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SECRETARY OF THE AIR FORCE**

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Medical Operations

MENTAL HEALTH



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This instruction implements Air Force Policy Directive (AFPD) 44-1, *Medical Operations*; Public Laws 101-510 and 102-484. It incorporates requirements outlined in Department of Defense Instruction (DODI) 6490.04, *Mental Health Evaluations of Members of the Military Services*; DODI 6490.08, *Command Notification Requirements to Dispel Stigma in Providing Mental Health Care to Service Members*; DODI 6490.09, *DoD Directors of Psychological Health*; DODI 6490.10, *Continuity of Behavioral Health Care for Transferring and Transitioning Service Members*; DODI 6490.11, *DoD Policy Guidance for Management of Mild Traumatic Brain Injury/Concussion in the Deployed Setting*; DODI 6490.13, *Comprehensive Policy on Neurocognitive Assessments by the Military Services*; DODI 6490.15, *Integration of Behavioral Health Personal Services Into Patient-Centered Medical Home Primary Care and Other Primary Care Service Settings*; and Assistant Secretary of Defense/Health Affairs Memorandum, *Military Treatment Facility Mental Health Outcomes Guidance*, 9 September 2013. This instruction provides guidance for the operation of the Mental Health (MH) services [as distinguished from the Combat Stress Center, Disaster Mental Health (DMH) operations, and Exceptional Family Member Program (EFMP)] and the assessment and treatment of USAF personnel and beneficiaries with MH concerns. It establishes rules for confidentiality, defines conditions requiring communication between Mental Health Providers (MHP) and Commanders/supervisors, and outlines the scope for the Limited Privilege Suicide Prevention (LPSP) Program. This instruction applies to all active component Air Force (AF) members and members of the Air National Guard (ANG) when activated under Title 10 active duty in the Air National Guard of the United States (ANGUS) status and Air Force Reserve (AFR) IMAs and unit-based personnel that are on Title 10 active duty orders for even one or two days and

functioning within a DoD medical facility (or equivalent). However, given the mission/nature of weekend trainings for unit-based personnel (i.e., Unit Training Assemblies or UTAs) and the limited privileges, it does not apply to such individuals during unit drill weekends when not on active duty orders. Our Airmen are in Title 10 status during those weekends, IAW AFI 41-210, *TRICARE Operations and Patient Administration Functions*, Section 2B. The AFR does not have a separate system to provide mental health treatment. Clarification about AFR-specific policies, processes, and/or procedures should be directed to HQ AFRC/SG's MH Consultant. This publication requires the collection and/or maintenance of information protected by the Privacy Act (PA) of 1974, 5 United States Code (U.S.C.) Section 552a. Forms affected by the PA have an appropriate PA statement. System of Records Notices F044 AF SG D and F044 F SG E apply to Mental Health records referenced in this AFI. This 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, Ste. 1023, 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 IAW Air Force Manual (AFMAN) 33-363, *Management of Records*, and disposed of IAW Air Force Records Information Management System (AFRIMS) Records Disposition Schedule (RDS). The authorities to waive wing/unit level requirements in this publication are identified with a Tier ("T-0, T-1, T-2, T-3") number following the compliance statement. See AFI 33-360, *Publications and Forms Management*, Table 1.1 for a description of the authorities associated with the Tier numbers. Submit requests for waivers through the chain of command to the appropriate Tier waiver approval authority, or alternately, to the Publication OPR for non-tiered compliance items.

SUMMARY OF CHANGES

This document has been substantially revised and must be completely reviewed. This revised instruction deletes the requirement for a Resiliency Element and Function. Additionally, Family Advocacy Program (FAP) documentation will be maintained in a separate FAP record. Also, the Command-Directed Evaluation Process has been changed to include the role of supervisors.

Chapter 1— ROLES AND RESPONSIBILITIES	6
1.1. Air Force Surgeon General (AF/SG).....	6
1.2. Commander, Air Force Medical Operations Agency.	6
1.3. Mental Health Division Chief, AFMOA.	6
1.4. Air Force Director of Psychological Health (DPH).....	6
1.5. The Judge Advocate General, USAF (AF/JA).....	7
1.6. MAJCOM/Direct Reporting Unit (DRU) SG or Equivalent.	7

1.7.	Installation Commander.....	7
1.8.	Military Treatment Facility (MTF) Commander and Reserve Medical Commanders (where applicable).	8
1.9.	Chief of Medical Staff (SGH).....	8
1.10.	Squadron Commander Responsible for MH.....	9
1.11.	MH Flight Commander or Equivalent.	9
1.12.	Active Duty Installation Director of Psychological Health (DPH).....	9
1.13.	AFRC Installation DPH.....	10
1.14.	Mental Health Flight Medical Director (designated assigned psychiatrist or from a remote site if not assigned).	11
1.15.	Mental Health Provider (MHP).	11
1.16.	MH Flight Chief or Noncommissioned Officer in Charge (NCOIC).	12
1.17.	Mental Health Technician.....	12
Chapter 2—	STANDARD MENTAL HEALTH CLINIC PROCEDURES.	14
2.1.	MH Flight Structure.....	14
2.2.	Safety.	14
2.3.	Access to Care.	15
2.4.	Initial Encounter.	16
2.5.	Standard Screening and Outcome measures.	16
2.6.	Mental Health Case Management.....	17
2.7.	MCCC meeting:.....	18
2.8.	No Show/Noncompliance with Treatment.....	18
2.9.	Patient Transfer/Termination.	19
2.10.	Termination.....	20
2.11.	Peer Review.	21
2.12.	Suitability and Fitness Determinations.	21
2.13.	Mobility Restrictions and Duty Limiting Conditions (DLCs).	21

2.14.	Deployment Mental Health (DMH) Clearances.	22
2.15.	Overseas Clearances for Service members.	24
2.16.	Family Member Relocation Clearances (FMRCs).....	24
2.17.	Family Child Care Applications.	24
2.18.	Special Clearances.	24
2.19.	Personnel Reliability Program (PRP)/Presidential Support Program (PSP).....	25
2.20.	On-Call Procedures.....	25
Chapter 3—	MH TREATMENT PROCEDURES	26
3.1.	Transporting Patients in Crisis (during duty and after-duty hours).	26
3.2.	Clinical Management of Suicidal Patients.....	26
3.3.	High Interest List (HIL).....	27
3.4.	HIL Procedures.....	27
Chapter 4—	MISCELLANEOUS ROLES	31
4.1.	Behavioral Health Optimization Program (BHOP) Services.....	31
4.2.	Forensic Consultation in Courts-Martial and Military Justice Matters.....	31
4.3.	MH Prevention:.....	31
4.4.	Hypnosis.	31
4.5.	Biofeedback.	32
Chapter 5—	MENTAL HEALTH (MH) NOTES AND RECORD MANAGEMENT	33
5.1.	MH Notes and Record Organization.....	33
5.2.	Special Documentation requirements.	34
5.3.	Exceptions to the Electronic MH Record.	34
5.4.	MH Record Retirement.....	35
Chapter 6—	MENTAL HEALTH AND THE LAW	36
6.1.	Confidentiality:	36
6.2.	Military Rule of Evidence.....	36

6.3.	Who May Claim the Privilege Under Military Rule of Evidence.....	37
6.4.	Limited Applicability of Military Rule of Evidence 513.....	37
6.5.	Disclosure of confidential communications.....	37
6.6.	Limits of Confidentiality:	37
6.7.	Release of Information and Health Insurance Portability and Accountability Act (HIPAA) Accounting of Disclosures.	38
6.8.	Limited Privilege Suicide Prevention (LPSP) Program.....	39
6.9.	Commander-Directed Evaluations (CDE) Procedures.	40
6.10.	Inpatient Hospitalization.....	42
6.11.	Administrative Separations.....	44
Attachment 1— GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION		47
Attachment 2— MENTAL HEALTH PROVIDER (MHP) TRAINING CHECKLIST		52
Attachment 3— MENTAL HEALTH (MH) CLINIC CONFIDENTIALITY/INFORMED CONSENT SHEET		55
Attachment 4— MENTAL HEALTH (MH) CLINIC CONFIDENTIALITY INFORMATION SHEET FOR ONE TIME EVALUATIONS		60
Attachment 5— MENTAL HEALTH CLINIC MONTHLY PEER REVIEW		63
Attachment 6— BHOP CLINIC MONTHLY PEER REVIEW – IBHC		65
Attachment 7— INTAKE NOTE TEMPLATE		67
Attachment 8— FOLLOW-UP NOTE TEMPLATE		72
Attachment 9— MULTIDISCIPLINARY CLINICAL CASE CONFERENCE		76

Chapter 1

ROLES AND RESPONSIBILITIES

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

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

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

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

1.2. Commander, Air Force Medical Operations Agency.

1.2.1. Appoints AFMOA MH Division Chief.

1.2.2. Provides personnel and resources for the MH Division.

1.3. Mental Health Division Chief, AFMOA.

1.3.1. Leads development, implementation and management of AF MH services and initiatives.

1.3.2. Appoints and supervises Alcohol and Drug Abuse Prevention and Treatment (ADAPT), MH, and FAP branch chiefs and program managers.

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

1.3.4. Oversees branch chiefs and program managers to ensure integrated, effective and efficient MH for beneficiaries.

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

1.3.6. Provides consultation to Major Command (MAJCOM) Behavioral Health (BH) consultants, and through them, disseminates best practices and in collaboration with the Air Force Director of Psychological Health (DPH), consults on the activities of installation DPHs.

1.3.7. Solicits input for strategic planning for AF Psychological Health (PH) from MAJCOM BH consultants, installation DPHs, the 4C0X1 Career Field Manager, and other MH specialty consultants.

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

1.4. Air Force Director of Psychological Health (DPH).

1.4.1. Designated or appointed by AF/SG, engages in strategic planning and leadership to implement the Air Forces strategic plans for PH.

1.4.2. Serves as the PH representative to the AF Community Action Information Board (CAIB) and Integrated Delivery System (IDS) and the voting AF representative to the DOD Psychological Health Council (PHC). Using these fora and other appropriate leadership structures, monitors and reports on the availability, accessibility, quality, and effectiveness of the continuum of MH services available to Airmen and their family members and monitors the psychological health of service members and their families.

1.4.3. Coordinates with the Chief, AFMOA MH Division to:

1.4.3.1. Provide leadership and PH strategic planning and to manage the development and coordination, distribution and effective utilization of training materials not to be redundant with the training materials produced by DCoE and MH policy.

1.4.3.2. Ensure communication with and between installation DPHs and Reserve component DPHs to provide guidance, share best practices, and resolve emerging issues.

1.4.3.3. Represent PH issues raised by installation and MAJCOM BH consultants to AF IDS.

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

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

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

1.6.2. Appoints a MAJCOM BH consultant who shall be a senior MH officer serving full-time or any clinical officer or civilian equivalent to address MH concerns within the command.

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

1.6.3.1. Coordinates with installation DPHs to provide geographically separated units (GSUs) with treatment and evaluation services otherwise unavailable at associated Military Treatment Facilities (MTF) or by Memorandum of Understanding (MOU).

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

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

1.6.6. Provides assistance and guidance to installation-level MH staff.

1.6.7. Develops MAJCOM specific MH initiatives to address MAJCOM specific requirements in coordination with the AFMOA MH Division.

1.7. Installation Commander.

1.7.1. Assures installation's delivery of MH services and PH. (T-1).

1.7.2. Promotes cooperation among installation organizations to build healthy and resilient communities. (T-1).

1.7.3. Appoints an installation DPH IAW DODI 6490.09. (T-0).

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

1.8.1. Ensures the availability of adequate resources for the effective and efficient implementation of MH. (T-1).

1.8.2. 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 IAW UFC 4-510-01, *Design: Medical Military Facilities*. (T-0).

1.8.3. Establishes MTF guidance for emergency MH evaluations both during and after duty hours, see paragraphs 2.2. and 2.20.2. of this AFI. (T-1).

1.8.4. Ensures effective patient care coordination and clinical support between MH, primary care and other medical services. (T-1).

1.8.5. Limited Scope MTFs (LSMTF): LSMTFs may not have sufficient MH personnel to provide all MH services or meet all requirements described in this AFI. Some services/requirements may need to be provided by a supporting MTF or through civilian services.

1.8.5.1. If the LSMTF Commander identifies non tiered 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/SGHW as the final waiver approval authority. (T-1). Waivers will be revalidated every three years by the LSMTF by sending an updated request through the MAJCOM/SG for concurrence by AFMOA/SGHW. (T-1).

1.9. Chief of Medical Staff (SGH). Note: For the ANG, the Air National Guard Behavioral Health Branch (NGB/SGPK).

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

1.9.1.1. Substance abuse identification, referral process and treatment resources. (T-1).

1.9.1.2. Family maltreatment prevention, identification, referral process and treatment resources. (T-1).

1.9.1.3. Mental health and suicide risk identification, referral process and treatment resources. (T-1).

1.9.1.4. Limited Privilege Suicide Prevention (LPSP) Program and additional requirements for maintaining confidentiality of LPSP MH records.

1.9.2. Ensures privileging is consistent with Master Privilege List (MPL), MHP training and assigned clinical practice. (T-0).

1.9.3. Ensures care coordination and monitoring of fitness for duty for active component service members receiving MH care from providers outside the MTF is accomplished by the patient's MTF PCM or the base MH provider at least quarterly, or more frequently as clinically indicated. (T-1).

1.10. Squadron Commander Responsible for MH.

1.10.1. Ensures MH personnel provide annual training on MH issues as required by AFI or other AF/SG guidance. (T-1).

1.10.2. Assigns an independently privileged MHP to serve as the MH Flight Commander. (T-1).

1.11. MH Flight Commander or Equivalent.

1.11.1. Ensures safety for MH staff and patients, including maintaining a duress system and establishing and enforcing local procedures for limiting assessments to appropriately supported clinical settings, with the exception of those discussed in paragraph 2.20.4. of this instruction. (T-1).

1.11.2. Supervises all element leaders ensuring implementation of AFI 44-121, *Alcohol and Drug Abuse Prevention and Treatment (ADAPT) Program*; AFI 40-301, *Family Advocacy*; MH Flight documentation requirements IAW AFI 44-121, AFI 40-301, AFI 41-210; and this instruction, to include documentation of patient care and coordination between other clinics. (T-1).

1.11.3. Monitors the appropriateness of clinical services delivered to MH patients in collaboration with the MTF Executive Committee of the Medical Staff (ECOMS). (T-1).

1.11.4. Ensures effective clinic operation to include performance of MH case management, Multidisciplinary Clinical Case Conferences (MCCCs), High Interest Log (HIL) procedures, and required peer review IAW this AFI and AFI 44-119, *Medical Quality Operations*. (T-1).

1.11.5. Supports GSUs and personnel IAW MOUs for required treatment resources and evaluations. (T-2).

1.11.6. Oversees and documents MH Flight orientation training for all staff, including military, civilian, and contractors, and tracks yearly compliance with the same using the MHP Training Checklist (Attachment 2). (T-1). Establishes periodic review of compliance trends and develops and implements corrective actions. (T-1).

1.11.7. Conducts flight self-assessment using AFMOA sanctioned inspection MICT communicators IAW AFI 90-201, and oversees program improvements. (T-1).

1.11.8. Collaborates with the SGH and the Chief of Nursing Staff (SGN) to train Family Practice, Internal Medicine, Flight Medicine providers and staff on evidence-based practices in the care of MH patients. (T-2).

1.12. Active Duty Installation Director of Psychological Health (DPH).

1.12.1. Functions as the Wing (or Installation) Commander's primary MH consultant and advocate for psychological health. (T-0).

1.12.2. Serves as the MH representative to the installation CAIB and the IDS. (T-1).

1.12.3. Oversees required outreach and prevention activities for the MH flight. (T-1).

1.12.4. Within the existing CAIB/IDS and leadership structure:

1.12.4.1. Advocates and informs installation command, MAJCOM and the Chief, AFMOA MH Division, on the installation's PH status such as psychological health in the

local beneficiary population, and the degree to which needs for prevention, early intervention, and treatment are being met, IAW DODI 6490.09. (T-0).

1.12.4.2. Reports to the installation commander, MAJCOM and the MTF commander on the adequacy of staffing and organizational processes and resources needed to meet the psychological health of the installation, and recommends courses of action to ensure that services and access to those services are provided throughout the deployment cycle and other surge situations, IAW DODI 6490.09. (T-0).

1.12.4.3. Ensures coordination of military and non-military services between the various programs for Service members and their families providing support for psychological health, including but not limited to family advocacy, chaplains, family centers, Casualty Assistance Calls Offices, and TRICARE, IAW DODI 6490.09. (T-0).

1.12.5. Where different service installations or components exist in proximity or operate at the same installations, the affected services' DPHs should establish a standing committee to ensure coordination of services to facilitate equitable coverage and access to care for all service members and their families regardless of military service affiliation IAW DODI 6490.09. (T-0).

1.12.6. The MH Flight Commander typically serves as the DPH. When the duties of the MH Flight Commander and the DPH are held by different individuals, the MH Flight Commander is senior in terms of MH Flight leadership. (T-1).

1.13. AFRC Installation DPH

1.13.5.1. Functions as Wing or other assigned leadership's primary MH consultant. (T-0).

1.13.5.2. Advises leadership on PH matters and coordinates referral to appropriate MH services. (T-0).

1.13.5.3. Serves as the MH representative to the installation CAIB and the IDS. (T-1).

1.13.5.4. Within the existing CAIB/IDS structure, advocates and informs installation command, MAJCOM pertaining to PH such as the adequacy of PH referral resources, PH trends in the community, the degree to which needs for MH prevention, treatment, and continuity of care are being met, and achievements toward applicable program improvements or PH strategic objectives. (T-1).

1.13.5.5. Liaisons with Total Force DPH partners to promote an enterprise-wide culture of psychological health. (T-0).

1.13.5.6. Clinical and nonclinical roles

1.13.5.6.1. Subject to other applicable guidance, AFRC DPHs may be privileged at AF MTFs and consequently may be serving in either clinical or nonclinical roles at different times. When serving in clinical roles, they will be subject to the requirements of a MHP under this AFI. (T-1).

1.13.5.6.2. When AFR DPHs are serving a nonclinical consultative DPH role, many of the requirements of a MHP under this AFI may not be applicable. Examples may include provisions for after-hours availability, limits on confidentiality, documentation of activities, role in disability determination, etc. (T-1).

1.14. Mental Health Flight Medical Director (designated assigned psychiatrist or from a remote site if not assigned).

- 1.14.1. Provides oversight of MH Review in Lieu of (RILO)/MEB process. (T-1).
- 1.14.2. Consults with PCMs on medical issues. (T-1).
- 1.14.3. Advises non-physician flight leaders on medical protocols and needs in the flight. (T-1).
- 1.14.4. May be assigned as the ADAPT Medical Director, and responsible for reviewing and monitoring lab work for members in ADAPT treatment, random drug screens, prescribing medication to assist with rehabilitation, and providing consultation to ADAPT staff regarding potential detoxification issues or referrals to Primary Care or Flight Medicine (for members on flight status) for medical conditions. (T-1).

1.15. Mental Health Provider (MHP).

- 1.15.1. Review and follow all DODIs and AFIs referenced in this instruction relevant to clinical care of all patients with whom they interact, including: (T-1)
- 1.15.2. Assesses service members for safety and ability to perform their duty with each encounter. (T-1).
- 1.15.3. If the initial contact is provided by MH technicians and involves patient screening and/or data collection, then in all cases a privileged MHP provides eyes on assessment and evaluation, ensures the encounter is appropriately documented to include a thorough risk assessment, and if indicated provides consultation to the command. (T-1).
 - 1.15.3.1. If care is provided by a resident or provider in training at a Graduate Medical Education Program (GME)/Allied Health Professions Program, then evaluation/assessment of patients must be supervised by a privileged provider. (T-1).
- 1.15.4. Ensures documentation of HIL patients is completed within 24 hours, and other MH notes are completed within 72 hours. (T-1).
- 1.15.5. An appropriately trained/privileged Psychiatric Mental Health Nurse Practitioner (PMHNP) may perform duties in paragraphs 1.14.2 and 1.14.3 and, if waiver request approved by AFMOA ADAPT PM IAW AFI 44-121, *Alcohol And Drug Abuse Prevention and Treatment (ADAPT) Program*, paragraph 1.14.4, of this instruction. (T-1).
- 1.15.6. Prepares MH RILO/MEB Narrative Summaries (MH NARSUMS) when indicated. (T-1).
- 1.15.7. Enrolls individuals in Exceptional Family Member Program (EFMP) IAW AFI 36-2110, *Assignments*, Attachment 25, and AFI 40-701, *Medical Support to Family Member Relocation and Exceptional Family Member Program (EFMP)*. (T-0).
- 1.15.8. Complies with PRP regulations for individuals assigned to PRP IAW DOD 5210.42-R_AFMAN 13-501, *Nuclear Weapons Personnel Reliability Program (PRP)*. (T-0).
- 1.15.9. Provides DMH support and pre-exposure preparation IAW AFI 44-153, *Disaster Mental Health Response & Combat and Operational Stress Control*. (T-1).

1.15.10. Follows available published MH VA/DOD evidenced based treatment and clinical practice guidelines. (T-1).

1.15.11. Demonstrates current competency IAW AFI 44-119 and applicable MTF bylaws to maintain clinical privileges. Providers must have an active, unrestricted license and be awarded clinical privileges in order to deploy. (T-1).

1.15.12. Maintains appropriate certifications and licensure IAW AFI 44-119. AD clinical psychologists must obtain an active, unrestricted state license within 3 years from the date the clinical internship is completed or from the date the doctoral degree is awarded, whichever is earlier. Social workers on AD or employed by the AF, unless specifically exempted as an entry-level clinical social worker, must be licensed/certified by a United States jurisdiction at a level that allows practice of clinical social work without supervision. Social Workers accessed without an independent clinical practice level license must obtain such license within three years of accession. (T-1).

1.15.13. Consults with PCMs within privileged scope of care. (T-1).

1.15.14. Completes other extra duties which may include, but are not limited to, credentials function, Pharmacy & Therapeutics, Deployment Availability Working Group (DAWG), Executive committee on Nursing Supervision (ECONS) and ECOMS meetings. (T-1).

1.15.15. An appropriately trained/privileged Psychiatric Mental Health Nurse Practitioner (PMHNP) may also perform duties in paragraph 1.14.2 through 1.14.3 of this instruction . (T-1).

1.15.16. An appropriately trained/privileged Psychiatric Mental Health Nurse Practitioner (PMHNP) may perform duties in paragraph 1.14.4 of this instruction if a waiver request is approved by AFMOA ADAPT PM IAW AFI 44-121, *Alcohol And Drug Abuse Prevention and Treatment (ADAPT) Program*. (T-1).

1.16. MH Flight Chief or Noncommissioned Officer in Charge (NCOIC).

1.16.1. Develops, mentors, and manages enlisted personnel in the MH Flight. (T-1).

1.16.2. Oversees MH Flight in-service and recurring training. (T-1).

1.16.3. Manages and oversees MH Flight records IAW with this AFI and AFI 41-210. (T-1).

1.16.4. Collects and updates administrative and statistical data at the request of flight, squadron, group, wing, MAJCOM and AF agencies using AF sanctioned databases. (T-1).

1.16.5. Oversees enlisted evaluation, feedback, recognition processes and monitors all upgrade training for enlisted personnel in MH. (T-1).

1.16.6. Ensures enlisted involvement in clinical care activities as appropriate for training level and experience. (T-1).

1.17. Mental Health Technician.

1.17.1. MH Technicians will review and follow all DODIs and AFIs referenced in this instruction, including: (T-1).

1.17.1.1. Complies with PRP regulations and tracks individuals assigned to PRP IAW DOD 5210.42-R . (T-0).

1.17.2. Performs patient care related duties IAW their training and skill level under the oversight of a privileged MHP. (T-1).

1.17.3. Participates in MCCC meetings. (T-1).

1.17.4. Adheres to documentation standards and obtains signature by a privileged MHP. (T-1).

1.17.5. Provides prevention, education and outreach briefings. (T-1).

1.17.6. Provides DMH support and pre-exposure preparation IAW AFI 44-153. (T-1).

1.17.7. Completes other extra duties as assigned. (T-1).

Chapter 2

STANDARD MENTAL HEALTH CLINIC PROCEDURES.

2.1. MH Flight Structure. MHCs differ in size. Dependent on location, providers/staff may have multiple overlapping responsibilities. (T-1).

2.1.1. 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.

2.1.2. The MH element:

2.1.2.1. Provides inpatient (if available) and outpatient MH services at the installation within the sanctioned MTF scope of care. (T-1).

2.1.2.2. Performs special duty assessments and screenings as requested [PRP/Presidential Support Program (PSP), Military Training Instructor (MTI)/Military Training Leader (MTL), security clearances, etc.]. (T-1).

2.1.2.3. Conducts Commander-Directed Mental Health Evaluations (CDEs). (T-1).

2.1.2.4. Refers patients for specialized and/or higher level of care. (T-1).

2.1.2.5. Provides DMH and pre-exposure preparation. (T-1).

2.1.2.6. Completes IRILOS/RILOS/MEB/profile/duty-limiting condition (DLC) processes for psychiatric conditions when indicated. (T-1).

2.1.2.7. Performs sanity board and forensic evaluations if an appropriately trained and privileged provider is available. (T-1).

2.1.2.8. Consults with Commanders on MH issues. (T-1).

2.1.2.9. Supports neurocognitive testing when required by the AF for pre-deployment and post-injury. (T-1).

2.1.2.10. Monitors and reports MH data as required by the MTF, MAJCOM or AFMOA. (T-1).

2.1.2.11. Accomplishes other duties falling under the scope of MH care. (T-1).

2.1.2.12. Supports DPHs with MH outreach initiatives. (T-1).

2.1.2.13. Accomplishes other duties as required by the MH Flight Commander or equivalent. (T-1).

2.1.3. ADAPT Element. ADAPT promotes readiness, health and wellness through the prevention, evaluation and treatment of substance abuse IAW AFI 44-121. (T-0).

2.1.4. Family Advocacy Element. The Family Advocacy element is led by the Family Advocacy Officer (FAO) and provides services to prevent/treat family maltreatment and to promote community health and resilience IAW AFI 40-301. (T-0).

2.2. Safety.

2.2.1. MH assessments will only be performed in established clinical locations where both security and medical support are available. This may not be possible in mass casualty situations, or when conducting an assessment of an inmate in an AF confinement facility. (T-1).

2.2.1.1. Unauthorized entry into patient care areas is prohibited. (T-1).

2.2.1.2. MH facilities will have an internal and external electronic duress alarm notification system. Duress alarms will be tested monthly in coordination with Security Forces Squadron (SFS). (T-1).

2.2.1.3. Each MH clinic (MHC) will have a duress response plan to respond to threats of violence. Duress exercises will be conducted and documented at least semi-annually, with one being an external exercise coordinated with the SFS. Note: Coordinate duress exercises involving SFS personnel in advance through Wing/IG office. (T-1).

2.2.1.4. An annual security/threat assessment of MH facilities and security procedures from the SFS will be requested.

2.2.2. Appointments extending beyond duty hours may increase risk. The MH Flight Commander ensures there is adequate staffing to minimize or respond to these risks. It is important for MDG leadership to be notified when MH staff is staying after hours to provide emergency care. (T-1).

2.2.3. AFR DPH Safety

2.2.3.1. Site POCs should ensure AFR DPHs assess clients in a safe and secure professional environment that ensures the safety, privacy and confidentiality, specifically prohibiting MH evaluations outside of the DPH office locations. This does not prohibit MH outreach, prevention or DMH services from being provided outside of the DPH office locations. (T-1).

2.2.3.2. Appointments extending beyond duty hours may increase risk. The DPH and onsite supervision must always ensure there is adequate staffing to minimize or respond to these risks. (T-1).

2.2.3.3. The AFR DPH oversees and documents scenario-based exercises (e.g. active shooter, hostage, etc.) at least annually IAW with Installation's/Wing's Exercise Program. (T-1).

2.2.3.4. At least annually requests security/threat assessment of the DPH office location and security procedures from the SFS. (T-1).

2.3. Access to Care.

2.3.1. MH will optimize the availability of services to meet the beneficiaries' needs. The MH Flight Commander is responsible to ensure access standards are met (i.e., same day for emergent appointments, seven days for routine appointments). (T-1).

2.3.2. If a victim of sexual assault or intimate partner violence calls or walks into the clinic, they should be immediately triaged to assess for safety concerns and to develop an initial plan for further assessment and treatment (T-1).

2.3.3. All patients who walk-in to the clinic requesting to be seen the same day will be triaged and evaluated for risk. (T-1). Completion of intake is preferably done on the same day, but can be scheduled for a later date if clinically appropriate and if provider availability limits same day completion. (T-1).

2.3.4. Clinics with formal tele-psychiatric/tele-mental health services will have appropriate Operating Instructions/MOUs in place. (T-1).

2.4. Initial Encounter.

2.4.1. All patients will receive information on MHC policies including the possible need for transfer of MH information upon transition as part of the initial orientation to the MHC, ADAPT Program, or FAP IAW DODI 6490.10, using the MHC Confidentiality/Informed Consent Sheets (Attachment 3 and 4). (T-0).

2.4.2. The MH staff determines whether the member is there voluntarily or at the direction of his or her Commander/supervisor. (T-0). If the member responds with the latter and the Commander has not initiated a CDE IAW DODI 6490.04, the MHP contacts the Commander or supervisor to determine if a CDE was intended. (T-0).

2.4.3. A Primary Mental Health Provider (PMHP) will be clearly identified for each patient and is responsible for ensuring coordination of care with other providers (e.g., MHPs, PCMs) and communicating any duty or mobility restrictions with the patient's Commander. (T-1).

2.4.4. Each intake and follow up MH note will contain a documented risk assessment addressing the following domains: suicide-related ideation and/or suicide related behaviors and intent/plan, warning signs, risk factors, protective factors, and other clinically relevant information. (T-1).

2.4.5. Patients will be asked if they plan to acquire or currently possesses a privately owned firearm, ammunition, or other weapon/means of hurting themselves at all intakes; and only at follow-ups when the provider judges the service member is at significant risk for suicide or causing harm to others. (T-1).

2.4.6. Visits for all open MH patients will be tracked, and engagement in treatment will be reviewed at least every three months. (T-1). Clinic staff will alert the PMHP to review open cases in which the patients have no contact in the last three months and will contact those patients to offer continued care and/or discuss closure based on the case. (T-1).

2.5. Standard Screening and Outcome measures.

2.5.1. The following standardized screening and outcome measures will be used during initial evaluation and periodically until termination of treatment in MH treatment settings for patients diagnosed with: depression (Patient Health Questionnaire (PHQ-9), anxiety (Generalized Anxiety Disorder Assessment 7 (GAD 7), and post-traumatic stress (Post Traumatic Checklist (PCL) IAW Assistant Secretary of Defense/Health Affairs Memorandum, *Military Treatment Facility Mental Health Outcomes Guidance*, 9 September 2013. (T-0).

2.5.1.1. The Patient Health Questionnaire (PHQ) -9 and the Alcohol Use Disorders Identification Test-Consumption (AUDIT-C) are used during all intake evaluations. (T-1).

2.5.1.2. The PHQ-9 is distributed to every MH and ADAPT patient during every visit as a screening for suicide risk. (T-1).

2.5.1.3. The MH Flight Commander implements a procedure for the PMHP to communicate with the front desk staff when additional outcome measures are needed. (T-1).

2.5.1.4. When available at the MTF and MH staff is properly trained, use the Behavioral Health Data Portal (BHDP) to track outcome measure on all MH and ADAPT beneficiaries IAW Assistant Secretary of Defense/Health Affairs Memorandum, *Military Treatment Facility Mental Health Outcomes Guidance*, 9 September 2013. (T-0). Initial training for the AF BHDP launch will be conducted by AFMOA contract trainers at each MTF MH clinic. Thereafter, sustainment training will be provided by local MTF staff. (T-1).

2.6. Mental Health Case Management. MH Case Management manages the MH needs of high risk patients and others as necessary. (T-1). If staffing permits, a single MH staff member can be assigned to manage these functions. (T-1). If not, the provider who placed the referral for MH care off base acts as the case manager. MH case Management duties include: (T-1).

2.6.1. Tracking & Care Coordination of MH Referrals.

2.6.1.1. MH Referrals to the Network for service members are reviewed by MH to determine if the service requested is available in the MTF within access standards. (T-1). If the services are not available, then the MH Flight Commander or his/her designee defers patients to the network via the Referral Management Center (RMC). (T-1). The MH Case Management function ensures all Regular Air Force or service members that are active patients in the clinic and referred off base are seen quarterly for tracking and monitoring for compliance to treatment/fitness for duty. (T-1). If the member is a patient in the MHC, then their PMHP will provide case management. (T-1). If the primary care provider placed a psychiatry referral, a request should be made for Behavioral Health Optimization Program (BHOP) staff to case manage those patients. (T-1).

2.6.2. Reviews documentation of external MH care for MHC patients. (T-1). For non-MHC patients, the primary care team is responsible for reviewing external MH notes. The documents from external MH care are provided by the MTF medical records department or by the patient. (T-1).

2.6.3. Completes a Case Management log during the MCCC meeting to ensure continuity and coordination of care. (T-1).

2.6.4. Monitors no-shows and follow-up. (T-1).

2.6.5. Oversees transfer of patients and records upon permanent change of station (PCS). (T-1).

2.6.6. Identifies local community/network resources. (T-1).

2.6.7. Registers service members with Posttraumatic Stress Disorder (PTSD), Traumatic Brain Injury (TBI), and/or other MH diagnoses into the Wounded Warrior Program, as appropriate. (T-1).

2.6.8. Collaborates with ARC medical personnel in all matters dealing with ARC personnel. (T-1).

2.6.9. Clinic Case Management of Special MH Cases:

2.6.9.1. The MH case manager may not be able to manage cases with a potential conflict of interest. These special cases are directly referred to the SGH who leads a meeting to review the case and determine the final disposition. (T-1).

2.6.9.1.1. If the SGH agrees with the referral, the RMC defers the case directly to the network without MH review. (T-1).

2.6.9.1.2. The PCM teams must case manage these patients with the assistance of the Medical Case Manager or BHOP behavioral health care facilitator (BHCF). (T-1). The Medical Case Manager or BHCF ensures the member is evaluated by the PCM at least quarterly for tracking and monitoring for compliance to treatment/fitness for duty. (T-1).

2.6.9.2. In cases where a high risk MH patient has medical issues that might require civilian specialty referrals, the Medical Case Manager and MHC co-manage these high risk patients.

2.7. MCCC meeting:

2.7.1. MCCC is held weekly to coordinate the care of HIL patients, complex patients who are involved in multiple elements within the MH Flight, and track off base MH referrals for service members. An MCCC log will be created to document the meeting. (T-1).

2.7.2. Sufficient information necessary to coordinate care, and manage risk is to be shared with all MHC personnel, and will be documented in the electronic health record (EHR). (T-1).

2.7.2.1. As an option for MH Flights with 25 or more privileged providers, the MCCC meeting can be divided into two teams modeled after the patient centered medical home approach. In this method, the MH element is separated into two teams each consisting of therapists, mental health specialty medication prescribers, and technicians. Each team has their own MCCC meeting with one representative from each of the ADAPT and FAP elements. The ADAPT and FAP elements will have a process in place to share the information discussed during each of the MCCC meetings with all the providers within their respective elements. (T-1).

2.7.3. The MCCC log is not shared outside MH, with the exception of the HIL portion which is shared with PCMs weekly. (T-1).

2.7.4. Clinical notes documenting the MCCC that include coordination with FAP services are entered into the individual's electronic MH record and into the FAP record. (T-1).

2.8. No Show/Noncompliance with Treatment.

2.8.1. If a patient refuses to continue treatment and/or to schedule a follow-up appointment as recommended by the MHP, the provider documents the encounter and the decision by the patient to refuse services. (T-1). The MHP completes a summary of treatment in the EHR. (T-0).

2.8.2. If, in the provider's judgment, the failure to continue care results in risk to the patient, others, or the military mission, the MHP will contact the patient's Commander and communicate concerns regarding increased risk and discuss the possible need for a CDE to answer questions such as safety, ability to perform the mission, deployability, or fitness/suitability for continued military service. (T-1). In addition, the provider should consider the need for an AF Form 469, *Duty Limiting Conditions Report*, to restrict PCS, duty, and/or mobility. If the member is going to PCS and refuses to follow up with MH care at the gaining base, then the provider shall notify Command. A sample notification letter can be found on MH Branch KX. (T-1).

2.8.3. At the provider's discretion, voluntary patients currently not at clinically significant suicide risk who no show, may be considered for case closure after 3 valid attempts (phone calls and/or letter) to reach the patient. (T-1).

2.8.3.1. No shows can be included in overall MDG no shows and Command notifications as long as MH no shows are not differentiated from other MDG no shows and no HIPAA information is released.

2.9. Patient Transfer/Termination.

2.9.1. Closure or transfer notes must be completed and uploaded or scanned into the EHR and marked sensitive upon completion or transfer of MH care IAW DoDI 6490.10 and this instruction. (T-0). A sample MH Record Termination-Transfer of Care Summary can be found on AF/SG Mental Health KX site and is recommended to assist with meeting DoDI 6490.10 documentation requirements.

2.9.2. The MH Flight will be included on the installation out-processing checklist to screen Service member's records. (T-0). MH technicians will review the out processing list and will screen the EHR for any MH Flight/BHOP treatment during the last 180 days, including care received during deployment or temporary duty assignment. (T-0).

2.9.3. If this screen is positive, a MHP will review the record to assure: care received has been appropriately terminated and there is no need for ongoing follow up. (T-0).

2.9.4. Transfer of MH information will be accomplished IAW DODI 6490.10 and this instruction. (T-0). When transferring to a new command, transfer of clinical care of a Service member receiving MH care within the MTF system shall be arranged through direct MHP-to-MHP communication via secure methods (e.g., telephone call or encrypted e-mail), as clinically indicated by the losing MHP. (T-0). This communication must be documented within the EHR.

2.9.4.1. If the Behavioral Health Data Portal (BHDP) is available, the losing MHP will utilize the PCS Flag which tracks SMs that are in need of continued behavioral health care when they reach their next duty station. Within a month of the anticipated PCS, the losing provider should complete a transfer summary and enter it into the EHR. The transfer summary must contain information about the kind of follow-up care the patient will need at the gaining installation, whether ongoing treatment is deemed necessary to ensure mission safety, and the anticipated arrival date to the new installation. (T-1).

2.9.5. The MHP at the receiving location shall have a level of expertise consistent with the patient's mental health needs and treatment plan. (T-0).

2.9.6. The MHC at the gaining base will track transferred MH patients with an open MH case in the MCCC meeting. The gaining installation should generate a report within the BHDP of incoming SMs due to their installation within the coming month and review it for cases identified as needing follow-up MH care. The gaining MH clinic will assist in scheduling an appointment at the gaining MH clinic prior to the SMs PCS. The gaining MH clinic shall also track no-shows for any flagged SM on the PCS list. If a flagged SM no-shows for the scheduled appointment (or, for reasons beyond control, arrives at the gaining base without an appointment), the gaining MH clinic will contact the SM to arrange an appointment. If the MHP is unable to contact the SM then the SM's Commander will be notified if adherence to treatment is deemed necessary to ensure mission readiness and or safety based on information obtained from the MHP.

2.9.6.1. Once an adequate hand-off has occurred, the gaining MH provider shall indicate the handoff within the BHDP via the drop-down menu (behavioral health appointment attended, patient declined appointment, contact attempted etc.) which will alert the losing MH Clinic that the handoff has occurred.

2.9.6.2. In cases where SMs have been flagged by their losing MH providers as being in need of follow-on care but then refuse to schedule a follow-up appointment with the MH Clinic at the gaining base, the gaining MH Clinic shall alert the SM's Commander and discuss the need for a CDE only if the losing provider determined that ongoing treatment is necessary to ensure mission readiness and/or safety. (T-1).

2.9.7. For transfer cases, the patient:

2.9.7.1. Shall be made aware of available resources for care during and after the PCS, separation or retirement to ensure continuity of care during transition. (T-0).

2.9.7.2. Shall be provided with the losing and gaining command's contact information and emergency contact information from the time of travel during transition. (T-0).

2.9.7.3. Shall be provided the name of a MHP at the gaining base, contact information and an appointment. (T-0). If the patient is separating or retiring from service or the patient is a family member, they are responsible for providing contact information of a provider with whom they have established follow up care.

2.9.7.4. If the patient is a service member, then the member may choose to utilize the "In Transition" program as described in Assistant Secretary of Defense for Health Affairs Memorandum, "*Department of Defense in Transition Program*", dated January 12, 2010. (Information on the in Transition mental health coaching and support program is available at <http://www.health.mil/InTransition/default.aspx>).

2.10. Termination.

2.10.1. For patients involved with multiple MHPs, document coordination/collaboration regarding case closure. (T-1).

2.10.2. The decision to close a case is based on clinical indications and not simply due to a move or for administrative convenience. (T-1).

2.10.3. Patients receiving FAP services at the time of contemplated closure of the MH record must be staffed with the FAP provider(s) prior to closure/transfer, with consultation noted in the written MH record. (T-1).

2.11. Peer Review.

2.11.1. A minimum of 5% of routine cases and 100% of HIL cases seen in the last 30 days must be reviewed per provider per month and the provider and departments must receive feedback IAW AFI 44-119. (T-1).

2.11.2. A professional peer is defined as a professional with similar training, clinical experience and AFSC IAW AFI 44-119. (T-1)

2.11.3. All MHCs will utilize the Monthly Mental Health Peer Review template (Attachment 5) for both MH and ADAPT patients. (T-1).

2.11.4. BHOP providers will be peer reviewed only by another BHOP trained provider using the BHOP Peer Review template (Attachment 6). (T-1).

2.11.5. The reviewing provider advises the treating provider of the identified discrepancies for process improvement. Correctable actions should be completed same day, when possible, but not later than one duty day. (T-1).

2.12. Suitability and Fitness Determinations.

2.12.1. Military personnel must be fit and suitable for their assigned duty, both physically and psychologically. MHPs will make determinations on fitness and suitability for duty or deployment regarding MH disorders and the individual's ability to perform job-related duties and relate effectively, accomplish mission tasks and tolerate environmental stressors. (T-0).

2.12.2. Certain duty statuses, such as PRP/PSP, weapons bearing, security clearances and/or flight status, have specific requirements for medical fitness and suitability. MH will notify and advise Flight Medicine anytime a patient on flight status is seen. (T-0). Flight Medicine will clear the member prior to resuming flight duties IAW 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. (T-0).

2.12.3. 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 IAW AFI 48-123. (T-0). MHPs will advise Commanders when Service members are either unsuitable for continued service IAW DODI 1332.14, *Enlisted Administrative Separations*; AFI 36-3208, *Administrative Separation of Airmen*, and this instruction, or unfit for continued service IAW DODI 1332.18, *Physical Disability Evaluation*. (T-0).

2.13. Mobility Restrictions and Duty Limiting Conditions (DLCs).

2.13.1. Providers will evaluate and annotate a patient's suitability and fitness for duties and deployability at every clinical contact. (T-1). Any change in status must be accompanied by appropriate justification and rationale. (T-1).

2.13.2. Prescribing providers are required to initiate an AF Form 469 profile when managing care involving the disqualifying medications listed in the Health Affairs Memorandum *Clinical Practice Guidance for Deployment-Limiting Mental Disorders and Psychotropic*

Medications dated 7 Oct 2013, paragraph 3.e.1-6. Members who are taking these medications are not eligible for waiver. (T-0).

2.13.3. Providers are required to initiate an AF Form 469 or medical profile when patients are diagnosed with psychotic or bipolar disorders or other disorders with associated psychotic symptoms. These conditions are unfitting for military service and disqualifying for deployment and not eligible for waiver. (T-0).

2.13.4. If, in the clinical judgment of the MHP the MH condition is expected to worsen or physical trauma is likely to have grave medical outcome or negative impact on mission execution; the MH condition is not stable and is anticipated to worsen during deployment in light of the physical, physiological, physiological, and nutritional effects of the duties and location; ongoing MH care or medication is anticipated to be needed for the duration of the deployment and are not available in theater within the military health system; or the medication indicated requires special handling, storage or other requirements, is not well tolerated within harsh environmental conditions and could cause significant side effects in the setting of moderate dehydration; or if there is there an anticipated need for routine evacuation from theater for continued diagnostics or other evaluations, the MHP will use AF Form 469 to initiate a mobility restriction recommendation. (T-0).

2.13.4.1. Providers, to include MHPs, will not notify an Airmen's Commander when an Airman self-refers or is medically referred for mental health care or substance misuse/abuse education services unless disclosure is authorized, as described in DODI 6490.08 and paragraph 6.6.1.1 through 6.6.1.9. of this Instruction. (T-0). If Command notification is not warranted, an AF Form 469 will not be created for the specific encounter or clinical concern. However, providers must carefully weigh the rigors of potential assignments or deployments carefully to avoid exacerbations of conditions brought on by the rigors of contingency operations IAW AFI 10-203. (T-1).

2.13.4.2. For a situation that might require a deployment waiver, pursuant to DODI 6490.07, Enclosure 2, Section 3, an AF Form 469 must be initiated in order to inform the Airman's Commander to initiate the waiver IAW AFI 10-203. (T-1).

2.13.4.3. If, in the clinical judgment of the MHP, the patient's diagnosed condition is not amenable to treatment and restoration to abilities to perform duties required of their AFSC in garrison and the patient deployed within one year of onset of treatment, the patient will be referred to the DAWG for consideration for a RILO.

2.14. Deployment Mental Health (DMH) Clearances.

2.14.1. All deploying members' medical records will be screened for MH/ADAPT/FAP visits prior to deployment and seen for further assessment as appropriate. (T-0).

2.14.1.1. Regular AF members with a MH history will be screened prior to deployment and the results will be documented in the EHR. (T-1). MH Record Review Waiver Checklists are available on the AF/SG MH Branch KX site and are recommended to assist with screening members.

2.14.1.2. Members with a psychiatric disorder (excluding those in paragraph 2.12.3 above) in remission or whose residual symptoms do not impair duty performance may be

considered for deployment duties if they have demonstrated a pattern of stability without significant symptoms for at least three months prior to deployment. (T-0).

2.14.1.2.1. If a patient with an open MH record has not been seen in three months, then the patient will need to be evaluated in person by a MHP to assess stability prior to clearance. If the chart had been closed within 3 months, the MHP will review the chart and determine if the member is cleared for deployment or requires an in person evaluation. (T-1).

2.14.1.3. IAW DODI 6490.07, some MH conditions and/or treatments usually preclude deployment. In general, Service members with these conditions/treatments shall not deploy unless a waiver is granted. (T-0). MH Record Review Waiver Checklists are available on the AF/SG MH Branch KX site and are recommended to assist with determining if MH patients are appropriate for deployment.

2.14.1.4. If a Commander wishes to deploy an individual with a condition that could be disqualifying, a waiver must be submitted to the applicable Combatant Commander through the individual's servicing military medical unit. (T-0).

2.14.1.5. IAW DODI 6490.03, *Deployment Health*, and DODI 6490.13, at a minimum, all Service members deploying OCONUS, for more than 30 days, to a location with a non-fixed MTF will receive a pre-deployment neurocognitive baseline assessment utilizing the designated DOD neurocognitive assessment instrument within 12 months prior to deployment and at each of the following deployment phases: (T-0).

2.14.1.6. PRE-DEPLOYMENT. Perform a pre-deployment baseline neurocognitive assessment within the 12 months before deployment using the designated DOD neurocognitive assessment instrument. (T-0).

2.14.1.7. POST-INJURY. Perform a neurocognitive assessment following a diagnosed concussion or mild TBI (mTBI) in accordance with DODI 6490.11, DODI 6490.13, the Defense Centers of Excellence for Psychological Health (DCoE) clinical practice recommendation, *Indications and Conditions for In-Theater Post-Injury Neurocognitive Assessment Tool Testing*, and the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury website, http://www.dcoe.health.mil/TraumaticBrainInjury/TBI_Information.aspx. (T-0).

2.14.1.7.1. Post-injury neurocognitive assessments will be compared to Service member baseline neurocognitive assessments, when available, to inform return-to-duty decisions by medical providers. To request baseline neurocognitive assessments during deployment, medical providers will call or email the Neurocognitive Assessment Branch helpdesk at (855) 630-7849, DSN 471-9242 or usarmy.jbsa.medcom.mbx.otsg--anam-baselines@mail.mil. (T-0).

2.14.1.7.2. Post-injury evaluations on Service members without baseline neurocognitive assessments may be compared to pre-deployment-relevant norms.

2.14.1.8. POST-DEPLOYMENT. Upon return from deployment, those Service members who respond affirmatively to the TBI risk assessment questions on the PDHA contained in DODI 6490.03, will be referred for further clinical evaluation that may include the administration of a neurocognitive assessment. (T-0).

2.14.1.8.1. IAW DODI 6490.13., paragraph 3.f., civilian expeditionary workforce employees will be screened for cognitive changes in the same manner as military service members to the extent practical and consistent with DODD 1410.10, *DOD Civilian Expeditionary Workforce*. (T-0).

2.14.1.9. Neurocognitive assessment measures other than the ANAM may only be used if authorized by a waiver granted by the Assistant Secretary of Defense. (T-0).

2.14.1.10. Assessment and Disposition during Deployments:

2.14.1.10.1. Members diagnosed with psychotic or bipolar disorders or other disorders with psychotic symptoms during deployment should return to their home station. (T-0).

2.14.1.10.2. Members who are determined to be at significant risk for performing poorly or decompensating in the operational environment or whose condition does not improve within a reasonable time should be evacuated from theater. (T-0).

2.15. Overseas Clearances for Service members.

2.15.1. Compliance with the current medical review process for each location is mandatory. (T-1). Assignment to certain remote and overseas bases requires more stringent clearance processes and approval.

2.16. Family Member Relocation Clearances (FMRCs). MHPs support the FMRC process as clinical consultants where MH or substance abuse issues are identified, IAW AFI 40-701. (T-1). 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. (T-1).

2.16.1. When MH identifies conditions that meet criteria for EFMP enrollment, MH makes mandatory referral to the EFMP Medical (EFMP-M) office, IAW AFI 36-2110 and AFI 40-701. (T-1).

2.17. Family Child Care Applications.

2.17.1. 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. (T-1).

2.17.2. MH Flight Commanders 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 is referred to a privileged MHP for review. (T-1). The role of the MH staff in the background screening process is to provide information that may preclude the selection of an applicant for any position (paid or volunteer) working with children. MH staff members do not assess the suitability of the applicant, nor do they approve or disapprove the applicant for such positions. MHPs will provide details of the incident or state the diagnosis to the requesting DOD agency only with appropriate release of information. (T-1).

2.17.3. A signed release is provided by the applicant prior to the record review. (T-1).

2.18. 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, Independent Duty Medical Technician (IDMT) etc.]. A signed consent for the release of

confidential information is not required to disclose fitness for duty information to command, per DOD 6025.18-R. (T-1). Requests for clearances are considered personnel evaluations rather than MH evaluations, but a clinical note will be placed in the EHR. (T-1).

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

2.19.1. For personnel being certified, recertified or otherwise evaluated for PRP/PSP, the entire health record (hard copy and electronic) must be reviewed in order to determine if PDI exists (e.g., FAP, MH, ADAPT, relevant medical problems, MH issues treated by a PCM). (T-0). Ensure emergency department (ED) documentation and Personal Health Assessments (PHAs) documentation is thoroughly reviewed. (T-0). 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* in order to screen for responses made about prior-to-service behaviors or events that indicate discrepancies or potential disqualification. (T-0).

2.19.2. Consult DODI 5210.42 Regulation and AFMAN 10-3902 for more information on selection, evaluation, treatment and reporting of PRP/PSP personnel.

2.20. On-Call Procedures.

2.20.1. MHPs will provide consultation to Commanders after established duty hours. (T-1). MHPs offer recommendations on managing crisis situations to Commanders, law enforcement agencies, first sergeants and other helping agencies. (T-1).

2.20.2. After-hours MH assessments will only be conducted in an ED or Urgent Care Clinic (UCC). At installations without an ED or UCC, emergencies will be handled similar to other acute medical emergencies using community medical resources. (T-1).

2.20.3. 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. On-call providers and/or MH personnel will not be directed to engage with individuals exhibiting threatening behaviors. (T-1). Personnel requiring evaluation must be taken to the ED by the member's command. Emergency response personnel or Security Forces/law enforcement will be consulted as appropriate for assistance. (T-1).

2.20.4. MHPs may be required to evaluate inmates in AF base confinement facilities in the rare instances that a detainee/inmate is placed on suicide watch by the confinement officer and the MHC is closed during the mandated evaluation requirement IAW AFI 31-205 (as soon as possible and within the first 24 hours of the initiation of segregation and a minimum of every 24 hours after the initial segregation). The detainee/inmate will require a full clinical assessment. Since there are notable concerns about privacy/confidentiality and emergent medical care availability within the confinement setting itself, clearly the preferred method would be to transfer the inmate (in shackles if needed) to the MHC if the MHC is open. (T-1).

Chapter 3

MH TREATMENT PROCEDURES

3.1. Transporting Patients in Crisis (during duty and after-duty hours).

3.1.1. If an emergent evaluation is conducted at the MHC, the requesting Commander will provide an escort for the patient. (T-1).

3.1.2. MH does not provide manpower for the transportation of any MH patients. This responsibility lies with the Commander. If the situation warrants assistance from Security Forces/law enforcement then a response/request will be properly coordinated through the Base Defense Operation Center. MH will assist with the coordination as appropriate. The exception is the use of MH technicians to aid in air evacuation of certain categories of MH patients on military airlift. (T-1).

3.1.3. If an emergent evaluation is conducted at the MHC or at the request of another medical clinic, the requesting clinic staff should escort the patient to the MHC and the requesting provider should call the MHP to perform a provider to provider hand off. (T-1).

3.2. Clinical Management of Suicidal Patients.

3.2.1. MHPs will implement clinical practices IAW currently published AFMOA guidance, unless otherwise clinically indicated. (T-1).

3.2.1.1. All patients will be given the appropriate AFMOA approved preliminary suicide screening instrument prior to each MH appointment. (T-1).

3.2.1.2. MHPs will make an informed decision about suicide risk based on all available data and document rationale for classifying risk level. (T-1).

3.2.2. MHPs must communicate risk level as appropriate with command. (T-1).

3.2.3. MHPs will carefully evaluate every Airman with a recent suicide attempt for both ongoing care and fitness/suitability for continued duty. (T-1). Following any service member suicide attempt, the MTF SGH will lead a meeting with the member's MHP and PCM to review the case and determine the medical disposition of the individual. (T-1). An Airman with a potentially medically disqualifying diagnosis will be discussed at the Deployment Availability Working Group (DAWG) to determine if an RILO and consideration for an MEB is warranted, or processing for an administrative separation is more suitable due to a personality disorder or other unsuitable condition. For suicide attempts by ARC members, a fitness for duty determination will be instituted (See AFRC/SGP Consolidated Program Memorandum). (T-1).

3.2.4. Every mental health evaluation or treatment case in which a Service member ultimately commits an act resulting in suicide, homicide, serious injury, or significant violence will be systematically reviewed. (T-0). The findings will be used to inform patient care process, risk management, and technical competence of staff members. (T-0). To the extent this review by the MTF constitutes peer review, it is privileged under 10 U.S.C. § 1102.

3.2.4.1. Every review will focus upon the assessment, treatment, and clinical progress of the Service member, as well as the administrative recommendations and follow-through. (T-0). Quality reviews will be documented in the risk management record, and if appropriate, the credentials record. (T-0).

3.2.5. MHPs will initiate a fitness for duty determination for suicide attempts by ARC members and notify HQ AFRC/SGP at Robins AFB, GA about all suicide attempts by AFR personnel to ensure proper disposition. (T-1).

3.2.6. MH personnel will accomplish the DOD Suicide Event Report (DODSER) for all suicide attempts resulting in medical care including mental health care. (T-0). For completed suicides, entries should not be entered into DODSER until the Armed Forces Medical Examiner makes a determination about the manner of death.

3.3. High Interest List (HIL)

3.3.1. HIL status reflects a provider's judgment that heightened monitoring is indicated and meets the notification criteria discussed in paragraph 6.6.1. of this AFI (includes but not limited to increased risk of harm to self or others, or harm to mission). Therefore, any patient, including those seen in ADAPT and FAP, meeting these criteria can be categorized as high interest. (T-1).

3.3.2. Patients assessed to be at a serious risk of self-harm (clinically significant suicide risk) will be added to the HIL. (T-1).

3.3.3. The HIL serves as a communication strategy for coordinating care, closely monitoring the improvement and/or exacerbation of symptoms, and ensuring timely delivery of treatment.

3.3.4. The PMHP is generally responsible for entering and removing their patients from the HIL. When adding patients to the HIL, in order to facilitate coordination of care and to address limiting access to means, trained/certified staff notify the patient's PCM and the on-call MHP, and the Commander or First Sergeant (if military) the same duty day (or NLT the next duty day if after duty hours). A HIL Hospitalization Checklist is available on the AF/SG MH Branch KX site and is recommended to assist with tracking HIL patients.

3.3.5. At a minimum, the HIL contains the name of the patient, PMHP responsible for the coordination of the patient's care, date entered onto HIL, diagnosis, nature and level of the risk (e.g. risk factors, specific concerns), PCM, command representative and the next scheduled follow-up appointment. (T-1).

3.3.6. The MHCs shall forward the HIL to the PCMs weekly. (T-1). MDG members who meet the HIL criteria are also included on the HIL. (T-1). The designated MHP will meet with PCMs at least monthly to discuss all HIL cases and document the meeting in the MCCC log. (T-1).

3.3.7. The HIL is maintained at the MH reception desk. (T-1).

3.4. HIL Procedures.

3.4.1. HIL patients will be evaluated weekly, and in person when at all possible. (T-1). The only exceptions are patients who are in a psychiatric hospital or enrolled and attending

intensive outpatient or partial hospitalization programs since these patients are being managed by outside providers and communication exists weekly with the providers. (T-1).

3.4.2. A face to face treatment team meeting will be scheduled with the patient, the PMHP and the Commander/First Sergeant or their designee within seven calendar days upon entry into the HIL or discharge from the hospital, whichever is appropriate. (T-1). If a face to face meeting is not possible, the treatment team meeting can be accomplished via telephone or video teleconference. The treatment team meeting must be documented in the patient's mental health record. (T-1). A High Interest Treatment Team Meeting template is available on the AF/SG MH Branch KX site and is recommended to assist with such documentation.

3.4.3. Cases on the HIL are discussed weekly at the MCCC meeting to include risk level, progress with the treatment plan, case management decisions, and whether high interest status is still warranted. In addition, peer consultation is sought if needed. (T-1).

3.4.4. A special flag will identify HIL patients in the EHR. Special flags are added in from the demographics section. BH1 will be used for harm to others and BH2 will be used for harm to self. (T-1).

3.4.5. HIL patients will be placed on mobility limiting profile for the duration of their elevated risk, generally not less than 90 days.

3.4.6. Names of the patients admitted to a hospital for MH or alcohol/drug reasons are added to the HIL as soon as the clinic becomes aware of the admission. (T-1).

3.4.7. MH staff coordinates with inpatient, intensive outpatient, or partial hospitalization staff for continuity of care before, during (at least weekly, as clinically indicated) and after psychiatric hospitalizations. (T-1).

3.4.8. Once a member is discharged from the hospital, the discharge summary is uploaded into the EHR and marked as sensitive. The MHP notifies the PCM of the discharge. (T-1).

3.4.9. If a service member attempts suicide, the PMHP ensures a meeting between the MHP, SGH, and the PCM occurs IAW AFI 41-210 in order to discuss the most appropriate treatment course and disposition for the member. (T-1). The meeting must occur within two weeks of discharge from the inpatient psychiatric ward. The purpose of this meeting is to discuss the appropriateness for an RILO/MEB or administrative separation and document the decision and supported information.

3.4.10. **High Interest Log Walk-Ins.** If a HIL patient walks into the clinic, the patient is seen by on-call MHP or the PMHP if available. (T-1). When the PMHP anticipates being unavailable for an extended period of time, the PMHP informs other providers who are covering any HIL patients from his or her caseload. (T-1).

3.4.11. **High Interest Log Cancellations/No Shows.**

3.4.11.1. If a HIL patient calls the MHC for any reason, the MH staff obtains the number where the patient is calling from and connects the patient to either the patient's PMHP or the on-call MHP, depending on which individual is available. (T-1).

3.4.11.2. If a HIL patient calls to cancel an appointment, the patient's PMHP, or if the PMHP is not available, the on-call MHP, speaks directly with the HIL patient to assess risk and document the reason for the cancellation. (T-1).

3.4.11.3. In order to ensure that HIL patients are unable to cancel their appointments without speaking to a MHP, ideally, the MH Flight Commander will disable the appointment cancellation ability in the CHCS clinical telephone reminder system and the web based TRICARE online cancellation system. If that is not possible, the MH Flight Commander will ensure a procedure is in place for the MHC to receive a list of the MH appointments that were canceled via the telephone reminder system and the web based TRICARE online cancellation system. (T-1).

3.4.11.4. If the HIL patient no shows, the MH staff contacts the PMHP immediately, and attempts to contact the member. (T-1).

3.4.11.5. The Commander/First Sergeant or their designee will be informed if contact cannot be established within one hour or the HIL patient refuses follow-up. (T-1).

3.4.11.6. A course of action is recommended to the Commander/First Sergeant or their designee by the PMHP based on the patient's individual needs. (T-1).

3.4.11.7. All attempts to contact the patient, their Commander/First Sergeant or their designee are documented in the EHR as a telephone consult. (T-1).

3.4.11.8. Removing patients from the HIL occurs after the PMHP obtains collateral information from the command, recommends removal to the MCCC, and a collaborative decision is made, but always requires at least four weeks of documented risk and symptom stability. (T-1).

3.4.11.9. If a service member who meets HIL criteria, declines therapy, the PMHP should offer weekly brief sessions to provide supportive therapy and crisis management. If the member continues to refuse care or brief supportive sessions, then the PMHP should discuss patient safety with command and offer another TTM before closing the case. If the member continues to refuse care, is not an imminent risk to self or others and involuntary hospitalization is not indicated, then the case is closed with goals not met. (T-1).

3.4.12. HIL Special Considerations.

3.4.12.1. If a dependent or retiree empaneled to the MTF for their primary care is hospitalized, the primary care team shall track their progress if the patient is not being treated in the MTF's MHC. (T-1).

3.4.12.2. When the patient is placed on the HIL, and is on PRP/PSP status, or holds a Top Secret or higher clearance, is a controller, or is on flight status, the MHP will ensure that appropriate notifications to the competent medical authority (CMA) and/or program monitors are made IAW governing policies including HIPAA, DOD 5210.42-R, AFMAN 10-3902, DODI 6490.08, and AFI 48-123. Notifications must be documented in the EHR and updated as needed. (T-0).

3.4.12.3. High Interest Log and military dependents or retirees.

3.4.12.3.1. Civilian Beneficiaries, Dependent Family Members, or Retirees who receive MH care in the MHC will be placed on the HIL when meeting other risk criteria if they are eligible for services under any element within the MH Flight. (T-1). Documentation of case consultation and clinical interventions is placed in all applicable charts. (e.g., the EHR and FAP records). (T-1). All HIL procedures

including a treatment team meeting with a family member or friend the patient considers supportive shall be offered to the family member patient but cannot be mandated. If the civilian beneficiaries, dependent family member, or retiree choose not to comply with the HIL procedures, that will be documented in their MH record. If the patient continues services in the MHC, the patient will be tracked on the HIL and discussed during the MCCC meeting in order to facilitate peer consultation and knowledge sharing with on call providers. (T-1). It is important to obtain a release of information for a support person and contact information to be used in the event of no shows. Ideally, the release would last until treatment or HIL monitoring is complete. (T-1).

3.4.12.3.2. When the immediate family member of a service member who is on PRP/PSP status is placed on the HIL, the MHP should consider whether, due to potential stress on the service member, the information should be disclosed to the service member's PCM. This ensures the service member is provided appropriate healthcare and the service member's PCM can assess the member and determine if there is potentially disqualifying information that must be reported to the CMA. (T-1).

Chapter 4

MISCELLANEOUS ROLES

4.1. Behavioral Health Optimization Program (BHOP) Services.

4.1.1. BHOP services are provided in primary care IAW DODI 6490.15, *Integration of Behavioral Health Personnel (BHP) Services Into Patient-Centered Medical Home (PCMH) Primary Care and Other Primary Care Service Settings*, August 8, 2013. (T-0).

4.1.2. BHOP staffing requirements will be met IAW DODI 6490.15. (T-0).

4.1.3. Personnel providing BHOP services will be trained in the AF BHOP model via internship or externship training and adhere to the service delivery model activities and clinical and administrative standards for work in primary care clinics IAW DODI 6490.15. (T-0).

4.1.4. BHOP providers are required to use the IBHC template located in EHR for all patient encounter documentation. (T-1).

4.1.5. A Medical Group Instruction (MDGI) for BHOP must be written that includes the MTF's processes for managing suicidal patients within BHOP and Primary Care Clinics. (T-1).

4.2. Forensic Consultation in Courts-Martial and Military Justice Matters. MHPs may consult regarding forensic MH issues, conduct forensic evaluations of service members and testify as expert consultants in military courts-martial if current, competent, and privileged to do so, with approval from local chain of command. Funding for sanity boards is not provided by DHP funds. (T-1). While MHPs may assist, it should be noted that as DHP funded personnel, regular patient care duties take precedence.

4.2.1. AFI 51-301 governs consultation and testimony in other settings, and requires approval by the appropriate legal office. Permission to consult and/or testify as an expert witness in non-military justice matters is not generally granted. All requests for testimony should be forwarded to the in-house MLC or the installation SJA. (T-1).

4.3. MH Prevention:

4.3.1. Within specialty MHCs, patient care is top priority. Refer to AFI 90-506, *Comprehensive Airman Fitness (CAF)*, for Population Health initiatives. (T-1).

4.3.2. If manning and access to care allows, MH prevention strategies target increasing organizational and individual awareness of MH issues, trends and threats to mission readiness. (T-1).

4.3.3. DMH's primary function 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 DMH teams is to foster resiliency through education, screening, psychological first aid and referral in those exposed to traumatic stress. Refer to AFI 44-153 and DODI 6200.03, *Public Health Emergency Management within the Department of Defense*, for more information. (T-0).

4.4. Hypnosis.

4.4.1. MHPs who are privileged by an MTF in clinical hypnosis practice IAW accepted guidelines, and the following restrictions: (T-1).

4.4.2. MHPs may not use hypnosis on individuals in the PRP, PSP, or engaged in a Sensitive Duty program without the consent of the certifying official. (T-1).

4.4.3. MHPs and MH technicians ensure that chaperones are present during hypnosis sessions. (T-1).

4.5. Biofeedback.

4.5.1. MHPs may be granted privileges to administer biofeedback if they are current, competent, and trained (accomplished biofeedback training coursework). (T-1).

4.5.2. Biofeedback equipment must be approved by the IT office prior to being installed on a network computer. (T-1).

Chapter 5

MENTAL HEALTH (MH) NOTES AND RECORD MANAGEMENT

5.1. MH Notes and Record Organization.

5.1.1. Within one year of this publication, all MH flights will remove FAP service documentation from MH records and establish separate FAP records IAW AFI 40-301. (T-1). New Parent Support Program (NPSP) and Family Advocacy Strength-based Therapy (FAST) prevention records will continue to be maintained separately IAW AFI 40-301. (T-1). Records must be separated prior to staging for record retirement. (T-0).

5.1.2. An electronic MH record will be established for each patient from the date of this publication forward. (T-1). Previous hard copy MH records will not be integrated into the electronic MH record; instead the open hard copy MH record will be transferred to the gaining installation MHC when the service member PCSs. The electronic MH record will be distinguished by marking each entry sensitive (i.e., “break the glass”). (T-1). The electronic MH record will contain all documentation created by ADAPT and MH from the date of establishment of the electronic record forward. (T-1).

5.1.3. All MHPs will use the Intake note template (Attachment 7) and Follow-up note Template (Attachment 8). (T-1). Notes by non-privileged staff must be reviewed and signed by a privileged provider. (T-1). NOTE: Template must be transferred into the EHR, or in com-out contingencies, onto a SF 600 in order to be in compliance with Privacy Act Standards.

5.1.3.1. The MHP is ultimately responsible for ensuring unnecessary details of a very private nature are not included in the treatment note. (T-1).

5.1.3.2. Treatment plans will be completed with patients and integrated in MH notes by the third session and will include clear explanation of the goals, therapeutic modalities, and outcome measures. Treatment plans will be reviewed and updated regularly. A stand-alone treatment plan is not permitted. (T-1).

5.1.4. In addition, the following MH documentation will be placed into the EHR and marked sensitive: (T-1).

5.1.4.1. Patient information sheets. These include: Privacy Act Form, the Patient Information and Informed Consent Sheet, ADAPT Substance Use Assessment Tool (SUAT) generated patient information sheets, and sheets that are completed by patients and capture demographics, contact information, reasons for seeking care, presenting complaints, prior history of treatment, current medications and other information as needed. (T-1).

5.1.4.2. Behavioral logs, safety plans, suicide assessment tools and related information. (T-1).

5.1.4.3. All collateral contacts, which occur over the phone, will be entered as telephone consults. (T-1).

5.1.4.4. Administrative documentation such as patient no-shows, rescheduling of appointments, telephonic contact, unsuccessful attempts to contact Commander/First

Sergeant or their designee or family members, etc. will be documented as telephone consults. (T-1).

5.1.4.5. Clinical notes documenting High-Interest meetings and/or MCCC meetings that include coordination with FAP services. The MCCC template (Attachment 9) will be used to document the discussions. (T-1).

5.1.4.6. Psychological testing interpretation reports. (T-1).

5.1.4.7. MEB Narrative Summaries. (T-1).

5.1.4.8. Termination/transfer notes. (T-1).

5.1.4.9. Release of Information Requests.

5.1.4.10. CDE reports and administrative recommendation memos. (T-1).

5.1.4.11. MH Documentation from outside the MTF MHC. Civilian MH notes, discharge summaries, and admission notes are entered into the EHR and marked sensitive and the treating MHP will be notified. (T-1). If the patient is not being treated in the MHC, then the primary care provider will be notified. (T-1).

5.2. Special Documentation requirements. In addition to marking the record as sensitive (i.e., “break the glass”), certain records require additional protections as detailed below.

5.2.1. Documentation of sessions where a restricted report of sexual assault is discussed must have special protection to avoid unauthorized release of information. (T-1). The following wording in bold type is placed in each notation in the EHR: *“Restricted from disclosure unless and until determined to be releasable by the MTF Commander or designee. Do not release without specific patient authorization or as specifically authorized by DOD or AF policy”*. (T-1). Documentation must include information regarding the emotional injuries resulting from the assault. (T-1). The level of detail provided should be sufficient for continuity of care IAW AFI 44-102, *Medical Care Management*. (T-1).

5.2.2. Notes written while members are on the HIL will be marked with “HIGH INTEREST” in the first sentence of the MH note; this facilitates awareness to allied health providers of increased risk status. (T-1).

5.2.2.1. Clinical notes documenting High-Interest meetings and/or MCCC meetings that include coordination with FAP services are entered into the individual’s MH note in the EHR and the FAP record. (T-1).

5.2.3. Notes written while members are on PRP status must contain the PRP stamp. (T-1). The PRP stamp is completed in a word document and entered into the EHR note using the “add note” function. (T-1). The PDI letter is placed into the EHR. (T-1).

5.2.4. Notes written when a member is on LPSP status must be labeled with *“Limited Privilege Suicide Prevention (LPSP) Program. LPSP notes are restricted from disclosure unless determined to be releasable after consultation with the medical-legal consultant. Do not release without specific patient authorization or as specifically authorized by DOD or AF policy”*. (T-1).

5.3. Exceptions to the Electronic MH Record.

5.3.1. DMH psycho-educational counseling. No record is required if a member is seen for DMH psycho-educational counseling (up to four meetings by any member of the DMH team) following a potentially traumatic event. (T-1). These meetings must be for the purpose of education and consultation and not for medical assessment and treatment IAW AFI 44-153. (T-1).

5.3.2. 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. This exception does not include ADAPT Alcohol Brief Counseling sessions, which must be documented in the EHR and marked sensitive. (T-1).

5.3.3. Only the MH documents identified below will be filed in the hard copy MH record. (T-1). MH documentation maintained in a two-part folder is required to have a privacy act statement.

5.3.3.1. Psychological testing raw data.

5.3.3.2. Sanity Board Reports. Long and Short Sanity Board Reports will be printed off and placed in the hard copy mental health record unless otherwise authorized by the convening authority or, after referral of charges, by the military judge. (T-1)

5.3.3.2.1. These reports will be labeled with *"Do not release unless approved by proper legal authority and consultation with SJA or for medical reasons."* (T-1)

5.3.4. MH documentation that cannot be placed in the EHR is kept in a two-part folder. (T-1). The highest top right corner of the record is labeled with:

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

5.3.4.2. Regular Air Force or service member's family member prefix and sponsor's Social Security Number IAW AFI 41-210.

5.3.5. MH hard copy records must be kept in a properly secured location in the clinic. (T-1). Records will be stored under a double lock system (e.g., stored in a locked cabinet/file system in a locked room). (T-1).

5.3.6. For the exceptions to the EHR listed in paragraphs 5.3.3.1 and 5.3.3.2. of this Instruction, an abbreviated entry will be made in the Subjective (S) section of the SOAP note, in the individual's EHR: type of appointment, length of appointment, and the reason why the full note is kept in the hard copy MH record. (T-1). MSE, assessment, and plan are also documented in the EHR. (T-1).

5.4. MH Record Retirement. Hard copy MH records will follow the procedures for physical record retirement IAW AFMAN, 33-363, and the Air Force Records Information Management System (AFRIMS). (T-0).

5.4.1. Opened hard copy MH records will be mailed to the gaining MH Clinic at time of Service member's PCS. (T-1).

Chapter 6

MENTAL HEALTH AND THE LAW

6.1. Confidentiality: Psychotherapist-Patient General Rule.

6.1.1. General Rule. Communication between a patient and a psychotherapist or an assistant to a psychotherapist made for the purpose of facilitating diagnosis or treatment of the patient's mental or emotional condition are confidential communications and shall be protected from unauthorized disclosure. (T-0). However, confidential communications will be disclosed to persons or agencies with a proper and legitimate need for the information and who are authorized by law or regulation to receive it, unless the evidentiary privilege described in paragraph 6.2. of this instruction applies. (T-0). See also the limited protections afforded confidential communications under LPSP in paragraph 6.8. of this Instruction. (T-1).

6.1.2. In cases not arising under the Uniform Code of Military Justice (UCMJ), the psychotherapist should consult with the Medical Law Consultant (MLC) and may appeal requests for confidential communications by persons or agencies to the installation Staff Judge Advocate (SJA). (T-1).

6.2. Military Rule of Evidence. This evidentiary rule provides a patient the privilege to refuse to disclose and to prevent any other person from disclosing a confidential communication made between the patient and the psychotherapist or an assistant to the psychotherapist, in a case arising under the UCMJ, if such communication was made for the purpose of facilitating diagnosis or treatment of the patient's mental or emotional condition. (T-0). There is no privilege under this rule in the following conditions:

6.2.1. When the patient is dead. (T-0).

6.2.2. When the communication is evidence of child abuse or neglect, or in a proceeding in which one spouse is charged with a crime against a child of either spouse. (T-0).

6.2.3. When federal law, state law, or service regulation imposes a duty to report information contained in a communication. (T-0).

6.2.4. When a psychotherapist or assistant to a psychotherapist believes that a patient's mental or emotional condition makes the patient a danger to any person, including the patient. (T-0).

6.2.5. If the communication clearly contemplated the future commission of a fraud or crime or if the services of the psychotherapist are sought or obtained to enable or aid anyone to commit or plan to commit what the patient knew or reasonably should have known to be a crime or fraud. (T-0).

6.2.6. When necessary to ensure the safety and security of military personnel, military dependents, military property, classified information, or the accomplishment of a military mission. (T-0).

6.2.7. When an accused offers statements or other evidence concerning his/her mental condition in defense, extenuation, or mitigation, under circumstances not covered by R.C.M. 706 or Mil. R Evid. 302. In such situations, the military judge may, upon motion, order

disclosure of any statement made by the accused to a psychotherapist as may be necessary in the interests of justice. (T-0).

6.2.8. When admission or disclosure of a communication is constitutionally required. (T-0).

6.3. Who May Claim the Privilege Under Military Rule of Evidence. The privilege may be claimed by the patient or the guardian or conservator of the patient. A person who may claim privilege may authorize trial counsel or defense counsel to claim the privilege on his or her behalf. The psychotherapist or assistant to the psychotherapist who received the communication may claim the privilege on behalf of the patient. The authority of such a psychotherapist, assistant, guardian, or conservator to so assert the privilege is presumed in the absence of evidence to the contrary. (T-0).

6.4. Limited Applicability of Military Rule of Evidence 513. The evidentiary privilege only applies when access to confidential information is being sought for the purpose of a criminal investigation or proceeding under the UCMJ. If access is requested for any other purpose, the evidentiary privilege has no application and the general rule in paragraph 6.1. applies. (T-0).

6.5. Disclosure of confidential communications. When the disclosure of confidential communications is requested from a MHP for the purpose of criminal investigation or proceedings under the UCMJ, consult the in-house MLC or the installation SJA, when there is no in-house MLC. (T-1).

6.6. Limits of Confidentiality: Command Notification and Duty to Take Precautions.

6.6.1. Command Notification. Presumption of non-notification. Command notification by healthcare providers will not be required for Service member self and medical referrals for mental health care or substance misuse education unless disclosure is authorized for one of the reasons listed in subparagraphs 6.6.1.1. through 6.6.1.9. of this Instruction. Healthcare providers shall notify the commander concerned when a Service member meets the criteria for one of the following mental health and/or substance misuse conditions or related circumstances: (T-0).

6.6.1.1. Harm to Self. The provider believes there is a serious risk of self-harm by the Service member either as a result of the condition itself or medical treatment of the condition. (T-0).

6.6.1.2. Harm to Others. The provider believes there is a serious risk of harm to others either as a result of the condition itself or medical treatment of the condition. This includes any disclosures concerning child abuse or domestic violence consistent with DoD Instruction 6400.06 . (T-0).

6.6.1.3. Harm to Mission. The provider believes there is a serious risk of harm to a specific military operational mission. Such serious risk may include disorders that significantly impact impulsivity, insight, reliability, and judgment. (T-0).

6.6.1.4. Special Personnel. The member is in the PRP/PSP as described in DOD 5210.42- R and AFMAN 10-3902 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. (T-0).

6.6.1.5. Inpatient Care. The Service member is admitted or discharged from any inpatient MH or substance abuse treatment facility as these are considered critical points in treatment and support nationally recognized patient safety standards. (T-0).

6.6.1.6. Acute Medical Conditions Interfering With Duty. The Service member is experiencing an acute MH condition or is engaged in an acute medical treatment regimen that impairs the Service member's ability to perform assigned duties. (T-0).

6.6.1.7. Substance Abuse Treatment Program. The Service member has entered into or being discharged from, a formal outpatient or inpatient treatment program consistent with DODI 1010.6, *Rehabilitation and Referral Services for Alcohol and Drug Abusers*, for the treatment of substance abuse or dependence. (T-0).

6.6.1.8. Command-Directed MH Evaluations. The MH services are obtained as a result of a CDE consistent with DODI 6490.04. (T-0).

6.6.1.9. 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 on a case-by-case basis by a healthcare provider (or other authorized official of the MTF involved) at the O-6 or equivalent level or above or a commanding officer at the O-6 level or above. (T-0).

6.6.2. Minimum Necessary Disclosure. In making a disclosure pursuant to the circumstances described in subparagraphs 6.6.1.1. through 6.6.1.9. of this Instruction, MHPs will provide the minimum amount of information to satisfy the purpose of the disclosure. (T-0). In general, this will consist of the diagnosis; a description of the treatment prescribed or planned; impact on duty or mission; recommended duty restrictions; the prognosis; any applicable duty limitations; implications for the safety of self or others; and ways the command can support or assist the Service member's treatment. (T-0).

6.6.3. Healthcare providers shall maintain an accounting of disclosures as required by DOD 6025.18-R, *DOD Health Information Privacy Regulation*. (T-0).

6.7. Release of Information and Health Insurance Portability and Accountability Act (HIPAA) Accounting of Disclosures.

6.7.1. Accounting of disclosures is generally required IAW DOD 6025.18-R. Consult with MTF HIPAA privacy officer for further guidance. (T-0).

6.7.2. MH records will be released IAW DOD 6025.18-R, Military Rule of Evidence 513, LPSP guidance, 5 USC 552a (the Privacy Act), 42 USC 290dd, and DOD/AF Restricted Reporting policies. (T-0).

6.7.3. If request is from a law enforcement agency, consult with the installation SJA or medical law consultant for advice on release. (T-1).

6.7.4. When release of information to a third-party requestor is required, the primary provider (if licensed and independently privileged), element officer in charge (OIC), and/or the MH Flight Commander will review the record and make recommendations regarding the minimum necessary to respond to the request. (T-1).

6.7.4.1. Consult with the in-house MLC or the installation SJA for advice on release of MH records (T-1).

6.8. Limited Privilege Suicide Prevention (LPSP) Program.

6.8.1. Program Objective. The objective of the LPSP program is to identify and treat AF members who, because of the stress of impending disciplinary action under the UCMJ, pose a genuine risk of suicide. In order to encourage and facilitate treatment, the LPSP program provides limited confidentiality under the enumerated circumstances. (T-1).

6.8.2. Program Eligibility. Any AF member is eligible for entry in the LPSP after the member has been officially notified, verbally or in writing that he or she is under investigation or is suspected of the commission of an offense under the UCMJ. (T-1).

6.8.3. Initiation. If subsequent to the notification described in paragraph 6.8.2., defense counsel, trial counsel, law enforcement official, staff judge advocate, first sergeant, squadron executive officer or any other individual officially involved in the processing of the disciplinary action in good faith believes that the member may present a risk of suicide, the individual shall communicate that concern to the member's immediate Commander with a recommendation that the member be referred for a mental health evaluation and possible placement in the LPSP program. (T-1).

6.8.4. Based on the provided information or relevant information from other sources and after consultation with MHP, the Commander may refer the member for a MH evaluation.

6.8.5. The provisions of paragraph 6.9. (CDEs) apply to any referral for possible LPSP initiation. (T-1).

6.8.6. The MHP will evaluate the member to determine if the member poses a risk of suicide, and if so, initiate treatment, explain LPSP protections to the member, and place the member into the LPSP program and notate this on the MH notes. (T-1).

6.8.7. If the MHP is engaged with a patient that meets LPSP criteria, then the MHP can recommend to the member's command the patient be placed on LPSP. (T-1).

6.8.8. Duration. The limited protections provided by the LPSP program shall apply only so long as the MHP determines that there is a continuing risk of suicide. The MHP shall notify the member's immediate Commander when, in his or her professional opinion, the member no longer poses a risk of suicide and shall appropriately annotate the member's medical records. (T-1). The limited protections afforded by the LPSP program cease at that time. However, matters that were disclosed while the member was in the LPSP program remain protected.

6.8.9. Limited Protection. AF members enrolled in the LPSP program are granted limited protection with regard to information revealed in, or generated by their clinical relationship with MHPs. Such information may not be used in existing or any future UCMJ action or when weighing characterization of service in an administrative separation. Commanders or persons acting under their authority, such as staff judge advocates, squadron executive officers, or first sergeants, may use the information for any other purposes authorized by law, this instruction, and other AFIs and programs. (T-1).

6.8.9.1. The limited protection provided by the LPSP program does not apply to:

6.8.9.1.1. The introduction of evidence for impeachment or rebuttal purposes in any proceeding in which evidence generated by, and during the LPSP relationship has first been introduced by the member. (T-1).

6.8.9.1.2. Disciplinary or other action based on independently derived evidence (other than from the LPSP relationship). (T-1).

6.8.9.1.3. Any information or evidence acquired or created by MHPs or other medical providers before placement in the LPSP program or subsequent to release from the program, except for those medical summaries or other similar documents created after release from the program but which pertain to treatment while in the LPSP program. (T-1).

6.8.10. Disclosing Case File Information.

6.8.10.1. MHPs engaged in LPSP programs may disclose case-file information of service members, including providing copies of documentation; however, except for disclosures to other healthcare providers for treatment, MHPs shall provide the minimum amount of information to satisfy the purpose of the disclosure. (T-1). Information may be released to:

6.8.10.1.1. Other medical personnel directly engaged in evaluating and treating program participants. This would include MHP staff at other facilities to which the member may be referred. (T-1).

6.8.10.1.2. VA treatment personnel when members are transferred directly to a VA facility. (T-1).

6.8.10.1.3. The confinement facility Commander when members are transferred to a confinement facility as a result of an ongoing court-martial. (T-1).

6.8.10.1.4. Other authorized personnel with a need to know in the performance of their official duties, if disclosure is otherwise permitted under DOD 6025.18-R and MRE 513. (T-1).

6.8.10.2. Before an MHP or other medical provider releases any information generated while a member is enrolled in the LPSP Program to sources other than those designated in this instruction, the member must grant permission by signing and dating a statement (DD Form 2870, *Authorization for Disclosure of Medical or Dental Information*) specifying what information may be released and to whom it may be released. (T-1).

6.8.10.3. Do not disclose LPSP case file information to any person or agency unless the Privacy Act of 1974, DOD 6025.18-R, and MRE 513 authorize the disclosure and the MLC approves the disclosure. (T-1).

6.8.10.4. All patients entered into the LPSP program will require each MH note written while the member is in the LPSP to be labeled appropriately, see paragraph 5.2.4. of this instruction. (T-1).

6.9. Commander-Directed Evaluations (CDE) Procedures.

6.9.1. Commanders or supervisors may make informal, non-mandatory recommendations for Service members under their authority to seek care from a MHP when circumstances do not require a CDE based on safety or mission concerns. (T-0). Under such circumstances, the Commander or supervisor will inform the Service member that he or she is providing a recommendation for voluntary self-referral and not ordering the care. (T-0). This will not trigger a CDE.

6.9.2. Commanders and supervisors will demonstrate leadership and direct involvement in development of a culture of total well-being of Service members by providing consistent and ongoing messaging and support for the benefits and value of seeking mental health care and voluntarily-sought substance abuse education. (T-0).

6.9.3. Commanders or supervisors may request a CDE for a variety of concerns including fitness for duty, occupational requirements, safety concerns, or significant changes in performance or behavioral changes that may be attributable to possible mental status changes. (T-0).

6.9.3.1. A supervisor is a commissioned officer within or out of a Service member's official chain of command, or civilian employee in a grade level comparable to a commissioned officer, who: Exercises supervisory authority over the Service member owing to the Service member's current or temporary duty assignment or other circumstances of the Service member's duty assignment; and Is authorized due to the impracticality of involving an actual commanding officer in the member's chain of command to direct an MHE IAW DODI 6490.04, Enclosure 3, 2.a. and Glossary, Part II.

6.9.3.2. MHPs, whenever possible, will assist the Commander or supervisor with following the process for initiating the CDE. (T-1). MHPs initially discuss the reason for the request with the Commander or same rank or higher supervisor and assist the Commander in answering specific duty-related and/or safety questions.

6.9.4. CDEs will be conducted IAW DODI 6490.04 and this instruction. (T-0). A CDE checklist is available on the AF/SG MH Branch KX site and is recommended to assist with documenting CDE compliance.

6.9.5. A psychiatrist, clinical psychologist, a person with a doctorate in clinical social work, or a psychiatric nurse practitioner may conduct CDEs in both an inpatient and outpatient setting if trained and privileged. In cases of outpatient MH evaluations only, licensed clinical social workers who possess a master's degree in clinical social work may also conduct CDEs IAW DODI 6490.04. (T-0).

6.9.5.1. MHPs must complete AFMOA annual CDE training. (T-1).

6.9.6. Before the initial appointment, MHPs will obtain the proper CDE information IAW DODI 6490.04. (T-0).

6.9.7. At intake evaluation, MH staff shall ensure the member understands they are being evaluated at the direction of the Commander or supervisor IAW DODI 6490.04. (T-0).

6.9.8. The MHP will complete a formal written response to the Commander or supervisor within one duty day following completion of the CDE IAW DODI 6490.04. (T-0). Reports will be consistent with requirements outlined in DODI 6490.04. (T-0). A CDE Report template is available on the AF/SG MH Branch KX site and is recommended to assist with preparing the formal written response.

6.9.9. All emergency CDEs will be accomplished IAW DODI 6490.04. (T-0). Emergency CDEs are conducted to assess imminent safety concerns (i.e., danger to self or others). MHPs will ensure that an emergency CDE is warranted and conducted IAW DODI 6490.04. (T-0). Verbal feedback regarding the crisis will be provided to the referring Commander/supervisor as soon as possible after the evaluation. (T-0). Other questions will

be addressed through follow up evaluations once the crisis is stabilized. (T-0). A full report will be generated within 24 hours of completion of the CDE. (T-0).

6.9.9.1. MHPs will consult with the Commander or supervisor to maximize the safety of the member during the referral process. (T-0).

6.9.9.2. A senior enlisted Service member may be designated by the commander of supervisor for ordering an emergency CDE for enlisted members. (T-0)

6.9.10. For cases in which Airmen are undergoing administrative separation, sample Administrative Separation Checklists are available on the AFMOA MH Branch KX site and are recommended to assist with processing. (T-1).

6.9.11. When separating Basic Military Training (BMT) students or tech school students, the USAF needs to demonstrate the member had an opportunity to overcome their deficiencies. The member can waive their right to be counseled concerning deficiencies or be afforded an opportunity to overcome them. Commanders must demonstrate they allowed members the opportunity to overcome, or MHPs need to submit an additional memorandum indicating a return to training would only further aggravate the condition. (T-1). If the MHP determines the member's condition is likely to improve enough to allow the member to return to training, a memo stating such must be submitted to the Commander. (T-1). Sample memorandums are available on the AF/SG MH Branch KX site and are recommended to assist with writing additional memorandums.

6.10. Inpatient Hospitalization.

6.10.1. Voluntary and involuntary psychiatric inpatient admission to an MTF will be conducted IAW DODI 6490.04. (T-0).

6.10.1.1. Pursuant to a referral, only a psychiatrist, or, when a psychiatrist is not available, a physician or another MHP with admitting privileges may admit a Service member for an inpatient MHE. (T-0).

6.10.1.2. The evaluation will be conducted in the most appropriate clinical setting, IAW the least restrictive alternative principle. (T-0).

6.10.1.3. Voluntary inpatient admission is appropriate when a psychiatrist, or, when a psychiatrist is not available, a physician or another MHP with admitting privileges, determines that admission is clinically indicated and the Service member has the capacity to provide and does provide informed consent regarding treatment and admission. (T-0).

6.10.1.4. An involuntary inpatient admission to an MTF is appropriate only when a psychiatrist, or, when a psychiatrist is not available, a physician or another MHP with admitting privileges, makes an evaluation that the Service member has, or likely has, a severe mental disorder or poses imminent or potential danger to self or others. Guidelines include: (T-0).

6.10.1.4.1. Level of Care. Placement in a less restrictive level of care would result in inadequate medical care. (T-0).

6.10.1.4.2. Admission Criteria. Admission is consistent with applicable clinical practice guidelines. (T-0).

6.10.1.4.3. Re-evaluation Following Admission. The Service member will be re-evaluated, under the purview of the admitting facility, within 72 hours of admission by an independent privileged psychiatrist or other medical officer if a psychiatrist is not available. (T-0).

6.10.1.4.3.1. The independent medical reviewer will notify the Service member of the purpose and nature of the review and of the member's right to have legal representation during the review by a judge advocate or by an attorney of the member's choosing at the member's own expense if reasonably available within the required time period for the review. (T-0).

6.10.1.4.3.2. The independent medical reviewer will determine and document in the inpatient medical record whether, based on clear and convincing evidence, continued involuntary hospitalization is clinically appropriate. If so, the reviewer will document the clinical conditions requiring continued involuntary hospitalization and the circumstances required for discharge from the hospital, and schedule another review within 5 business days. (T-1).

6.10.1.4.3.3. The independent medical reviewer will notify the Service member of the results of each review. (T-0).

6.10.1.4.4. Medical Record Documentation. Documentation of the evaluation encounter, findings, and disposition must be consistent with applicable standards of care and will additionally:

6.10.1.4.4.1. Document information pertaining to the inpatient admission in the Service member's MTF EHR including at a minimum communication of the assessment of risk for dangerousness, treatment plan, medications, progress of treatment, discharge assessment, and recommendations to commanders or supervisors regarding continued fitness for duty and actions the MHP recommends be taken to assist with the continued treatment plan.

6.10.1.4.4.2. Upon discharge, MHPs will provide, consistent with DODI 6490.08, memorandums or copies of consultation reports to the Commander or supervisor with sufficient clinical information and recommendations to allow the Commander or supervisor to understand the Service member's condition and make reasoned decisions about the Service member's safety, duties, and medical care requirements.

6.10.1.4.5. Additional Patient Rights. The Service member has the right to contact a relative, friend, chaplain, attorney, any office of Inspector General (IG), and anyone else the member chooses, as soon as the Service member's condition permits, after admission to the hospital.

6.10.1.4.5.1. Service members will be entered into the HIL as soon as the MHC becomes aware of the hospitalization.

6.10.1.4.5.2. Following discharge from higher levels of care, such as inpatient psychiatric care, partial hospitalization programs or substance abuse rehabilitation, an MHP assesses military personnel for fitness for duty and safety the same day when possible, but NLT the next duty day after discharge. MHPs

coordinate with civilian facilities to request timing of discharge during duty hours when possible to facilitate care transition. (T-1).

6.10.1.5. When a physician who is not an MHP admits a Service member pursuant to the referral for an MHE to be conducted on an inpatient basis, the physician will:

6.10.1.5.1. Make reasonable attempts to consult with an MHP with admitting privileges prior to and during the admission (e.g., by telecommunications).

6.10.1.5.2. Arrange for transfer to an MHP with admitting privileges as soon as practicable.

6.10.1.6. IAW DODI 6490.04, in the case of referral for an involuntary inpatient admission to a civilian facility, guidelines in the National Center for State Courts, *“Guidelines for Involuntary Civil Commitment,”* 1986 will be considered and the process established under the law of the State where the facility is located will be followed. If in a foreign country, the applicable laws of the host nation will be followed. Service members will be entered into the HIL as soon as the MHC becomes aware of the hospitalization. (T-0).

6.10.2. MH staff will communicate directly with Commander or first sergeant when a service member is released from inpatient care or partial hospitalization. (T-1).

6.10.3. MH staff will establish new safety plans post discharge. (T-1).

6.10.4. If the member declines this evaluation and there is an indication of elevated risk, an emergency CDE is recommended to the Commander to ensure adequate safety assessment of the member. (T-1).

6.10.5. If MHPs become aware of a discharge that occurs during non-duty hours, the MHP collaborates with the patient’s Commander to recommend a safety plan and set up a time for the patient to be evaluated in the MHC during the next duty day. (T-1).

6.11. Administrative Separations.

6.11.1. When a MH evaluation results in a recommendation for administrative separation, the MHP must determine if the recommendation requires higher-level approval. (T-0). Administrative separation checklists are available on the AF/SG MH Branch KX site and are recommended to assist with determining if MH administrative separation recommendations require higher-level approval.

6.11.1.1. Administrative separation recommendation on the basis of personality disorder or another mental health condition IAW AFI 36-3206, paragraph 2.3.7., AFI 36-3208, paragraph 5.11.9., and AFI 36-3209 paragraph 2.34.7.1. is authorized only when the Airman is evaluated and diagnosed by a psychiatrist or Ph-D-level clinical psychologist. (T-1). If a social worker or psychiatric mental health nurse practitioner recommends administrative separation, the case must have a second level review completed by a psychiatrist or Ph-D-level psychologist. (T-1). If the second-level reviewer concurs with the diagnosis and the conclusion that the disorder is so severe that the member’s ability to function effectively in the military environment is significantly impaired, they will co-sign the formal written report. (T-1).

6.11.1.2. Administrative separation recommendations for an Airman with a diagnosis of personality disorder or other mental disorder not constituting a physical disability and who has served in an imminent danger pay area at any time during their military career, must be endorsed by the AFMOA/CC prior to separation IAW DODI 1332.14, Enlisted Administrative Separations, 27 January 2014, AFI 36-3208 and the AF/SG memo “*Administrative Separation of Airmen Endorsement Authority*” dated 19 May 2014. (T-0).

6.11.1.3. Special Processing Procedures for Airmen Deployed Overseas in Support of a Contingency Operation. The following additional criteria as stipulated below applies to Airmen who are being recommended for discharge under Chapter 5 of AFI 36-3208 and who have been deployed overseas in support of a contingency operation within 24 months prior to initiation of discharge:

6.11.1.3.1. Must receive a medical examination in accordance with **Chapter 6**, paragraphs 6.3. and 6.9.3. of AFI 36-3208 (T-1). The medical examination must assess whether the effects of post-traumatic stress disorder (PTSD) or traumatic brain injury (TBI) constitute matters in extenuation that relate to the basis for administrative separation if the Airman:

6.11.1.3.1.1. Is being administratively separated under a characterization other than Honorable (T-1); and

6.11.1.3.1.2. Was deployed overseas to a contingency operation during the previous 24 months (T-1); and

6.11.1.3.1.3. Is diagnosed by a physician, clinical psychologist, or psychiatrist as experiencing PTSD or TBI, or reasonably alleges the influence of PTSD or TBI based on deployed service to a contingency operation during the previous 24 months. (T-1). **NOTE:** In a case involving PTSD, the medical examination shall be performed by a clinical psychologist or psychiatrist. In a case involving TBI, the medical examination may be performed by a physician, clinical psychologist, psychiatrist, or other health care professional, as appropriate (T-1); and

6.11.1.3.1.4. Is not being separated under a sentence of a court-martial, or other proceeding conducted pursuant to the UCMJ to include request for separation under Chapter 4 of AFI 36-3208. (T-1).

6.11.1.3.2. Before an Airman can be discharged under other than honorable conditions, the initiating commander, administrative discharge board (if applicable), SPCM authority and GCM authority must receive and review a medical examination in compliance with AFI 36-3208 paragraph 1.30.1. (T-1). Although specific comments are not required; the commander and other reviewing authorities identified in this paragraph must indicate the medical examination was reviewed. (T-1).

6.11.1.3.3. This provision does not change any other processing requirements of AFI 36-3208 to include but not limited to Dual Action Processing, Service Retirement Eligibility and Airmen with Lengthy Service under AFI 36-3208, Chapter 6.

6.11.1.4. IAW para 2.b.8 of DODI 6490.04 and the U.S. Army’s OTSG/MEDCOM Policy Memo 14-049, dated 23 June 2014, MHPs may be requested to conduct

evaluations of Army soldiers regardless of deployment history, prior to the administrative separation of a soldier in order to assess for PTSD, mTBI, SUDs, depression, sexual assault that has occurred while serving in uniform, and other MH conditions that may constitute matters in extenuation that relate to the basis of administrative separation. The exam is an Army requirement for Army personnel who are undergoing administrative separation and can be performed by a USAF MHP without initiating a CDE. (T-0).

MARK A. EDIGER, Lieutenant General, USAF,
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Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

References

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AFI 10-403, *Deployment Planning and Execution*, 20 September 2012

AFI 31-205, *The Air Force Corrections System*, 7 April 2004

AFI 33-332, *Air Force Privacy and Civil Liberties Program*, 5 June 2013

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AFI 36-2110, *Assignments*, 22 September 2009

AFI 36-3208, *Administrative Separation of Airmen*, 9 July 2004

AFI 36-6001, *Sexual Assault Prevention and Response (SAPR) Program*, 29 September 2008

AFI 40-301, *Family Advocacy*, 30 November 2009

AFI 40-701, *Medical Support to Family Member Relocation and Exceptional Family Member Program (EFMP)*, 19 November 2014

AFI 41-210, *TRICARE Operations and Patient Administration Functions*, 6 June 2012

AFI 41-307, *Aeromedical Evacuation Patient Considerations and Standards of Care*, 20 August 2003

AFI 44-102, *Medical Care Management*, 20 January 2012

AFI 44-119, *Medical Quality Operations*, 16 August 2011

AFI 44-121, *Alcohol and Drug Abuse Prevention and Treatment (ADAPT) Program*, 8 July 2014

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DOD 6025.18-R, *DOD Health Information Privacy Regulation*, 24 January 2003

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DODI 6490.03, *Deployment Health*, 11 August 2006 (certified as current 30 September 2011)

DODI 6490.04, *Mental Health Evaluations of Members of the Military Services*, 4 March 2013

DODI 6490.07, *Deployment-Limiting Medical Conditions for Service Members and DOD Civilian Employees*, 5 February 2010

DODI 6490.08, *Command Notification Requirements to Dispel Stigma in Providing Mental Health Care to Service Members*, 17 August 2011

DODI 6490.09, *DOD Directors of Psychological Health*, Incorporating Change 1, 2 October 2013

DODI 6490.10, *Continuity of Behavioral Health Care for Transferring and Transitioning Service Members*, 26 March 2012

DODI 6490.11, *DOD Policy Guidance for Management of Mild Traumatic Brain Injury/Concussion in the Deployed Setting*, 18 September 2012

DODI 6490.13, *Comprehensive Policy on Neurocognitive Assessments by the Military Services*, 4 June 2013

DODI 6490.15, *Integration of Behavioral Health Personnel (BHP) Services Into Patient-Centered Medical Home (PCMH) Primary Care and Other Primary Care Service Settings*, August 8, 2013

DODI 6495.02, *Sexual Assault Prevention and Response (SAPR) Program Procedures*, Incorporating Change 1, 12 February 2014

Assistant Secretary of Defense/Health Affairs Memorandum, “*Clinical Practice Guidance for Deployment-Limiting Mental Disorders and Psychotropic Medications*,” 7 October 2013

Assistant Secretary of Defense/Health Affairs Memorandum, “*Military Treatment Facility Mental Health Clinical Outcomes Guidance*”, 9 September 2013

Assistant Secretary of Defense/Health Affairs Memorandum, *Military Treatment Facility Mental Health Outcomes Guidance*, 9 September 2013

Manual for Courts-Martial, 2012 Edition

National Center for State Courts, “*Guidelines for Involuntary Civil Commitment*,” 1986

Prescribed Forms

None

Adopted Forms

AF Form 847, *Recommendation for Change Publication*

AF Form 469, *Duty Limiting Conditions Report*

DD Form 2870, *Authorized Disclosure for Release of Medical or Dental Information*

DD Forms 2807-1, *Report of Medical History*

DD Forms 2807-2, *Medical Prescreen of Report of Medical History*

SF Form 93, *Report of Medical History*

SF 600, *Chronological Record of Medical Care*

Abbreviations and Acronyms

ADAPT—Alcohol and Drug Abuse Prevention and Treatment

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

ANGUS—Air National Guard of the United States

ARC—Air Reserve Component (Air National Guard and Air Force Reserve Command)

AUDIT-C—Alcohol Use Disorders Identification Test-Consumption

BHC—Behavioral Health Consultant

BHOP—Behavioral Health Optimization Program

CAIB—Community Action Information Board

CDE—Commander-Directed Evaluation

DLC—Duty Limiting Condition

DAWG—Deployment Availability Working Group

DMH—Deployment Mental Health

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
EHR—Electronic Health Record
FAP—Family Advocacy Program
FAO—Family Advocacy Officer
FAST—Family Advocacy Strength-based Therapy
FDI—Facility Determination Inquiries
FMRC—Family Member Relocation Clearance
GAD-7—Generalized Anxiety Disorder Assessment
HI—High Interest
HIL—High Interest Log
HIPAA—Health Insurance Portability and Accountability Act
HRVRT—High Risk for Violence Response Team
IAW—In Accordance With
IDS—Integrated Delivery System
JA—Judge Advocate
LPSP—Limited Privilege Suicide Prevention
MAJCOM—Major Command
MCCC—Multidisciplinary Clinical Case Conference
MDG—Medical Group
MEB—Medical Evaluation Board
MH—Mental Health
MHC—Mental Health Clinic
MHP—Mental Health Provider
MLC—Medical Law Consultant
MOU—Memoranda of Understanding
MTI—Military Training Instructor
MTL—Military Training Leader
MTF—Military Treatment Facility
NCOIC—Non Commissioned Officer in Charge
NOTAM—Notice to Airmen

NPSP—New Parent Support Program
OIC—Officer in Charge
PCM—Primary Care Manager
PDHA—Post Deployment Health Assessment
PDI—Potentially Disqualifying Information
PH—Psychological Health
PHA—Personal Health Assessment
PHAP—Psychological Health Advocacy Program
PHC—Psychological Health Council
PHI—Protected Health Information
PHQ-9—Patient Health Questionnaire
PMHP—Primary Mental Health Provider
PCL-5—Post Traumatic Checklist
PRP—Personnel Reliability Program
PSP—Presidential Support Program
RILO—Review-in-Lieu-of
RDS—Records Disposition Schedule
RMU—Reserve Medical Unit
RPA—Remotely Piloted Aircraft
SERE—Survival Evasion Resistance Escape
SFS—Security Forces Squadron
SG—Surgeon General
SJA—Staff Judge Advocate
TTM—Treatment Team Meeting
UCMJ—Uniform Code of Military Justice
USAF—United States Air Force

Attachment 2

MENTAL HEALTH PROVIDER (MHP) TRAINING CHECKLIST

Mental Health Provider (MHP) Training Checklist			
Purpose: This checklist provides MHPs with need to know guidance and processes. This checklist will be completed by all contract/GS and AD MHPs regardless of rank or time in service. Members should complete this within 60 days of clinic start date, annually thereafter and filed in the member's training record, credentials file or PAF. MHPs will review all policies referenced in AFI 44-172 relevant to clinical care of all patients with whom they interact.			
#1 Command Directed Evaluations	Date Trained	Member Initials	Supervisor Initials
1.1 Demonstrate comprehension of the CDE requirements IAW DODI 6490.04 and AFI 44-172			
#2 Patient Transfers			
2.1 Demonstrate comprehension of the transfer of clinical care at time of patient PCS requirements IAW DODI 6490.10 and AFI 44-172. Both open hard-copy MH records (if there are any) and closed (within the last 3 months) hard-copy MH records (if there are any) will be forwarded to gaining installation MTF MH clinic. If all records are electronic, charts do not have to be send to gaining installation			
#3 Documentation			
3.1 Demonstrate comprehension of the mental health record documentation requirements IAW AFI 44-172			
#4 High Interest List (HIL)			
4.1 Demonstrate comprehension of the HIL procedures IAW AFI 44-172 and local policy			
#5 Exceptional Family Member Program-Medical (EFMP-M)			
5.1 Demonstrate comprehension of the EFMP Enrollment Criteria IAW DODI 1315.19			
5.2 Demonstrate comprehension of the EFMP-M referral requirements IAW AFI 40-701			
#6 Alcohol and Drug Abuse Prevention & Treatment (ADAPT)			
6.1 Demonstrate comprehension of the requirements for ADAPT referrals when indicated (know difference between command referrals, self-referrals, and medical referrals)			
6.2 Demonstrate comprehension of the Technician certification process (ADC handbook) and oversight			
6.3 Demonstrate comprehension of the review of patient medical history requirements, including past and current medications			
6.4 Demonstrate comprehension of the appropriate use of random labs in support of the ADAPT program. (Use psychiatrist, PMHNP or PCM assigned as ADAPT medical director to interpret lab results)			
6.5 Demonstrate comprehension of the American Society of Addiction Medicine Patient Placement Criteria to determine level of care			
6.6 Demonstrate comprehension of the mandatory components of ADAPT: Report no shows to command, ensure TTMs are held within the appropriate timeframe, document command involvement in treatment			

#7 Personnel Reliability Program			
a. Demonstrate comprehension of the administration of PRP medical procedures IAW DoD 5210.42-Regulation, AFMAN 13-501 and local policy			
#8 Duty Limiting Conditions (DLC)			
8.1 Demonstrate comprehension of the requirements for initiating and removing DLCs IAW AFI 48-123 and AFI 44-172. Demonstrate the ability to initiate and change a profile in the AF profiling system.			
#9 Inpatient hospitalizations			
9.1 Demonstrate comprehension regarding options and processes for hospitalizations and discharge follow-up IAW AFI 44-172, AFI 90-505 and local policy			
#10 Family Advocacy Program (FAP)			
10.1 Demonstrate comprehension of the referral requirements to FAP when indicated (know difference between restricted and unrestricted reporting)			
10.2 Demonstrate comprehension of all components of FAP: New Parent Support Program (NPSP), Outreach Manager's programs, Family Advocacy Strength-Based Therapy Services			
10.3 Demonstrate comprehension of the role of the Domestic Abuse Victim Advocate			
10.4 Demonstrate comprehension for referrals to NPSP for all expectant clients and clients with children under 3 years of age			
10.5 Demonstrate comprehension of the High-Risk For Violence Response Team/Child Sexual Maltreatment Response Team and your role as a MHP			
#11 Suicide Prevention			
11.1 Demonstrate comprehension of the suicide risk guidelines in the AF Guide to Suicide Risk Assessment, Management, and Treatment			
11.2 Demonstrate comprehension of LPSP IAW AFI 44-172			
11.3 Demonstrate comprehension of the DoDSER Reporting Instructions IAW AFI 90-505			
#12 Traumatic Stress Response			
12.1 Demonstrate comprehension of the appropriate roles and responsibilities of an installation TSR team IAW AFI 44-153			
#13 Administrative Separations/Medical Evaluation Boards (MEB)			
13.1 Demonstrate comprehension of the requirements of administrative separation IAW AFI 44-172, AFI 36-3206 and AFI 36-3208			
13.2 Demonstrate comprehension of the MEB requirements IAW AFI 48-123, AFI 44-172 and AFI 41-210			

Installation Name & Key Personnel Signatures:	
Installation Name:	
Member:	
Supervisor:	
MHF/CC:	Clinic Start Date:

Attachment 3**MENTAL HEALTH (MH) CLINIC CONFIDENTIALITY/INFORMED CONSENT SHEET**

Patients are often unsure what to expect in a mental health (MH) clinic. We encourage you to consider the following points regarding MH care and to discuss them with your MH provider if you wish. You can expect the attention, respect, and best professional efforts of your MH provider. Your MH provider will treat you as a responsible individual and will expect you to take an active part in your treatment. You should also expect to take part in treatment decisions.

You should understand the goals and direction therapy is taking, and if you do not understand, you should ask. Before initiating a professional evaluation or treatment relationship with a MH provider, we want you to know about privacy ground rules and terms of your treatment. Generally, information discussed during the evaluation and treatment sessions is confidential and may not ordinarily be revealed to anyone outside the clinic without your permission. Under some circumstances, including but not limited to those listed below, information may be released without your permission.

A. Records of Care for All Patients. Every clinical visit to MH is documented in the electronic medical record and marked as sensitive. Generally, only healthcare providers are allowed to view these sensitive records, if needed. It is important that providers caring for you in other clinics are aware of the care or evaluation you are receiving here. If there is a hard copy record, the MH record of Service members will be transferred to the MH clinic at the gaining installation at the time of Permanent Change of Station (PCS). At the time of retirement or separation of Service members, the MH record will be maintained at the installation MH clinic in accordance with existing records disposition schedules. For military dependents who are actively involved in treatment at the time of PCS, the provider will discuss the option of transferring care/records.

B. Disclosure Policy for All Patients. All medical and mental health records are protected by the Privacy Act, HIPAA and other applicable laws/regulations. Most information related to treatment of military dependents or retirees is not releasable without the patient's written authorization. Some of the instances excluded from authorization requirements are quality assurance reviews by other mental healthcare providers (MHPs) and collection of information for medical research. There may also be instances where we are required to disclose your record in response to a court order or other lawful demand if an exception to the general rule of confidentiality applies. The most common exceptions which may require your mental health provider to disclose information to appropriate authorities without your authorization are as follows:

1. Child or Spouse Maltreatment. Providers must report suspected child abuse or neglect to military agencies and/or local child protective authorities. Providers may also be required to report other family maltreatment incidents.
2. Crimes or Fraud. Providers must report any threat to commit crimes or fraud.
3. Danger to Self or Others. Providers must take steps to protect individuals from harm when they have reason to believe there is a serious threat to the life or safety of the individual or others.
4. Pursuant to a court order or other lawful demand.

5. Sexual Assault. Providers are required to report all sexual assaults to the Sexual Assault Response Coordinator (SARC).

C. Disclosure Policy for Service members. In addition to the disclosure policies, above, Command notification by healthcare providers that a Service member has sought and/or is in MH treatment or is taking medication is not necessarily required when an individual voluntarily seeks MH care. However, pursuant to Department of Defense Regulations, healthcare providers must notify your Commander if you meet one of the following criteria:

1. Harm to Self. The provider believes there is a serious risk of self-harm either as a result of the condition itself or medical treatment of the condition.
2. Harm to Others. The provider believes there is a serious risk of harm to others either as a result of the condition itself or medical treatment of the condition. This includes any disclosures concerning child abuse or domestic violence consistent with DoD regulations.
3. Harm to Mission. The provider believes there is a serious risk of harm to a specific military operational mission. Such serious risk may include disorders that significantly impact impulsivity, insight, reliability, and judgment.
4. Special Personnel. The Service member is in the Personnel Reliability Program as described in DoD Instruction 5210.42 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.
5. Inpatient Care. The Service member is admitted or discharged from any inpatient mental health or substance abuse treatment facility.
6. Acute Medical Conditions Interfering With Duty. The Service member is experiencing an acute mental health condition or is engaged in an acute medical treatment regimen that impairs the member's ability to perform assigned duties.
7. Substance Abuse Treatment Program. The Service member has entered into or is being discharged from a formal outpatient or inpatient treatment program for the treatment of substance abuse or dependence.
8. Command Directed MH Evaluation. The mental health services are obtained as a result of a command-directed mental health evaluation.
9. 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 on a case-by-case basis by a health care provider (or other authorized official of the medical treatment facility involved) at the O-6 or equivalent level or above or a commanding officer at the O-6 level or above.

In making a disclosure based on the circumstances described in subparagraphs 1-10 above, healthcare providers shall provide the minimum amount of information to satisfy the purpose of the disclosure.

D. Second Opinion Process for Service Members: If you disagree with the recommendations made to your Commander, you can discuss this with your provider, the MTF Patient Advocate, and/or your Commander. Additionally, if you have a potentially disqualifying condition, you have the option of seeking a second opinion IAW the provisions of AFI 10-203, *Duty Limiting Conditions*.

E. High Interest Log (HIL). When a provider considers a patient (Service members, retirees and military dependents) to be a serious risk for harming themselves or others, the patient is placed on the MH clinic 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 primary care clinic providers and the 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 the patient's safety. Other persons or agents the provider might contact include, but are not limited to, the patient's Commander, first sergeant and Security Forces, as appropriate. Should a Service member high risk patient decline to reschedule an appointment, the member's Commander will be notified. Commanders of members must be informed when one of their personnel is placed on or removed from the HIL.

F. Continuity of Care. Regarding Service members, information may be released for purposes of official military processes such as Medical Evaluation Boards or Commander Directed Evaluations. In all cases (Service members, retirees and military dependents), 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).

G. Coordination of Care at the Time of Permanent Change of Station (PCS) and Transfer of Information. The care/records of any Service members 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 Service member, but does not require the Service member's authorization. However, every effort shall be made to involve Service member in the process. In cases of Service members who have terminated treatment, records are reviewed prior to PCS and the hard copy mental health record (if there is a hard copy record) will follow the member along with the dental and medical records. If there are concerns, the Service member may be contacted by a provider for a status check, and the provider will determine if follow up care will be recommended at the gaining base. If you are a dependent, your provider will assist in facilitating appropriate transfer of your care to the MTF or a civilian mental health provider and forward your records to the provider assuming your care at the new location.

H. Profiles/Duty Limiting Conditions for Service Members. MHC providers will consult with Commanders and/or first sergeants any time they feel a Service member has a condition or circumstance that makes him/her not fit for duty, not deployable or requires any change in his/her normal duties.

I. Drug or Alcohol Abuse by Service Members. Providers must report all new diagnoses of substance use disorders and all service members who have entered into or being discharged from a formal outpatient or in patient substance misuse treatment program to Commanders. Per AFI 44-121, a 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 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 an administrative separation.

J. Appointment Cancellation and No-Show Policy for All Patients. We ask that you give us at least 24 hours' notice if you will be unable to make an appointment you have scheduled. 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.

K. 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.

L. Exceptional Family Member Program (EFMP). If you are a family member of a Service member and you 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 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.

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

N. Telephone Consultations Policy for All Patients. 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.

O. Treatment options vary depending on the condition(s) and your preferences. Treatment options may include various types of therapies and medications. Your provider will discuss treatment options with you and together you will create a treatment plan with measureable outcomes. Treatment is voluntary and can be terminated by you at any time, though we request prior to terminating you discuss your plans with the provider.

[Signature block of MH Flight Commander or equivalent]

I have read and understand the limits of confidentiality and consent to evaluation and treatment in the Mental Health clinic as described above..

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

Witness' Printed Name, Signature:_____ Date:_____

Attachment 4

MENTAL HEALTH (MH) CLINIC CONFIDENTIALITY INFORMATION SHEET FOR ONE TIME EVALUATIONS

Patients are often unsure what to expect in a mental health (MH) clinic for a one time evaluation. Before initiating a professional evaluation or treatment relationship with a MH provider, we want you to know about privacy ground rules. Generally, information discussed during the evaluations is confidential and may not ordinarily be revealed to anyone outside the clinic without your permission. Under some circumstances, including but not limited to those listed below, information may be released without your permission. One time evaluations do not consist of treatment, but after the evaluation you may be offered a treatment plan or referred elsewhere for treatment.

A. Records of Care for All Patients. Every clinical visit to MH is documented in the electronic medical record and marked as sensitive. Generally, only healthcare providers are allowed to view these sensitive records, if needed. It is important that providers caring for you in other clinics are aware of the care or evaluation you are receiving here. If there is a hard copy record, the MH record of Service members will be transferred to the MH clinic at the gaining installation at the time of Permanent Change of Station (PCS). At the time of retirement or separation of Service members, the MH record will be maintained at the installation MH clinic in accordance with existing records disposition schedules. For military dependents who are actively involved in treatment at the time of PCS, the provider will discuss the option of transferring care/records.

B. Disclosure Policy for All Patients. All medical and mental health records are protected by the Privacy Act, HIPAA and other applicable laws/regulations. Most information related to treatment of military dependents or retirees is not releasable without the patient's written authorization. Some of the instances excluded from authorization requirements are quality assurance reviews by other mental healthcare providers (MHPs) and collection of information for medical research. There may also be instances where we are required to disclose your record in response to a court order or other lawful demand if an exception to the general rule of confidentiality applies. The most common exceptions which may require your mental health provider to disclose information to appropriate authorities without your authorization are as follows:

1. Child or Spouse Maltreatment. Providers must report suspected child abuse or neglect to military agencies and/or local child protective authorities. Providers may also be required to report other family maltreatment incidents.
2. Crimes or Fraud. Providers must report any threat to commit crimes or fraud.
3. Danger to Self or Others. Providers must take steps to protect individuals from harm when they have reason to believe there is a serious threat to the life or safety of the individual or others.
4. Pursuant to a court order or other lawful demand.
5. Sexual Assault. Providers are required to report all sexual assaults to the Sexual Assault Response Coordinator (SARC).

C. Disclosure Policy for Service members. In addition to the disclosure policies, above, Command notification by healthcare providers that a Service member has sought and/or is in MH

treatment or is taking medication is not necessarily required when an individual voluntarily seeks MH care. However, pursuant to Department of Defense Regulations, healthcare providers must notify your Commander if you meet one of the following criteria:

1. Harm to Self. The provider believes there is a serious risk of self-harm either as a result of the condition itself or medical treatment of the condition.
2. Harm to Others. The provider believes there is a serious risk of harm to others either as a result of the condition itself or medical treatment of the condition. This includes any disclosures concerning child abuse or domestic violence consistent with DoD regulations.
3. Harm to Mission. The provider believes there is a serious risk of harm to a specific military operational mission. Such serious risk may include disorders that significantly impact impulsivity, insight, reliability, and judgment.
4. Special Personnel. The Service member is in the Personnel Reliability Program as described in DoD Instruction 5210.42 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.
5. Inpatient Care. The Service member is admitted or discharged from any inpatient mental health or substance abuse treatment facility.
6. Acute Medical Conditions Interfering With Duty. The Service member is experiencing an acute mental health condition or is engaged in an acute medical treatment regimen that impairs the member's ability to perform assigned duties.
7. Substance Abuse Treatment Program. The Service member has entered into or is being discharged from a formal outpatient or inpatient treatment program for the treatment of substance abuse or dependence.
8. Command Directed MH Evaluation. The mental health services are obtained as a result of a command-directed mental health evaluation.
9. 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 on a case-by-case basis by a health care provider (or other authorized official of the medical treatment facility involved) at the O-6 or equivalent level or above or a commanding officer at the O-6 level or above.

In making a disclosure based on the circumstances described in subparagraphs 1-10 above, healthcare providers shall provide the minimum amount of information to satisfy the purpose of the disclosure.

D. Second Opinion Process for Service members: If you disagree with the recommendations made to your Commander, you can discuss this with your provider, the MTF Patient Advocate, and/or your Commander. Additionally, if you have a potentially disqualifying condition, you have the option of seeking a second opinion IAW the provisions of AFI 10-203, *Duty Limiting Conditions*.

E. Continuity of Care. Regarding Service members, information may be released for purposes of official military processes such as Medical Evaluation Boards or Commander Directed Evaluations. In all cases (Service members, retirees and military dependents), 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).

F. Special duty evaluations: Evaluations for special duties or occupational classifications and other evaluations expressly required by applicable DOD issuance or Service regulations are not considered Commander Directed Evaluations.

G. Profiles/Duty Limiting Conditions for Service Members. MHC providers will consult with Commanders and/or first sergeants any time they feel a Service member has a condition or circumstance that makes him/her not fit for duty, not deployable or requires any change in his/her normal duties.

H. Drug or Alcohol Abuse by Service Members. Providers must report all new diagnoses of substance use disorders and all service members who have entered into or being discharged from a formal outpatient or in patient substance misuse treatment program to Commanders. Per AFI 44-121, a 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 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 an administrative separation.

I. 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.

[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

MENTAL HEALTH CLINIC MONTHLY PEER REVIEW

THIS IS A PRIVILEGED QUALITY ASSURANCE DOCUMENT EXEMPT FROM DISCOVERY OR RELEASE IAW TITLE 10 U.S.C. SECTION 1102

MENTAL HEALTH CLINIC MONTHLY PEER REVIEW									
Provider Reviewed:					MONTH/YEAR OF REVIEW				
Reviewer									
Type of Review (Check One)		Routine		Other					
LEGEND	(Y) Criteria Met	(N) Criteria Not Met (Requires Comment)			(N/A) Not Applicable				
					Last 4 SSN Date	Last 4 SSN Date	Last 4 SSN Date	Last 4 SSN Date	Last 4 SSN Date
ADMINISTRATIVE REVIEW- all notes									
1.AFMOA approved intake or f/u note template used (may add to the template but not take away or rearrange the formatting/flow of the note. If an area does not apply or not addressed during that appointment, document N/A. Non-prescribers can delete the prescription sections)									
2.MH notes are entered in AHLTA and marked sensitive (clinic note, t-con)									
3.Privacy Act/MH Patient Info Sheet/Informed Consent completed and signed									
4.Signed release of information was obtained if applicable									
5.Security clearance/PRP/PSP/FLY status appropriately identified/ documented									
6.Missed appointments were documented in the MH Record and AHLTA									
7.LPSP status appropriately identified and documented									
8.Transfer/Termination Summary is documented in record if applicable									
PROVIDER REVIEW									
<i>INTAKE-only</i>									
9.Source and reason for referral documented (self, provider, CDE)									
10.Chief complaint and HPI is documented									
11.Diagnosis is consistent with assessment									
12.PCM/FSO of ADM is notified where applicable									
<i>SUICIDE ATTEMPT/ HOSPITALIZATION/HIGH INTEREST LIST/INTAKE NOTES</i>									
13.Suicide Status Form was completed when appropriate									
14.Patient added to the High Interest Log when appropriate									
15.High Interest Log/Hospitalization checklist filled out when appropriate									
16.Patients who attempted suicide and/or recently hospitalized entered to the HIL for minimum of 4 weeks									
17.Documentation of contact with SGH following suicide attempt to discuss whether MEB is warranted									
18.Management of risk is appropriate									
<i>All Clinic Appointments</i>									
19.All clinical encounter documentation was completed in AHLTA and the MH record within 72 hours									
20.PHQ-9 (additional GAD-7 for anxiety and PCL for PTSD) administered and scores documented									
21.Appropriate clinical practice guideline treatment was utilized									
22.Profile/WWQ/Deployment status and if applicable expiration date of profile documented									
23.If a condition has caused or is expected to cause significant duty impairment or limitations for greater than one year and for conditions in which there is recurrent impairment or there is documentation that an IRILO/ MEB was considered and reason for continued treatment IAW AFI 48-123, 5.3.									
24.Suicide and/or Homicide Risk Assessment to include warning signs, risk & protective factors, risk level listed on all notes. SSF was used as clinically indicated or justification was provided									

25. Follow-up plan is appropriate					
26. Use of consultation/referral services is appropriate					
27. If more than one MH Clinic provider is treating the patient, was the diagnosis consistent/the same within 4 visits with each provider?					
28. Tx plan completed within four sessions and includes specific goals, objective and therapeutic intervention for each identified problem					
29. Tx plan reviewed with the patient each session and progress was reflected in note documentation					
30. Overall Clinical Standard of Care Met					

	Last 4 SSN Date	Last 4 SSN Date	Last 4 SSN Date	Last 4 SSN Date	Last 4 SSN Date
<i>CDE</i>					
31. CDE checklist is completed					
32. CDE answer the CCs questions					
33. Recommendations to the CC appropriate					
<i>PSYCHIATRY REVIEW – med-management notes only</i>					
34. Allergies are annotated on AHLTA encounter					
35. Medication reconciliation documented					
36. Appropriate use of Medications					
37. Laboratory studies ordered when indicated & results documented					
38. Did Not use unauthorized abbreviations (Psychiatry)					
<i>PEER REVIEW DISCREPANCIES</i>					
39. Discrepancies discussed? Y / N / NA					
40. Referred to Clinic Chief for resolution? Y / N / NA					

Last 4 SSN	Item/section number	Review Comments	If applicable, date correction was made (to be completed by reviewer after provider makes changes)

Additional Comments:

Reviewer's Signature/Stamp

Reviewee's Signature/Stamp

Flight CC's Signature/Stamp

Attachment 6

BHOP CLINIC MONTHLY PEER REVIEW – IBHC

THIS IS A PRIVILEGED QUALITY ASSURANCE DOCUMENT EXEMPT FROM DISCOVERY OR RELEASE LAW TITLE 10 U.S.C. SECTION 1102

BHOP CLINIC MONTHLY PEER REVIEW - IBHC									
Provider Reviewed:					MONTH/YEAR OF REVIEW:				
Reviewer:									
Type of Review (Check One)		Routine		Other					
(Y) Standard Met	(N) Standard Not Met				(N/A) Not Applicable				
				Last 4 SSN	Last 4 SSN	Last 4 SSN	Last 4 SSN	Last 4 SSN	
ADMINISTRATIVE REVIEW- Every Appointment									
1.AFMOA approved intake or f/u note template used (e.g., TSWF-IBHC)									
2.IBHC notes are entered in AHLTA and NOT marked sensitive (unless by necessity)									
3.Verbal informed consent (Introduction)									
4.Brochure provided to the Patient (Initial visits ONLY)									
5.Referral – Presenting problem is documented									
6.Referring PCM is documented									
7.Time spent with Patient is accurately documented; Rationale provided if visit exceeds 30 min (e.g., safety assessment)									
8.Appointment number (1 st , 2 nd , 3 rd , 4 th) is documented. If >4, rationale is accurately documented and appropriate to BHOP/PCBH consultation model									
9.If appointment is deployment-related, it is documented and coded									
10. Feedback provided to PCM when appropriate									
PROVIDER REVIEW									
<i>Admin Tab (Initial Visit Only) NOTE: For follow-up appointments, relevant information below is present if directly related to Presenting Problem.</i>									
11. Relevant health behaviors assessed (i.e., tobacco, alcohol, caffeine) and documented									
12. General Symptom Measurement screening given and score documented (e.g., BHM-20) for patients 18 and older									
13. If other assessment measures used (e.g., PHQ-9, GAD-7, AUDIT-C), total score is documented									
HPI – Presenting Problem Tab									
14. A functional assessment specific to the presenting problem is conducted and documented succinctly									
15. Intervention delivered is appropriate to presenting problem									
16. For follow-up visits, status of presenting problem is assessed									
17. For follow-up visits, progress on recommendations is noted since last appointment									
18. For follow-up visits, barriers to goals are assessed and goals are revised with Patient's input									
ROS/MSE Tab									
19. Mental Status Exam completed; Abnormal areas include supporting documentation									
20. Suicidal/Homicidal screening is documented									
21. Appropriate risk assessment is completed and documented (if SI or HI is endorsed); P4 is completed in AHLTA and SSF was completed and documented when warranted.									
A/P									
22. Diagnosis is congruent with HPI									
23. Clinical impressions are documented succinctly									

24. Current interventions, education, and recommendations to patient and PCM are appropriate to diagnostic impression/goals/presenting concerns					
25. If applicable, recommendation for referral services (e.g., MH, FAP, ADAPT) are appropriate					
26. If applicable, Health & Behavior CPT code (i.e., 9615x series) is documented (only when a medical diagnosis previously assigned by medical provider is used)					
	Last 4 SSN	Last 4 SSN	Last 4 SSN	Last 4 SSN	Last 4 SSN
DISCREPANCIES					
27. Discrepancies discussed? Y / N / NA					
28. Referred to Clinic Chief for resolution? Y / N / NA					

Last 4 SSN	Item number	Review Comments	If applicable, date correction was made (to be completed by reviewer after provider makes changes)

Additional Comments:

Reviewer's Signature/Stamp/Date

Reviewee's Signature/Stamp/Date

Attachment 7

INTAKE NOTE TEMPLATE

Date/Time:

Type of Visit: Intake

Voluntary: Y/N

Current Special Duty
Status:

Duration of Session: XX minutes

Session #

Deployment Related: Y/N

Fly	Jump	Weapons	PRP	Security Clr
N/A	N/A	N/A	N/A	Secret

S: Patient IS/IS NOT on the HIGH INTEREST Log

Referral Source: Pt was self-referred/Supervisor-referred (CDE)/Medical referral for...**Pt ID/Chief Complaint:** Patient's identity verified via name and DOB. Patient is a XX y/o, marital status, ethnicity, AD USAF, rank, gender, job. Reviewed limits of confidentiality and clinic policies as outlined in the patient information sheet; patient expressed understanding and agreed to voluntarily proceed with the evaluation.**History of Presenting Illness (focus on current symptoms/conditions and why the patient is presenting to the clinic now):****Psychiatric Review of Systems:** ((Coding requirement for prescribing providers) Example: Patient denied current and past depressive episodes, denied current and past SI/HI, suicide attempts, self-mutilation and violence, denied psychotic, manic, delusional, PTSD, panic, GAD, OCD, social phobia, and eating disorder symptoms.)**Pain:** Patient reported his/her current pain level is a XX/10 on an ascending scale. And this issue was/was not addressed during the session.**Current medications/OTC/herbs/supplements:****(for non-prescribing providers:** Pt reported medication changes YES/NO Contact with prescriber needed? YES/NO)

Medication changes/results of contact with prescriber:

*(for prescribing providers delete if not applicable: meds reconciled in CHCS)***CURRENT MEDICATIONS:**

X	Congruent. Rx list was given to Pt with encouragement to maintain accurate copy of Rx for all future healthcare visits
	Incongruent. Rx list was given to Pt with specific instruction for Pt to contact PCM ASAP to ensure that current combination of Rx is safe to take together and to ensure that MTF is able to maintain accurate list of Rx for future visits. Pt verbalized understanding of potential safety issues that could result if prescribers have inaccurate data on which meds which are in use.
	The pt's medication list was updated.

Medication Allergies (for prescribing providers):**Past Medical, Social, Family History:****(Option 1)**

Past psychological, family, medical/surgery, occupational, legal, social/developmental, financial, spiritual/religious and substance use history was reviewed and concur with the information documented by the patient in the intake paperwork. (Document any relevant history into this note and scan and upload patient documented intake paperwork into AHLTA/Add note)

OR

(Option 2)

(At provider's discretion, if patient documented intake paperwork is too sensitive or illegible for AHLTA, summarize past psychological, family, medical/surgery, occupational, legal, social/developmental, financial, spiritual/religious and substance use history into SF600 intake note per below)

Past Psych:

Prior Outpatient MH care:

Prior medication TX and response:

Prior Inpatient MH Care/Psych Hospitalization:

Prior Suicide attempts:

History of other Self harm:

Fam Psych:

Family IP and/or OP Psychiatric TX History:

Family HX of Substance use disorders and/or treatment:

Family HX of Suicide attempts/completions:

Medical History (including significant family history):

Surgery:

Occupational/military history:

**AFSC –*

Job title/description:

Duty History (examples include years here, prior assignments as relevant):

Duty function:

Deployment History: (examples include dates and locations, combat/trauma exposure timeframe if applicable, medical resources utilized during deployment; successful completion or early return)

Legal/financial information:

Social/Developmental History: (relationship history, exposure to trauma)

Spiritual/Religious/Cultural Beliefs/Concerns:

Barriers to Learning: Readiness to Learn:

Substance Use:

Prior ADAPT referrals, or other Alcohol related events/consequences:

Current use: Should comment specifically as to whether there is or is NOT evidence of a current ETOH use
DO

Tobacco:

Caffeine:

Supplements:

Illicit Drugs:

Referral to ADAPT necessary: Y/N

O: MSE:

Orientation	Alert and oriented x4
Attention	WNL
Appearance	Appropriately attired; adequate hygiene; appeared stated age
Behavior	Good eye contact; Cooperative; Pleasant; no overt agitation
Psychomotor	WNL
Speech	Rate, rhythm, tone and volume WNL

Mood	“XXXX”
Affect	Affect was of limited range and intensity congruent with reported mood
Memory (ST & LT)	Intact; WNL
Impulse Control	Intact
Overall Cognition	Intact; WNL
Thought Process	Logical/linear; goal directed
Thought Content	No obsessions/compulsions; no delusions; no evidence of perceptual disturbances. Pt. denied current suicidal and homicidal ideation, plan, intent, or preparatory behavior both verbally and on the PHQ-9 (or other measure).
Insight	WNL
Judgment	WNL

Vital Signs: *(For prescribing providers delete if not applicable)*

Abnormal Involuntary Movement Scale/Labs/Rads *(For prescribing providers delete if not applicable)*

Measurement Results *(PHQ-9, and if applicable GAD- 7, PCL, AUDIT-C, etc)*

(Results should include severity classification ranges; mild, moderate, severe etc.) Results were shared with patient, who agreed with their accuracy.

Measure	Baseline Score	Previous Visit Score	Current Score	Current Score Severity

A: DSM-5 Diagnoses:

Clinical Impression/Summary (justification for giving diagnosis):

RISK ASSESSMENT: *(Adjust risk assessment for patients at risk for harm to others as clinically appropriate)* The patient denied any suicide-related ideation and/or behaviors and intent/plan, denied thoughts about death and dying both in session and on the PHQ-9. The patient also denied any homicidal-related ideation and/or behaviors and intent/plan in session. No significant risk changes were reported or identified during this clinical encounter.

OR

RISK ASSESSMENT: *(Adjust risk assessment for patients at risk for harm to others as clinically appropriate)* The patient endorsed suicide-related **ideation and/or behaviors and intent/plan, thoughts about death and dying in session and during the period since last appointment.**

Suicidal Ideation: *(Address frequency, intensity, duration, and onset; quote thoughts)*

Suicidal Intent: *(Address extent of wish to die, likelihood of acting on thoughts, reasons for dying, time frame)*

Suicidal Plan: *(Address when where how availability and lethality of means, motivation, planning, rehearsal)*

Suicidal Behaviors: *(Address specifics of behavior, e.g. how many pills taken, did pt load the gun)*

Access to Means: *(Assess if the patient owns a weapon including a privately owned firearms, have plans to acquire a weapon/firearm, ammunition or other weapons/means of hurting themselves or others).*

(The below warning signs, risk and protective factors must be in each note and updated as needed)

Warning Signs: *(possible warning signs, document only those that apply):*

Threats of harming or killing self, seeking means, such as access to weapons, talking or writing about death, dying, or suicide, giving belongings away, hopelessness, rage, anger, seeking revenge; acting reckless or engaging in risky activities; feeling trapped; increased alcohol or drug use; withdrawing from family, friends, society; anxiety, agitation, insomnia, hypersomnia; dramatic changes in mood; no perceived reason for living or sense of purpose

Current risk factors are: *(possible risk factors, document only those that apply):*

History of suicide attempt; history of psychiatric inpatient care; history of non-suicidal self-injurious behaviors; depression or other mood disorders; personality disorders or traits; PTSD or anxiety disorders; sleep disorders; substance-use disorders; family history of suicide and /or psychiatric illness; psychotic disorders, hopelessness; thwarted belongingness; perceived burdensomeness; acquired capability for suicide; impulsivity; problem-solving deficits; shame; guilt, relationship problems; legal or financial problems; work related problems; lack of social support, TBI or other physical injury, chronic pain, other medical problems, access to lethal means; combat exposure; history of physical, emotional, mental and or sexual abuse; sexual orientation; mental health stigma and perceived barriers to care; recent local cluster of suicides (consider possible contagion)

Current Protective factors are: *(possible protective factors, document only those that apply):*

Compliance with psychiatric medication; engagement in evidenced-based treatment; motivation and readiness to change; insight about problems, problem solving and effective coping strategies; resilience; reasons for living; future orientation; perceived internal locus of control, healthy intimate relationships; social support and community involvement, medical compliance; able to access care as needed; support for help seeking, restricted access to lethal means; religion/spirituality, crisis response or other related training.

Risk Level:**High Interest log:**

No indication at this time

OR

Indicated at this time (document Command, PCM, ED and MH provider notifications)

Hospitalization **is/is not** deemed necessary at this time as the patients **does/does not** present a clear or imminent danger to self or others. No indication for pursuing higher level of care-Out pt management is currently most appropriate and least restrictive level of care. Pt is deemed to be a reliable reporter. Pt is competent to make healthcare decisions.

P: TREATMENT PLANNING: Established/Reviewed the following plan in collaboration with pt:

Goals	Intervention/Objective	Target Outcome	Progress
Risk management	- SSF as needed - HIL tracking as needed	- No SI/HI and risk stability for at least four weeks as measured by PHQ-9 screening and patient report	Please Select from Drop Down List
Improve symptoms of	- Individual therapy – CBT/BT /supportive/insight oriented - Med management	- Decrease score in symptom screeners	Please Select from Drop Down List
Improve symptoms of	- Individual therapy – CBT/BT /supportive/insight oriented - Med management	- Decrease score in symptom screeners	Please Select from Drop Down List

PLAN/DISPOSITION

- 1) Next scheduled session:
- 2) Homework for Next Session (if applicable):
- 3) Plan for next session (if applicable):
- 4) **Crisis Response Plan** *(personalize for your patient or delete as appropriate)*: Reviewed emergency resources with the patient and the patient expressed understanding; including: If feeling suicidal, patient will call or present to the Mental Health Clinic during duty hours (xxx-xxxx); call or present to closest ED (phone number), call 911 or crisis hotline (1-800-273-TALK) after duty hours; or call chaplain (xxx-xxxx) or Command Post (xxx-xxxx) during or after duty hours.
- 5) Referrals:
- 6) Medication—**prescribing providers only** (discuss risks/benefits/side effects discussed)
Patient was advised:
 - a. not to drive or operate machinery if drowsy or impaired by medications
 - b. not to combine medications with alcohol or sedatives

- c. to comply with medications and treatment, do not stop medications abruptly
 - d. to call and/or get seen right away at the clinic or the emergency room if there are severe side effects, worsening symptoms, or suicidal or homicidal ideation/impulses
 - e. to discuss plans for future pregnancy with provider due to possible medication impact on fetus.
 - f. Other:
- 7) Labs—**prescribing providers only**: (ordered, reviewed) (if applicable)
- 8) Prevention Topics Discussed: (Examples include: Safety and Emergency Contact Information, Medication Compliance, Social support, Sleep, Stress Management, Alcohol use, Tobacco use, Caffeine use, Substance abuse, Nutrition, Exercise, Safety, Domestic Violence/Family Maltreatment, Sexual behaviors, Other, None)
- 9) Treatment plan formulated with the pt and pt voiced understanding of diagnosis, prognosis, plan, goals, potential benefits/risks
of treatment, and alternatives, including no treatment; contacting emergency services if needed; and agreement with, plan and goals as annotated above. Patient provided verbal informed consent for recommended treatment. Provider agrees with plan.

Duty Restriction Report (AF Form 469):

DLC Y/N	If yes, list DLC restrictions: Member DOES/DOES NOT require MEB at this time	DLC Release Date:	Code 31 or Code 37
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Disposition: No alterations to duty status or security clearance recommended at this time.

Prognosis: poor, fair, good, excellent, guarded

Consultation: **(describe peer consultation here if applicable)**

Command Notification/Collateral Information: **(Summarize command communication or put N/A)** None, no significant safety nor, duty limiting/restrictions concerns identified during today's contact; Discussed addition to HIL; no-show, reporting procedures relayed; reinforced importance of command relaying information to provider; None, no change from previously discussed safety/duty concerns; Contacted command to discuss current safety risk/safety plan; potential duty limitations/restrictions, and/or profile.; Discussed removal from HIL, treatment/safety/follow-up plan, reinforced importance of command relaying information to provider; Other:

If applicable, Flt Surgeon contacted (name/date)

Place PRP stamp here if applicable

Attachment 8

FOLLOW-UP NOTE TEMPLATE

(MTF and/or Clinic Name) Mental Health Record

Date/Time:

Duration of Session: XX minutes

Type of Visit: Follow Up

Session #

Voluntary: Y/N

Type of CPG supported treatment provided:

Deployment Related: Y/N

Current Special Duty

Status:

Fly	Jump	Weapons	PRP	Security Clr
N/A	N/A	N/A	N/A	N/A

S: Patient IS/IS NOT on the HIGH INTEREST Log

Chief Complaint: The patient presented for a follow-up individual session to address XXXXX.

Pt ID/Current Situation/Content of Session: Patient is a XX y/o, marital status, ethnicity, AD USAF, rank, gender, job. Patient returns today with report that...(describe progress toward treatment goals):

Pain: No change in pain assessment from previous encounter

Current medications/OTC/herbs/supplements:

(for non-prescribing providers: Pt reported medication changes YES/NO Contact with prescriber needed? YES/NO)

Medication changes/results of contact with prescriber:

(for prescribing providers delete if not applicable: meds reconciled in CHCS)

CURRENT MEDICATIONS:

X	Congruent. Rx list was given to Pt with encouragement to maintain accurate copy of Rx for all future healthcare visits
	Incongruent. Rx list was given to Pt with specific instruction for Pt to contact PCM ASAP to ensure that current combination of Rx is safe to take together and to ensure that MTF is able to maintain accurate list of Rx for future visits. Pt verbalized understanding of potential safety issues that could result if prescribers have inaccurate data on which meds which are in use.
	The pt's medication list was updated.

Medication Allergies (for prescribing providers delete if not applicable):

O: MSE:

Orientation	Alert and oriented x4
Attention	WNL
Appearance	Appropriately attired; adequate hygiene; appeared stated age
Behavior	Good eye contact; Cooperative; Pleasant; no overt agitation
Psychomotor	WNL
Speech	Rate, rhythm, tone and volume WNL
Mood	"XXXX"
Affect	Affect was of limited range and intensity congruent with reported mood
Memory (ST & LT)	Intact; WNL
Impulse Control	Intact
Overall Cognition	Intact; WNL
Thought Process	Logical/linear; goal directed
Thought Content	No obsessions/compulsions; no delusions; no evidence of perceptual disturbances. Pt. denied current suicidal and homicidal ideation, plan, intent, or preparatory behavior both verbally and on the PHQ-9 (or other measure).

Insight	WNL
Judgment	WNL

Vital Signs: *(For prescribing providers delete if not applicable)*

Abnormal Involuntary Movement Scale/Labs/Rads *(For prescribing providers delete if not applicable)*

Measurement Results *(PHQ-9, and if applicable GAD-7, PCL, AUDIT-C, etc)*

(Results should include severity classification ranges; mild, moderate, severe etc.)

Measure	Baseline Score	Previous Visit Score	Current Score	Current Score Severity

A: DSM-5 Diagnoses:

Clinical Impression/Summary:

RISK ASSESSMENT: *(Adjust risk assessment for patients at risk for harm to others as clinically appropriate)* The patient denied any suicide-related ideation and/or behaviors and intent/plan, denied thoughts about death and dying both in session and on the PHQ-9. The patient also denied any homicidal-related ideation and/or behaviors and intent/plan in session. No significant risk changes were reported or identified during this clinical encounter.

OR

RISK ASSESSMENT: *(Adjust risk assessment for patients at risk for harm to others as clinically appropriate)* The patient endorsed suicide-related **ideation and/or behaviors and intent/plan, thoughts about death and dying in session and during the period since last appointment.**

Suicidal Ideation: *(Address frequency, intensity, duration, and onset; quote thoughts)*

Suicidal Intent: *(Address extent of wish to die, likelihood of acting on thoughts, reasons for dying, time frame)*

Suicidal Plan: *(Address when where how availability and lethality of means, motivation, planning, rehearsal)*

Suicidal Behaviors: *(Address specifics of behavior, e.g. how many pills taken, did pt load the gun)*

Access to Means: *(Assess if the patient owns a weapon including a privately owned firearm, have plans to acquire a weapon/firearm, ammunition or other weapons/means of hurting themselves or others).*

(The below warning signs, risk and protective factors must be in each note and updated as needed)

WARNING SIGNS

<input type="checkbox"/>	Threats of harming/killing self	<input type="checkbox"/>	Talking/writing about death/suicide	<input type="checkbox"/>	Seeking means or access to weapons
<input type="checkbox"/>	Giving belongings away	<input type="checkbox"/>	Hopelessness	<input type="checkbox"/>	Seeking revenge
<input type="checkbox"/>	Anger	<input type="checkbox"/>	Acting reckless/risky activities	<input type="checkbox"/>	Rage
<input type="checkbox"/>	Increased alcohol/drug use	<input type="checkbox"/>	Withdrawal from family/friends/society	<input type="checkbox"/>	Feeling trapped
<input type="checkbox"/>	Agitation	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	Anxiety
<input type="checkbox"/>	Dramatic changes in mood	<input type="checkbox"/>	No perceived reason for living	<input type="checkbox"/>	Hypersomnia
<input type="checkbox"/>	No sense of purpose	<input type="checkbox"/>	Other:	<input type="checkbox"/>	Other:

CURRENT RISK FACTORS

<input type="checkbox"/>	History of Suicide Attempts	<input type="checkbox"/>	Psychiatric inpatient care	<input type="checkbox"/>	Non-suicidal self-injurious behaviors
<input type="checkbox"/>	MH condition	<input type="checkbox"/>	Substance use disorders	<input type="checkbox"/>	Family Hx of suicide or psychiatric illness
<input type="checkbox"/>	Sleep disorders	<input type="checkbox"/>	Thwarted belongingness	<input type="checkbox"/>	Perceived burdensomeness
<input type="checkbox"/>	Hopelessness	<input type="checkbox"/>	Problem solving deficits	<input type="checkbox"/>	Shame
<input type="checkbox"/>	Acquired capability for suicide	<input type="checkbox"/>	Impulsivity	<input type="checkbox"/>	Work related problems

<input type="checkbox"/>	Guilt	<input type="checkbox"/>	Legal or financial problems	<input type="checkbox"/>	Hx of physical, emotional, mental, or sex abuse
<input type="checkbox"/>	Relationship problems	<input type="checkbox"/>	Chronic pain	<input type="checkbox"/>	Perceived barriers to care
<input type="checkbox"/>	Lack of social support	<input type="checkbox"/>	Combat exposure	<input type="checkbox"/>	Access to lethal means
<input type="checkbox"/>	TBI	<input type="checkbox"/>	Mental health stigma	<input type="checkbox"/>	Recent local cluster of suicides
<input type="checkbox"/>	Sexual orientation	<input type="checkbox"/>	Other:	<input type="checkbox"/>	Other:

CURRENT PROTECTIVE FACTORS

<input type="checkbox"/>	Compliance with psychiatric medication	<input type="checkbox"/>	Engagement in evidence-based treatment	<input type="checkbox"/>	Motivation and readiness to change
<input type="checkbox"/>	Insight about problems	<input type="checkbox"/>	Resilience	<input type="checkbox"/>	Reasons for living
<input type="checkbox"/>	Problem solving	<input type="checkbox"/>	Perceived internal locus of control	<input type="checkbox"/>	Effective coping strategies
<input type="checkbox"/>	Future Orientation	<input type="checkbox"/>	Social support	<input type="checkbox"/>	Community involvement
<input type="checkbox"/>	Healthy/Intimate relationships	<input type="checkbox"/>	Access to care as needed	<input type="checkbox"/>	Support for help seeking
<input type="checkbox"/>	Medical compliance	<input type="checkbox"/>	Religion/spirituality	<input type="checkbox"/>	Crisis response or other related training
<input type="checkbox"/>	Restricted access to lethal means	<input type="checkbox"/>	Other:	<input type="checkbox"/>	Other:

Risk Level:

High Interest log:

No indication at this time

OR

Indicated at this time (document Command, PCM, ED and MH provider notifications)

Access to Means: *(Assess if the patient owns a weapon including a privately owned firearm, have plans to acquire a weapon/firearm, ammunition or other weapons/means of hurting themselves or others).*

Hospitalization **is/is not** deemed necessary at this time as the patients **does/does not** present a clear or imminent danger to self or others. No indication for pursuing higher level of care-Out pt management is currently most appropriate and least restrictive level of care.

P: TREATMENT PLANNING:

TREATMENT PLANNING: Established/Reviewed the following plan in collaboration with pt:

Goals	Intervention/Objective	Target Outcome	Progress
Risk management	- SSF as needed - HIL tracking as needed	- No SI/HI and risk stability for at least four weeks as measured by PHQ-9 screening and patient report	Please Select from Drop Down List
Improve symptoms of	- Individual therapy – CBT/BT /supportive/insight oriented - Med management	- Decrease score in symptom screeners	Please Select from Drop Down List
Improve symptoms of	- Individual therapy – CBT/BT /supportive/insight oriented - Med management	- Decrease score in symptom screeners	Please Select from Drop Down List

PLAN/DISPOSITION

- 1) Next scheduled session:
- 2) Homework for Next Session (if applicable):
- 3) Plan for next session (if applicable):
- 4) **Crisis Response Plan** (*personalize/update for your patient or delete as appropriate*): Reviewed emergency resources with the patient and the patient expressed understanding; including: If feeling suicidal, patient will call or present to the Mental Health Clinic during duty hours (xxx-xxxx); call or present to closest ED

(phone number), call 911 or crisis hotline (1-800-273-TALK) after duty hours; or call chaplain (xxx-xxxx) or Command Post (xxx-xxxx) during or after duty hours.

5) Referrals:

6) Medication:— START/CONTINUE/DISCONTINUE/INCREASE/DECREASE:

Discussed:

<input type="checkbox"/>	Risks/benefits	<input type="checkbox"/>	Side effects	<input type="checkbox"/>	Alternatives
<input type="checkbox"/>	Black box warnings	<input type="checkbox"/>	Suicidal ideation	<input type="checkbox"/>	Worsening Symptoms
<input type="checkbox"/>	Drowsiness	<input type="checkbox"/>	Sexual function changes	<input type="checkbox"/>	HTN/cardiac impact
<input type="checkbox"/>	Desquamating rashes	<input type="checkbox"/>	Serotonin Syndrome	<input type="checkbox"/>	Discontinuation symptoms
<input type="checkbox"/>	Drug interactions	<input type="checkbox"/>	Potential impact on pregnancy	<input type="checkbox"/>	Potential impact on deploy ability, profile, MEB
<input type="checkbox"/>	No Medication Changes	<input type="checkbox"/>	Other:	<input type="checkbox"/>	Other:

Patient Was Advised:

<input type="checkbox"/>	Do not operate machinery if drowsy or impaired by medications	<input type="checkbox"/>	Comply with medications and treatment/do not stop abruptly
<input type="checkbox"/>	Do not combine medication with alcohol or sedatives	<input type="checkbox"/>	Call/go to ER if symptoms worsen, suicidal/homicidal impulses
<input type="checkbox"/>	Discuss plans for future pregnancies/impacts on fetus	<input type="checkbox"/>	Other:

7) Labs—**prescribing providers only**: (ordered, reviewed) (if applicable)

8) Prevention Topics Discussed:

<input type="checkbox"/>	Safety and Emergency Contact Info	<input type="checkbox"/>	Medication compliance	<input type="checkbox"/>	Social support
<input type="checkbox"/>	Sleep	<input type="checkbox"/>	Stress management	<input type="checkbox"/>	Alcohol use
<input type="checkbox"/>	Tobacco use	<input type="checkbox"/>	Caffeine use	<input type="checkbox"/>	Substance abuse
<input type="checkbox"/>	Nutrition	<input type="checkbox"/>	Exercise	<input type="checkbox"/>	Safety
<input type="checkbox"/>	Domestic violence/family maltreatment	<input type="checkbox"/>	Sexual behaviors	<input type="checkbox"/>	Other:

9) Treatment plan discussed with the pt and pt voiced understanding of diagnosis, prognosis, plan, goals, potential benefits/risks of treatment, and alternatives, including no treatment; contacting emergency services if needed; and agreement with plan and goals as annotated above. Patient provided verbal informed consent for recommended treatment. Provider agrees with plan.

Duty Restriction Report (AF Form 469):

DLC Y/N	If yes, list DLC restrictions: Member DOES/DOES NOT require MEB/recommendation for administrative separation for their MH conditions at this time	DLC Release Date:	Code 31 or Code 37
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Disposition: No alterations to duty status or security clearance recommended at this time.

Prognosis: poor, fair, good, excellent, guarded

Consultation: (describe peer consultation here if applicable)

Command Notification/Collateral Information: *Select from this drop down list*

If applicable, Flt Surgeon contacted (name/date)

Place PRP stamp here if applicable

Attachment 9

MULTIDISCIPLINARY CLINICAL CASE CONFERENCE

Date: _____ @ _____

☐ High Interest Meeting ☐ Multidisciplinary Case Management (MCM)

Primary Provider: _____ Date Added to HIL: _____

Diagnoses (reconciled w/in 4 visits): _____ Last appt: _____

Risk/Risk Level: _____ Next appt: _____

Duty Restrictions: _____ Date of Initial TTM: _____

Sensitive Duties: _____ DLC/Profile Exp Date: _____

Is a CDE warranted? Yes No N/A Status:

Is a MEB warranted Yes No N/A Status:

Was PCM contacted? Yes No Date:

Was Command contacted? Yes No Date:

Clinical Update (i.e., presenting problem, risk factors, clinical progress, and disposition)*If removing from HIL, ensure proper NOTIFICATIONS (PCM and CC) and JUSTIFICATIONS are documented in AHLTA. A minimum of 4 consecutive weeks of stability is required before removing from the HIL.

Comments from other Mental Health Providers present at the meeting:

Referral(s): In-Transition /Psychiatry / ADAPT / FAP / NPSP / HAWC / PCM / Psych Testing / Chaplain / Groups/Classes: _____ Other: _____

Providers from the following Flight Elements were present:

- ☐ ADAPT
☐ FAP
☐ Mental Health