMOA/SGHW, 485 Quentin Roosevelt Rd, Ste 400, San Antonio, TX 78226-2018 Include all documents relevant to the case such as chart notes and the letters required as part of the CDE process.	
21.f.	Received endorsement memo from AFMOA/CC	
21.g.	Routed AFMOA/CC endorsement memo through MTF/CC and SGH for initials	
21.h.	Returned copy of initialed memo to AFMOA/SGHW	