



DEPARTMENT OF THE AIR FORCE  
HEADQUARTERS UNITED STATES AIR FORCE  
WASHINGTON DC

AFI44-109\_AFGM2014-01  
17 July 2014

MEMORANDUM FOR DISTRIBUTION C  
MAJCOMs/FOAs/DRUs

FROM: HQ USAF/SG  
1780 Air Force Pentagon, Rm 4E114  
Washington, DC 20330-1780

SUBJECT: Guidance Memorandum to Air Force Instruction (AFI) 44-109, *Mental Health, Confidentiality, and Military Law*

By Order of the Secretary of the Air Force, this is an Air Force Guidance Memorandum immediately changing AFI 44-109, *Mental Health, Confidentiality, and Military Law*. In advance of the rescission of AFI 44-109, the Attachment to this Memorandum updates the Commander-Directed Evaluation (CDE) guidance to incorporate requirements outlined in Department of Defense Instruction (DoDI) 6490.04, *Mental Health Evaluations of Members of the Military Services*. In addition, it incorporates the 2012 amendment to MRE 513(d)(2) to remove the spouse abuse exception. Compliance with this Memorandum is mandatory. To the extent its directions are inconsistent with other Air Force publications, the information herein prevails in accordance with AFI 33-360, *Publications and Forms Management*. 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*, 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" publications

This Memorandum becomes void after one year has elapsed from the date of this Memorandum, or upon incorporation by interim change, or rewrite/rescission of AFI 44-109, whichever is earlier.

THOMAS W. TRAVIS  
Lieutenant General, USAF, MC, CFS  
Surgeon General

1. Attachment: Guidance Changes

**ATTACHMENT**  
***Guidance Changes***

**The below changes to AFI 44-109 are effective immediately.**

**(Replace)** 1.2. This AFI supplements the mandatory requirements for commander-directed mental health evaluations (CDE) found in DoD Instruction 6490.04, *Mental Health Evaluations of Members of the Military Services*, March 4, 2013; and AFI 44-172, *Mental Health*. Portions of this AFI are based on this DoDI and AFI and must be read in conjunction with them. **(Tier 0)**

**(Replace)** 1.3. Records Disposition. Ensure that all records created by this instruction are maintained and disposed of IAW AFI 33-322, *Records Management Program*.

**(Replace)** 2.2.2. 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.

**(Replace)** 4.1. CDEs will be conducted IAW DoDI 6490.04, AFI 44-172 and this instruction. To the extent this instruction or AFI 44-172 is inconsistent with DoDI 6490.04, follow DoDI 6490.04. 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. 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. This will not trigger a CDE, IAW DoDI 6490.04, Enclosure 3, 3.a. **(Tier 0)**

**(Add)** 4.1.1. Commanders and supervisors will develop a culture of total well-being of Service members by providing ongoing encouragement and support for the benefits and value of seeking voluntary Mental Health care and substance abuse education IAW DoDI 6490.04, Enclosure 3, 3.b. **(Tier 0)**

**(Replace)** 4.2. 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. To the extent commanders or supervisors have concerns over the Service members' fitness for duty not previously addressed by the MHP, a CDE will be initiated. Supervisor is defined as 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. **(Tier 0)**

**(Replace)** 4.2.2. On intake for evaluation, mental health staff shall ask whether the member is there voluntarily or at the direction of his or her commander/supervisor. If the member responds with the latter and the commander/supervisor has not initiated a commander-directed mental

health evaluation (CDE) IAW DoDI 6490.04, the MHP shall contact the commander/supervisor to determine if a CDE was intended. If not, the MHP shall inform the member that the evaluation is not required, but may proceed on a voluntary basis if the member chooses. If the commander/supervisor intended a CDE, the MHP shall ensure the commander/supervisor follow the prescribed process for a CDE outlined in DoDI 6490.04, Enclosure 3, paragraph 2 before proceeding with any evaluation. The MHP shall clearly document the member's statement and any interaction with the member's commander/supervisor in the member's mental health record. **(Tier 0)**

**(Replace)** 4.2.3. Follow the procedures outlined in DoDI 6490.04, Enclosure 3, paragraph 4 for a CDE shall be followed whenever a member is directed to undergo involuntary psychiatric hospitalization. Reserve members can undergo involuntary psychiatric hospitalization in a DoD MTF only when on active duty status. **(Tier 0)**

**(Replace)** 4.3. Providers Performing Evaluations. A psychiatrist or clinical psychologist, a person with a doctorate in clinical social work, or a psychiatric nurse practitioner may conduct CDEs in both inpatient and outpatient setting if trained and privileged. In cases of outpatient MHEs only, licensed clinical social workers who possess a master's degree in clinical social work may also conduct CDEs if trained and privileged IAW DoDI 6490.04. **(Tier 0)**

**(Delete)** 4.3.1. Paragraphs 6.3.3.2. and 6.3.3.3. of DoDI 6490.4 do not restrict non-doctoral-level MHPs from performing non-CDEs on members or MHEs on other beneficiaries, to include assessments of potential dangerousness. Therefore, non-doctoral-level MHPs should continue to practice to the full scope of their privileges in all situations, except those involving non-emergency and emergency (e.g., imminent dangerousness) CDEs. This includes Air Force Family Advocacy Program assessments, Alcohol and Drug Abuse Prevention and Treatment evaluations, routine outpatient mental health assessments, and carrying out on-call responsibilities. If in the course of their routine clinical practice, a non-doctoral-level MHP assesses a reasonable risk that a member may be imminently dangerous, he or she will refer the member to a doctoral-level MHP for a definitive assessment of dangerousness. **(Tier 0)**

**(Replace)** 4.3.2.1. All emergency CDEs will be accomplished IAW DoDI 6490.04 and AFI 44-172. Emergency CDEs are conducted to assess imminent safety concerns (i.e., danger to self or others). Verbal feedback regarding the crisis will be provided to the referring commander/supervisor as soon as possible after the evaluation. Other questions will be addressed through follow up evaluations once the crisis is stabilized. A full report will be generated within 24 hours of completion of the CDE. **(Tier 0)**

**(Replace)** 4.3.2.2. MHPs will consult with the commander or supervisor to maximize the safety of the member during the referral process. **(Tier 0)**

**(Delete)** 4.3.2.3. When a non-doctoral-level MHP assists a non-psychiatrist physician in an evaluation for dangerousness, the responsibility for the final judgment rests solely with the non-psychiatrist physician.

**(Delete)** 4.3.2.4. When non-doctoral-level MHPs perform emergency CDEs, one of the following courses may be taken:

**(Delete)** 4.3.2.4.1. If the risk of imminent dangerousness cannot reasonably be ruled out, arrange for evaluation by a doctoral-level MHP within 24 hours, to include transportation, inpatient admission by a privileged physician provider, or a means of continuous direct observation, e.g. in the custody of squadron personnel or law enforcement officials on or off base, until such evaluation can be completed. Provide an interim oral report to the commander at the earliest opportunity. Document this action in the medical record and provide a written report to the commander within 72 hours.

**(Delete)** 4.3.2.4.2. If the risk of imminent dangerousness can reasonably be ruled out, arrange for the required evaluation by a doctoral-level MHP as soon as practical, but within 72 hours. Provide an interim oral report to the commander at the earliest opportunity and document this action in the medical record.

**(Delete)** 4.3.2.4.3. If the time requirements cannot be met due to geographical or other factors beyond the control of the MTF, arrange for the required evaluations as soon as reasonably possible.

**(Delete)** 4.3.2.5. MTFs shall establish standard procedures for obtaining doctoral-level evaluations for CDEs or for definitive dangerousness assessments of Regular Air force or active component members (IAW paragraph 3.2.1. above) from either civilian providers or military providers if such services will be frequently unavailable within the MTF. This includes facilities with only one doctoral-level MHP.

**(Replace)** 4.3.2.6. MTFs shall not violate the least restrictive alternative principle to save MTF financial resources (DoDI 6490.04, paragraph 4.d.1.). **(Tier 0)**

**(Delete)** 4.3.3. Non-emergency CDEs. Qualifications of providers performing non-emergency CDEs are found in DoDD 6490.1 and DoDI 6490.4.

**(Delete)** 4.4. DoD Directive 6490.1, paragraph 4.6.3.2, does not require discharge of Air Force members with a pattern of imminently dangerous behavior unless they have also been determined to be unsuitable for continued service based upon a personality disorder which is so severe that the member's ability to function effectively in a military environment is significantly impaired, as defined in AFI 36-3208, *Administrative Separation of Airman*, and AFI 36-3206, *Administrative Discharge Procedures for Commissioned Officers*. For Air Force members with sufficiently severe personality disorders and a pattern of imminently dangerous behavior, the recommendation to the commander should note that considering the circumstances, separation action should be initiated as soon as reasonably possible. Recommendations for discharge based on mental health diagnoses will be IAW AFI 36-3206 for Air Force officers and AFI 36-3208 for enlisted Air Force members.

**(Delete)** 4.5. Non-doctoral level MHPs will not be sent on deployments in which operation of a mental health unit or clinic is a primary responsibility unless military doctoral-level MHPs are

reasonably available to provide emergency CDEs. Non-doctoral-level MHPs are not restricted from deployments in which their role is to provide humanitarian or critical incident stress management services IAW AFI 44-153, *Critical Incident Stress Management*.

**(Delete)** 4.6. Personnel Records. The referring commander will be responsible for providing the personnel records to the MHP when the provider requests them as background material for the mental health evaluation.

**(Delete)** 4.7. Exemptions. MHEs conducted under Air Force Instruction 40-404, *Biographical Evaluation and Screening of Troops*, are to be included with the exemptions listed in DoD Directive 6490.1, paragraph 4.3.5.

**(Delete)** 4.8. Pre-Discharge Notifications to Victims of Assault (DoDI 6490.4, paragraph 6.6.1.3). Pending clarification by DoD (General Counsel), the provider will not notify an assault victim about the patient's discharge unless in the judgment of the MHP, there is a reasonable risk to the health or safety of the person assaulted. The commander will still be notified.

**(Replace)** 4.9. Independent Review Procedures for Continued Involuntary Psychiatric Hospitalization. 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 IAW DoDI 6490.04, 4, d, 3. Time lapsed while the member is awaiting transportation or otherwise being detained or observed outside the responsibility of an inpatient medical facility does not count toward the 72 hours. This does not apply to Reserve members not on active duty who are admitted to civilian facilities. **(Tier 0)**

**(Replace)** 4.9.1. The commander of the Air Force MTF performing the involuntary inpatient psychiatric care shall appoint a qualified medical officer (refer to DoDI 6490.04 Enclosure 3, section 4 for qualifications) to conduct the review required by DoDI 6490.04. In the case of referral for an involuntary inpatient admission to a civilian facility 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 IAW DoDI 6490.09, Enclosure 3, Paragraph 4.5.f. **(Tier 0)**

**(Replace)** 4.9.2. The reviewing officer will comply with the procedures outlined in DoDI 6490.04, Enclosure 3, section 4, when conducting an independent review for continued involuntary psychiatric hospitalization. **(Tier 0)**

**(Replace)** 4.9.3. Inspector General (IG) Referrals. Any Service member who believes a CDE is a reprisal for the Service member having made a protected communication may file a complaint with the DoD IG Hotline or the Air Force IG in accordance with DoD Directive 7050.06, "Military Whistleblower Protection," July 23, 2007. **(Tier 0)**

**(Replace)** 4.10.1. To comply with DoDI 6490.04, paragraph 3.g, Air Force units will include "recognition of personnel who may require MHE for dangerousness to self, others, or mission, based on the individual's behavior or apparent mental state" to the topics covered in training. Training must meet requirements listed in DoDI 6409.04 enclosure 3.,1. **(Tier 0)**

**(Replace)** 4.10.2. MAJCOMs, Field Operating Agencies, and Direct Reporting Units will ensure commanders are familiar with the requirements of DoD Instruction 6490.04. **(Tier 0)**

**(Replace)** 6.6. Commanders of members certified under the nuclear weapons personnel reliability program shall be notified of potentially disqualifying information (PDI) by the competent medical authority in accordance with AFMAN 10-3902, *Nuclear Weapons Personnel Reliability Program*, and DoDD 5210.42, *Nuclear Weapons Personnel Reliability Program*. **(Tier 0)**

## Attachment 1

### GLOSSARY OF REFERENCE AND SUPPORTING INFORMATION

#### *References*

**(Delete) DoDD 6490.1**, *Mental Health Evaluations of Members of the Armed Forces*, October 1, 1997

**(Delete) DoDI 6490.4**, *Requirements for Mental Health Evaluations of Members of the Armed Forces*, August 28, 1997

**(Add) DoDI 6490.04**, *Mental Health Evaluations of Members of the Military Services*, March 4, 2013

**(Replace) AFI 90-301**, *Inspector General Complaints Program*, Current August 23, 2011

**(Delete) AFI 40-404**, *Biographical Evaluation and Screening of Troops*, November 1, 1997

**(Delete) AFI 37-124**, *The Information Collections and Reports Management Program*, August 4, 1997

**(Delete) AFI 36-2104**, *Nuclear Weapons Personnel Reliability Program*, August 5, 2005

**(Add) AFMAN 10-3902**, *Nuclear Weapons Personnel Reliability Program*, December 5, 2012

#### *Abbreviations and Acronyms*

**(Delete) Doctoral-Level Mental Healthcare Provider**—For the purpose of conducting commander-directed evaluations, a psychiatrist, doctoral level clinical psychologist or doctoral level clinical social worker with necessary and appropriate professional credentials to conduct mental health evaluations as a licensed independent provider.

**(Replace) Emergency**—Any situation in which a Service member is found or determined to be a risk for harm to self or others in accordance with DoD Directive 6490.04.

**(Replace) Imminent Dangerousness**—A clinical finding or judgment by a privileged mental healthcare provider based on a comprehensive mental health evaluation that an individual is at substantial risk of committing an act or acts in the near future which would result in serious personal injury or death to himself, herself, another person or persons, or of destroying property under circumstances likely to lead to serious personal injury, or death, and that the individual manifests the intent and ability to carry out that action. A violent act of a sexual nature is considered an act that would result in serious personal injury.

**(Delete) Non-Doctoral-Level Mental Healthcare Provider**—A master’s level clinical social worker or others as designated by AFMOA/CC.

**(Delete) Potential Dangerousness (Not Imminently Dangerous)**—A clinical finding or judgment by a privileged, doctoral-level mental healthcare provider based on a comprehensive mental health evaluation that an individual has demonstrated violent behavior against himself, herself, another person or persons, or of destroying property under circumstances likely to lead to serious personal injury or death, or possesses long-standing character traits indicating a tendency towards such violence, but is not currently immediately dangerous to himself, herself or to others. A violent act of a sexual nature is considered an act that would result in serious personal injury.



**(Replace) Attachment 2:**

**MENTAL HEALTH (MH) CLINIC CONFIDENTIALITY/RELEASE OF INFORMATION 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 the 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. 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 be aware of the care you are receiving here. If there is a hard copy record, the MH record of RegAF (Regular Air Force) 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 RegAF 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. However, records will not be transferred to the gaining installation without the military dependent's consent.

**B. Disclosure Policy for All Patients.** All medical and mental health records are protected by the Privacy Act and HIPAA. Most information related to treatment of the military dependents is not releasable without written consent. Some of the instances excluded from consent requirements are quality assurance reviews by other mental healthcare providers (MHPs) and collection of information for medical research. There may also be some rare 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.

**C. Disclosure Policy Exceptions for Military Dependents:**

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 self or others.

4. Pursuant to a court order or other lawful demand.

**D. Disclosure Policy for RegAF and ARC (Air Force Reserve and Air National Guard) members.** Command notification by healthcare providers that a RegAF or ARC member has sought and/or is in MH treatment or is taking medication may not be required when you voluntarily agree to MH care. The following exceptions apply, and healthcare providers must notify your Commander if you meet one of the below 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.

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 RegAF or ARC 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 RegAF or ARC member is admitted or discharged from any inpatient mental health or substance abuse treatment facility. These types of facilities are considered critical points in treatment and support nationally recognized patient safety standards.

6. Acute Medical Conditions Interfering With Duty. The RegAF or ARC 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 RegAF or ARC 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. Crimes or Fraud. Providers must report any threat to commit crimes or fraud.

10. Pursuant to a court order or other lawful demand

11. 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. In general, this shall consist of:

1. The diagnosis; a description of the treatment prescribed or planned; impact on duty or mission; recommended duty restrictions; the prognosis; any applicable duty limitations; and implications for the safety of self or others.
2. Ways the Command can support or assist the RegAF or ARC member's treatment.

**F. Second Opinion Process for RegAF or ARC 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 provision of AFI 10-203, *Duty Limiting Conditions*.

**G. High Interest Log (HIL).** When a provider considers a patient (RegAF, ARC, 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 family practice 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 RegAF, 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.

**H. Continuity of Care.** Regarding RegAF and ARC members, information may be released for purposes of official military processes such as Medical Evaluation Boards or Commander Directed Evaluations. In all cases (RegAF, ARC, 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).

**I. Coordination of Care at the Time of Permanent Change of Station (PCS) and Transfer of Information.** The care/records of any RegAF 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 RegAF member, but does not require the RegAF member's. However, every effort shall be made to involve RegAF member in the process. In cases of RegAF 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 RegAF 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. For military dependents, who are actively involved in treatment at the time of PCS, the provider will discuss any need to transfer care/records. However, records will not be transferred to the gaining installation without the military dependent's consent. Closed records on military dependents are also reviewed prior to PCS. If the reviewing provider has concerns about elevated risk, the provider may contact the military dependent for a status check and determination of any need to transfer the record. Again, this records transfer cannot be accomplished without the individual's consent.

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

**K. Drug or Alcohol Abuse by RegAF and ARC Members.** Providers must report all suspected instances of drug/alcohol abuse by RegAF, AFR, and ANG patients to rehabilitation programs (ADAPT) and 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.

**L. 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.

**M. 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.

**N. Exceptional Family Member Program (EFMP).** For family members of RegAF members who receive care for mental health conditions, your provider must determine if your condition would require enrollment in the EFMP. This may entail disclosure of your condition to proper medical and Command authorities in order to ensure adequate medical care is available at any

projected new duty location. Enrollment in the EFMP is mandatory for the RegAF members 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.

**O. 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 as to not disrupt the medication treatment course. You may request a medication refill if you are actively under the provider's care and doing well. If not, we ask that you schedule an appointment.

**P. 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.

[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: \_\_\_\_\_

**1 MARCH 2000**

**Certified Current 20 September 2010  
Medical**



**MENTAL HEALTH, CONFIDENTIALITY, AND  
MILITARY LAW**

**COMPLIANCE WITH THIS PUBLICATION IS MANDATORY**

---

**ACCESSIBILITY:** Publications and forms are available on the e-Publishing website at [www.e-publishing.af.mil](http://www.e-publishing.af.mil) for downloading or ordering.

**RELEASABILITY:** There are no releasability restrictions on this publication.

---

OPR: AFMOA/SGOC

Certified by: HQ USAF/AFMOA  
(Col P. Christianson)

Supersedes AFI 44-109, 1 March 1997

Pages: 14

---

This instruction implements AFPD 44-1, *Medical Operations*; Public Laws 101-510 and 102-484; and Department of Defense Directive (DoDD) 6490.1, *Mental Health Evaluations of Members of the Armed Forces*, October 1, 1997, and supplements Department of Defense Instruction (DoDI) 6490.4, *Requirements for Mental Health Evaluations of Members of the Armed Forces*, August 28, 1997. It describes rights for members who are directed by their commanders to undergo a mental health evaluation (MHE) (except for those conducted in the Alcohol and Drug Abuse Prevention and Treatment, and Family Advocacy Programs.) It establishes rules for confidentiality, defines conditions requiring communication between mental health providers (MHP) and commanders, and expands the scope of the Limited Privilege Suicide Prevention (LPSP) program. This instruction requires collecting and maintaining information protected by the Privacy Act of 1974. This is authorized by 10 U.S.C. 55, *Medical and Dental Care* and 10 U.S.C. 8013, *Powers and Duties of the Secretary of the Air Force*. *Systems of Records Notice F044 SG E*, Medical Records System, applies. Send comments and suggested improvements on AF Form 847, Recommendations for Change of Publication, through channels to AFMOA/SGOC, 110 Luke Avenue, Room 405, Bolling AFB DC 20332-7050.

**SUMMARY OF CHANGES**

**This document is substantially revised and must be completely reviewed.** This revision establishes rules for psychotherapist-patient confidentiality, defines conditions requiring communication between MHPs and commanders, and expands the scope of the LPSP program.

**1. Introduction.**

1.1. It is Air Force policy to encourage Air Force personnel to seek needed help from Air Force social support agencies, including mental health clinics. To promote this policy, this AFI sets forth the rules concerning psychotherapist-patient confidentiality. These rules balance the commander's need to

know the mental well being of members of his/her command with the mental health patient's need for confidentiality and privacy.

1.2. This AFI supplements the mandatory requirements for commander-directed mental health evaluations (CDE) found in DoD Directive 6490.1, *Mental Health Evaluations of Members of the Armed Forces*, October 1, 1997, and DoD Instruction 6490.4, *Requirements for Mental Health Evaluations of Members of the Armed Forces*, August 28, 1997. Portions of this AFI are based on these DoD documents and must be read in conjunction with them.

1.3. Records Disposition. Ensure that all records created by this instruction are maintained and disposed of IAW AFMAN 37-139, *Records Disposition Schedule*.

## 2. Psychotherapist-Patient Confidentiality.

2.1. General Rule. Communications 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. 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 paragraphs 2.2. through 2.5. applies. See also the limited protections afforded confidential communications under the Limited Privilege Suicide Prevention Program in paragraphs 3.5. through 3.5.1.3.

2.1.1. In cases not arising under the Uniform Code of Military Justice (UCMJ), the psychotherapist may appeal requests for confidential communications by persons or agencies to the installation Staff Judge Advocate (SJA).

2.2. **Military Rule of Evidence.** This evidentiary rule provides a patient has a privilege to refuse to disclose and to prevent any other person from disclosing a confidential communication made between the patient and a 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. There is no privilege under this rule:

2.2.1. when the patient is dead;

2.2.2. when the communication is evidence of spouse abuse, child abuse, or neglect or in a proceeding in which one spouse is charged with a crime against the person of the other spouse or a child of either spouse;

2.2.3. when federal law, state law, or service regulation imposes a duty to report information contained in a communication;

2.2.4. 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;

2.2.5. 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;

2.2.6. when necessary to ensure the safety and security of military personnel, military dependents, military property, classified information, or the accomplishment of a military mission;

2.2.7. when an accused offers statements or other evidence concerning his 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; or

2.2.8. when admission or disclosure of a communication is constitutionally required.

2.3. Who May Claim the Privilege under Military Rule of Evidence 513. The privilege may be claimed by the patient or the guardian or conservator of the patient. A person who may claim the 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.

2.4. 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 2.1. applies.

2.5. Procedure to follow when Military Rule of Evidence 513 issues arise. When disclosure of confidential communications is requested from a MHP for the purpose of a criminal investigation or proceeding under the UCMJ, the MHP must determine if an exception to the general rule of privilege applies that authorizes disclosure. If legal advice is needed in making this decision, the MHP shall consult the installation SJA, as provided in subparagraph 2.5.3. below.

2.5.1. If an exception to the privilege exists, the communication is not privileged and should be disclosed to the requestor.

2.5.2. If an exception does not exist, the MHP should inform the requestor that the privilege is being claimed on behalf of the patient; that information sought will not be disclosed; and that any disagreement with this decision should be directed to the attention of the installation SJA. However, if the patient waives the privilege, the information should be disclosed by the MHP.

2.5.3. Questions concerning the applicability of psychotherapist-patient privilege, whether from the MHP or requestor, will be referred to the installation SJA for determination. When this occurs, the confidential communications will be disclosed to the SJA to determine whether an exception to the privilege applies and whether the information should be disclosed to the requestor. While the SJA's determination on disclosure of the information is binding on the MHP and requestor; the ultimate issue of admissibility at trial is reserved to the military judge.

2.6. Guidance on how to respond to subpoenas and court orders for production of MHP files will be obtained from the installation SJA.

### **3. Limited Privilege Suicide Prevention (LPSP) Program.**

3.1. Program Objective. The objective of the LPSP program is to identify and treat those Air Force members who, because of the stress of impending disciplinary action under the Uniform Code of Military Justice (UCMJ), pose a genuine risk of suicide. In order to encourage and facilitate treatment, the LPSP program provides limited confidentiality under the enumerated circumstances.



3.2. Program Eligibility. Any Air Force 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.

3.3. Initiation. If, subsequent to the notification described in paragraph 3.2., 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 has a good faith belief 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.

3.3.1. Based on the provided information or relevant information from other sources, and after consultation with MHP, the commander may refer the member for a MHE.

3.3.1.1. The provisions of paragraphs 4. to 4.9.3. apply to any referral under this paragraph.

3.3.2. The MHP will evaluate the member to determine if the member poses a risk of suicide, and if so, initiate treatment.

3.4. 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. 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.

3.5. Limited Protection. Air Force 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 the existing or any future UCMJ action or when weighing characterization of service in a 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 Air Force instructions and programs.

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

3.5.1.1. 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.

3.5.1.2. Disciplinary or other action based on independently derived evidence (other than from the LPSP relationship).

3.5.1.3. 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.

3.6. Disclosing Case File Information.

3.6.1. MHP staff engaged in LPSP programs may disclose case-file information of military members, including providing copies of documentation to:

3.6.1.1. 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.

3.6.1.2. VA treatment personnel when members are transferred directly to a VA facility.

3.6.1.3. The confinement facility commander when members are transferred to a confinement facility as a result of an ongoing court-martial.

3.6.1.4. Other authorized personnel with a need to know in the official performance of their duties. See paragraph 2.1. However, if the disclosure is for the purpose of a criminal investigation or proceeding under the UCMJ, the privilege in Military Rule of Evidence 513 (described in paragraph 2.2.) will preclude disclosure unless an exception applies. MHPs should consult with the staff judge advocate before any release made under this provision. Also see paragraph 6.2. for when MHP are required to contact the commander.

3.6.2. Before an MHP or other medical provider releases any information to sources other than those designated in this instruction, the member must grant permission by signing and dating a statement (AF Form 2746) specifying what information may be released and to whom it may be released.

3.6.3. Do not review, handle, or disclose any LPSP case file information to any person or agency unless the Privacy Act of 1974 (AFI 37-132) authorizes the disclosure. Disclosures within the DoD are only authorized on a need-to-know basis when personnel need the information to perform official duties.

#### **4. Referring Air Force Members for Mental Health Evaluations.**

4.1. Supervisory personnel, including commanders, may encourage Air Force members to voluntarily seek mental health care. The Air Force recognizes that members who receive help from mental health professionals can improve their job performance as well as their overall well being, and consciously endorses caring involvement by supervisors. Supervisors and commanders may not, however, under any circumstances attempt to coerce members to voluntarily seek a mental health evaluation.

4.2. Only the member's commander may direct the member to undergo a mental health evaluation or to submit to involuntary admission to an inpatient medical or mental health (psychiatric) unit. This provision applies to members of the Air Force Reserve and Air National Guard (Reserve members) on active and weekend duty status.

4.2.1. The following procedures apply to Reserve members in active duty status:

4.2.1.1. The Reserve member should be placed on Invitational Travel Orders and referred to the nearest MTF with appropriate mental health evaluation resources in the case of a commander directed evaluation.

4.2.1.2. The Reserve member should also be seen at the Reserve Medical Unit to provide for appropriate profiling and to facilitate the scheduling of the referral.

4.2.1.3. If the Reserve member is considered an immediate danger to himself, herself, or others, the member should be kept safe and not left alone until being properly transferred to a receiving facility by emergency medical personnel.

4.2.2. On intake for evaluation, mental health staff shall ask whether the member is there voluntarily or at the direction of his or her commander/supervisor. If the member responds with the lat-

ter and the commander has not initiated a commander-directed mental health evaluation (CDE) IAW DoDD 6490.1 and DoDI 6490.4, the MHP shall contact the commander to determine if a CDE was intended. If not, the MHP shall inform the member that the evaluation is not required, but may proceed on a voluntary basis if the member chooses. If the commander intended a CDE, the MHP shall ensure the commander follows the prescribed process for a CDE before proceeding with any evaluation. The MHP shall clearly document the member's statement and any interaction with the member's commander in the member's mental health record.

4.2.3. The procedures for a CDE shall be followed whenever a member is directed to undergo involuntary psychiatric hospitalization. Procedures for an involuntary psychiatric hospitalization must also be followed as directed by DoDI 6490.4, paragraph 6.2.2. Reserve members can undergo involuntary psychiatric hospitalization in a DoD MTF only when on active duty status.

4.3. Providers Performing Evaluations. DoDI 6490.4, paragraph 6.3.3. provides the basic guidance as to who has authority to perform CDEs. Additional guidance for Air Force MTFs follows.

4.3.1. Paragraphs 6.3.3.2. and 6.3.3.3. of DoDI 6490.4 do not restrict non-doctoral-level MHPs from performing non-CDEs on members or MHEs on other beneficiaries, to include assessments of potential dangerousness. Therefore, non-doctoral-level MHPs should continue to practice to the full scope of their privileges in all situations, except those involving non-emergency and emergency (e.g., imminent dangerousness) CDEs. This includes Air Force Family Advocacy Program assessments, Alcohol and Drug Abuse Prevention and Treatment evaluations, routine outpatient mental health assessments, and carrying out on-call responsibilities. If, in the course of their routine clinical practice, a non-doctoral-level MHP assesses a reasonable risk that a member may be imminently dangerous, he or she will refer the member to a doctoral-level MHP for a definitive assessment of dangerousness.

#### 4.3.2. Emergency CDEs

4.3.2.1. Non-psychiatrist physicians who perform CDEs in emergency situations (pending evaluation by a doctoral-level MHP) must be specifically privileged to do so. Privileges will be granted based on documented training, beyond that normally provided in medical school and non-psychiatric residencies, and experience in conducting comprehensive MHEs. Such privileges will be documented by adding "Emergency Commander-directed Mental Health Evaluations" on the privilege list. Privileged MHPs should assist the credentials function in making recommendations to the MTF commander concerning privileging.

4.3.2.2. If the MTF has neither a doctoral-level MHP nor a non-psychiatrist physician privileged to perform emergency CDEs available, a non-doctoral-level MHP will perform the emergency CDE, pending an evaluation by a doctoral-level MHP.

4.3.2.3. When a non-doctoral-level MHP assists a non-psychiatrist physician in an evaluation for dangerousness, the responsibility for the final judgment rests solely with the non-psychiatrist physician.

4.3.2.4. When non-doctoral-level MHPs perform emergency CDEs, one of the following courses may be taken:

4.3.2.4.1. If the risk of imminent dangerousness cannot reasonably be ruled out, arrange for evaluation by a doctoral-level MHP within 24 hours, to include transportation, inpatient admission by a privileged physician provider, or a means of continuous direct obser-

vation, e.g. in the custody of squadron personnel or law enforcement officials on or off base, until such evaluation can be completed. Provide an interim oral report to the commander at the earliest opportunity. Document this action in the medical record and provide a written report to the commander within 72 hours.

4.3.2.4.2. If the risk of imminent dangerousness can reasonably be ruled out, arrange for the required evaluation by a doctoral-level MHP as soon as practical, but within 72 hours. Provide an interim oral report to the commander at the earliest opportunity and document this action in the medical record.

4.3.2.4.3. If the time requirements cannot be met due to geographical or other factors beyond the control of the MTF, arrange for the required evaluations as soon as reasonably possible.

4.3.2.5. MTFs shall establish standard procedures for obtaining doctoral-level evaluations for CDEs or for definitive dangerousness assessments of active duty members (IAW paragraph 3.2.1. above) from either civilian providers or military providers if such services will be frequently unavailable within the MTF. This includes facilities with one or fewer doctoral-level MHPs.

4.3.2.6. MTFs shall not violate the least restrictive alternative principle to save MTF financial resources (DoDD 6490.1, paragraph 4.5.2.).

4.3.3. Non-emergency CDEs. Qualifications of providers performing non-emergency CDEs are found in DoDD 6490.1 and DoDI 6490.4.

4.4. DoD Directive 6490.1, paragraph 4.6.3.2, does not require discharge of Air Force members with a pattern of imminently dangerous behavior unless they have also been determined to be unsuitable for continued service based upon a personality disorder which is so severe that the member's ability to function effectively in a military environment is significantly impaired, as defined in AFI 36-3208, *Administrative Separation of Airman*, and AFI 36-3206, *Administrative Discharge Procedures for Commissioned Officers*. For Air Force members with sufficiently severe personality disorders and a pattern of imminently dangerous behavior, the recommendation to the commander should note that, considering the circumstances, separation action should be initiated as soon as reasonably possible. Recommendations for discharge based on mental health diagnoses will be IAW AFI 36-3206 for Air Force officers and AFI 36-3208 for enlisted Air Force members.

4.5. Non-doctoral level MHPs will not be sent on deployments in which operation of a mental health unit or clinic is a primary responsibility unless military doctoral-level MHPs are reasonably available to provide emergency CDEs. Non-doctoral-level MHPs are not restricted from deployments in which their role is to provide humanitarian or critical incident stress management services IAW AFI 44-153, *Critical Incident Stress Management*.

4.6. Personnel Records. The referring commander will be responsible for providing the personnel records to the MHP when the provider requests them as background material for the mental health evaluation.

4.7. Exemptions. MHEs conducted under Air Force Instruction 40-404, *Biographical Evaluation and Screening of Troops*, are to be included with the exemptions listed in DoD Directive 6490.1, paragraph 4.3.5

4.8. Pre-Discharge Notifications to Victims of Assault (DoDI 6490.4, paragraph 6.6.1.3). Pending clarification by DoD (General Counsel), the provider will not notify an assault victim about the patient's discharge unless, in the judgment of the MHP, there is a reasonable risk to the health or safety of the person assaulted. The commander will still be notified.

4.9. Independent Review Procedures for Continued Involuntary Psychiatric Hospitalization. Reviews of involuntary inpatient psychiatric hospitalizations of members must be conducted within 72 hours of the first admission, whether that occurs in a military or civilian hospital. Time lapsed while the member is awaiting transportation or otherwise being detained or observed outside the responsibility of an inpatient medical facility does not count toward the 72 hours. This does not apply to Reserve members not on active duty who are admitted to civilian facilities.

4.9.1. The commander of the Air Force MTF performing the involuntary inpatient psychiatric care shall appoint a qualified medical officer (refer to DoDI 6490.4, paragraph 6.2.3.1. for qualifications) to conduct the review required by DoDI 6490.4, paragraph 6.2.3. In cases where Air Force members are involuntarily admitted to MTFs operated by other military Services, or when the inpatient care is provided in the civilian sector, the Air Force medical facility commander responsible for coordinating the care of the Air Force member will work with the commander or officials of the inpatient facility to ensure the required review is performed. If the medical facility commander or a superior directed the mental health evaluation, a commander superior to the officer directing the evaluation will appoint the review officer, take his or her report, and direct any investigation.

4.9.2. The reviewing officer will comply with the procedures outlined in DoDI 6490.4, paragraph 6.2.3 when conducting an independent review for continued involuntary psychiatric hospitalization. The reviewer will submit his or her written report to the responsible MTF commander or superior commander who ordered the review (hereafter referred to as the appointing authority) within 72 hours of the member's admission. A reviewing officer's determination that the member should be released shall be reviewed by appropriate MHPs and the appointing authority, and, absent compelling reasons to the contrary, the member should be released. In the event the appointing authority determines that the member will not be released, the appointing authority will document the reason in writing. A copy of this report will be placed in the medical record. Absent new information, the member may not be involuntarily readmitted for inpatient psychiatric evaluation after the review officer has determined he or she should be released.

4.9.3. Inspector General Referrals. When the reviewing officer's report concludes that the referral or admission was made improperly, the reviewer shall forward the report to the appointing authority or to the level of command above the referring commander, whichever is higher. Unless this officer determines that there is clear and convincing evidence that the reviewer was incorrect in his or her conclusion, the officer will refer the case to the servicing Inspector General for possible investigation and disposition IAW AFI 90-301, *Inspector General Complaints*.

4.10. Training.

4.10.1. To comply with DoDD 6490.1, paragraph 4.1 and DoDI 6490.4, paragraph 5.2.4, Air Force units will include "identification, initial management, and referral of active duty Air Force members who are believed to be imminently dangerous" to the topics covered in training conducted IAW AFI 44-154, *Community Training: Suicide And Violence Awareness Education*.

4.10.2. MAJCOMs, Field Operating Agencies, and Direct Reporting Units will ensure commanders are familiar with the requirements of DoD Directive 6490.1 and DoD Instruction 6490.4.

**5. Mental Health Inquiries Under Rule for Courts-Martial (R.C.M.) 706.** Doctoral-level MHPs will conduct inquiries into a member's mental responsibility for alleged offenses or mental capacity to stand trial per R.C.M. 706 and Military Rule of Evidence (M.R.E.) 302.

**6. Communications between MHPs in Air Force MTFs and Commanders.**

6.1. Appropriate communications between MHPs and commanders aid in managing human resources and can improve the therapeutic results for Service members. MHPs are encouraged to discuss the beneficial effects of commander involvement with members and, whenever possible, to obtain the member's prior consent to the communication with the commander. Some situations may, however, justify contacting the commander without the member's knowledge. In these cases, the MHP should, under ordinary circumstances, consult with another MHP prior to communicating with the commander. The final judgment, however, rests with the member's own provider.

6.2. The MHP is required to contact the commander when:

6.2.1. In the MHP's opinion, the member is a danger to self or others, or poses a threat to security;

6.2.2. The member is admitted to or discharged from a mental health unit or ward, or when a member is referred for admission to a medical unit by an MHP for a mental health related concern (e.g., detoxification, treatment of a self-inflicted injury, assessment of neurological impairment, etc.);

6.2.3. In the MHP's opinion, the member's mental status has deteriorated to the degree that it may significantly affect work or family functioning. (NOTE: "Significantly affect" is defined as posing a risk to self, others, property, security, or the accomplishment of the military mission.)

6.2.4. The MHP suspects the existence of family maltreatment, substance abuse, or other child abuse. (Notification to Family Advocacy is also required IAW AFI 40-301, *Family Advocacy*.)

6.3. If the patient consents, the MHP may contact the commander whenever the member would benefit from additional support from the unit.

6.4. In fulfilling the requirements of paragraph 6, MHPs will provide the commander the information required for informed decision-making, but should, to the extent possible, maintain the confidentiality of communications from the patient. For example, details of a childhood history of sexual abuse, which has been appropriately addressed, may not be necessary for making a decision about a security clearance.

6.5. Commanders and other personnel receiving information concerning a member's confidential communications shall not disclose such information beyond the extent necessary to ensure accomplishment of the military mission.

6.6. Commanders of members certified under the nuclear weapons personnel reliability program shall be notified of potentially disqualifying information (PDI) by the competent medical authority in accordance with AFI 36-2104, *Nuclear Weapons Personnel Reliability Program*, and DoDD 5210.42, *Nuclear Weapons Personnel Reliability Program*.

**7. Consent Form.** A consent form for all categories of mental health patients is provided at [Attachment 2](#). Local MTFs may modify the consent form when local conditions dictate, however, each of the elements in [Attachment 2](#) must be addressed.

PAUL K. CARLTON, JR., Lt General, USAF, MC  
Surgeon General

**Attachment 1****GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION*****References***

Public Laws 101-510 and 102-484

Manual for Courts-Martial, United States, Current Version

DoDD 5210.42, *Nuclear Weapons Personnel Reliability Program*

DoDD 6490.1, *Mental Health Evaluations of Members of the Armed Forces*, October 1, 1997

DoDI 6490.4, *Requirements for Mental Health Evaluations of Members of the Armed Forces*, August 28, 1997

AFPD 44-1, *Medical Operations*, September 1, 1999

AFI 90-301, *Inspector General Complaints Program*, August 12, 1999

AFI 40-404, *Biographical Evaluation and Screening of Troops*, Current Version

AFI 37-124, *The Information Collections and Reports Management Program*, Current Version

AFI 36-3206, *Administrative Discharge Procedures for Commissioned Officers*, Current Version

AFI 36-3208, *Administrative Separation of Airman*, Current Version

AFI 36-2104, *Nuclear Weapons Personnel Reliability Program*, Current Version

***Abbreviations and Acronyms***

**AFI**—Air Force Instruction

**AFPD**—Air Force Policy Directive

**CDE**—Commander-directed Evaluation

**DoD**—Department of Defense

**DoDD**—Department of Defense Directive

**DoDI**—Department of Defense Instruction

**IG**—Inspector General

**MHE**—Mental Health Evaluation

**MHP(s)**—Mental Health Provider(s)

**MRE**—Military Rules of Evidence

**MTF**—Medical Treatment Facility

**RCM**—Rules for Courts-Martial



### *Terms*

**Assistant to a Psychotherapist**—A person directed by or assigned to assist a psychotherapist in providing professional services, or is reasonably believed by the patient to be such a person.

**Child**—A person under 18 years of age for whom a parent, guardian, foster parent, caretaker, employee of a residential facility, or any staff person providing out-of-home care is legally responsible. The term "child" means a natural child, adopted child, stepchild, foster child, or ward. The term also includes an individual of any age who is incapable of self-support because of a mental or physical incapacity and for whom treatment in a MTF is authorized.

**Confidential Communication**—A communication not intended to be disclosed to third persons other than those to whom disclosure is in furtherance of the rendition of professional services to the patient or those reasonably necessary for such transmission of the communication.

**Commander-Directed Evaluation**—A clinical assessment of a member for a mental, physical, or personality disorder, the purpose of which is to determine a member's clinical mental health status and/or fitness and/or suitability for service. The mental health evaluation shall consist of, at a minimum, a clinical interview and mental status examination and may include, additionally: a review of medical records; a review of other records, such as the Service personnel record; information forwarded by the member's commanding officer; psychological testing; physical examination; and laboratory and/or other specialized testing. Interviews conducted by the Family Advocacy Program or Service's drug and alcohol abuse rehabilitation program personnel are not considered CDEs for the purpose of this AFI.

**Doctoral-Level Mental Healthcare Provider**—For the purpose of conducting commander-directed evaluations, a psychiatrist, doctoral level clinical psychologist or doctoral level clinical social worker with necessary and appropriate professional credentials to conduct mental health evaluations as a licensed independent provider.

**Emergency**—A situation in which a member is threatening imminently, by words or actions, to harm himself, herself, or others, or to destroy property under circumstances likely to lead to serious personal injury or death, and to delay a mental health evaluation to complete administrative requirements in accordance with DoD Directive 6490.1 or DoD Instruction 6490.4 could further endanger the member's life or well-being, or the well being of potential victims. An emergency with regard to self may also be construed to mean an incapacity by the individual to care for him or herself, such as not eating or drinking; sleeping in inappropriate places, etc. While the member retains the rights as described in DoDD 6490.1 and DoDI 6490.4 in cases of emergency, notification to the member of his or her rights shall not take precedence over ensuring the member's or other's safety and may be delayed until it is practical to do so.

**Evidence of a Patient's Records or Communications**—Testimony of a psychotherapist, or assistant to the same, or patient records that pertain to communications by a patient to a psychotherapist, or assistant to the same for the purposes of diagnosis or treatment of the patient's mental or emotional condition.

**Imminent Dangerousness**—A clinical finding or judgment by a privileged, doctoral-level mental healthcare provider based on a comprehensive mental health evaluation that an individual is at substantial risk of committing an act or acts in the near future which would result in serious personal injury or death to himself, herself, another person or persons, or of destroying property under circumstances likely to lead to serious personal injury, or death, and that the individual manifests the intent and ability to carry out that action. A violent act of a sexual nature is considered an act that would result in serious personal injury.

**Least Restrictive Alternative Principle**—A principle under which a member of the Armed Forces committed for hospitalization and treatment shall be placed in the most appropriate and therapeutic available setting that is no more restrictive than is conducive to the most effective form of treatment, and in which treatment is available and the risk of physical injury and/or property damage posed by such a placement are warranted by the proposed plan of treatment. Such treatments form a continuum of care including no treatment, outpatient treatment, partial hospitalization, residential treatment, inpatient treatment, involuntary hospitalization, seclusion, bodily restraint, and pharmacotherapy, as clinically indicated.

**Maltreatment**—A general term encompassing child abuse or neglect and spouse abuse.

**Non-Doctoral-Level Mental Healthcare Provider**—A master's level clinical social worker or others as designated by AFMOA/CC.

**Patient**—A person who consults with or is examined or interviewed by a psychotherapist for purposes of advice, diagnosis or treatment of a mental or emotional condition.

**Potential Dangerousness (Not Imminently Dangerous)**—A clinical finding or judgment by a privileged, doctoral-level mental healthcare provider based on a comprehensive mental health evaluation that an individual has demonstrated violent behavior against himself, herself, another person or persons, or of destroying property under circumstances likely to lead to serious personal injury or death, or possesses long-standing character traits indicating a tendency towards such violence, but is not currently immediately dangerous to himself, herself or to others. A violent act of a sexual nature is considered an act that would result in serious personal injury.

**Psychotherapist**—A psychiatrist, clinical psychologist, clinical social worker, or other privileged provider who is licensed in any state, territory, the District of Columbia or Puerto Rico to perform professional services as such or, if such person is a member of, employed by, or serving under contract with the armed forces, who holds credentials to provide such services from any military health care facility or is a person reasonably believed by the patient to have such qualifications.

## Attachment 2

### MENTAL HEALTH CLINIC CLIENT INFORMATION SHEET

Clients are often unsure what to expect in a mental health clinic. We encourage you to consider the following points regarding mental health care, and to discuss them with your provider if you wish. You can expect the attention, respect, and best professional efforts of your provider. Your provider will 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 the 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 provider, we want you to know about privacy ground rules. 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 limited circumstances, information may be released without your permission. These are discussed below.

Records of Your Care. Every client visit to mental health is documented in the outpatient medical record. These entries are as brief as possible to protect your privacy. It is important, however, that providers caring for you in other clinics be aware of the care you are receiving here. Detailed notes documenting your mental health care are maintained in your mental health record. The mental health record is secured in the mental health clinic.

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

Access to Records by Commanders. Commanders may obtain access to the records of their members to ensure fitness for duty or a client's record when the contents of mental health records are essential to the accomplishment of a military mission.

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

Crimes or Fraud. Providers must report any threat to commit crimes or fraud by non-military as well as military clients.

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

Exception for active duty only include:

Drug or Alcohol Abuse. Providers must report all suspected instances of drug/alcohol abuse by active duty clients to rehabilitation programs and commanders.

Signature \_\_\_\_\_ Date \_\_\_\_\_