

30 October 2008

Medical Services

Referring Soldiers for Mental Health Evaluations

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\*This regulation supersedes USAREUR Regulation 40-6, 8 February 1996.

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**Summary.** This regulation prescribes policy for referring Soldiers for mental health evaluations and provides guidance for using AE Form 40-6A and AE Form 40-6B.

**Applicability.** This regulation applies to USAREUR commanders who refer Soldiers to mental health providers, and to healthcare providers who conduct mental status evaluations and command-directed mental health evaluations.

**Supplementation.** Organizations will not supplement this regulation without Command Surgeon (CSURG), USAREUR (AEAMD), approval.

**Forms.** This regulation prescribes AE Form 40-6A and AE Form 40-6B. AE and higher level forms are available through the Army in Europe Publishing System (AEPUBS).

**Records Management.** Records created as a result of processes prescribed by this regulation must be identified, maintained, and disposed of according to AR 25-400-2. Record titles and descriptions are available on the Army Records Information Management System website at <https://www.arims.army.mil>.

**Suggested Improvements.** The proponent of this regulation is the CSURG (AEAMD, DSN 371-2010). Users may suggest improvements to this regulation by sending DA Form 2028 to the United States Army Europe Regional Medical Command (MCEU-AFRME), CMR 442, APO AE 09042-0130.

**Distribution.** B (AEPUBS).

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### 1. PURPOSE

a. This regulation prescribes policy and procedures for referring Soldiers for mental health evaluations. This regulation must be used with DOD Directive 6490.1 and DOD Instruction 6490.4, which provide additional requirements that apply to Soldiers who have been referred for mental health evaluations.

b. Evaluations that are not covered by these procedures include the following:

(1) Criminal responsibility and competency inquiries under Rule 706, Manual for Courts-Martial, United States.

(2) Diagnostic referrals from other healthcare providers who are not part of the Soldier's chain of command when the Soldier consents to the evaluation.

(3) Evaluations of Soldiers in Family advocacy or alcohol or drug abuse rehabilitation programs.

(4) Voluntary self-referrals for treatment.

### 2. REFERENCES

Appendix A lists references.

### 3. EXPLANATION OF ABBREVIATIONS AND TERMS

#### a. Abbreviations.

AE	Army in Europe
APO	Army post office
AR	Army regulation
CD	compact disk
CDMHE	command-directed mental health evaluation
DEROS	date eligible for return from overseas
DOD	Department of Defense
DSN	Defense Switched Network

ETS	estimated time of separation
GT	general/technical
IG	inspector general
MOS	military occupational specialty
MSE	mental status evaluation
MTF	medical treatment facility
SSN	social security number

**b. Terms.**

**emergency** (as defined by DOD Instruction 6490.4)

A situation in which a Service 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 (reference (a)) or this Instruction could further endanger the Service member's life or well-being, or the well-being of potential victims. An emergency with respect 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 or not maintaining a regular sleep schedule; not bathing; defecating or urinating in inappropriate places, etc. While the Service member retains the rights as described in reference (a) and this Instruction in cases of emergency, notification to the Service member of his or her rights shall not take precedence over ensuring the Service member's or other's safety and may be delayed until it is practical to do so.

**mental health evaluation** (as defined by DOD Instruction 6490.4)

A clinical assessment of a Service member for a mental, physical, or personality disorder, the purpose of which is to determine a Service 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 Service 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 mental health evaluations for the purpose of DoD Directive 6490.1 (reference (a)) and this Instruction.

**4. RESPONSIBILITIES FOR MENTAL STATUS EVALUATIONS**

a. Commanders will determine which type of referral is warranted: a mental status evaluation (MSE) or a command-directed mental health evaluation (CDMHE).

b. Referring a Soldier for an MSE is warranted only when required by regulation. This includes separation from service according to AR 135-178, paragraph 6-7b and chapter 10; AR 635-200, including but not limited to paragraphs 5-13 and 5-17, chapters 9 and 13, and paragraph 14-12; or when required for special duty or occupational classification (for example, drill instructor, recruiting, sniper training) or assignment. An MSE conducted to process an administrative separation must be done by a qualified behavioral health clinician according to AR 635-200.

c. If a referral for an MSE is warranted, commanders will complete AE Form 40-6A. The commander will then coordinate with the local behavioral health clinic for an evaluation to be conducted. In cases of administrative separation, the Soldier will be escorted to the clinic. Commanders will ensure that the Soldier's medical records and the signed AE Form 40-6A are given to the behavioral health clinician who will conduct the evaluation. An MSE is not subject to the restrictions imposed on a CDMHE (para 5).

## **5. RESPONSIBILITIES FOR COMMAND-DIRECTED MENTAL HEALTH EVALUATIONS**

a. A Soldier's referral for a CDMHE is warranted when the commander is concerned about the well-being or safety of the Soldier or the Soldier's fitness for duty. Evaluations may be requested as a result of the commander's concerns about changes in the Soldier's behavior, mood, or thinking that interfere with normal functioning. Because some evaluations requested by the commander are not required by regulation, the procedures in DOD Directive 6490.1 and DOD Instruction 6490.4 must be followed to ensure that the Soldier's rights are protected.

**(1) Emergency Command-Directed Mental Health Evaluations.** If a commander determines that a CDMHE is warranted, the commander must make a clear and reasonable judgment to determine if the condition of the Soldier's mental health may be considered an emergency. Emergencies typically exist when there is an immediate concern about the potential for a Soldier to harm him- or herself or others, or when the Soldier is gravely disabled or incapacitated. In emergencies, the commander will—

(a) Make every effort to consult with a qualified behavioral health clinician or, if a qualified behavioral health clinician is not available, with the emergency-room physician before transporting the Soldier. The purpose of the consultation will be to communicate the circumstances and observations that led the commander to believe that the Soldier's behavior constitutes an emergency. If the commander is unable to consult with a behavioral health clinician in advance because of the nature of the emergency, the Soldier will be safely transported to the nearest medical treatment facility (MTF) or emergency room. The commander must consult with a qualified behavioral health clinician as soon as practical.

(b) Ensure that the first priority is to protect the Soldier and others from harm.

(c) Forward a completed AE Form 40-6A documenting the reasons for the emergency command referral as soon as practical to the behavioral health clinician who evaluated or will evaluate the Soldier.

(d) Notify the Soldier of the reason for the referral and all applicable rights as listed on AE Form 40-6B and paragraph 7 of this regulation as soon as practical.

**(2) Routine Command-Directed Mental Health Evaluations.** In situations that do not constitute an emergency, commanders will—

(a) Consult with a qualified behavioral health clinician before making the referral to schedule an appointment for the evaluation.

(b) Complete AE Form 40-6A and give a copy to the behavioral health clinician conducting the evaluation. The behavioral health clinician conducting the evaluation need not be the same behavioral health clinician with whom the commander consulted.

(c) Complete AE Form 40-6B and give the Soldier the opportunity to read and sign the form, thereby advising the Soldier of the referral and of his or her rights as stated in paragraph 7. The Soldier must be notified at least 2 business days before the evaluation. If the Soldier refuses to sign the form, the commander will document the reasons given by the Soldier for not signing. The commander will give a copy of AE Form 40-6B to the behavioral health clinician conducting the evaluation.

**NOTE:** DOD Instruction 6490.4, paragraph 6.1.1.4.4, expressly prohibits commanders from offering Soldiers the opportunity to waive the right to receive the written memorandum and statement of rights.

(d) Give the Soldier a copy of the completed AE Form 40-6B and ensure that the Soldier keeps the appointment. Soldiers referred for routine CDMHEs may be escorted to the appointment.

b. Behavioral health clinician responsibilities include—

(1) Advising commanders when consulted on whether or not a CDMHE is warranted.

(2) Reviewing AE Form 40-6A and AE Form 40-6B before conducting a CDMHE to ensure that the referral was conducted properly.

(3) Conferring with the referring commander for clarification if there is evidence that indicates a CDMHE may have been requested improperly. If after conferring with the commander, the behavioral health clinician believes the referral may have been conducted improperly according to DOD Directive 6490.1, DOD Directive 7050.06, DOD Instruction 6490.4 or this regulation, the behavioral health clinician will report such evidence through his or her chain of command to the next higher level of the referring commanding officer according to DOD Instruction 6490.4, paragraph 6.1.3.2.

(4) Advising the Soldier of the purpose, nature, and likely consequences of the evaluation, and that the evaluation is not confidential. This advice will be provided before the evaluation begins.

(5) Preparing and sending a memorandum to the Soldier's commander that addresses diagnoses, prognosis, treatment plan, necessary duty limitations (if any), and recommendations regarding fitness and suitability for continued service. This memorandum will be provided to the Soldier's commander within 1 workday day after completing the evaluation. DOD Instruction 6490.4, enclosure 5, is a sample notification memorandum. The memorandum will—

(a) Include sufficient clinical information to allow the commanding officer to understand the Soldier's condition and make reasoned decisions about the Soldier's duties and medical care.

(b) Not include superfluous personal information not required to substantiate diagnoses, prognosis, treatment plans, or recommendations.

(6) Informing Soldiers who have been command-directed for a mental health evaluation of the possible conflict of duties if the behavioral health clinician who evaluates them also provides therapy to them. This should be done at the beginning of the therapeutic relationship. This explanation may not be possible in emergencies.

**NOTE:** In emergency or routine CDMHEs, the Soldier may first be evaluated by a non-doctoral-level mental healthcare provider to obtain information and conduct an initial assessment, followed by evaluation by the behavioral health clinician with whom the appointment was scheduled.

c. This regulation does not prohibit a behavioral health clinician from evaluating Soldiers and providing appropriate care if the provider has reason to believe that the Soldiers may be dangerous to themselves or others, or are suffering from a severe mental illness requiring urgent psychiatric care.

d. As patients, Soldiers have the right to authorize a behavioral health clinician to release information. This regulation does not prohibit a behavioral health clinician from making disclosures to commanders when DD Form 2870 is properly completed by the Soldier.

## **6. RECOMMENDATIONS TO COMMANDING OFFICERS**

a. When a behavioral health clinician returns a Soldier to his or her command after either outpatient evaluation or discharge from inpatient treatment status for which dangerous behavior was an issue, the behavioral health clinician will, as a minimum, address the following with the Soldier's commander:

(1) Proposed treatment based on the potential for therapeutic benefit as determined by the behavioral health clinician.

(2) Recommended precautions based on the behavioral health clinician's good faith clinical judgment of the need for, and feasibility of, reducing or eliminating the Soldier's risk to him- or herself or others.

(3) The Soldier's fitness and suitability for continued service. This will include a recommendation to return the Soldier to duty, refer the Soldier to a medical evaluation board for processing through the physical disability evaluation system according to AR 635-40, or administratively separate the Soldier for personality disorder or other condition causing the Soldier to be administratively unfit according to AR 135-178 or AR 635-200.

b. If a Soldier is clinically determined to be unsuitable for continued service based on a Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM IV), Axis II diagnosis of a personality disorder that is severe enough to preclude satisfactory performance of duty, a summary of the findings and recommendation for routine administrative separation will be forwarded to the Soldier's commanding officer. If the Soldier has shown a pattern of imminently dangerous behavior (more than one episode) as documented in personnel or medical records and, therefore, is considered to be potentially dangerous, a recommendation for expeditious administrative separation will be cosigned by the behavioral health clinician's commanding officer and forwarded to the Soldier's commanding officer. According to DOD Directive 6490.1, paragraph 4.8.2, if the Soldier's commanding officer declines to follow the recommendation of the MTF's commanding officer, the Soldier's commanding officer will forward a memorandum to his or her commanding officer within 2 business days explaining the decision to retain the Soldier against medical advice.

## **7. SOLDIER RIGHTS**

When referred for a CDMHE, a Soldier has the right to—

a. Freedom from interference regarding communications with an inspector general (IG), member of Congress, attorney, or any other persons about this referral.

b. Be notified by written memorandum at least 2 workdays before the evaluation (does not apply to emergency CDMHEs). The memorandum must include the following information:

(1) A brief, factual description of the behavior or verbal communication that led to the commander's decision to request an evaluation.

(2) Notification of the Soldier's legal rights.

(3) The date, time, and location of the evaluation, and the name, grade, and title of the behavioral health clinician who will conduct the evaluation.

(4) The name and signature of the commanding officer.

(5) The name, grade, and title of the behavioral health clinician who the commander consulted about the referral.

(6) The telephone number and location of authorities who can help the Soldier if the Soldier wants to question the necessity of the referral. As a minimum, these authorities will include attorneys (military and DOD civilian), the inspector general, and military chaplains.

c. Obtain a second opinion by an independent behavioral health clinician of the Soldier's choosing and at the Soldier's expense.

d. Submit complaints to or communicate with an IG.

## **8. PSYCHIATRIC HOSPITALIZATION OF SOLDIERS**

a. Commanding officers have a reasonable need to know basic facts about Soldiers under their command when those Soldiers are psychiatrically hospitalized to ensure Soldier safety and successful completion of the military mission. These basic facts include the diagnosis, prognosis, fitness for duty, and recommended duty limitations or precautions.

b. When a Soldier has been voluntarily or involuntarily hospitalized for psychiatric reasons, the commanding officer may request a report of MSE by giving a completed AE Form 40-6A to the treating psychiatrist.

c. Commanders and medical personnel will ensure Soldiers involuntarily hospitalized for psychiatric conditions are afforded the additional rights provided by DOD Instruction 6490.4, paragraph 6.2.2.

## **APPENDIX A REFERENCES**

### **SECTION I PUBLICATIONS**

Manual for Courts-Martial, United States

DOD Directive 6490.1, Mental Health Evaluations of Members of the Armed Forces

DOD Directive 7050.06, Military Whistleblower Protection

DOD Instruction 6490.4, Requirements for Mental Health Evaluations of Members of the Armed Forces

AR 25-400-2, The Army Records Information Management System (ARIMS)

AR 135-178, Enlisted Administrative Separations

AR 380-67, Personnel Security Program

AR 600-20, Army Command Policy

AR 635-40, Physical Separation for Retention, Retirement, or Separation

AR 635-200, Active Duty Enlisted Administrative Separations

### **SECTION II FORMS**

DD Form 493, Extract of Military Records of Previous Convictions

DD Form 2870, Authorization for Disclosure of Medical or Dental Information

DA Form 2028, Recommended Changes to Publications and Blank Forms

AE Form 40-6A, Unit Commander Request for Mental Health Evaluation

AE Form 40-60B, Command-Directed Mental Health Evaluation