Standard Clinical Operating Policy and Procedure Manual

National Guard
Psychological Health Program (NGPHP)

25 May 2013
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Section I
Scope and Objectives of the NGPHP

1-1. Policy
The National Guard (NG) has limited organic behavioral health gain access to behavioral health assets, as such significant challenges exist for Service Members (SMs) and their families to and related services across the 54 states and territories and 89 ANG Wing communities. The National Guard Psychological Health Program (NGPHP) is a modified Employee Assistance Program Model (EAP) using clinical providers licensed at the highest level, focused on biopsychosocial assessment and referral to community based resources, Department of Defense (DoD) entities and Military programs where they exist and are clinically appropriate. We believe by using this approach, the program will be successful in increasing community capacity, educating and advising NG leadership, providing clinical assessment and referral, promoting Individual Medical Readiness(IMR) and empowering proactive, help seeking behaviors. The new statement of the NGPHP is to advocate for and support NG members and families by promoting mental fitness and personal wellness for operational readiness. Methods used focus on strategic support services to leadership, wings, units and the local community, as well as direct services to NG SMs and their families.

The NGPHP provides each Air National Guard (ANG) Wing and Army National Guard (ARNG) Surgeon’s Office a Director of Psychological Health (DPH) to serve as a behavioral health consultant, subject matter expert (SME), and advocate for psychological health. Currently, a second ARNG DPH has been placed twenty-four states based of the following priorities: suicide rate, unemployment rate, multiple deployment rate, divorce, and NG SM population. The DPH is also a coordinator of clinical and counseling services and resources, and a resource to medical personnel and line leaders to support biopsychosocial and family health and growth.

A primary purpose of the NGPHP is to build unit and community capacity by promoting and empowering the creation of a culture of mental fitness, as well as providing active outreach and networking with NG leadership and local resources. The NGPHP provides consultation to operational leadership on psychological health issues and vertical integration of key military service and DoD-wide psychological health initiatives and population-health monitoring. The program promotes the availability of, and access to, a continuum of services to NG members and their families. The NGPHP promotes coordination of clinical, counseling, and other services addressing the psychological health of SMs and their families.

1-2. Applicability
This policy applies to all contracted personnel who provide psychological health services to the NG through the NGPHP.

a. Clients Served: Adult SMs and FMs
   1. General. The primary customer of the NGPHP is any NG SM and/or eligible beneficiaries. In emergency situations, no SMs, AD SMs, retirees, beneficiaries, or veterans from any military branch will be turned away for clinical assessment and referral services.
   2. Limitations on Services to Minors. Documented permission from a parent or legal guardian is required to serve a minor in person, telephonically, or via a referral to another provider. No services may be provided to minors who purport to be emancipated until the emancipation criteria are validated through legal channels. The legal definition of a minor is determined by state statutes.

b. Services Provided: Intake, Assessment and Referral
   1. The NGPHP offers access to clinically appropriate intake, assessment and referral services. These services may be conducted in person or telephonically; email and text messages may be used when other forms of communication are not available, and must be documented in the client record.
2. This process includes collection of demographics, military/deployment history, and the identification of the behavioral and emotional issues and/or stressors leading to the Service Member/Family Member (SM/FM) seeking services.

c. Case Management
1. DPH staff shall, when clinically appropriate, provide clinical case management services including assessment, intervention plan, referral, and monitoring of clinical progress.
2. The DPH shall assess the SM/FM for his/her presenting issues, define an appropriate intervention plan for emergent situations, and collaborate on appropriate intervention plans with treatment providers, work with collateral agents/providers (if applicable), conduct follow up with the SM/FM and collateral agents/providers, and consult with the SM’s supervisor/commander with duty re-entry issues (if applicable, and subject to obtaining a signed Statement of Understanding and Release of Information procedures).

d. Consultation
DPH staff engage in two distinct types of consultation:
1. Clinical consultations. Clinical consultations to leadership to foster quality care and mission readiness while respecting HIPAA and privacy regulations, and licensing and/or ethical standards.
2. Non-clinical consultations. Non-clinical consultations on a variety of behavioral health and wellness issues including elements of military or civilian life that do not clearly fit into a mental, behavioral, or emotional disorder, problem, concern or well-being framework, yet require the expertise of a behavioral health professional to assist in problem resolution.

e. Crisis Response & Critical Incident Response
DPH staff engage in two types of critical interventions:
1. Behavioral health crisis situations. Behavioral health crisis situations that demand immediate intervention to those involved or impacted by an active crisis situation. Many of these circumstances involve life-threatening situations, including risk for harm to self, others, property, etc.; and,
2. Individuals and groups impacted by a violent act or major injuries. Response to individuals and groups impacted by a violent acts (suicide, homicide, etc.) or major injuries and death, including large-scale emergencies and disasters (either human-caused or natural disasters). As appropriate, evidence-based or best practices critical incident response approaches such as Psychological First Aid (PFA), Traumatic Event Management (TEM), and Traumatic Stress Response (TSR) may be utilized.
3. Brief interventions. Brief interventions consistent with evidence-based crisis management and critical incident response models are within the scope of the PHP, with a focus on emotional/behavioral stabilization and short-term problem-solving.

f. Mental Health Awareness and Wellness Promotion
DPH staff engage in a wide variety of wellness promotion focused activities (Yellow Ribbon, Coping with Deployment, etc.) facilitating the prevention of mental health issues, early intervention, crisis response and post-incident recovery. DPH staff are Subject Matter Experts (SMEs) on topics including, but not limited to: coping skills, Post Traumatic Stress Disorder (PTSD), Traumatic Brain Injury (TBI), mood disorders, communication/conflict resolution, suicide prevention, family dynamics, violence to self and others, and substance abuse.

g. Hours of Service
1. DPHs are contracted to work a 40 hour work week. At the request of the POC, the DPH may be asked to participate in weekend events (Yellow Ribbon, SRP, drill weekend etc).
2. When participating in weekend events, the DPH should flex their time within the same pay period that the weekend event took place. DPHs coordinate with their RL, and will
communicate with their POCs when taking flex time. Accumulating flex days and then taking several days off in a row outside of the same pay period is not allowed.

3. DPHs may provide 24/7 telephonic coverage in a manner consistent with Policy 110. When unavailable, backup plans approved by your RL in coordination with the POC should be utilized. NGB has approved the use of a standardized message to be used by all DPHs on their military issued cell phone. The standardized greeting will direct all after-hours callers to the National Suicide Prevention hotline.

h. Responsibilities
   1. NGPHP Program Director and Deputy Director (contracted staff) with NG Bureau oversight will ensure that all NGPHP staff are appropriately trained and understand all clinical and administrative policies and procedures.
   2. NGPHP RL (contracted staff), in conducting supervision with state/territory Directors of Psychological Health, shall ensure that standards set forth in this document are being properly upheld and procedures executed.
   3. NGPHP Directors of Psychological Health (DPH) shall provide professional mental health services consistent with best practices in behavioral health and within the accepted practices of their local licensing boards.

i. Services Outside the NGPHP Scope
   NGPHP DPH staff do not provide any of the following services
   1. Psychological evaluations for the following: return to work, return to school, or medical leave documentation; and court-ordered assessments, counseling, treatment, or consultation. SMs/FMs requesting these services shall be referred.
   2. Fitness for Duty, Line of Duty (LOD) and Command Directed Evaluations.
      (a) However, when operating within privacy rules and regulations, DPH staff can provide clinical consultation to appropriate parties regarding a SM’s fitness for duty, LOD and Command Directed evaluations.
      (b) DPH staff do not make final decisions regarding a SM’s fitness for duty or LOD. The role of the DPH is limited to providing consultation. DPH staff are encouraged to assist in identifying appropriate providers to complete Fitness for Duty, LOD and Command Directed evaluations.
   3. Treatment. DPH staff do not engage in treatment, including counseling and psychotherapy.

1-3. References
   a. DoD Directive 6490.02, Comprehensive Health Surveillance, 23 Apr 07
   b. DoDI 6490.06, Counseling Services for DoD Military, Guard and Reserve, DoD Task Force on Mental Health Report, Jun 07
   c. MOU with U.S. Dept. of Health and Human Services (HHA), Substance Abuse and Mental Health Services (SAMSHA) (18 Nov 09)
   d. Title 10, USC, Section 1079, 1 Feb 2010
   e. Title 10 USC, Section 1074 (a) 1 Feb 2011
   f. FY 11 NDAA, Section 723, P.L. 113-383
   g. RC J-1, Manpower and Personnel Directorate, Item 1
   h. P.L. 111-84, Section 595 mandates via YRRP, suicide prevention training for SMs and FMs, in coordination with local communities
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i. CRC Policy Guidance, All States Log Number P09-0014, 2 (a)

j. RC-J1, Manpower and Personnel Directorate, Item 1

k. DoD Directive 6490.1, Mental Health Evaluations of Members of the Armed Forces, 1 Oct 97

l. Department of Defense Instruction (DoDI) 6490.4, Requirements for Mental Health Evaluations of Members of the Armed Forces, 28 Aug 97.

Section II
Administrative Operations Policy

1-4. Policy
Administrative operations for the NGPHP shall be guided by the requirements in the contract, and the expectations of NG Bureau leadership to provide effective and efficient services. Service delivery to customers/clients shall emphasize the highest degree of professionalism appropriate to the practice of behavioral health services in a military environment. Program personnel will operate within the framework of their job descriptions, and use and respect the chain of command identified by both corporate and military leadership. Services shall emphasize the efficient use of both corporate and government resources to achieve optimal results.

1-5. Organizational Structure and Key Responsibilities
a. The ANGPHP. The ANGPHP is aligned under the NG Behavioral Health (BH) Branch (NGB/SGPK), Clinical and Operational Medicine Division, Office of the Air Surgeon. At the installation level for the ANG, the DPH works with as contractor supports for NG BH operations.

b. The ARNG PHP (ARNGPHP). The ARNGPHP is aligned under the Office of the Chief Surgeon, Clinical Operations Branch. At the state and territory level for the ARNG, the DPH works with and supports NG BH operations as contract support in cooperation with Program Leadership and the Deputy State Surgeon.

1-6. Program Personnel Job Descriptions: (Please Reference Appendix)

1-7. Contract Program Manager
The Contract Program Manager has ultimate authority over all tasks performed under the contract and task orders and represents the Contractor and Subcontractors in all interactions with the Contracting Officer, the Contracting Officer Representative and NGB Leadership. The Contract Program Manager is the only one who can suggest and submit contract modifications to the Contracting Officer Representative and the Contracting Officer. The Contracting Officer is the only one who can approve contract modifications. The PHP Director(s) report to the Contract Program Manager.

1-8. PHP Director
The Program Director oversees all program policies and procedures and administrative and management functions necessary for optimal functioning within the NGPHP Program. This includes management of all duties necessary to ensure optimal functioning of NGPHP, including policies, procedures and practices of all qualified staff. Oversight of program-wide committees on mission-critical topics, and cross branch coordination of services is a central component of the Program Director’s job.

1-9. PHP Deputy Director
The Deputy Director assists the Program Director in administering the NGPHP. The Deputy Director guides and assist with the daily operational management of the regions, including 89 Wings within ANG, and 78 ARNG DPHs assigned to 54 states and territories. In the absence of the Director, the
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Deputy Director will manage day to day operations, oversee programmatic responsibilities, provide clinical and policy guidance and reporting. Duties include managing information systems and records management, personnel management, organizing Administrative Assistants to support program-wide administrative tasks and projects, organizing clinical audit and review processes, publishing quality improvement and productivity reports, and managing travel and expense report processes.

1-10. RL DPH
The RL oversees the day-to-day clinical policies, procedures, and practice of staff, as well as coordinates communication between staff and Service liaisons. Each RL is assigned a region comprised of multiple states or territories, and supervises DPHs within those region. RLS are responsible for assuring the delivery of quality consultative, clinical, and referral services, ensuring best practices are identified, shared and applied where appropriate across the NGPHP Program, and for arranging, maintaining and documenting training needed for effective performance under this contract. RLS provide each DPH supervisee with at least one (1) hour of telephone supervision every other week. Face-to-face supervision is provided a minimum of one (1) time every three (3) months during a DPH's first year of service, or more frequently if circumstances require. RLS may also chair program-wide committees, or take on special projects that support the mission. RLS facilitate collaboration efforts with DPHs and Points of Contacts (POC) by engaging in outreach activities, and leading clinically-oriented case management teams promoting support systems for SMs.

1-11. DPH
The DPH operates at the local wing or military base/installation, and manages their priorities by jointly reporting to the RL and a NG POC. While the POC does not have direct supervision responsibilities, they are central to defining the priorities of the local NG and guiding the DPH to assist in fulfilling local behavioral health priorities that are consistent with the contract-based job description.

The DPH's primary job role is to provide a behavioral resource to NG leadership and SMs. They engage in consultation, provide intakes, assessments and referrals for SMs with acute behavioral health problems, conduct briefings, and engage in crisis and critical incident response services. They are expected to periodically travel to provide trainings, engage in promotional activities, conduct counseling as needed, take part in collaborative efforts with other supporting government support programs, personnel, and provide consultation with commanders/supervisors, and others across all levels of the NGPHP Program.

The DPH typically operates in a complex organizational environment, and indirectly deals with labor relations, military operations, the Military Health System, TRICARE and VA when accessing services for SMs. The DPH coordinates and consults with other military branches on all behavioral and psychological health initiatives and policy, and plan and coordinate region/state/territory/wing behavioral health related meetings.

1-12. Administrative Assistant
The Administrative Assistant reports directly to the RL to support the work of the DPH, the Program Director, and the Deputy Director to support program-wide operations. Administrative Assistants coordinate administrative procedures within the program and assist others to process their reports in a timely manner. They are excellent communicators, computer literate, typists, and capable of functioning effectively in a fast paced environment. Administrative Assistants are also expected to be sensitive to the confidential nature of client contacts and work to manage program records so they address the need to develop and produce program productivity metrics.

1-13. Relationships between Contractor Leadership and NG Bureau Leadership
Contracted leadership personnel (i.e., the Program Contract Manager, Program Directors, Deputy Directors and RLS) work collaboratively with officials from the NG Bureau (including uniformed military, civilian General Services employees, and contractors working directly for NGB) and NG
officials at the wing/state/territorial levels to develop and implement policies, procedures and practices that advance program priorities and contract requirements. While the Program Contract Manager provides regular information to the NGB COR, Program Directors and Deputy Directors work directly with their branch chiefs of behavioral health services, and other NGB officials as required. RLS work directly with the POCs at the wing/state/territorial level, and provide direct supervision for DPHs. Program problem-solving and development is managed through internal company channels at the outset, and outreach is made to NG officials for both routine program functions and urgent operations that impact the client population. Senior leadership of both the Contractor and NG Bureau jointly determine acceptable policies and procedures to maximize the positive impact of services.

Figure 1-1. The NG Chain of Command
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Figure 1-2. Organizational Chart for NGPHP (ARNG PHP and ANG PHP have parallel Org Charts)

Contract Program Manager
National Program Director
Deputy Director

South East Regional Lead
North East Regional Lead
Midwest Regional Lead
North Central Regional Lead
West Regional Lead

South East Admin
North East Admin
Midwest Admin
North Central Admin
West Admin

State Director of Psychological Health
Alabama
Florida
Georgia
Maryland
Mississippi
North Carolina
South Carolina
Puerto Rico
Tennessee
Virginia
Virgin Islands

State Director of Psychological Health
Connecticut
District of Columbia
Delaware
Maine
Massachusetts
New Hampshire
New Jersey
New York
Pennsylvania
Rhode Island
Vermont
West Virginia

State Director of Psychological Health
Arkansas
Colorado
Iowa
Kansas
Louisiana
North Dakota
Nebraska
New Mexico
South Dakota
Texas
Wyoming
Oklahoma

State Director of Psychological Health
Illinois
Indiana
Kentucky
Michigan
Minnesota
Missouri
Ohio
Wisconsin
1-14. Local NG Responsibilities
Site POCs are obliged by the contract to provide a safe and secure office space for the DPH to be able to carry out the administrative and clinical expectations of this position within an environment that ensures privacy. Each office shall be maintained as a professional environment that ensures the safety, privacy and confidentiality of all employees who seek assistance. Utilities, equipment, office furniture and supplies to support the DPH should be the same as other Government employees performing similar functions, including automated data processing equipment (computers) and telecommunication equipment.

DPH Workplace Management

1-15. Regular Business Hours
a. On average, a 40-hour work week is expected of the DPH. To accommodate any hours worked on weekends, the DPH will coordinate non-standard hours with the military POC and contractor supervisory personnel (RL, Deputy/Program Director/Company).

b. The DPH will set a schedule of work appropriate to the needs of their assigned military unit in coordination with the military POC, including weekends, in accordance with the unit’s official schedule. The DPH’s schedule will be reviewed and approved by the RL prior to implementation.

c. A DPH’s standard office hours are typically 8 AM – 5 PM daily, but may require modifications depending on the unit’s actual schedule. Any modifications must be coordinated and approved by the supervising RL.
1. At the discretion of the unit commander/leadership, the DPH may be assigned various shifts to provide services when needed to properly serve unit shift workers. Such
assignments may be ongoing or temporary depending on the need and approved by the DPH’s program leadership.

2. The DPH will maintain eight-hour days unless arrangements are made with the RL and the unit appointed POC.

3. ANG DPHs are available for at least eight hours on each UTA day, with the exception of Friday to be available to meet clients and support the full complement of unit personnel.

4. ARNG DPHs are available for drill weekends to provide psychological health services in concert with Behavioral Health Officers (BHOs).

5. DPHs will work with their RL in pre-planning the even distribution of UTA, Drill Weekends and emergency flex time to ensure they stay within the hours corresponding to their company pay periods, the integrity of the 40-hour work week, and are fully available to Unit or Wing personnel. While the goal is to mirror the unit/wing schedule as much as possible, the primary objective is to maximize the DPH’s presence for as many days as possible within any given work week.

1-16. Holidays and Special Leave Situations
The DPH observes the same holidays as the NG
a. When Federal organizations are granted additional leave, including administrative leave as a result of inclement weather, potentially hazardous conditions, parades and/or other functions or special circumstances, DPHs may be required to be on duty at assigned locations to maintain an acceptable level of service for those NG members who are required to work.

b. DPHs will coordinate such duties with the site POC and their program leadership.

1-17. After Hours Access
a. DPHs flexing time to work after hours to see clients should do so only if others are also working those alternate hours. As a contractor, the DPH must have a supervisory uniformed person in the area where the office is located while working. Otherwise, an appointment will be made to see the client based on availability.

b. Office hours also include hours on the drill weekend, allowing members another opportunity for an appointment if they cannot come during regular office hours.

1-18. Telephone Access
a. During office hours, the DPH will be accessible by telephone.

b. The DPH will use the standard voicemail message on the office and mobile phones (see Communications Policy)

c. The DPH will answer phone calls professionally and in a courteous manner.

d. In non-emergency cases the DPH will respond to messages no later than the next workday.

e. Upon receipt of an emergent call the DPH will respond immediately and notify RL as soon as situation allows.

f. TTY access is available for hearing-impaired members and FMs at all times via Military OneSource.

1-19. Program Coordination with Key Stakeholders:
a. Sexual Assault Response Coordinators (SARC) Partnering. The DPH may provide consultation to the SARC and partner with them as a referral resource and psychological health subject matter expert in serving SMs. The DPH may NOT serve as SARC.
b. Airman and Family Readiness Program Managers (A&FRPMs) and State Family Programs (SFPs) Partnering. The DPH will provide consultation to the Airman and Family Readiness (A&FR) Program and State Family Program (SFP) personnel and partner with them as a referral resource and psychological health subject matter expert in serving wing/unit members.

c. A&FR/SFP Resilience and Comprehensive Airman/Soldier Fitness Efforts. The DPH will support A&FR/SFP Resilience and Comprehensive Airman/Soldier Fitness efforts. The DPH may not perform services which are the inherent responsibility of the A&FR/SFP programs, but instead will refer members to the A&FRPM or SFP for services.

d. Chaplain Partnering. The DPH will provide consultation to Chaplain personnel and partner with them as a referral resource and psychological health subject matter expert in serving NG members. As requested, the DPH may provide assistance to relationship enhancement and other Chaplain wellness initiatives. The DPH will not perform faith-based counseling services.

e. Casualty Affairs Partnering. The DPH supports members involved with casualty notification and assistance. This team’s duty is difficult and members may benefit from discussing the visit ahead of time to prepare for and afterward to discuss the impact. The DPH will not visit private homes, nor serve as a member of a casualty notification team. Military Medical Unit Partnering (for DPHs not assigned to the Medical Unit)

f. Medical Personnel. The DPH will form a good working relationship with medical personnel. The DPH may consult with the medical unit personnel on PH issues and the implications of corresponding symptoms/behaviors; however, DPHs are instructed not to obtain identifying information. The purpose of such consultations would be for the DPH to assist medical unit personnel in determining the best available course of action for the NG to pursue in PH-related cases.

1-20. Referral Network Creation and Partnering
To locate an EAP or behavioral health network provider, refer to www.MHN.com or http://www.tricare.mil

a. Since the NG does not provide treatment, all treatment is received externally through the Military Health System, TRICARE, the Veterans Health Administration (VA), health insurance provided through a NG SM’s or civilian spouse’s civilian employer, and personal finances.

b. The primary responsibility to provide the affiliated counselor network rests with MHN. The DPHs can assist with identifying interested providers who want to join MHN’s network. DPHs can refer interested providers to MHN’s website at https://www.mhn.com/provider/start.do.
1. Once the provider has reached the “Join Our Network” page, they will be able to click the orange bar at the bottom of the screen titled, “MHN Network Participation Request Form.” When asked for a Recruiter Code, they should enter Recruiter Code “900” for NG Bureau. The provider will need to follow the prompts to complete the questionnaire and submit when all required fields are completed.
2. MHN will review all application requests and respond with 15 business days. In case of an approval, a confirmation letter/packet will be sent to the provider and will contain a contract, W9, rates and a supplemental credentialing packet that should be returned to MHN.
3. The DPH will assist with familiarizing the mental health providers with military culture and unique stressors of the NG.
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1-21. Policy
All major aspects of program operation shall be addressed via approved bulletins, memorandums or policies. Any program personnel may propose new bulletins, memorandums, or policies; or changes to existing bulletins, memorandums, or policies. All new policies must be vetted through the respective Program Director, the Contract Program Manager and ultimately approved by NGB leadership.

1-22. Definition(s)

a. Bulletins: Bulletins are documents that provide National Guard Psychological Health Program (NGPHP) personnel with internal directives or procedures based primarily on the nature of the contractual relationship with the NG; the requirements of licensed mental health professionals' obligations to clients; and the laws, policies and directives from the NG pertaining to the contract. Bulletins define a course or method of action selected from among alternatives and in light of given conditions to guide and determine present and future decisions. Bulletins are generated by the PHP Policy Committee and approved through the PHP Leadership Team. Sub-categories of Bulletins include:
   1. “Draft” Bulletins, or those that have been developed for review and do not have approval of the Leadership Team;
   2. “Approved” Bulletins, or those approved by the Leadership Team for use by program personnel.

b. Memorandums: Memorandums are documents that provide NGPHP personnel with internal directives or procedures based primarily on the nature of the contractual relationship with the NG; the requirements of licensed mental health professionals' obligations to clients; and the laws, policies and directives from the NG pertaining to the contract. Memorandums define a course or method of action selected from among alternatives and in light of given conditions to guide and determine present and future decisions. Memorandums are generated by the NGPHP Policy Committee and approved through the NGPHP Leadership Team. Sub-categories of Memorandums include:
   1. “Draft” Memorandums: those that have been developed for review and do not have approval of the Leadership Team;
   2. “Approved” Memorandums: those approved by the Leadership Team for use by program personnel.

c. Policy: Policies are documents that provide overarching guidance and direction to all personnel, and have features similar to bulletins; however, they are approved through the NG or the Department of Defense. Policies over-ride Bulletins in terms of operational authority. A bulletin may be submitted to the NG to be considered for status as a policy by the Leadership Team if the elements of the Bulletin transcend the internal contractor responsibilities, addressing the larger scope of required behavioral health services regardless of provider.

1-23. General Procedures

a. The Policy Committee. The Policy Committee shall consider and review all memorandums, bulletins and proposed policies and procedures. The Policy Committee shall be divided into two groups: an “Authorship Team” and “Research and Review Team.” Committee members shall be appointed by the Program Director for one year appointments, and shall be responsible for drafting or reviewing bulletins, memorandums, policies or procedures as part of their job duties. This is considered a voluntary assignment, and should not be forced upon any personnel.
   1. The committee shall meet at least bi-monthly to review newly submitted bulletin, memorandum, and policy recommendations; along with recommendations for modifications to existing bulletins, memorandums, and policies.
   2. Minutes shall be kept of attendance, topics discussed, decisions made, and assignments made to committee members.
b. The bi-weekly Policy Committee meeting. The meeting will be attended by the Authorship Team. Agenda for these meeting will include:
1. Reviewing current program need for additions and changes to existing policy.
2. As existing needs are identified, the Authorship Team shall submit draft versions of related bulletins, memorandums, and policies to the Research and Review Team.
   (a) The Research and Review Team, once receiving new or revised bulletins, memorandums, and policies shall review the documents in order to make any grammatical or editing changes necessary, including the addition of supporting documentation. If substantial changes that affect the core nature of the document are required, they will submit the changes to the Chair for approval. The review process shall take no more than 1 week. Once finished with the review, the Program Director will return the document to the Chair.
   (b) If needing more than cosmetic changes, it shall be returned to the Authorship Team. The Chair will ensure that it undergoes a final grammar, spelling and format check before being sent to the Leadership Team for final approval.

a. New or changes to existing bulletins, memorandums, and policies
   1. Any staff member can recommend a new bulletin, memorandum, policy or procedure on any major topic of program operation. Submissions can be made to the Administrative Assistant or to the Chair at any time.
   2. The Administrative Assistant shall schedule the new proposal for consideration for the next session of the committee.
   3. The Administrative Assistant shall send the minutes of the meeting addressing the proposal, with any decisions made, to the initiator of the proposal.
   4. The Chair or Deputy Chair shall assign a committee member to address each recommendation and schedule time on the committee for formal review, subject to the discretion of the Chair.
   5. If approved by the committee, the document will follow the procedures outlined in section 1 of this document.

b. The Leadership Team will provide final approval for all policies within the NGPHP. Should a policy be clinical in nature and need to be reviewed by the Program Director, the Program Director will be responsible for this review process. Clinical policies needing customer review will not be considered approved until this step is complete.

c. When a new bulletin, memorandum policy or procedure or revision has final approval, the Chair’s Administrative Assistant will post the final version on the NGPHP SharePoint site.

d. All personnel shall be trained on NGPHP bulletins, memorandums, policies, and procedures. The Deputy Director will develop training on the bulletin, memorandums, policy and procedure process, and provide training through regional meetings, All Hands meetings, and others venues. An email will also be sent to all staff informing them of any changes and attaching a revised/new policy to add to their Policy & Procedure manual.

e. In the event that a bulletin, memorandum, or policy needs to be developed immediately, the Chair may authorize members of the Policy Committee, and any additional personnel required, to complete this work on an expedient basis. The Program Director and Contract Program Manager, will approve any such documents prior to their dissemination to program personnel.

Section IV
Communication Policy

1-25. Policy
Directors of Psychological Health (DPHs) will utilize a variety of communication tools and resources
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to advance the mission of the NGPHP (NGPHP). This policy has been developed to further define communication policies and procedures that are specific to the Program.

1-26. Internal Communication Procedures
Directors of Psychological Health and RLs will monitor their e-mails and voice mails on an hourly basis during hours of work to ensure that they are addressing emergencies and emerging problems requiring time-sensitive response. Communications from either corporate or NG leadership during duty hours will be responded to within one hour, unless dealing with an emergency, are in an area where electronic communications cannot be received or transmitted (e.g., an airplane), or where there is an equipment failure. If in a protracted meeting, a response via e-mail indicating the approximate time when the individual can make contact is acceptable in most circumstances.

a. Email Procedures. All DPH staff will respond in a timely fashion to emails.
   1. Out-of-Office Email Notifications: All DPH staff will indicate they are out of the office or unreachable by using the Microsoft Outlook Out-of-Office Message feature.
   2. All DPH staff will use the NGPHP standard "out of office message" as shown in Figure 1-4.

Figure 1-4 Out of Office Email Example:

“I will be out of the office until [enter date]. I will respond to your email upon my return. If you need immediate assistance, please contact my back up [list name] at [list phone #]. If this is an emergency, please call 911 or go to your nearest hospital Emergency Room. The National Suicide Prevention Lifeline telephone can be reached by calling 1-800-273-8255.”

The email signature block is to be placed into the out-of-office message box. Customize your email signature block according to policy guidance by your local level commander.

* Tip: Do not forget to turn off your Out-of-Office Message upon your return.

b. Voice Mail Procedures. All DPH staff will use the below designated Voicemail Recorded Greeting for their Office and mobile phone voice mail.
   1. Standard Voicemail Greeting: “You have reached the confidential voicemail for NAME, DPH for the LOCATION. (Optional: I have arranged for a backup to provide assistance in my absence. Please contact NAME (DPH, local Military or GS employee), TITLE, at PHONE NUMBER for assistance.) If this is an emergency, please call 911 or go to your nearest hospital Emergency Room. The National Suicide Prevention Lifeline telephone can be reached by calling 1-800-273-8255.”
   2. Extended Absence Voicemail Greeting: “You have reached the confidential voice mail of [Your Name], I will be out of the office from [date] to [date]. Please leave a message and I will return your call when I return to the office. [If using Backup DPH: (Name of back up) will be filling in for me while I am away and is available to take your call at (phone number).] If this is an emergency, please call 911 or go to your nearest hospital Emergency Room. The National Suicide Prevention Lifeline telephone can be reached by calling 1-800-273-8255.”

Tip: Do not forget to change your Extended Absence Voicemail Greeting upon your return.

c. Professional Communication Procedures
   1. Written Communication (internal and external where applicable):
   2. All documents created will include the following: Topic Line/Subject
   3. Priority Level
   4. Header
   5. Footer to include subject/topic, date, and page #
6. Status such as DRAFT or CONFIDENTIAL

1-27. External Communication Procedures

a. Media Requests
If a DPH staff receives a request from the news media for information, the DPH staff must immediately notify their RL of the request. The RL must forward this request to the Program Director and the Contract Program Manager. Some requests may need to be forwarded to the State NG Public Affairs Office (PAO). DPH staff will not engage in any public media interviews without first presenting the request to their RL and receiving guidance on how to respond to the request.

b. Chain of Command
1. DPH staff must be respectful of Chain of Command within the NG as well as within the NGPHP. Program staff are expected to attempt to communicate and resolve problems and/or concerns at the lowest level. If the problem/concern cannot be resolved at the lowest level, the DPH may then take the matter to the next step in their chain of command. DPHs are to utilize their NGPHP Leadership to seek advice and guidance on how to approach and resolve problems related to their clinical/program duties. For specific guidance on where the DPH is in their chain of command and what is expected for communications within that chain of command, they should consult with their RL and program leadership.
2. When communicating internally, DPH staff may send emails to anyone on the PHP Leadership team. However, when communication will be directed to whole organizations or to key stakeholders in external organizations, it must be first approved by the RL and the Deputy and/or Program Director.

c. Use of Social Media
1. PHP staff will follow the recommendations of the DPH Social Media Research Committee published on SharePoint. PHP staff are not authorized to utilize their own personal social media accounts to communicate with clients.
2. DPHs may be listed as a Program/Service on the State NG and the Joint Services Support System web sites. The DPHs name and contact information may be listed on these two web sites in order to encourage utilization of this service by NG Members. Any other listings on media sites must be approved by NGPHP Management, www.guardyourhealth.com, 703-607-2584.

d. Use of Titles
Staff may use the title of “Dr.” when they have earned a doctorate degree in a mental health related field from a University with accreditation recognized by their state or territory licensing body. Furthermore, the licensing body must also allow use of the title “Dr.” when acting under that license type.

1-28. High Profile, Emergent, and Crisis Event Communication Procedures
DPH staff will provide appropriate written communication during and following emergent events. These forms include Executive Summary reports (EXSUM), Situation Reports (SITREP), and After Action Reports (AARs).

a. EXSUMs. EXSUMs are written to address non-emergent topics and issues that arise when there is a need to notify chain of command or those who have a need to know. The guidelines for ExSum Reports include:
1. Nature of the issue/incident
2. Who is involved?
3. What is the impact on persons, programs, etc.
4. What are the controversies (if any)?
5. Recommendations
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b. SITREPs. SITREPs (Reference Policy # 306) serve the purpose of informing chain of command and those who have a need to know about the nature of a specific incident that has typically made a significant impact on a local NG or related military unit, and where it is clear that the situation will require monitoring and possible intervention over a period of time. The general format for a NGPHP SITREP is (similar to the guidelines noted above):
1. Date of Report
2. Date/time of incident
3. Description of the incident
4. Who
5. What
6. Where
7. Impact on persons and property
8. Why (if known)
9. Risk for continued harm to those involved in the incident
10. Forecast for immediate future/next steps (steps to mitigate continued risk)

c. AARs. AARs (Reference Policy #306 Incident Reports) are completed when an incident previously documented with SITREPS has largely concluded. If the nature of the incident allows for prompt handling and does not require monitoring or additional intervention over a period of time, then an AAR can be completed without the need for SITREP(s).

Section V
Communication Code of Conduct

1-29. Policy
Professional communication is to be encouraged among NGPHP personnel that will foster an organizational culture of mutual respect and collaboration. The policy includes standards for communication and focuses on respect in all areas and levels of employment. Etiquette, follow-up, enforcement, and accountability are integral parts of the policy.

1-30. Principles
Effective communication is dependent upon honesty, respect, integrity, and loyalty. These are essential to the existence and growth of the NGPHP. By maintaining high standards for communication, the NGPHP will gain respect throughout the NG community and will foster an atmosphere of fair treatment internally. Quality communication reduces conflict and increases our ability to collaborate as a program with state level stakeholders. This will lead to increased opportunity to serve SMs and their families. It is the responsibility of employees at all levels to conduct themselves professionally while communicating. It is the responsibility of the management of the NGPHP to ensure our verbal and written values are promoted and enforced.

1-31. Guidelines
a. General. All communication shall adhere to NGPHP values of Respect, Honesty, Accountability, and Excellence. Professional language shall be used at all times.

b. Verbal Communication. All PHP staff shall use appropriate volume, tone, and emotional control during verbal communication. PHP staff shall refrain from using profane language, offensive gestures, and racist, sexist or otherwise prejudiced language, harassing comments, or threatening actions.

c. Written Communication in General
1. Written documentation shall be provided when changes to essential program processes or procedures have been made to ensure they are understood by all parties.
2. Written communication should always be reviewed for proper spelling, grammar, and syntax. This is a basic requirement for all written communication including email. Failure to produce quality written correspondence reflects poorly on both the author and the organization.
3. Always use a “second set of eyes” to review written correspondence.

d. Email
1. Email is an important form of communication; it is valuable for quick dissemination of information to a large audience, documentation of actions and policies, and one-on-one correspondence. Care must be taken in the tone of the email. Employees should not write something in an email that you would not say in person. Pause and re-read the email before sending to ensure it is not offensive or confrontational.
2. Email is not a good medium for conflict resolution and should not be used as such. If agreement cannot be reached after the second round of email exchange, then the issue must be resolved by a phone call or meeting.
3. Self-edit the use of e-mails for controversial issues or those circumstances where there is apparent interpersonal conflict. Use of professional stock phrases (e.g., “It seems like we have some issues to work through, so please let me know when I can call you to go into this in more detail.”) in highly charged situations is preferable to lengthy e-mails denoting personal thoughts about a situation. Under no circumstances is it appropriate for e-mails generated by NGPHP personnel to contain:
   (a) Threatening language, including unfounded allegations of misconduct (If an individual feels the need to report alleged misconduct, it may be reported via e-mail to the reporting person’s direct supervision, the Deputy Director, or the Program Director, and should be labeled as “CONFIDENTIAL” in the e-mail subject line).
   (b) Use of obscene language, pictures or symbols
   (c) Confidential customer, client or company information (unless as part of a confidential discussion, and the e-mail is appropriate labeled "CONFIDENTIAL", "FOUO" (For Official Use Only), or “CLASSIFIED", as best fits the situation.
   (d) Overuse of the “cc” line. Care shall be taken in deciding to whom a courtesy copy (cc) of an email will be sent. Think through who needs to have the information and make sure they are copied on the email. Do not copy upper levels of management in the chain of command unless they have a need to know.
   (e) Wallpaper backgrounds, as they are not appropriate for business use. All email shall be sent using the standard white background.
   (f) Large and elaborate signatures, lengthy quotes, and lengthy confidentiality statements shall not be used in emails. Staff signature blocks shall be employed for all e-mails of a formal nature to provide those receiving the e-mail an opportunity to know the name and title of the sender, the e-mail contact information, and the telephonic contact information of the sender.
   (g) Anything other than mission related material. The use of NGPHP Distribution and Contact Lists are for business purposes only. Use of NGPHP Distribution Lists other than the Group Discussion List, must be approved by the RL.

1-32. Responsibilities
a. Treat others with respect.
1. In general, people acting on the NGPHP’s behalf should aim to be honest and ethical in their dealings with each other, with community members, state stake holders, partners, suppliers and the public.
2. The NGPHP will not practice or tolerate discrimination on the basis of place of origin, ethnicity, citizenship, gender, age, political or religious affiliation, sexual orientation, marital status, family relationships, economic or medical status. The NGPHP shall treat all people with respect, and will foster a productive environment free of harassment, intimidation, or discrimination.
3. People acting on the NGPHP’s behalf shall adhere to weapons possession laws and regulations of each state, territory and military facility.
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b. *Respect confidentiality.* People acting on the NGPHP’s behalf must respect and maintain the confidentiality of sensitive information they have gained due to their interactions with the SM and their families.

c. *Maintain accurate, honest and complete documentation.* The DPH staff clinical records must be maintained in appropriate detail and must conform both to applicable law and to the NGPHP’s Clinical Documentation Policy.

d. *Represent the best interests of the NGPHP.* People acting on the NGPHP’s behalf should aim to advance the NGPHP’s legitimate interests, and should never do anything that could bring the NGPHP into disrepute.
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Section VI
Professional Ethics and Conflict of Interest

1-33. Policy
NGPHP staff will maintain ethical, professional relationships with SMs in compliance with all NGPHP and NG policies, licensure guidelines, and regional laws.

1-34. Definition(s)
Conflict of interest: Any relationship or interaction with a SM that is exploitive, personal in nature, or presents risks for DPH employers and NGPHP or customer companies.

1-35. Procedures
Ethics Laws and Regulations
a. The DPH will ensure all services comply with guidance in this document and applicable Federal, State, DoD, Army and Air Force laws and regulations.

b. The DPH must be at a minimum a Masters level, independently licensed mental health professional in state or territory in which the DPH engages in the practice of mental health services.
   1. As a state-licensed mental health professional, DPHs are responsible for fulfilling any and all requirements specified by their state licensure board for license renewal in good standing, and being in full compliance with the code of ethics and conduct established by their profession and state licensure board.
   2. The DPHs are responsible for identifying any areas where their roles and practices as DPHs may be in conflict with the expectations/requirements of their state licensure board and notifying the RL of these potential conflicts for further consideration. Appropriate courses of action, if needed, will be determined to ensure proper resolution of these conflicts.

1-36. Ethical Behavior – Professional Boundaries and Relationships
DPHs will practice in an ethical manner according to the professional guidelines of their licensure.

a. Any NG member is a potential client. All relationships with NG members must be of a professional nature. Unprofessional behavior includes, but is not limited to, physical or emotional involvement with an NG member.

b. If the DPH has pre-existing personal relationships with NG members (i.e., prior to employment as a DPH), he or she needs to proceed with caution. A personal relationship is defined as a friendship or romantic relationship. If the DPH is uncertain what qualifies as a personal relationship, the DPH will contact his or her RL to discuss. If someone with whom the DPH has a personal relationship, or if the DPH has a personal relationship with someone closely associated with or related to that person, seeks the services of the DPH, the DPH will contact his or her RL to discuss the situation prior to proceeding. It may be appropriate to refer the individual to another resource.

c. Outside Employment
   1. DPHs should limit outside employment to five to ten hours per week. Time and stress management are also keys to the success of any employee.
   2. Outside employment must not negatively impact or restrict the DPH’s ability to complete his or her assigned work week or to perform any of his or hers contracted duties.
   3. To answer and respond to an emergent phone call from his or her leadership and may be expected to return to the command at a moment’s notice. At a minimum, this would necessitate formal agreements with outside employers recognizing these DPH responsibilities to the NGPHP. In cases when the DPH is facilitating a private practice, ethical considerations must be a priority in the event the DPH is required to leave a private practice session unexpectedly.
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4. At a minimum, this would necessitate standard informed consent notifications to private practice clients regarding the DPH’s need for last minute cancellations, shortening of a session, or leaving unexpectedly. In addition, it would necessitate a pre-arranged backup plan that could be implemented on a moment’s notice in the event of a crisis situation coincided with a crisis situation involving a private practice client. This pre-arranged backup plan will be submitted to the RL for review.

d. Healthy boundaries within the PHP - It is important to remember the DPH’s chain of command is as follows: RL, Deputy Director, National Director, Program Manager and Contractor. The DPH’s role within their assigned military organization is to provide three main services: Operational Leadership Consultation, Operational Support Services: Community Capacity Building, and Direct Client Services.

e. Social networking such as Facebook, My Space, Twitter, etc., initial guidance entails the DPH will be restricted from forming social media/networking connections with service SMs or their FMs. More detailed guidance is being researched and developed for future implementation by the Social Media Committee.

1-37. Conflict of Interest
The role of the DPH is to only provide information, assessment and referral to the appropriate resource to assist SMs who are seeking help on a variety of issues. This service requires DPH staff to strictly follow the procedures listed below:

a. DPH staff will not personally benefit, in any way from the services they offer SM’s

b. DPH staff will not refer SMs to his or her own private business, nor to any person or business with whom they have a personal or financial relationship.

c. The DPH will not accept anyone eligible to become an NGPHP client or his or her FMs as a private client.

d. DPH staff will not assist SM’s in establishing a complaint, claims, or litigation against the NG, DoD, DPH employers, fellow employees, or other customers.

e. DPH staff will not establish personal relationships with SMs or former SMs using DPH services at any time under any circumstances while an employee of the NGPHP.

f. DPH staff immediately transfer SMs with whom he or she has had prior personal contacts to another consultant.

 g. Whenever possible, DPH staff will not refer SMs acknowledging a personal relationship with another SM or from the same household to the same provider.

h. DPH staff will immediately bring to their RL any situations that present a personal, moral, or ethical dilemma.

i. DPH staff will not offer preferential treatment to any SM. DPH clinical staff credentialed and licensed as mental health professionals will not be allowed membership in any of the DPH employer’s EAP affiliate networks to avoid any conflict of interest in serving SM/FMs.

1-38. Exceptions
Affiliate provider referrals in rural areas where a temporary affiliate cannot be developed. When referring SMs acknowledging a personal relationship with another SM or from the same household to the same affiliate provider, DPH will inform provider to stagger appointments.
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Section VII
DPH Back Up Policy

1-39. Policy
The Directors of Psychological Health (DPHs) for both the Army National Guard (ARNG) and the Air National Guard (ANG) shall provide back-up support for one another during behavioral health emergencies, when responding to critical incidents, and when local NG units are responding to disasters as part of a Domestic Operations (DOMOPS) response.

Back-up support during absences shall be managed, when possible, by DPHs within the same military branch. When that is not feasible, DPHs from the other military branch shall provide limited on-call, consultation, and emergency services only, unless otherwise authorized by the RL, Deputy Program Director, or Program Director of the branch providing the back-up service.

Local NG requests for behavioral health surge support for extraordinary incidents requiring on-site response or travel shall be communicated immediately to the RL, who shall contact the branch Program Director or Deputy Director to determine an appropriate, timely response.

1-40. Definition(s)

a. **DPH Back-Up:** A DPH who is substituting for an absent DPH, or providing additional support in a surge support effort. The DPH Back-Up is licensed at the independent level in the same state or territory as the DPH in need of support, and is preferably a DPH providing services to the same branch as the absent DPH. Where there is no DPH available for back-up services within the same military branch, a DPH from another military branch licensed at the independent level in that state or territory may provide back-up services. When other DPHs are not available, a Behavioral Health Officer or other behavioral health assets in the local NG unit may be acceptable, subject to RL approval. Should none of the above be available, the RL is responsible for the provision of back-up services.

b. **Behavioral Health Surge Support:** The use of all available DPH professionals, regardless of branch assignment, to address the behavioral health needs of SMs. The request is authorized in writing (e.g., e-mail) by a command-level NG authority (i.e., the Chief of Behavioral Health for either the ARNG or ANG PHP, or the Deputy or Joint Surgeon of the NG Bureau), and must involve an incident or situation requiring a response that is beyond the capacity of existing branch-specific resources, which would include Behavioral Health Officers, 68X Mental Health Technicians, Case Managers, and others assigned to respond to behavioral health-related incidents. The circumstances will need to be communicated to the RL, and the Program Director or Deputy Director, to determine the amount of resources needed to address the concerns highlighted within the request.

1-41. Procedures

a. **Planned Back-Up Coverage Procedures:** DPHs will notify their RL of the specific days of needed coverage at least two weeks prior to needing coverage. The RL will contact the RL supervising the prospective Back-Up (if other than self) and request Back-Up support for the days specified. Should the prospective Back-Up have an emergency that changes their availability, he/she will immediately notify the RL and DPH. Should the DPH and RL be unreachable, the Provider will notify the Deputy Director or Program Director.

b. **General procedures for back up services are:**

1. Back-up coverage for any absence is required. Development of a written contingency plan is an essential part of this back-up coverage requirement.
2. If the DPH will be unavailable or on leave, they will indicate their contingency plan instructions via their voicemail. The contingency plan should include contact information for each backup contact. The DPH will form the contingency plan, have it approved by the RDPH, and then will share it with the POC.
3. Any and all absences will be coordinated with the RDPH. This coordination will occur in a timely manner.
manner and with as much advanced notification as possible. For unexpected or emergency absences, notification should occur as soon as possible. In situations where an unreported absence is discovered and contact cannot be established with the DPH, the RDPH will be responsible for activating the contingency plan for that Wing/Unit. If the Wing/Unit makes this discovery, they should contact the RDPH as soon as possible.

4. A copy of the contingency plan will be provided to the Wing commander, NG POC, RDPH for both branches, and each back-up contact included in the plan.

5. When the DPH will be away for more than two week days or work days due to vacation, leave-of-absence, or illness/or unexcused absence, appropriate options will be examined, including, but not limited to, back-up on-site coverage.

c. Program Regional or National Meetings procedures:
1. Each DPH will coordinate their standard contingency plans with their Wings/Bases prior to departure to ensure the key players/stakeholders are aware of their support roles during the DPH’s absence.
2. Each DPH will be responsible for monitoring their BB phones (at least one time per hour) for calls from their leadership/POC. They will use scheduled breaks and other lulls in the schedule to return non-emergent calls as needed. They will return emergency calls as soon as possible.
3. In more extreme situations and depending on the situation, the branch management team will confer and make decisions regarding the need to send a DPH back to their duty station prior to the end of the regional meeting. This has been done in the past and has been favorably received by NG leadership.

1-42. Procedures for Back-Up DPH (General)
While on duty as a DPH Backup, services include:

a. Provision of on-call behavioral health emergency clinical coverage 24/7 to NG SMs who are exhibiting signs and symptoms consistent with a behavioral health emergency.

b. Referrals from NG Leadership will be responded to as soon as possible after the DPH receives notification (generally one hour or less).

c. Clinical assessments using NGPHP established processes and procedures for behavioral health assessments in the state/jurisdiction of practice, generating diagnostic impressions using the current edition of the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association, as appropriate. Clinical consultation and coordination with officials of NG Leadership, Military Treatment Facilities (MTF’s), local Emergency Room clinicians, VA hospitals and clinics (as available), local agency law enforcement and mental health professionals, FMs, and others who have a legitimate involvement with the subject (s) of the assessment.

1-43. Emergency Response Guidelines
a. When the Back-Up DPH is contacted regarding an emergency case, the Back-Up DPH will determine the potential risk of harm to those involved and facilitate the emergency response, as appropriate, prior to briefing the RL (and other NGPHP Leadership, as available) and obtaining authorization to continue working on the case. For emergencies, refer to procedures in Policy 308 (Crisis, Emergency, Critical Incident, and Disaster Response).

b. Most initial contacts can be expected to require no more than two hours for an initial assessment of the situation.

c. The RL is to be contacted via phone or email within 24 hours after the initial assessment/stabilization for clinical consultation (such that notification and communication occurs in a timely manner).

d. Inclement weather or other conditions that are barriers to safe transport to the face-to-face site constitute adequate reason to not engage in face-to-face interviews. DPH back-up services shall
be provided in an office or public setting that offers appropriate privacy and promotes the safety of all concerned. In-home assessments and transportation of clients is not permissible.

e. Complete case note documentation (as described in Record Keeping section) on all cases, and brief the DPH for whom the Back-Up is providing coverage on all aspects of these cases upon return of the DPH. Unless otherwise arranged with the RL, this briefing shall take place within one business day of the DPHs return to duty.

f. The principles of emergency clinical practice as defined by the SAMHSA Core Elements in Responding to Mental Health Crises (Attachment 1) serve as the foundation for any behavioral health emergency response by personnel in the NGPHP. Similarly, the practice standards in the Psychological First Aid (PFA) Operations Field Guide (2nd Edition) (Attachment 2) serve as the foundation for all response to large scale emergencies and disasters.

1-44. Surge Support
The deployment of DPH resources is managed through prioritization of the following resources in descending order of availability and need:

a. DPHs within a state, territory or wing that are assets of a specific military branch (i.e., ARNG DPHs will support other ARNG DPHs, and ANG DPHs will support other ANG DPHs).

b. DPHs within the appropriate military branch and the region of the incident who are independently licensed in the state or territory.

c. DPHs who are within the appropriate military branch who are deployed to provide non-clinical postvention services.

d. DPHs from either military branch to provide non-clinical postvention services.

1-45. ANG and ARNG DPH Cross-Branch Support
a. In certain circumstances. In certain circumstances, there may be a need for cross-branch support of a DPH in the state. These circumstances may include temporary periods of DPH vacancy, extended DPH leave, local crisis requiring additional mental health support, or where geographic proximity facilitates a more effective delivery of PHP services to cross-branch SMs. Under the supervision of their RL, DPHs are available to respond and may be asked to provide services telephonically and/or in person where feasible, depending on the situation. The authority for provision of cross-branch services requires:

1. Approval of the RL and either the Deputy Director or Director of both branches.
2. RLs shall coordinate the services provided with NG POCs, and shall provide the DPHs providing services with support, training, and other assistance as necessary to accomplish the task.
3. RLs may seek out subject matter experts (SMEs) within either program on topics critical to the success of the immediate mission to assist DPHs providing Back Up services.
4. RLs involved in the supervision of Back Ups shall conduct a review of the services provide with either the Deputy Director or Directors of both branches.
5. The assigned RLs from both branches will collaborate in determining the appropriate level of DPH services required and will use the following thresholds in authorizing services:

(a) The supervising RL may authorize up to 8 hours per week of cross-branch support, to include routine, day-to-day PHP services.
(b) Assigned RL collaboration and consultation with a National-level Director from each branch is required to obtain authorization for anything beyond 8 and up to 16 hours per week of cross-branch support. Authorizations at this level should be carefully considered to ensure the DPH’s assigned-branch responsibilities are not neglected (compromised?) and their caseloads remain manageable.
(c) Any cross-branch support beyond 16 hours per week, for whatever reason, requires COR review and approval.
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b. In certain locations. In certain locations, NG SMs will have primary duty assignments (embedded) in cross branch settings/units. In these instances, the DPH serving in this setting will be available to provide routine, day-to-day PHP services to cross branch SMs, to include assessment, referral and case management services.

1. Primary duty assignments in cross branch settings/units are often temporary and/or task-specific within designated timeframes. When or if a SM returns to their home station or is assigned to a different unit where a different DPH is providing services, the managing RLs will oversee and ensure the proper transfer of clinical case coverage and management to the appropriate DPH, as needed.

2. Data tracking/collection processes and procedures will ensure the integrity of branch-specific information.

c. DPHs providing Back Up clinical services. DPHs providing Back Up clinical services to cross branch SMs or FMs shall:

1. Assess the SM’s situation and determine the most appropriate clinical course of action to stabilize that member and ensure they are receiving the required support and standard of care.

2. For FMs, the DPH shall provide referral resources and provide a warm handoff to those services, subject to the wishes of the FM. The ARNG DPHs may elect to provide additional consultation services, depending upon the problems presented, and should seek RL consultation in these situations.

3. Ensure the client’s required care is properly in place, and will work with the POCs identified by the RL and/or local branch Leadership in establishing a proper follow-up and after-care plan necessary to support the client upon their release from professional treatment/care.

4. Prepare a summary AAR to document the essential factors involved with the case and retain it until a designated MH professional representing the supported branch is available to receive the summary AAR.

5. Be available telephonically to consult with the appropriate or designated cross branch leadership to sustain proper standards of care and support plans for the client who is in crisis.

6. Keep their RL updated concerning services rendered to cross branch clients and the RL will communicate this information to the absent DPH’s RL (if they happen to be different).

7. Provide a back brief on services rendered to any cross branch clients and provide clinical documentation information in order for the branch CPH to follow up.

d. Record Keeping, Confidentiality and Ethical Standards

1. Maintain accurate, written clinical records of services provided per NGPHP policies and formats.

2. Keep all client names and identifying information confidential per HIPAA and local licensing/mandated reporting requirements.

3. Maintain professional relations with clients per the professional standards of local state licensing laws, requirements, and regulations.

4. Refrain from making referrals for additional service to self or to colleagues in a practice in which the contractor is a member.

5. Maintain professional boundaries regardless of personal opinions about the military, government or war.

6. Follow RL guidance related to communication with the press/media.

1-46. References

a. PHP Policy 307: PHP Incident Reports

b. PHP Policy 308: PHP Critical Incident Response

Section VIII
DPH On-Call Services

1-47. Policy
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Directors of Psychological Health (DPHs) for the Army National Guard (ARNG) shall ensure that access to services exists on a 24 hours/7 days per week basis. Services may include a range of direct, person-to-person services, electronic communications (e.g., telephone and e-mail), or access to emergency services after duty hours.

DPHs shall respond to either NG or PHP Leadership requests for emergency consultation within one hour of receiving the contact during time periods when the DPH is engaged in On Call duties. Local notifications from Leadership may include calls from the JOC, or specific unit leaders as defined in a notification and alert protocol. These protocols are developed by local NG units, and coordinated with the DPH and the RL.

Time spent responding to On Call duties shall be documented by the DPH, and adjustments to the work schedule shall occur during the pay cycle. Coordination with local NG POC and program RL is required prior to flexing time off to compensate for work while providing On Call duties. DPHs cannot provide services beyond the 80 hours in a work cycle, which may be adjusted for local state employment laws. As exempt contract employees, DPHs are not authorized to receive overtime payments for work beyond their scheduled work cycle hours.

1-48. Definition(s)
   a. Duty Hours: Hours of work in a typical pay cycle. DPHs are on a two-week pay cycle, and are contracted to provide 80 hours of work during those two weeks. The hours of work may be adjusted to conform to local NG work schedules, subject to the approval of the POC and the RL.

   b. Notification and Alert Protocol: A set of procedures that specifies the criteria for notifications and alerts, and includes the contact information of key personnel in the notification and alert chain of command. For behavioral health situations, this typically involves setting the criteria for the reasons for notifications and alerts (e.g., suicide attempt), the individuals that need to be notified, those who require notification of the primary responders are unavailable or non-responsive, and the obligations of those in the notification chain once messages have been received.

   c. On Call Duties: Time spent after duty hours to respond to emergencies and/or time sensitive issues based on contacts made by NG or PHP leadership.

1-49. Procedures
   a. On Call Duties in States/Territories with Existing Rotation Systems: States or territories who manage locally developed on call systems, which include organic resources of the NG unit, may include the DPH in those rotation systems subject to the work hours restrictions cited within this policy. It is the responsibility of the DPH to work with the POC and RL to ensure that compensatory time is taken off for those hours worked while in the On Call status during the pay cycle.

   b. On Call Duties in States/Territories with Two ARNG DPHs: States and territories that have two ARNG DPHs will develop a locally acceptable practice of rotation of On Call duties between the two DPHs, and other local assets as deemed appropriate by the POC.

   c. On Call Duties in States/Territories with One ARNG DPH: DPHs who are the lone contract provider of psychological health services in their state or territory are urged to work with other support services personnel to develop an On Call system that does not rely solely on one individual. Such systems might include others in a notification and alert system that might include Behavioral Health Officers, Chaplains, military medical personnel, and local civilian resources (e.g., local civilian emergency mental health services). In such circumstances, others could be trained to provide initial, triage-based services, referring only to the DPH when the situation constitutes an emergency.
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**d. Voice Mail and E-mail DPH Communication After Duty Hours:**

1. DPHs shall provide voice mail and e-mail out-of-office messages that provide those who are making contact with viable options for addressing problems and issues. Such options include, but are not limited to:

2. Provision of phone numbers and e-mail addresses of local military and civilian emergency mental health services, as available:
   (a) Provision of phone numbers and e-mail addresses of local civilian hospital emergency room.
   (b) Emergency room contacts. In some areas, web sites have this information.
   (c) Provision of times when the DPH is engaged in routine duty hours.
   (d) Provision of 1-800 phone numbers and/or internet sites or e-mail addresses of military and civilian crisis response services.

Section IX
Investigations of Complaints Made Against Program Personnel

1-50. Policy

When complaints are made against PHP program personnel, Supervisory-level personnel shall obtain detail from the complainant regarding the nature of the complaint and expectations of the complainant. The Human Resources representative of the employing company shall be immediately consulted after receipt of the complaint, and company policies and procedures regarding employment practices of that company shall be followed. Investigations shall be conducted by an employee of the same company as that of the employee under investigation in accordance with that Company’s policies/procedures and the Program guidelines. Notifications of the branch Program Director, Deputy Director, and the Contract Program Manager shall be made by the Company’s PHP Manager no later than COB on the day of receipt of the complaint. The Program Director or Deputy Director will work with the Company’s Human Resources Department to appoint an investigator employed by the same company as the PHP employee under investigation.

Where complaints involve the potential for impacting the safety of any of the participants involved in the situation, measures shall be taken to promote the safety and welfare of these individuals. This may include immediate assignment of the affected individuals to alternative work settings, and may require directives to individuals to not have contact with others involved in the complaint. In incidents involving the threat of harm to self or others, precautions shall be taken that may include referrals of affected individuals to mental health or law enforcement authorities. The workplace safety and violence prevention policies of the employing company shall be adhered to promote the safety for all concerned.

Once the investigation has been completed, senior Leadership in the program and the employing company will make a determination as to the disposition of the complaint. Both the complainant and the employee(s) involved in the situation shall be informed of the disposition, and be provided with appropriate guidance and resources to address the remediation plan. The employee’s supervisor will be included in the process, and will have responsibility for follow-up and any plan-generated compliance monitoring (e.g., performance improvement plans, etc.).

1-51. Applicability

All employees of the NGPHP, unless the employing company policy and procedure provides an alternative method for intake, investigation and disposition of complaints by employees, SMs, or others.

1-52. Procedures

a. *Complaint received by company or program employee.* The individual receiving the complaint shall document the date and time of receipt. If the complaint is telephonic, he/she shall make every effort to interview the complainant with an objective, information-gathering perspective, attempting to understand the perspective of the caller and their concerns. The individual receiving the complaint should not agree with the perspective of the complainant,
but agree to assist them to make sure that the concerns expressed will be investigated in a fair manner by program or company Leadership. The Employee Complaint Form (attached) shall be used to document the concerns of the complainant.

b. The individual receiving the complaint. The individual employee should make immediate contact with the Human Resources representative of the employing company of the individual(s) named in the complaint.

c. If the complaint is of an internal nature. If the complaint is of an internal nature (i.e., employee complaint against another employee), the supervisors of the employees involved shall be notified of the complaint. The supervisors and Human Resources representatives shall consider the nature of the complaint, and determine if a recommendation for temporary suspension of partial or all duties. Such recommendations shall be immediately communicated to Program Leadership and Prime Contract Leadership for disposition.

d. If the complainant is an SM. If the complainant is an SM, Program Leadership and the Contract Program Manager shall be notified immediately, and they shall notify NGB Leadership as to the nature of the allegations and the steps being taken to address the complaint.

e. Human Resources. Human Resources representatives shall contact with company and program leadership who shall appoint an investigator; the investigator shall be supervisory level and preferably an employee of the same company as the employee under investigation. Health Net would conduct the investigation if our associate complains or has a complaint lodged against them. Health Net would then confer with the Prime/Program Leadership on the recommended follow up actions.

f. Personnel Investigation Format. The attached “Personnel Investigation Format” shall be employed in all investigations, unless the employing company has a different procedure to be followed. Release of the investigation to external sources will follow Company policy. (1) Once completed, the investigation results shall be to company and program Leadership for disposition, as appropriate. (2) Release of the investigation to external sources will follow Company policy.

g. Consult. Program Leadership shall consult with company leadership to consider disposition of the complaint.

h. Findings and Disposition. Findings and disposition shall be communicated to the employee(s), complainant, and the employee’s supervisor. The employing supervisor is responsible for follow-up of the plan, including any supervision and monitoring requirements. If the complaint involves SMs, NGB shall be notified of the disposition.
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Section I
Field Operations Policy

2-1. Policy
NGPHP personnel shall emphasize the support of DPHs providing both clinical and non-clinical services to SMs and their families. The service delivery model employed incorporates the spectrum of prevention, early intervention, crisis response, and postvention (i.e., aftercare/recovery), and evidence-based practices as established by scientific studies and government agency and professional association recommendations for best practices. Clinical services shall be provided by addressing the acuity/severity of mental health signs and symptoms, and provide efficient methods to assist SMs to access effective clinical services in a timely manner.

2-2. Strategic Service: Operational Leadership Consultation

a. Advisor to NG leadership
   1. The primary role of the DPH is to be an advisor and consultant to the NG leadership on the psychological health of the NG population.
   2. The DPH encourages and coaches the NG leadership to actively promote psychological health and help-seeking as part of the NG culture.
   3. DPHs are active in supporting military leadership in addressing the psychological health of the units under their command. All DPHs assist leadership in understanding the interface between psychological health and operational readiness, and the role of the DPH in developing and helping leadership apply psychological health solutions to functional/operational problems.

b. Consultant to Unit Leadership
   1. The DPH encourages and coaches unit leadership to actively promote psychological health and help-seeking as part of the wingman/battle buddy culture at the military unit.
   2. The DPH consults on workplace issues identified by unit leadership, e.g., unit cohesiveness, conflict in the unit, unit stressors, etc. These issues may affect individual or unit performance. Consultation with leadership may include, but is not limited to, coaching and change management.
   3. The DPH provides an NGPHP briefing to newly-appointed commanders and others in leadership positions as they assume new leadership roles, to include key unit leadership; including, Group/Battalion, and Squadron/Company Commanders and First Sergeants.
   4. The DPH conducts annual training for unit leadership on psychological health issues and the NGPHP.
   5. The DPH provides psychological educational presentations tailored to the needs of the unit, to include leadership-specific training.
   6. The DPH educates NG leadership on how to recognize and assist individuals experiencing psychological health conditions.
   7. If a supervisor or commander would like a member to seek psychological health services, he or she should call and consult with the DPH to avoid unnecessary use of CDE. Leadership may recommend or encourage the member to visit the DPH, but only as one of several options suggested to the member. Providing options helps ensure the referral is not coercive or directed.
   8. The DPH will NOT conduct command-directed evaluations (CDEs). CDEs are governed by DODD 6490.1, DODI 6490.4, AFI 44-109, and AFI 44-172, nor may they serve as the mental health gatekeeper to a CDE.
      (a) If a CDE appears to be the appropriate course of action, the DPH will refer a supervisor to their commander and a commander to the Inspector General (IG), Judge Advocate General (JAG), and Mental Health at the servicing Military Treatment Facility for guidance on the process.
      (b) DPHs are bound by laws of confidentiality and will not discuss client information with the referring supervisor or commander unless the NG member has signed a release of information form authorizing the release of specific information. The exception to
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9. After hours, the DPH will generally be available via telephone to consult with leadership command. See Policy 106 for a further description of after-hours DPH support.

10. In a crisis situation, leadership may consult, give a heads up, or even call the DPH into action in extreme situations (e.g., recall to their assigned military unit for a natural disaster response).

11. If leadership is concerned about an individual, in a potentially life-threatening situation, the DPH's role is consultative only. The DPH will provide professional and situational advice.

c. Community Capacity Building

1. The DPH raises NGPHP awareness inside and outside of NG through a standardized briefing. The NGPHP Briefing is designed to increase awareness of the program, including who is eligible for services, how to access the DPH, and the limits of confidentiality. The DPH may tailor the briefing to be a quick introduction, or a more in-depth presentation.

2. The DPH uses the in-depth program briefing for leadership, medical personnel, and other helping agencies.

3. The DPH educates NG personnel on how to recognize and assist individuals experiencing psychological health conditions.

4. The DPH educates NG personnel on psychological health emergency and crisis response resources, such as crisis hotlines.

5. The DPH fosters collaboration and cooperation, and network with other NG and civilian resource agency representatives. In the ANG, this collaboration will be accomplished through the Community Action Information Board (CAIB) and Integrated Delivery System (IDS). In the ARNG this is accomplished through the Joint Operations Center (JOC), and working with the J-1 or J-9 at the local level.

6. The DPH will support the NG in their resilience, Comprehensive Airman/Soldier Fitness, suicide prevention, and wingman culture efforts (for ANG DPHs).

7. Deployment Support – To the extent possible, the DPH will brief all NG members leaving for and returning from deployments about the PHP and other potential impacts of the deployment cycle. He or she will support and consult with Yellow Ribbon Reintegration Program representatives. Additionally, the DPH will coordinate their participation in these events with their POC and RL.

8. The DPH will coordinate with leadership to visit work areas and engage regularly with SMs. Except while seeing clients in private sessions, much of the DPH's work is conducted outside of the office.

9. Any informal interaction between the DPH and an eligible beneficiary, where information is provided and/or a resource is suggested, is categorized as information and referral. For example, when the DPH is walking through a unit and someone asks the DPH where they could get help making a budget, the DPH may refer them to the Family Readiness Program Manager. This exchange is considered an anonymous information and referral and the interaction would not constitute the need for case management-related services for that eligible beneficiary.

d. Annual Program or Strategic Plans

1. The DPH will annually develop and submit a prevention and outreach (Annual) plan to the RL.

2. The DPH will take into account the changing needs of the wing, state, and/or territory and will enhance and build upon previous years of psychological health promotion when developing the plan. Sources of information for plan development may include the Airman Needs Questionnaire, Unit Risk Inventory (URI), other AF or Army surveys/assessments, and data collected for the CAIB, Unit, MEDCOM, and JOC.

   (a) The SMs Needs Questionnaire or Unit Risk Inventory may be used to gather data from wing personnel to informally gain a sense of what would be helpful for the wing
or unit and the NGPHP.
(b) The DPH must present a methodology for gathering this information to the NG
leadership or designee for approval prior to collecting information.

e. The DPH will coordinate the plan with the wing IDS (for ANG) and with the Deputy State
Surgeon (for ARNG). ANG DPHs will submit their plans for inclusion in the wing’s
Community Action Plan.

f. The DPH Annual plan will, at a minimum, address:
1. State/Wing-specific or local community issues and challenges
2. Projected psychological health promotional activities, events, presentations, and program
briefings, to include new member orientations
3. Projected contacts with NG leadership, including supervisors
4. Planned participation in meetings with NG and community partners
5. How, to the extent possible, the DPH will brief NG SMs annually to increase and maintain
awareness of the NGPHP.

e. **Psycho-Educational Presentations, Trainings, Workshops, and Orientations**
1. The DPH will use approved presentations only, whether in PowerPoint or talking point
format. Approved presentations include any presentation developed by the Air Force,
Army or NG, as well as DPH-developed presentations approved in accordance with the
presentation approval process identified in this policy.
2. These evidence-based presentations may be tailored to the audience.
3. The DPH will coordinate at the appropriate level to schedule training sessions,
orientations, or briefings at mutually agreeable times.
4. The DPH is encouraged to notify other DPHs in the geographical area when
presentations are offered so they may refer other SMs as appropriate.
5. The DPH will distribute and collect evaluation questionnaires with every psycho-
educational presentation when 30 people or less are in attendance or when the number
of attendees are at a manageable level to do so.

6. Developing a Presentation
   (a) Check SharePoint for existing presentations.
   (b) Develop new oral and written psycho-educational presentations and materials,
   including protocols and curricula to effectively meet customer needs.
   (c) When developing a presentation, DPHs will use evidence-based approaches as
   much as possible, presenting accurate, updated information.
   (d) Develop the presentation using an NGPHP-approved template and accompanying
guidelines.
   (e) Utilize NG-provided distance learning technologies when requested by the POC.

7. Presentation Approval Process
   (a) The DPH will submit presentations for approval in accordance with guidance by their
   RL.
   (b) If a short-notice presentation is requested, the DPH will note in the subject line:
   URGENT – Presentation Approval Needed (insert date).
   (c) Once the presentation is approved, it is placed in the DPH Presentation Library,
currently housed in SharePoint.

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**Section II**

**Clinical Documentation Timeliness Policy**

**2-3. Policy**

DPHs shall strive to complete their clinical reports in a timely manner. The standards adopted by the
NGPHP regarding timeliness of submitting clinical documentation are noted below. These standards
adopted by the NGPHP are in accordance with the highest standards in the industry. This policy
applies to all personnel in the NGPHP.
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2-4. DPH Clinical Documentation
   a. Daily Activity Tracking Log
      1. May be submitted via SharePoint.
      2. Is due by noon the following business day after the previous work day.
      3. The RAA will conduct a weekly audit between Monday noon through COB for the
         previous week and email results to the RL. The RAA is responsible for electronic
         archival of these records.
   
   b. Intakes
      1. May be submitted via SharePoint.
      2. Intakes may take more than one appointment to gather data. The individual
         appointments and collateral contacts that comprise the intake must be entered into
         SharePoint within 24 hours of the contact. Referral follow-up information is to be
         completed in SharePoint 6 weeks from the date of the intake. Timeliness of referral
         follow-up is based first on clinical need, but should not exceed 6 weeks.
      3. The RL will audit a minimum of 1 intake for each DPH per month by no later than the last
         day of the following month. Audits are to be completed and submitted to the Deputy
         Director in the approved format by COB on the last day of each month.
   
   c. PRS Progress Notes
      1. May be submitted via SharePoint.
      2. Are due within 24 hours from the date of service.
      3. The RL, as part of the intake audit, will also audit all progress notes associated with the
         specified intake. Audits are to be completed and submitted to the Deputy Director in the
         approved format by COB on the last day of each month.
   
   d. Corrective Actions for Non-adherence
      Staff members failing to adhere to the NGPHP Clinical Documentation Submission Timelines
      Policy may receive a:
      1. Verbal or written warning (1st)
      2. Mandatory re-training session with RL and/or Deputy Director (2nd)
      3. Meeting between DPH, RL, and POC (3rd)
      4. 30-day Performance Improvement Plan (4th)
      5. The staff member’s company supervisor and/or company HR representative will receive
         an email notification for each of the events above from the RL.

Section III
DPH Clinical Consultation with RL

2-5. Policy
   All full-time or backup DPH staff will have supervision and access to telephone consultations when
   clinically indicated with the DPH RL.

2-6. Definition(s)
   a. Clinical Consultation: An ongoing process of quality assurance designed to generate
      feedback helpful in the professional development of staff DPH staff. It is a process in which
      RL, as supervisor, review cases for accurate assessment and documentation, appropriate
      care, customer service, professional liability, and DPH debriefing.
   
   b. RLs: Independently licensed mental health professionals experienced in short-term problem
      resolution and employee assistance services. In the PHP (NGPHP), administrative
      supervision and clinical guidance is provided by the RL to Directors of Psychological Health
      (DPH).

2-7. Procedures
   a. Clinical consultation is available to DPHs 24 hours a day, 365 days a year.
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b. RL shall discuss all high interest cases with DPHs. High interest cases include all of the following: reactivated cases; cases involving alcohol and/or other drug use; risk, threats or actual acts of violence; child, elder or partner abuse/neglect; positive alcohol or other drug test results; and other cases selected by the DPH based upon need for consultation.

c. DPH staff shall document all clinical consultation in the client case record on the appropriate forms (Intake Form, Consultation Form, and Progress Note Form).

d. All potentially reportable cases, especially ones that include risk to self or others, the NG, the Department of Defense, the general public, and GBGHS must be reviewed for quality standards by a RL.

e. RL shall take steps to ensure adequate knowledge of state laws are appropriately integrated into the delivery of services. RL shall take steps to ensure that DPH staff are sensitive to possible special needs of SMs or their families.

f. Clinical consultation with a RL should not be considered "clinical supervision" which is typical an activity governed by state/territory statutes.

NOTE: See Policy #304 “Consultation and Program Development” for a more detailed review of consultation.

Section IV
Internal Quality Assurance and Continuous Quality Improvement

2-8. Policy
The NGPHP (NGPHP) shall apply a protocol to ensure that high quality direct services are being provided by program clinical personnel, and for case management of sensitive or high profile cases. The NGPHP will ensure the utilization of confidentiality standards and the Privacy Act for a compliant clinical record management systems. The NGPHP will implement policies and procedures to ensure and verify that services being performed by the program are performed according to acceptable standards. A program improvement plan shall be developed and implemented in a timely manner in any circumstance where noncompliance is identified.

2-9. Procedures
a. Clinical Consultation

1. All DPHs within the NGPHP will have clinical consultation available to them 24 hours a day by a RL, Deputy Director, or Program Director. Leadership staff are available telephonically or via e-mail for contact by the DPHs for emergency clinical consultation 24/7. For planned absences, the RL will identify and communicate to their DPHs, back-ups and other stakeholders the backup supervisor that will be available for supervision and consultation during periods of absence.

2. RLs will provide each of the DPHs assigned to them with at least one (1) hour of telephonic supervision every other week. Face-to-face supervision will be provided a minimum of one (1) time every three (3) months during a DPH’s first year of service, or if under a performance improvement plan or otherwise involved in a progressive disciplinary process. The frequency of face-to-face supervision for DPHs will be dictated by clinical and administrative need on at least an annual basis.

3. Each RL will maintain a State-Indexed Reference Manual that lists each of their supervised state’s significant mental health laws including, but not limited to, legal requirements for duty-to-warn, licensure, the reporting of child and elder abuse and neglect, etc. Each RL will develop a basic knowledge of state laws of the states they supervise and will facilitate the integration of state law compliance into the DPH-based delivery of services.

4. RLs shall review all high interest cases during the course of consultation. High interest cases include all of the following:
   • compromised readiness to deploy;
   • reactivated cases;
   • cases involving alcohol and/or other drug use;
   • risk, threats or actual acts of violence;
   • positive alcohol or other drug tests;
• settlement agreements;
• critical incident response; and,
• other cases selected by DPHs based upon need for consultation.

Every high interest case is to be reviewed by the RL before the third session with the client (or when can be done in a safely and in a reasonably timely manner when responding to a critical incident). Consultation shall be requested by the DPH on each case when assessment reveals a risk of violence is present.

In addition, RLs will review each critical incident response and, when appropriate, make suggestions regarding corrective actions to be taken with respect to the critical incident as part of an AAR.

5. DPHs shall document high interest case reviews and consultation with their RL in the case record utilizing the NGPHP Consult Note. The RL will document case audits, priority case reviews and consultation utilizing the NGPHP Consultation Note Form filed under the DPH’s name in the NGPHP Case Management System. Case records reviewed by the RL will be documented by on a NGPHP Progress Note Form with a note indicating that the case record was reviewed.

6. The RL shall personally review a minimum of one (1) randomly selected case record for each DPH quarterly, including cases assigned to affiliate counselors when oversight of affiliate cases is provided by the DPH. When working with new DPHs, or whenever it is otherwise deemed appropriate, a larger sample of cases shall be reviewed. Program leadership will provide DPH staff with verbal and written feedback documenting points of interest from monthly case review. The Assessment, Referral and Case Management Policy (Policy 302) serves as an audit resource by RLs, as is the NGPHP Scope of Service Policy (Policy 100). When a DPH fails case audits for two consecutive months, the RL will utilize corrective retraining in order to promote future compliance. Ongoing or egregious clinical and administrative issues uncovered by the RL will be discussed with the Deputy Director or Program Director, resulting in a formal corrective action plan.

7. NGPHP Leadership will review the audit results of the RLs quarterly, analyze audit results (e.g. trends, isolated issues, actions taken or planned), and submit these results and recommendations quarterly to the Contract program Manager for review and forward to the Leadership Team.

b. NGPHP Staff Licensure and Insurance Tracking

1. The NGPHP Staff’s employing company shall complete a thorough qualification, reference, and background check on each of the employee upon hire. This process shall include, but not be limited to:
   (a) Confirmation that the candidate is a member in good standing of the professional organization most appropriate for his/her credentials; and,
   (b) Prime source verification of each final candidate’s current licensure by the appropriate state’s professional licensing authority.

2. DPHs are required to complete the DPH Master List within seven (7) days of their first day of employment. The DPH Master List requires DPHs to input and keep updated their clinical licensure and professional certification information (with expiration dates) and their professional liability policy number and expiration date. RLs will review the DPH Master List quarterly and remind DPHs to submit their renewals to the corporate Human Relations office for inclusion in personnel records.

3. NGPHP staff should be encouraged to consider supplementing corporate professional liability insurance with a personal malpractice insurance policy.

c. HIPAA and Privacy Compliance

1. The NGPHP Notice of Privacy Practices (NPP) and NGPHP Statement of client Understanding (SCU) are provided to each client at the outset of an assessment...
session. These documents describe the limits of confidentiality and the services available through NGPHP. NGPHP NPP and SCU includes consent information, any applicable HIPAA information or requirements, and other unique provisions of PHP that should be disclosed to the client.

2. The NGPHP Release of Information also is a document provided to the client if applicable. The NGPHP Release of Information Form enables the counselor to discuss the client’s case with a qualified professional at a referral resource, or with others as may be specifically authorized in the Release of Information.

3. All client medical and counseling-problem solving records, as well as any other information obtained (e.g., from client FM contacts with, or visits to NGPHP), will be kept in a confidential manner in accordance with Government / DoD requirements and the mental health system of records and Section 122 and 303 of PL 93-282, the Privacy Act of 1974 and 42 CFR, Part 2 “Confidentiality of Alcohol and Drug Abuse Patient Records.”

4. All client records maintained by the NGPHP are kept electronically or in locked file cabinet(s) at all times except when working on the case/record/file. To the extent feasible, electronic records are preferred in lieu of hard copy records. The RL is responsible for verifying that each DPH office containing client files has a working door lock and filing cabinets with bar locks. Should locking storage containers not be made available by the government at their work site, the DPH shall notify their RL, who shall work with program Leadership to remedy the situation. The DPH will provide their RL with the information on how to access keys/codes to gain admittance to client files if they should become absent.

5. Professional ethics and the principles of confidentiality stated in the Privacy Act will be adhered to at all times, with the exception of the limited confidentiality extended to any client who has divulged information that requires a mental health provider to report that information per applicable state and federal laws, guidelines and regulations.

d. Release of Information Tracking

1. Documentation of each incident in which there was a release of any information is tracked in the client’s record (e.g. date of release, reason for release, the person to whom information was released, what information was released and an original signed release).

2. In the event that the DPH is providing services to the client via telephone, the DPH shall communicate the full text of the ROI to the client through whatever means is available and acceptable to the client (e.g., FAX, scanning and attaching to an email message, or by reading it over the phone). TTY also may be used. The client’s consent to the release must be documented on the ROI, including the time consent was obtained and when and how the copy of the ROI was sent to the client.

3. All completed ROI forms must be placed into the client’s secure hardcopy file.

e. Data and Report Quality Assurance (data redundancy, integrity and transmission). All data, including email, SharePoint, and the PHP case records system, is transmitted via secured (encrypted) transport protocols meeting or exceeding current privacy law requirements. All PHP clients are assigned a Case ID and no Personally Identifiable Information (PII) is electronically stored. Lists which link case numbers to clients are stored in HIPAA compliant locked file cabinets at the DPH’s duty location. All digitally stored client records, which do not contain PII, are only accessible by authorized program personnel and stored on encrypted servers which are housed in a secure location. All data is backed up daily as part of an automated disaster recovery process. See Policy 204.

f. Report and Follow-up on Formal Complaints

1. Within two business days of receipt of any formal complaint about the NGPHP Staff’s provision of services, the Contractor shall provide the COR or designee with a description of the complaint and an action plan for resolution.
2. All Program complaints are inputted and tracked through the Contractor’s Complaints / Concern tracking system. This system provides a central repository for capturing complaints and concerns from all sources (including external government contacts, internal staff, and counselors) and managing them through resolution. The Quality Improvement staff updates the system with the new data, maintaining a historical record of complaints and concerns tracked by counselor and type of issue identified. In addition to monitoring internal processes, the contractor obtains external feedback on the quality of DPH performance, using feedback provided by NGPHP clients and ANG / ARNG leadership.

3. Investigations regarding complaints regarding staff conduct are orchestrated by NGPHP Policy 108 (Investigations of Complaints Made Against Program Personnel).

4. Complaints and actions taken are summarized in the CQI Quarterly Report. Review and analysis of complaint data by QA Team will result in the development of improvement procedures. Program improvement is tracked to ensure analysis and corrective actions addressed the root cause of the concerns. Actions and improvements made as a result of complaints are reported to NGB, JSG-PH Complaint Analysis is included in CQI Quarterly Report and reviewed by Corporate Oversight Committee.

g. Effectiveness of Services (Outcomes)

1. DPHs will utilize the Program Rating Scale (PRS) or other measures as designated by the NG Behavioral Health Branch Chief for the purposes of tracking client progress and gathering data on the performance of the program.

2. The PRS and/or other designated measures will be utilized for every contact with the client, whether in person or telephonically.

3. The DPH is responsible for collecting and reporting all NGPHP contact activities. This allows the NGPHP to better understand the DPH’s utilization of time, the scope of outreach efforts, the demographics of clients served, and other pertinent information.

4. The DPH will utilize the NGPHP Tracking Form daily to collect and report all NGPHP contact activities.

5. The DPH will ensure the NGPHP Tracking Form data is up to date in support of monthly reports for NGPHP and military leadership.

6. Other data will be collected, at the discretion of program Leadership, in various formats to support the quality of the program and other contract deliverables.

Section V
Storage and Release of Clinical Information/Records

2-10. Policy
The NGPHP maintains all case information, whether paper or in electronic form, in compliance with company and legal policies on confidentiality. This policy includes the storage and retention of records. Requests for release of records by SM/FM are processed within specific guidelines outlined below. In most circumstances, responses to record requests are only sent to the SM/FM directly or the SM/FM’s medical command, unit leadership, treating provider and/or treatment team. Typically, originals or copies of client information/records are not released to third parties, even if requested by the SM/FM (exceptions would be very specific, such as court-ordered release of records).

2-11. Procedures for Releasing Records Directly to a Client
a. Clients may request release of their records.

1. The request will contain the SM/FM's signature.

2. The request will contain the SM/FM’s address to which s/he wants the response sent.

3. The DPH will attempt to ascertain the reason for the request of records and determine how the case notes will be used.

4. Process the request if s/he is the case manager. If the DPH receiving the request is not the case manager AND the case manager is currently employed as a DPH, then the request may be directed to the DPH who is the case manager within one business day.
5. DPH staff receiving a request for release of SM/FM’s records MUST consult with his/her DPH RL. The DPH RL will consult with the Program Director or Deputy Director who will review the receipt of the notarized written request and any applicable case note documentation.

b. When responding to requests by SM/FMs for release of records, DPH staff may be asked to amend the SM/FM’s case record. DPH case notes cannot be altered once entered into the electronic record. However, DPH staff may add an addendum specific to their own assessment, notes, or observations of the SM/FM. SM/FMs or their legal guardians may request an addendum by sending a written notarized request to the Program Director or Deputy Director. The request from SM/FMs for amending records must include the specific additions and reasons for the addendum. The Program Director or Deputy Director will respond within 30 days of receipt of the request. All case note additions must comply with applicable laws and clinical guidelines. The Program Director and/or Deputy Director has the discretion to edit or deny the request. However, all denials must be reviewed by the COR and before NGPHP management responds in writing to the SM/FM.

c. DPH staff must then review the case with his/her RL and print out a report. The response must contain a cover letter with a statement that this is "PERSONAL AND CONFIDENTIAL"

d. The DPH must first review the response with his/her DPH RL. The RL will obtain final approval from the Program Director after receiving final approval from the Program Manager. The final response will incorporate any changes made by the reviewers.

e. The envelope must be labeled with a statement that the contents are "PERSONAL & CONFIDENTIAL" and "TO BE OPENED BY THE ADDRESSEE ONLY".

f. Should a SM/FM feel that the records response does not sufficiently comply with his/her request; the DPH staff RL must consult with the Program Director who will determine the appropriate response to the request.

g. Should an outside provider or a network provider contact a DPH asking for assistance in handling a request for SM/FM records, the DPH will explain the process and should they have further questions may direct the provider to the MHN Provider Network Manager.

h. Records, whether electronic or paper form, must be stored in a way that reasonably offers safeguard against fire, water, loss, damage, and unauthorized access. Computers must have anti-virus protection, electronic backup off-premises and procedures to protect the confidentiality and integrity of internal databases and sensitive records.

i. All release of records requests and completed Release Request Response letters must be maintained in a secure location. Any paper documents with identifying information must never be kept lying in the open for general access and must be re-filed immediately after use. This must always occur by the end of business day.

j. When no longer needed, paper documents must only be disposed of in a confidential, locked disposal container for shredding or shredded by the DPH. Destruction of any paper documents containing confidential information requires RL authorization. Electronic case record information will be archived by the database administrator according to company archival policies.

2-12. Procedures for Releasing Records to the SM/FM’s Unit Leadership, Medical Command, Treating Provider, and/or Treatment Team

a. SM/FMs may authorize the release of their records to their unit leadership, medical command, treating provider and/or treatment team by signing a Release of Information (ROI).
b. DPHs will reduce risk of unintentional disclosure of the SM/FM’s personal information by verbally transmitting directly to the authorized recipient whenever possible. If written communication is required, the DPH will first obtain authorization from the RL and Program Director or Deputy Program Director. If authorization is obtained, the DPH will ensure that the communication is transmitted securely and only to the authorized recipient. The only exception to this rule is when there is a signed ROI to enter SM data into a military medical IT system (see 204.16 below).

2-13. Procedures for Handling of Client Records

a. Apart from standard ROI practices supporting client care and case management services, any other requests to remove, transport or destroy client records or other protected confidential information requires approval through the DPH’s corporate chain of command. In addition, the corporate chain of command must obtain permission from the COR prior to granting this approval. The COR is responsible for communicating and coordinating approvals or denials with the appropriate NG Branch Chief. If the approval is granted and an original client record is to be released to another party, a chain of custody must be maintained, communicated and documented by the DPH and his/her RL. Upon termination, a DPH must coordinate with their RL to ensure any remaining paper confidential files are kept secure in their absence or moved to a secure site.

b. DPH case note entries are permanent and are not be altered in either electronic or hand-written formats. Any and all clarifications or corrections will be made in the form of additions/addendums to the existing case note entries.

c. When a client with an existing case file is involved in a critical incident of self-directed violence, or violence toward others, the DPH will have 24 hours to make any final case note entries into the file. The COR and/or their designated representative(s) will be responsible for implementing a process to secure the case file (sequester) and deliver/transport it to the proper NG clinical authority for audit/review.

d. The COR has the discretion of determining the need to sequester a client case file and also in determining if or when a sequestered client case file will be returned to the DPH for record keeping purposes.

e. When an electronic record is sequestered, electronic access to the client case file will be restricted such that no modifications can be made.

1. To reduce stigma and create a safe environment allowing SMs greater freedom to disclosure behavioral health concerns, with an appropriately completed ROI, DPHs will only release information to the SM’s unit leadership or medical command related to the following area:

Table 2-1: ROI
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<table>
<thead>
<tr>
<th>I. Contact Information</th>
<th>III. High Risk Status</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Name, Rank, Unit, SSN</strong></td>
<td><strong>A. Suicidal, Homicidal, Abuse—Aggressor (Potential; e.g., threats to harm others), and Abuse—Victim</strong></td>
</tr>
<tr>
<td><strong>B. Address, Phone, Email</strong></td>
<td><strong>B. Hospitalization related to high risk status: voluntary or involuntary commitment</strong></td>
</tr>
<tr>
<td><strong>C. Emergency Contact Information</strong></td>
<td><strong>C. Duty to Warn/Protect/Mandated Reporting (legal obligations to warn or file a report)</strong></td>
</tr>
<tr>
<td><strong>II. Combat Operational Stress Rating (&quot;See&quot; Combat Operation Stress Rating&quot; for Further Details)</strong></td>
<td><strong>D. Safety Planning and Recommendations for Unit, Leadership and Medical</strong></td>
</tr>
</tbody>
</table>

#### A. Green
1. Good to Go
2. Well-trained
3. Prepared
4. Fit and Tough
5. Cohesive Units
6. Ready Families

#### B. Yellow
1. Mild or Transient Stress or Impairment
2. Anxious or Irritable
3. Behavior Change

#### C. Orange
1. More Severe of Persistent Distress or Impairment
2. Leaves Lasting Evidence

#### D. Red
1. Stress injuries that don’t heal without intervention
2. Diagnosable PTSD, Depression, Anxiety, Addiction, etc.

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See Appendix 21: SM COSC Review Form

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2. **Release of Information.** When conducting services face-to-face, DPHs will obtain a signed release that is stored with the DPH’s locked clinical records. When providing services via the telephone, when allowed by the DPH state/territory’s statutes, DPHs may obtain a verbal release of information that is documented on a ROI and stored with the DPH’s locked clinical records. The DPH must also send a copy of the ROI, via email or fax, in order to obtain a signature. The DPH will document when and how the ROI was sent to the client and on the ROI that indicates the client’s verbal consent.

c. **Storage of Client Records in Contractor’s case management system.**
   
   See policy #203.

d. **Storage of Client Records in military medical IT systems.**

1. DPHs may be required to document services performed in the approved military forms/systems and the approved contractor IT system. DPHs will evaluate SMs on the Combat Operational Stress Continuum (COSC). The COSC codes SMs into four categories: green, yellow, orange, and red. These categories are not military medical determinations, but are used to assist SMs in seeking appropriate treatment. The four classifications were designed to reduce stigma and promote help-seeking behaviors.

2. Any information entered by a DPH into either a military medical record or approved contractor system must follow contract, State, and Federal rules and regulations regarding informed consent. When documenting in the approved military forms or systems, DPHs are only permitted to enter PHI on SMs related to the following five areas (as defined below):
   - SM contact information, COSC rating, high risk status, referrals made, and the estimated length of time until the SM will be returned to a green COSC with appropriate treatment. DPHs may also document in the approved military form or system their follow up contacts.
with SMs in order to track if they are making their referral appointments, current COSC rating, high risk status, any additional referrals made, and estimated time until the SM will return to a “green” COSC rating.

3. DPHs are allowed to document in eCase when asked by their state. It should be noted that DPHs are bound by the contract only to enter data into eCase when the SM has signed a ROI. Often military leaders and medical command will ask DPHs to review cases or client records and provide consultation on how they should proceed—you may provide consultation without having a signed SCU and/or ROI. However, if the SM in question is a client of our program, you may not reveal PHI without a signed ROI and must limit the consultation provided to what would normally be offered for SMs with whom you have never met.

4. On occasion DPHs may need to enter consultative advice in eCase about SMs for whom they have not seen personally; this is permissible even without an SCU. However, staff do not enter any PHI on SMs into the NGPHP CMS without having a signed SCU.

2-14. Records Management
   a. The DPH will maintain client records containing documentation of the Notice of Privacy Practices (NPP), Statement of Client Understanding (SCU), any release(s) of information, demographics form, intake form and intake notes forms, ongoing progress notes, outcome measures (e.g., Program Rating Scale), related referral management activities, and case closure forms.

   b. Paperwork and Documentation (See Appendix)
      1. Every action taken by the DPH in managing the case will be documented, with the most recent information kept at the front of the record.
      2. Notes will be brief. The DPH will keep documentation notes on the notes forms until an electronic records system is implemented. Notes will contain specific characteristics of the client’s issue(s), goals and/or purpose for seeking services, as opposed to a diagnostic impression. A full assessment and diagnosis is the responsibility of the referral Mental Health Provider.
         (a) Ensure every record is orderly and notes are legible.
         (b) When appropriate (e.g., brief solution-focused, problem-solving support), a collaborative action plan should be completed with the client and filed in the record.

2-15. Disposition/Ownership of Record
   a. NGPHP client records are owned by the NG. Therefore, the disposition of client records is ultimately subject to the discretion and approval of the COR and designated NGB representatives. Paper records will be maintained until an electronic management information system (MIS) is implemented. Once the MIS is implemented, the DPH will electronically scan the paper records and add them to the MIS. The DPH will shred the paper records once it is confirmed they have been successfully saved to the MIS.

   b. The DPH will keep records in accordance with the Standard Clinical Operating Policy and Procedure Manual. Only the COR and authorized NGB representatives may approve the destruction of NGPHP records.

   c. Each DPH will ensure a secure chain-of-custody system for any record removed from an office. Other than for record disposition, records should remain locked in the DPH office.

   d. The DPH will document the approval to remove any client record and/or other confidential information.

   e. The DPH will advise the RL prior to the removal of any record, or any part of a record, and again when the record is returned.
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Section VI
NGPHP Training Plan

2-16. Policy
All personnel within the PHP shall develop professional development and training plans that promote
the knowledge, skills and abilities required to competently support the mission of the program.
Within ten (10) working days after a DPH’s start date, the Region Lead shall provide a thorough
orientation about the NG PH-RC Program. This orientation shall include, but not be limited to, a
review of all policies and procedures necessary for the DPH to perform under the terms of this
contract. Evidence of the successful completion of a structured orientation protocol resulting in
adequate knowledge to perform assigned duties shall be retained in the personnel file of each DPH.
NG PH-RC leadership and DPH staff shall demonstrate clinical competency in several core areas
essential to performing in their respective roles. NG PH-RC leadership and DPH staff shall complete
a professional development plan within ninety (90) days of their date of hire. In addition, a national
training committee and peer mentor program will be established for the NG PH-RC Program. All
personnel, including administrative, shall have access to professional development and training
opportunities to enhance their abilities to support the program mission.

2-17. Implementation
   a. NG PHP policies and procedures:
      1. Within 10 working days of the hire date, RLs will review all policies and procedures with
         new hires.
      2. RLs will review policies during weekly region meetings.
      3. Major changes to core policies and procedures will be reviewed by both ANG and ARNG
         Program Directors and Deputy Directors during quarterly reviews.

   b. Clinical competency
      1. RLs will develop a professional development plan (PDP) with each DPH within ninety
         (90) days of their date of hire.
      2. PDP shall identify strengths and gaps in each DPHs competency within the core clinical
         areas identified below in the “Core Clinical Education/Training Requirements” section.
      3. PDP shall be reviewed and updated every six months.

   c. Establish a National Training Committee
      1. Under the direction of the program directors, and oversight of the program manager, a national
         training committee shall be established to:
            (a) Identify essential training and professional development elements for the range of
                staff employed by the program, including leadership, managers, supervisors,
                administrative assistants, and DPHs.
            (b) Develop training modules
            (c) Identify national and local training opportunities
            (d) Identify best practices
            (e) Track completion of trainings
            (f) Assist RLs in training DPH staff during weekly staff meetings

   2. Membership:
      (a) ARNG
      (b) Region Lead
      (c) ARNG DPH representative from each region
      (d) ANG
      (e) Region Lead
      (f) ANG DPH representative from each region

   d. Peer Mentoring Program
      1. Within 14 working days of their hire date, new hires shall be assigned a peer mentor by
2. RL and assigned mentor will develop a schedule for peer phone conferences in support of the orientation of the new hire.
3. New hires shall hold weekly phone conferences for the first 60 days. (Omit this sentence for the one above).
4. RL, mentor and the new hire will review the need for ongoing mentorship and adjust the scheduled meetings as required.
5. When deemed appropriate by the RL, the peer mentor may travel to the new hires state for face to face mentoring/training.
e. With NGB guidance in collaboration with program Leadership, quality measures for the evaluation of training programs will be developed that address core program components.

Section VII
Professional Development and Training Plans

2-18. Policy
All PHP personnel shall develop professional development and training plans that will maximize their potential to provide competent, professional services relative to the mission of the program. To ensure that all personnel have the knowledge, skills and abilities to maximize their value to the NG, this plan shall be developed by the employee in consultation with the immediate supervisor. For those newly hired into their roles, this plan becomes an ongoing responsibility once the orientation period is completed.

Supervisors are expected to ensure that personnel understand and are in compliance with program policies, the professional standards expected of personnel relative to their respective codes of ethics and professional standards, and the need to regularly refine and update professional development and training plans to address both the growth of the individual and the changing demands of the professional environment. The Leadership Team is responsible for the definition of professional development and training priorities that support the essential functions of all personnel, and the seeking of resources to implement those priorities. Staff shall be included in these training opportunities as resources allow.

2-19. Applicability
a. Applies to the Program Director and Deputy Director
b. Applies to RLs
c. Applies to all Directors of Psychological Health (DPH)
d. Applies to all Administrative Assistants
e. Applies to personnel who may assume one of these three roles for a period of more than 30 days

2-20. Definition(s)
a. Knowledge, Skills, and Abilities (common core):
   1. In-depth knowledge of the PHP, and its Policies, Protocols and Procedures
   2. Knowledge and skill in management/ administration, which may include supervision, consultation, negotiation, monitoring, and report writing
   3. Ability to work on a team or project, with a varying level of overall responsibility
   4. Ability to organize work, set priorities, meet multiple deadlines, and evaluate assigned program areas
   5. Ability to provide training, orientation, consultation and guidance.

b. High Quality Professional Development (HQPD): A set of coherent learning experiences that is systematic, purposeful and structured over a sustained period of time with mission-related goals and objectives. HQPD conforms to best practice, evidence-based guidance in research, DPH assignments, and professional responsibilities.
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c. Professional Development (PD): The learning experiences that increase our skills, knowledge, or abilities in a particular area of our practice. It challenges us to improve our practice and our outcomes, and is part of a continuous experience.

2-21. Standards of Professional Development
a. Clear goals and objectives relevant to desired outcomes
b. Aligns with state and/or program goals or priorities
c. Is developed through collaboration and the sharing of ideas
d. Makes use of relevant resources to ensure that goals and objectives are met
e. Is sequential and coherent, connecting to previous learning
f. Is assessed to ensure that it is meeting targeted goals and objectives

2-22. Training

Informational sessions focused on increasing awareness or learning discrete skills associated with specific topics, and/or performing individual tasks associated with those topics. An example of training is a session on how to access a report in a database.

2-23. Policy Implementation Guidelines
a. New DPHs will meet the requirements set forth in the Education and Training Requirements document. DPHs with more than one year experience will add selected modules into their Professional Development Plan.

b. A national committee will be formed with at least 8 current DPHs and shall be chaired by a member of the program Leadership Team. Their mission is to review all training materials/modules included on SharePoint. These “gatekeepers” will ensure the high quality and relevancy of all material included in the Training Library.

c. Training shall include opportunities to promote ARNG and the ANG programs toward a synchronized work environment. Shared applications, HR support, training and collaboration must continue at all levels (leadership, state and wing level, admin support). Deputy Program Directors will manage this process.

d. RLs (RL) shall consider professional development and training issues as they manage the hiring process, professional development planning and performance review processes. RLs in both branches shall coordinate efforts to promote professional development and training that supports the mission of the program as defined by the NG Bureau.

e. Administrative assistants shall be actively encouraged to seek out appropriate professional development and training activities. Supporting regional teams as well as developing sub-specialties is necessary for long-term program growth.

f. Teamwork shall be fostered through collaboration between state and branch personnel, including training that overcomes the limitations of a virtual approach to communication. The PHP must utilize every technological means available to maintain our personal and professional connectedness, as such connectedness promotes mutual aid and support for program objectives.
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g. Program Leadership Team will facilitate provision of training modules on SharePoint or through other electronic means. A database of completed modules and date/time will be maintained. Branch-specific models will be supported. Leadership has a role in both monitoring and providing the training opportunities that support the mission of the DPHs. Professional organizations in each state are the best providers of this specific training.

h. RLs shall monitor the degree of organic resources that exist in each region and use mutual support as a method of sharing resources. Regions with no DPH trained in a formal methodology may schedule a group training with SMEs from other regions.

i. With five contracting companies and two military branches involved in this program, the need for professional flexibility is essential to program management. Such flexibility includes the ability to provide consultation and support for personnel from other military branches when responding to critical incidents or dealing with emergencies.

2-24. Education and Training Requirements

a. Professional Development Planning

b. Each DPH shall develop a Professional Development Plan, no later than 6 months after being employed.

c. For current DPHs, this planning is part of the Performance Review Process.

d. Through supervision, RLs develop a clear understanding of DPH strengths and developmental needs. These are discussed regularly and built into the PRP.

2-25. Supervision and Performance Evaluations

a. With increased collaboration between the Army and the Air Programs increased familiarity is necessary.

b. Leaders in both programs need to train up on their knowledge gaps. DPHs need to train up in order to be an effective back up or consultant.
   1. Program leadership ensures these systems and structures are working to support the mission of the DPHs. Leadership meeting routinely discuss the effectiveness of supervisory process.
   2. Program leadership will utilize post-training surveys to evaluate the quality and effectiveness of the training provided.

2-26. Independently Licensed Provider in State/Territory

a. Directors of Psychological Health (DPHs) shall hold a Master's Degree and/or Doctorate Degree in a clinical or administrative mental health field. Must show evidence of independent license.

b. All DPHs have either a Master's or Doctoral Degree in a clinical or administrative mental health field from an accredited college or university. These credentials are verified by RL and HR recruiting professionals prior to employment.

2-27. Maintain Independent License

a. DPHs will show evidence of license renewals as they occur. Time needed for continuing education to meet these requirements will be provided and supported by both PHP program opportunities and external workshops. Policy 203, Section 2 governs the documentation of this process.

b. All DPHs possess a license to practice in their respective state or territory without mandated
clinical supervision. These credentials are verified by HR professionals and the RLs. A database of credentials, certifications and state licenses will be maintained.

2-28. Privacy Act and HIPAA

a. Each DPH shall be trained in the regulations set forth in the Privacy Act and HIPAA. DPHs shall demonstrate an understanding of the application of these acts in a military environment (for both civilian and military individuals). The trainings must be completed within the first 30 days of employment. Notify admin/ RL when completed.

b. DPH training modules are found on SharePoint (Training Library) or a link to the training is listed and active. Admins will ensure an updated listing is readily available.

2-29. Military Culture

a. DPHs shall have demonstrated capability to work with and within the military culture of their respective components. DPHs are expected to mentor new DPHs in the development of a military-specific skill set.

b. All DPHs will receive training by a SME within the first 30 days of employment. Mentorship by an identified regional peer, as well as the RL will be ongoing for year 1.

c. Role of the NG within the total force structure.

d. DPHs will know and be able to impart to others the unique role of the citizen soldier/airman and their respective contribution to the total force.

e. All DPHs shall become SMEs with respect to the transitions between military service and civilian life, and the family adjustments required to support SMs.

f. Cross branch military culture: With increased collaboration between the Army and the Air Programs increased familiarity is necessary. Leaders in both programs need to provide training on perceived knowledge gaps. DPHs need such training in order to be an effective back up or consultant to colleagues in other military branches.

2-30. Clinical Skills and Training

a. All DPHs shall have demonstrated skill in completing bio-psychosocial assessments and consultations. Substance abuse and critical event training are key additional skills.

b. All DPHs assessments and consultations are audited on a monthly basis. High Interest cases are staffed/ reviewed by the RL.

c. TBI and PTSD training: All DPHs are required to attend government sponsored training in TBI and PTSD.

d. DPHs are trained to use program-developed assessment formats to promote consistency in clinical methods using evidence-based practices.

e. Suicide Risk Assessment and ASIST: All DPHs will be trained in suicide risk assessment by a completion of training approved by a supervisor. This training module is required for all DPHs in their first 6 months of employment. The objective of developing safety plans for those involved in high risk situations is essential to promote the program mission. Additional training is defined by the RL and the Leadership Team.

f. Violence and threat assessment: DPHs need to be trained in professional models of assessment of violence towards others. In-service training shall be developed with organic and external resources to address the potential for violence by SMs, and interventions that promote the safety of all concerned.
g. Legal and Ethics training: All DPHs are required to know the specific laws governing their practice in their state, district or territory. It is encouraged that formal training becomes part of the DPHs annual professional development plan. Local laws and regulations regarding civil commitment, mandatory reporting, and Duty to Warn vary among jurisdictions. DPHs shall communicate with local NG officials as to the specifics of these requirements so as to inform local POCs of the limitations of their clinical practice.

2-31. Critical Incidents
a. DPHs shall be trained in crisis, emergency, critical incident, and disaster response procedures as defined by NGPHP Policy 307, and related documentation procedures defined in Policy 306. (Attachment X)

b. Critical Incident Response Training: Training in response to critical incidents shall be authorized for all personnel responsible for supporting a response to a crucial incident involving the NG. Training shall be approved for evidence-based methods and those methods approved by the NG Bureau. Completion of online courses, including Psychological First Aid, Traumatic Event Management, or Traumatic Stress Response courses shall be completed by all DPHs in a time frame defined by the branch Leadership Team.

c. The NGPHP works with the American Red Cross in matters related to training and emergency response. The Leadership team shall promote DPH involvement and collaboration with the American Red Cross chapters at the state and local level in support of NG response efforts.

Section VIII
NGPHP Duty to Warn/Protect Requirements

2-32. Policy
Directors of Psychological Health (DPHs) are required to consider the potential danger posed to self and others when they conduct clinical assessments with NG SMs (SMs). Should a client pose a threat to self or others by virtue of verbal or written threats of harm or violence, or demonstrated behavior that reveals that the client is at imminent risk for engaging in harm to self or others, they are to document the nature of the client’s behavior, the reasons for believing the threat posed are imminent, and the actions taken to address the threat based on local state/territorial laws and regulations. In most instances, this requires notification of those directly affected by the threat(s), and local mental health and law enforcement authorities.

Should local laws and regulations also require the “duty to protect”, such documentation shall include those aspects required by law and regulation to assist those who are the targets of the threats to prevent or mitigate the risk of harm. The “duty to protect” typically goes beyond the requirements of warnings, and includes providing the intended targets of harm with consultation on means to protect themselves. DPHs shall familiarize themselves with their own state/territorial laws and regulations, and shall consult with their RL as part of the notification process.

Notifications to those who are the intended targets of violence or harm by client shall be done in a manner consistent with federal regulations and state laws regarding confidentiality. In all contacts with clients who pose a threat to self or others, DPHs shall engage in safe clinical practices, and adopt measures of personal safety that are consistent with federal and corporate policies for a safe work environment.

2-33. Definition(s)

a. Duty to Warn: The “duty to warn” is a legally required duty within state or territorial laws and regulations mandating that licensed mental health professionals warn those who are the targets of threats of violence or harm posed by a client. In some jurisdictions, this may include threats of self-harm. A review of these obligations by Felthous (2006), and in considering the elements of the precedent-setting Tarasoff case, indicated, “According to the Tarasoff principle, the intended victim is to be warned of the “danger” posed by the patient, not simply of the patient’s verbal threat.” In addition, “If the duty is to warn of a danger and not of a specific threat, then
verbal threat may not be necessary to trigger the duty.” Hence a threat that is posed, but not necessarily made verbally or in writing, may provide sufficient justification for the duty to warn. While the laws in each state/territory differ, the types of warnings typically required include:

- Warning of the risk of violence after the clinician appraised the risk to be serious and probable;
- Warning of the threat of violence based only on the threat itself;
- Requested warning, based on a potential victim's perceived risk to self; and,
- Required criminal victim warning mandated by statute when requested by a person who had already been criminally victimized by the offender in question.

Duty to Warn responsibilities may also occur, depending upon state laws and regulations (see attached "Mental Health Professional’s Duty to Protect/Warn" grid detailing the requirements for all states), in the following categories:

b. **Duty to Protect:** The “duty to protect” is a requirement in some states/territories to not only warn a potential victim of the threat posed to them by a client, but to also advise them on practices that will assist them to prevent, mitigate or offset the risk of violence.

c. **Homicide warnings involve** breaking confidentiality by alerting the identified or identifiable victim and the police, parent or legal guardian or an authority at the school, workplace, or other facility:
   - SM/FM reports their intent to harm another person and has a specific plan and means to act upon the plan.
   - SM/FM reports having recurrent ideation and a lethal means immediately available to harm others

d. **Public safety warnings involve:**
   - SM employed in a safety-sensitive NGB/DoD position engages in behaviors that violate NGB/DoD or Service Branch regulations on the job, such as substance abuse, not following safety procedures, etc.
   - Other high-risk employees with readily available lethal means of harming the public, such as military personnel meeting Personnel Reliability Program (PRP) certification status, etc.

e. **Suicide warnings involve** breaking confidentiality by alerting mental health agencies, the police, military authorities, parent, legal guardian, or others under the following circumstances:
   - SM/FM reports they are going to harm themselves and has a specific plan and means to act upon the plan; and/or,
   - SM/FM reports recurrent ideation to harm themselves and has immediate access to lethal means of self-harm; and/or,
   - SM/FM denies risk of self-harm, but informs PHP that they intend to engage in risky behaviors that have the potential for imminent lethal injury.

2-34. **Assessment Procedures:**

a. In the event of an immediate crisis (lethal/high interest), the DPH must take immediate emergency action, and consult with their RL as soon as possible. The priority for immediate action is the safety of all concerned, and behavioral stabilization of the client. Depending upon the circumstances, the DPH may need to engage in any combination of the following actions to promote life safety.

b. Engage in non-threatening efforts to diffuse the situation, assisting the client to consider options other than violence to remedy the current situation.

c. Contact local law enforcement or security personnel to assist in restraining the client if evidencing violent behaviors, or if the client has access to firearms/weapons and appears to be likely to use...
them in the perpetration of violence.

d. Provide intended target with information and resources to maintain their personal safety, including contact information for law enforcement agencies, domestic violence prevention organizations, workplace violence prevention programs, and other related resources.

Suggest to the client they consider evaluation/admission to hospital (either VA, MTF, or civilian) to develop emotional/behavioral stability.

e. If chemical impairment appears to an escalation factor, contacting local chemical dependency specialist, AA sponsor, or other similar professional to assist with de-escalation.

f. At any point where a DPH determines that a threat posed by a client constitutes an imminent threat of harm or violence to another, the DPH shall, to the extent possible, conduct a threat assessment, addressing the degree to which:
   1. The nature of the threat, and how it is communicated (e.g., verbal, written, behaviors, etc.)
   2. The threat identifies a specific person or group.
   3. The method of violence based on observed behavior, communication for the client, or past history.
   4. Attitudes that support the use of violence as a problem-solving method.
   5. The intent of the client in terms of outcome.
   6. The thresholds crossed by the client in terms of pattern of escalation.
   7. The reported response to the client by the intended victim's knowledge of the threat.
   8. The ability of the client to carry out the threat immediately or in the future.
   9. The likely signs or symptoms of escalation of behavior that is consistent with the client's history of violence perpetration.

The history of compliance versus non-compliance with violence prevention interventions.

2-35. Notification Procedures
   a. Notification of those who are the targets of the intended harm or violence shall be done in the manner and time frames prescribed by local laws and regulations.

   b. In non-lethal situations, DPHs shall consult with their RL before engaging in reporting or warning procedures. The DPH will:
      1. Attempt a face-to-face support and intervention by the DPH if geographically and situational possible. DPH's will use sound clinical judgment and consultation as needed.
      2. May also work with a client to involve a FM/friend/coworker who may be nearby to assist face to face.
      3. Obtain an immediate/urgent affiliate appointment for a personal assessment, assuring safe transportation
      4. Consider calling emergency services for the SM/FM. (local 911 or Guard escort services) If unsuccessful, then coordinate a 3-way call with the SM/FM and FM/friend
      5. Or as a last resort, break confidentiality by informing the command and/or police, or other person in authority.
      6. Reportable events that fall outside numbers 1 through 3 above, including domestic violence (DV), sexual assaults (SA), illegal practices and drug abuse for SMs and domestic violence (DV) for FMs will be made to the appropriate authorities as indicated, again in consultation with the DPH Lead.

   c. Reports for child abuse and neglect will be made to local child protection services and to the Family Assistance Program.

   d. Reports for special needs FMs will be made to local adult protective services or designated authorities and to the Family Assistance Program.

2-36. Documentation Procedures
Chapter 2
Clinical-Administrative Policies

a. All Duty to Warn/Protect incidents shall be documented on the Behavioral Health SITREP form, and forwarded to the RL within 24 hours of the incident. The RL shall consult with the Deputy Director or Program Director, and forward the form to program leadership, including:
   1. Behavioral Health Branch Chief
   2. COR
   3. Program Manager
   4. Program Director
   5. Program Deputy Director
   6. Others as defined by the Behavioral Health Branch Chief or COR

b. Documentation in the clinical file, including a copy of the SITREP(s) that apply to the incident.

2-37. Case Management
a. Follow up incident with appropriate contacts with mental health and law enforcement authorities, and determine the custodial status of the client, and any legal implications stemming from the incident.

b. Subject to HIPAA and privacy provisions, notify the SM’s command of follow up of situation. Consider consultation with commander to assist with referral for possible Command Directed Mental Health Evaluation.

2-38. Exceptions
NG PHP DPHs may not be mandated to make reports/warnings from third party persons (e.g., civilian cases of suspected child abuse) but will offer such participants the opportunity to report the incident themselves by 3-way call. Parents or legal guardians will act as the agent for minor children in making reports/warning.

2-39. References
a. NGPHP Confidentiality Policy & Procedure
b. NGPHP Sexual Assault Restricted Reporting
c. Local State Laws regarding Child Abuse/Neglect and Special Needs Adults, Intimate Partner
d. Federal Laws related to Mental Health & Substance
e. Abuse Confidentiality regulations
   DODI 6400.06- Domestic Abuse involving DOD
f. DOD Directive 6495.01- Sexual Assault Prevention Response
g. DOD 6400.1 Child Abuse & Spouse Abuse/Neglect
h. ANG & ARNG Suicide Prevention Programs


Chapter 3
Clinical-Services Policies

Section I
Referrals to the PHP

3-1. Policy:
NG SMs (SMs) and FMs (FMs, including partners) have access to local Directors of Psychological Health (DPH staff) for consultation and referral for behavioral health, emotional, or relationship problems. Referrals may be made via telephone, e-mail or in person. DPHs shall determine the type and urgency of the referral, and assign an appropriate referral category and level of urgency to each referral. DPH staff will then develop clinically appropriate referral plans for SMs/FMs based on presenting issues, level of urgency, and available resources to provide appropriate and safe care. DPHs shall document all referrals and maintain a log of referrals and follow-up activities. DPHs will adhere to ethical and confidentiality practices as defined by their respective state licensing boards and related professional associations, and the applicable policies of the PHP and the NG Bureau. The NGPHP Statement of Client Understanding (SCU) is the central document detailing the confidentiality agreement between the DPH and the client, and shall be adhered to as part of the referral process detailed within this policy.

3-2. Applicability
This Directive applies to the Directors of Psychological Health (DPH) who comprise the NG Bureau PHP, in regard to their work with SMs.

3-3. Responsibilities
NGPHP Program Director and Deputy Director will ensure that RLs and all DPH staff are appropriately trained and understand the policies and procedures herein delineated.

NGPHP RLs, in conducting their regular supervision with DPH Staff, shall ensure that standards set forth in this document are being properly upheld and procedures executed properly.

3-4. Procedures
   a. DPH staff will maintain a high level of awareness of telephonic, e-mail, and other methods of communication to ensure that SM/FMs have access to psychological health services.
      1. DPH staff shall ensure that local NG personnel, including the local Point of Contact (POC), are aware of referral methods and location of the DPH throughout each work week so as to maximize availability for referrals.
      2. DPH staff will make SM/FMs aware of services and referral criteria through briefings, attending NG functions (including weekend drills), Yellow Ribbon presentations, NG conferences, etc.
   b. DPH staff will maintain a log of all referrals, source of referrals, and follow-up activities. All referrals to the PHP shall be categorized as voluntary. For the purpose of tracking the utilization of the PHP, DPH staff will utilize the following referral categories when documenting client interaction
      1. Self-Referral: Voluntary request by a SM/FM for clinical services. The process shall typically include:
         (a) All NG SMs/FMs with psychological health needs will be encouraged to call the on-site DPH for psychological health services voluntarily, by leadership, and through public events, briefs and other written materials.
         (b) The DPH will assess the SM/FM’s concern and refer as appropriate.
         (c) All voluntary referrals are confidential within the parameters described by the PHP Statement of Client Understanding.
         (d) All referrals involving minors shall include permission to provide services by parent or guardian consistent with the statutory requirements and limitations of the state of residence.
   c. Medical and Command Referrals: A referral made by the SM’s command or military medical personnel who have indicated concerns for the psychological health of the SM/FM
based on observed behavior. In order to maintain the intent and integrity of the PHP program, these referrals are completely voluntary and according to military regulations, no consequences detrimental to a SMs can result for failure to comply/follow-up with a facilitated referral. Examples include referrals from PHA and pre/post-deployment health screenings. Upon obtaining client consent, the DPH may advise and consult with the referral source to determine and insure an appropriate care plan is developed.

d. Other Referral: An informal referral made by a peer SM, Battle Buddy/Wingman, FM or a friend who has observed potential problems with a SM’s psychological health. Referrals of this nature shall be managed similarly to those in the “Self” category.

e. Responding to referrals: **Emergent, Urgent and Routine**

1. Emergent Referrals are those situations in which the SM/FM are determined to be in imminent danger to themselves or others and require immediate intervention or services that extend beyond the scope of DPH licensure, practice, or expertise.

2. In conjunction with the Commanding Officer and/or supervisor, the DPH will make every effort to assess the SM/FM, provides professional guidance to facilitate safety of the SM/FM and make an appropriate referral. In such cases, calling 911 for police and paramedic support, referral to a hospital, an Urgent Care Center (UCC), or the SM/FM’s Primary Care Physician (PCP) may be the most appropriate course of action. Additionally, notifying command, a chaplain and the SM/FM’s family and other primary supports with SM/FM consent, if possible, may be beneficial for enhancing medical and behavioral health stability and can also aid in expanding support resource options.

3. The DPH must contact their RL in all high interest/emergent cases within 24 hours of initial case referral.

   (a) The DPH will follow up on SM/FM and emergency care providers within twenty-four (24) hours of emergent care referral to assess efficacy of care and assist with aftercare/discharge planning upon request. All contacts related to client care must be documented in the client’s record.

   (1) Urgent Referrals are conditions or disorders that are causing a SM/FM acute distress but are not considered life threatening and/or requiring emergent care.

   (2) Urgent referrals should be handled within (1) day of the initial contact by the SM/FM or the referral source and no later than (2) days from the date of initial contact with the SM/FM or referral source.

   (3) The DPH will contact the SM/FM or referral source; identify the presenting issues and complete a consultation and/or assessment.

   (b) Routine Referrals are conditions that are causing some general emotional or behavioral issue(s) and are not considered to be emergent or urgent at the present time.

   (1) Routine referrals should be handled within (3) days of the initial contact by the SM/FM or the referral source and no later than (5) days from the date of initial contact with the SM/FM or referral source. The RL is to notify the COR when this contact has not been made and provide the appropriate background and back up information. A weekly report is to be provided to the COR. (Why do we have both 3 and 5 “Days” listed?)

   (2) The DPH will contact the SM/FM or referral source; identify the presenting issues and complete an intake and/or assessment.

3-5. Referral Management

Overview – Referral management consists of helping clients navigate through the complex mental health care system, consulting with mental health providers as needed, checking in with the members regularly, and ensuring the members are receiving help to resolve their issue(s). All follow-up contact with the member is with their consent, and contacts with the mental health provider occur if the member has signed a release of information.

Follow-up activities will primarily be conducted over the phone to monitor progress on a scheduled
basis as clinically appropriate and within the guidelines listed below:

a. Within a week of the client’s initial appointment with the mental health provider, the DPH will contact the member and mental health provider to see if the member attended the appointment.

b. The DPH will ascertain if the member or mental health provider have any concerns or would like any additional information the DPH can provide.

c. The DPH will be available for consultation with the mental health provider as needed.

d. The DPH will request the mental health provider to contact the DPH about missed appointments and/or clinical concerns.

e. After the initial follow-up call and within a week of the initial appointment, the DPH will contact the member and mental health provider on a monthly basis to monitor the client’s progress until case resolution or the client no longer desires follow up contacts. More frequent contact will be made when indicated.
   1. The DPH will conduct brief follow-up contacts focused on satisfaction with progress made and additional needs with which the DPH might assist the individual.
   2. The DPH will encourage the client to actively work with the mental health provider to develop an aftercare or continuing care plan as needed.

f. The DPH will complete the Program Rating Scale (PRS) or other designated outcome measure with every follow-up contact with a client.

g. If the client cannot, or will not, resolve an issue with the mental health provider, the DPH may help the member choose another mental health provider, preferably after the member has spoken to his or her current mental health provider about terminating treatment.

h. For follow-up with high interest clients, refer to section 5.8 Managing High Interest Clients.

i. Case Closure
   1. The DPH will close the case when follow-up is complete.
   2. If the client is non-compliant with recommendations, or wishes to have his or her case closed, the DPH will document the discussion or his or her efforts to contact the member, and then the NGPHP case file will be closed at that time.
   3. When a client is not in contact with the DPH, the DPH will attempt to contact the client no fewer than three times over the course of 60 calendar days. If the client is unresponsive, the case will be closed. Each contact will be documented in client’s record.

3-6. Other Referral Management Activities

a. Once the client has a mental health treatment provider, the DPH does not provide further interventions as that is the role of the mental health treatment provider.

b. If the client visits the DPH in crisis after having previously been referred to a mental health provider/psychotherapist, the DPH will help stabilize the client, ideally with their mental health provider involved, and immediately refer the member to their mental health provider for intervention or to the emergency department, as appropriate.

c. Referral to programs and services that specifically provide assistance to minors is highly recommended. LtCol Cunningham add to another section: Globally generalization – and to all we serve.

d. Substance Abuse Issues
1. The DPH will facilitate NG members in addressing their substance abuse issues. The NGPHP is **NOT** an Alcohol and Drug Abuse Prevention and Treatment (ADAPT; referenced in AFI 44-121) Program.

2. Self-identification of use of illegal substances, or misuse of prescription drugs, to the unit commander, first sergeant, or military medical personnel is encouraged prior to testing positive and may provide some limited protection. Self-identifying to the DPH does not meet the guidelines for limited protection. Except as noted in the NPP, member substance use issues are kept confidential. **NOTE:** ARNG DPHs consult Policy #306 “Cases with Substance Abuse Concerns” for branch-specific guidance. (Attachment X)

3. The DPH will inform the member of the NGB Prevention, Treatment, and Outreach (PTO) program. As with the NGPHP, PTO services are voluntary.

4. The DPH will recommend NG members with substance use issues to also consult the Area Defense Council.

5. When desired by the client, the DPH will be available to provide a back-to-work meeting with the client and appropriate leadership to ease the client’s return-to-work transition after an absence due to treatment participation. The DPH will do this in conjunction with the mental health provider’s input and/or participation, if the mental health provider is willing.

### 3-7. References:

a. NG Bureau, Psychological Health Services, Contract Number W9133L-13-D-0002.

b. DoD 6490.1

c. DoD 1332.18 and 1332.38

d. MEDOM Regulation No. 40-38 (Dept. of the Army)

e. AFI44-119 (Air Force)

### Section II

#### Limits of Confidentiality

### 3-8. Policy

To identify the limits of the DPH providers in sharing confidential information to the NG Bureau regarding SM information.

### 3-9. Confidentiality Procedures

a. As independently licensed mental health professionals, contracted by the NG to provide clinical services to SMs and FMs (SM/FM), Directors of Psychological Health (DPH) shall maintain confidentiality with their clients per:
   1. State/territorial licensure requirements
   2. NGPHP Notice of Privacy Practices (NPP)
   3. NGPHP Statement of Client Understanding (SCU)
   4. Client’s signed “Release of Information” (ROI)

b. Disclosure of records shall be prohibited except with the consent of the SM/FM or as otherwise authorized by law. When the SM/FM gives prior written consent to release information, the release shall specifically indicate the following:
   1. The nature and scope of topics to be released.
   2. To whom information is to be released.
   3. The purpose of the disclosure, the date on which the consent terminates
   4. The prohibition on secondary release.
c. Possible exceptions that may mandate release of protected information include, but are not limited to:
1. When the SM/FM poses a danger to self or others.
2. When there is a suspicion of child, vulnerable adult, or elder abuse or neglect or intimate partner violence (according to state regulations or U.S./DoD regulations).
3. When it is legally permissible or required to warn the target(s) of a credible threat of violence or a future criminal act made by a member, or to warn the legal authorities of such threat.
4. When, in the opinion of the DPH, the SM’s behavior constitutes a risk of harm to self or others relative to mission readiness.
5. When it is legally permissible or required to report a past criminal act to the proper authorities.
6. When the disclosure of information is allowed by a valid court order.
7. When the disclosure is made to medical personnel in a medical emergency.
8. When such info is used by qualified personnel for research, audit, or program evaluation with consent or release.
9. When used for the purpose of defending an individual NG member in litigation per DoD/NG regulations and instruction from the Contracting Officer Representative or Contract Officer (KO).

d. All other releases of information require Contracting Officer Representative approval. The person to whom confidential information is released is notified of the prohibition on secondary disclosure of this information to another.
1. NGPHP personnel, while not responsible for reporting to military authorities regarding a SM’s medical information, shall assist the SM in this process upon request of the SM, subject to the provisions of the SCU and the completion of the ROI.
2. Domestic violence and sexual assault are disclosed only when state laws (or U.S./DoD regulations) mandate such action. Where not mandated or allowed, the DPH will keep such information confidential. Should the SM/FM desire to make a report to the proper authorities or command, it would remain the SM/FM’s responsibility to do so. The DPH shall recommend referral to the Sexual Assault Response Coordinator (SARC) in these cases.

3-10. Responsibilities
a. NGPHP Program Director and Deputy Director will ensure that all NGPHP Staff are appropriately trained and understand the policies and procedures.

b. NGPHP RL, in conducting supervision with DPH staff, shall ensure that standards set forth in this document are being properly upheld and procedures executed.

c. NGPHP shall ensure that all personnel are annually recertified in their knowledge of HIPAA and Privacy Act confidentiality requirements.

d. NGPHP Personnel Responsibilities
1. All NGPHP clinical staff shall be knowledgeable about the confidentiality and ethics laws in the states/territories to which they are assigned, and in which they are licensed to practice.
2. As a condition of employment, all NGPHP clinical staff and others who require access to confidential information shall read and sign an agreement prohibiting disclosure of confidential information, which is kept in the employee’s personnel file.

e. Records Storage & Maintenance
Protected healthcare information shall be stored and maintained in accordance with HIPAA and associated regulations.

f. Contact with the Legal System
Should NGPHP personnel receive a subpoena, a court ordered, or other similar contact from a court of law, staff are to notify their immediate supervisor, the RL, the Deputy Director, or the Program Director as soon as possible for guidance. The Program Director will also notify the Contract Program Manager. No action is to be taken without consultation from higher authority.

g. Client Contact
1. When NGPHP staff receive a call from a SM/FM seeking services, they will inform the caller of confidentiality and limits on confidentiality as part of the SCU and seek to obtain consent.
2. NGPHP clinical staff shall ensure that the ROI is properly completed and signed for those who are amenable to the terms, and when this release is necessary. An explanation of the purposes of information sharing with others is typically helpful for clients to understand that this can be beneficial.
3. In instances in which a client is resistive to signing a ROI, it is useful to explore the client’s reasoning to determine the beliefs underlying the resistance. If a client is adamant that he/she will not sign a ROI, the issue should be referred to the RL for clinical consultation.
4. When a SM self-discloses medical information that may have an impact on mission readiness, the DPH will attempt to educate the SM on the SM’s obligation for self-reporting this information to his/her commander or military medical professional. The DPH will also offer an ROI. An example of this is educating the ARNG SM about the Army’s drug/alcohol Limited Use Policy (LUP) for prevention and intervention services.
5. When instances of domestic violence or sexual assault are disclosed by a SM to a DPH, the DPH will suggest a referral to the SARC, provide any required materials supplied by the SARC and offer a ROI. If refused, these cases are handled in accordance with applicable laws (i.e., disclosure to authorities or continued confidentiality).

h. High Interest/Mandated Reporting Situations
1. Situations of high risk for harm to self or others, and/or requiring a duty to warn (DTW) someone of a dangerous situation, shall be responded to immediately. The DPH will notify the RL as soon as possible (before taking action, if circumstances permit), but the priority is the notification of those in the locality where the safety concern exists. The safety of the client and those involved in the situation is of paramount importance. The intervention process shall be documented and placed in the client file.
2. Refer to Policy 207 (NGPHP Duty to Warn/Protect Requirements)

i. Mandated Reporting
DPH staff are required by their state/territorial licensure to report to authorities if clients reveal information that is in violation of local or federal laws. DPH staff are required to know their local laws and regulations regarding mandated reporting requirements, and inform prospective clients of this obligation prior to the provision of services as part of the intake process. Typical mandated reporting requirements include, but are not limited to: child abuse, elder abuse, domestic violence, or threats or risk of violence to self or others, etc.

j. Restricted Reporting Options
SMs who reveal information regarding domestic abuse or sexual assault are reminded of the military directives involving the restricted reporting option for either of these types of incidents. Restricted reporting allows a SM who is the victim of abuse or has been sexually assaulted to confidentially disclose the details of his or her abuse/assault to specified individuals and receive medical treatment, counseling, and advocacy without automatically triggering the official investigative process. DPH staff and Network Affiliate Providers are not authorized to take a restricted report, and shall:
1. In the instance of domestic abuse, contact a Victim Advocate/Family Advocate to take the report if the SM is on Title 10 (Active Duty) status and signs an ROI. If the SM is on
title 32 status (M-Day), DPH will contact and coordinate with civilian and other relevant victim advocacy services if the SM signs an ROI.

2. In the instance of a sexual assault, contact the Sexual Assault Response Coordinator, or designee, to take the report if the SM signs an ROI;

3. Determine the degree of support needed by the SM to address the immediate reporting issues, including the potential need for a victim advocate;

4. Should the SM decline to make a restricted report, the DPH shall urge the SM to report the incident to the SARC, a victim advocate, healthcare provider, command authorities or law enforcement for investigation.

5. Develop a safety plan in collaboration with SM/FMs who report incidents of domestic violence or sexual assault to address the trauma associated with the reporting process, and the potential impact the report may have on interpersonal relationships.

k. Limited Use Policy Explanation (ARNG Only)

1. If the DPH determines a SM is engaged in the abuse of alcohol or illegal substances, the DPH shall explain any relevant options and potential consequences.

2. In the case of NG SM, the DPH will explain the Limited Use Policy (LUP), and the benefits of participation in the program.

3. If the NG SM agrees to sign the LUP, the DPH will refer the SM to the Prevention Treatment Outreach Coordinator (PTO) or other appropriate individuals for follow-up.
Section III
Policy and Procedure for Assessment, Information, and Referral

3-11. Policy
Directors of Psychological Health will conduct a telephonic or face-to-face intake to gather demographic information and perform a brief behavioral health needs assessment to determine the type and degree of assistance that will most appropriately help SMs/FMs (SM/FM) resolve personal problems, conflicts, and mental health-related issues. When indicated by the intake process/brief needs assessment, the DPH will provide or coordinate the facilitation of a more in-depth telephonic or face-to-face clinical assessment to further determine the type and degree of assistance that will most effectively assist the SM/FM to resolve the identified behavioral health issues. Directors of Psychological Health shall encourage SMs to complete the ROI, with release to the Deputy State Surgeon (DSS) or Wing Commander in the event that issues related to mission readiness are at stake.

3-12. Responsibilities
   a. NGPHP Clinical Director will ensure that RL and all DPH staff are appropriately trained and understand the policies and procedures herein delineated.
   b. NGPHP RL, in conducting their regular supervision with DPH staff, shall ensure that standards set forth in this document are being properly upheld and procedures executed properly.

3-13. Procedures
   a. The following chart documents the types of clients and a range of services offered by the NGPHP. This document is not exhaustive, but rather meant to be a guide: See Attachment X: Client Levels Decision Chart (Levels 1-6)
   b. For casual contacts and Anonymous Information & Referral contacts, because there is no formal clinical assessment or other clinically based service being offered, it is not necessary to explain the informed consent process (including the NPP and SCU). For clients whom the DPH is likely to provide clinical services to (typically COSC ratings of yellow, orange and red), informed consent is required and the DPH will explain the Statement of Client Understanding (SCU), Notice of Privacy Practices (NPP), the scope of PHP services, confidentiality policy and its limitations to the SM/FM before initiating clinical services.
      1. When provided clinical services face-to-face, the DPH will provide a copy of the NPP for the SM to review and obtain a signed SCU. If any information about the client needs to subsequently be released, the DPH will obtain a signed release of information.
      2. When providing services via the telephone, when allowed by the DPH state's/territory's statutes, DPHs may obtain a verbal consent that is documented on a SCU form and stored with the DPH’s locked clinical records. DPH’s are required to clearly explain all major elements of the NPP and SCU. The DPH must also send a copy of the SCU and NPP, via email or fax, in order to obtain a signature. The DPH may also obtain a signature via a certified electronic signature service utilized for this purpose. The DPH will document when and how the SCU was sent to the client on the SCU that indicates the client’s verbal consent. The DPH will conduct a sufficiently thorough behavioral health assessment to make appropriate referrals.
      3. In emergency situations, the DPH may forgo informed consent, consistent with their state’s/territory’s licensure rules and regulations. Once the situation is stabilized, all follow-up clinical services requires informed consent with a signed SCU on file.
   c. The DPH will screen for crisis and address any emergent safety issues (reference (c)).
   d. The DPH and SM/FM will determine the appropriate course of action and identify the appropriate resource(s) based on the brief assessment.
      1. The assistance plan will be prioritized based on level of urgency (reference (c)).
2. The brief assessment form should not include detailed information that is typically considered “process notes” from a HIPAA perspective.

e. If the DPH determines that the information presented reaches appropriate thresholds for mandated reporting for child, elder, domestic violence, or potential for violence to self or others, reports shall be made only to individuals authorized by the governing state or territory statutes, rules, and regulations.

f. If the DPH determines a SM is engaged in the abuse of alcohol or illegal substances, the DPH will explain the benefits of signing the Limited Use Policy (LUP). {ARNG Only}

If the SM agrees to sign the LUP, the DPH will refer the SM to the Prevention Treatment Outreach Coordinator (PTO) or other appropriate individuals for follow-up.

g. If the DPH determines the SM poses a risk to mission readiness, the DPH shall consider the completion of the Intake Assessment form and Release of Information (ROI) form.

1. Issues that may interfere with a SM’s mission readiness include: PTSD, depression, TBI, severe sleep difficulties, alcohol and drug abuse or severe distress due to financial, legal or relationship issues.

2. Factors that would impact the decision to move forward with the complete assessment and ROI include:
   (a) Previous clinical history (medical and psychiatric)
   (b) Duration of clinical history
   (c) Severe mood swings
   (d) Prior hospitalizations
   (e) Current acuity
   (f) Collateral reports indicating severity (violence)
   (g) Violence toward property and animals
   (h) Co-occurring substance abuse
   (i) Family history of mental health and suicide
   (j) Recent domestic violence incidents
   (k) Access to weapons
   (l) Severe financial or legal issues
   (m) Relationship conflicts
   (n) Poor work performance

If the DPH determines that completing the ROI is in the best interest of the SM, the DPH shall explain the benefits, risks, and obligations/duties associated with the ROI form, and have the SM sign the release to forward the relevant information to the designated/appropriate authority, e.g., DSS, Flight Surgeon, Wing Commander etc.

h. If the SM refuses to sign the ROI, the DPH will follow up with an interview as to the reasons why the SM is unwilling to sign and clarify any misunderstandings.

i. If the DPH determines the SM poses a risk to mission readiness, when there is a signed ROI, the DPH will complete a report for the Wing Commander or DSS.

The DPH should discuss and develop an understanding with his/her Wing Commander or DSS the process and content that will be shared with them.

j. When a SM’s current mental status impacts mission readiness, the DPH will provide the designated/appropriate authority a report that addresses the following:

1. SM contact information
2. SM COSC rating
3. High interest indicators
4. Referrals provided
5. Estimated time in treatment until green COSC
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k. DPH staff will monitor inpatient and outpatient services in emergent and urgent situations and provide follow-up care as clinically appropriate.

l. The DPH will encourage the SM/FM to pursue and accept needed assistance.

m. The DPH will contemplate the appropriate steps to make a successful referral and communicate to the SM/FM the steps needed to receive assistance from the resource.

n. The DPH will provide initial telephonic follow-up to help facilitate success of the referrals (when applicable) to determine whether additional resources were obtained and were helpful to the SM/FM.

o. After completing all follow-ups and the SM/FM reports their needs to have been met, the SM/FM satisfaction survey will be offered and the case will be categorized as closed and “inactive.”

p. Making Referrals
   1. The DPH will educate the member on the therapy process. This includes encouraging the member to disclose all issues for which they would like help and empowering the member to help their mental health provider understand what they need (e.g., a more direct approach).
   2. The DPH, whenever possible, will provide names and numbers of three potential mental health providers when referring a client for mental health treatment. In the case of referral to a non-profit organization, three organizations will be offered.
   3. Whenever possible, the DPH will subscribe to the member’s choice with respect to language, gender, religious, cultural, and/or ethnic preferences related to the referral resource.
   4. To promote follow-through, the DPH will encourage the member to make the call and set up the initial appointment with the mental health provider while still in the DPH’s office.
   5. The DPH will request the client to sign a release of information form for each mental health provider option to increase effectiveness of referral management services.
   6. If a client has a non-clinical issue that can be resolved in up to six sessions (including an intake biopsychosocial assessment session, if needed), then the DPH can assist them in meeting their goals or resolving their presenting issue/problem(s). In cases where more than three sessions (up to six are needed), RL approval is required. For non-clinical issues, the DPH and SM/FM will draft an action plan to resolve the problem, and will identify the appropriate resource(s) to implement the plan.
   7. If the client has a non-clinical issue that cannot be resolved in up to six sessions, the DPH will refer the client for services.
   8. If the client has an issue, which is clinical in nature, the DPH will refer the member to a mental health provider/psychotherapist following the intake assessment session(s).
      (a) If the client is eligible, the DPH will first recommend services through the Veterans Administration, MTF, or TRICARE.
      (b) The DPH may also recommend other options including but not limited to the NG member’s or spouse’s civilian employer benefits, community mental health agencies, and TRICARE Reserve Select.

3-14. References
   a. NG, Psychological Health Services, Contract Number W9133L-13-D-0002
   b. PHP Confidentiality Policy
   c. DPH Referrals Policy – Type and Level of Urgency
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d. DoD 1010.4 Substance Abuse
e. DoD 5400.11 Privacy Program
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Section IV
Consultation & Program Development Services

3-15. Policy
Directors of Psychological Health (DPH staff) may engage in either clinical or non-clinical consultation with clients or stakeholders based on the nature of presenting issues. If the DPH determines that the issue is of a clinical nature, the consultation will require a degree of confidentiality appropriate to the circumstance. If the consultation is of a non-clinical nature, there may still be a need for some degree of confidentiality. In all instances, the DPH shall make every effort to work with the client or stakeholder to assist them to effectively address their concerns.

When a barrier to mental health services in any state is noted, or when a behavioral health need of a SM or FM cannot be met with existing resources or systems, the DPH may work in conjunction with members of the NG and community stakeholders to address those needs by seeking out evidence-based programs or methods that would provide SMs and FMs (SM/FM) SM/FM with potentially cost-effective services.

Implementation of a consultation/program development plan for a state/territory would be developed jointly between the assigned DPHs and the designated POCs within the State/Territory, the NGPHP RLs, and Program and Contract leadership. They will work collaboratively in developing metrics for periodic progress reports that would focus on both process objectives and outcome measures.

3-16. Implementation Guidelines for the Consultation Process
a. Utilize the health promotion model endorsed by the public health community to address either universal or targeted prevention measures in the military community;

b. Utilize early intervention measures focusing on evidence-based methods;

c. Utilize crisis intervention methods adjusted for both population and environmental issues;

d. Utilize post-incident responses to emergencies emphasizing recovery;

3-17. Consultation Documentation
a. DPH staff shall keep appropriate records of their consultations provided in a manner consistent with their licensure requirements and state and federal statutes.

b. DPH staff record additional information regarding Points of Contact on their Activity Tracking Log, which assists NG in tracking how the DPH staff are coordinating/collaborating their PH services.

3-18. Program Development Guidelines
a. Identification of Need. DPH—through research, anecdotal evidence, professional experiences, and/or through NG Bureau leadership directive—identifies the need(s) and barrier(s) to effective service delivery.

b. Planning. Mental wellness/mental health programs should fit within the NG Bureau mission and its strategic plan. A new program should have a set of deliverables along with dates and persons responsible for achievement. Stakeholders are identified and engaged, ensuring that persons and/or agencies having both an interest and projected impact upon the program are included in the planning process.

c. Monitoring. Periodic assessment of resource allocation and expenditures along with outcomes can result in modifications to a project to make it more productive and efficient. Monitoring may be both formal and informal. Monitoring and evaluation are geared to the individual program, but all involve assessing results/outcomes, ensuring the degree to which a program is coordinated with other programs, and consideration of both short-term
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and long-term goals.

d. Evaluation. Evaluation includes assessment of process and outcomes in light of intended goals. Monitoring is a form of ongoing evaluation that happens throughout the life of the program. Major program evaluations should occur at regularly pre-planned intervals, (e.g. annually), and when the program ends.

e. Program Development Documentation.
1. Data is captured quarterly and includes all of the areas listed and provides data on: new programs in each state, depth of involvement of DPH, and time spent on each activity. Documentation also serves as an idea board for any DPH looking for greater state visibility.
2. DPH staff shall, at the request of program Leadership, complete appropriate NGPHP documentation in order to properly capture program development data.

See Appendix. Clinical Versus Non-Clinical Consultation, page 108

Section V
Case Management Services

3-19. Policy
DPH staff provide clinical case management services for NG SMs and FMs (SMs/FMs), based upon the DPH staff evaluation of the SM/FM’s need for clinical behavioral health services. DPH staff shall, when contacted for services, make every effort to provide competent clinical case management services by conducting clinical interviews, documenting intake reports, screenings, assessments, consultations, progress notes, and other reports to ensure that clients receive competent services to meet their needs within the limits of their licenses and program parameters.

DPH staff are required to consult with their RL and/or Deputy or Program Director on all high profile and high interest cases. When a DPH leaves the NGPHP, all of their open cases will be closed or transitioned to the appropriate PHP Lead, who shall follow up to ensure that the client is referred to the proper level of care.

DPH staff will ensure that high profile and high interest cases are provided with clinical oversight by qualified personnel prior to leaving employment, which may include a DPH back-up clinician, a contracted local therapist, a VA therapist, an MTF clinician, or other qualified professional. A review of all cases with the RL with disposition recommendations will occur prior to leaving employment.

3-20. Case Management Protocols
a. Opening a Case. Cases are considered “open” when contact has been made with a DPH along with a signed SCU, and a determination has been made via completion of an intake, assessment, screening, or consultation process that a SM/FM is in need of clinical assistance. Completion of PHP intake assessment, consultation and progress note forms on the secure SharePoint site formally initiate the opening of a case. Opening a non-clinical case only requires a signed SOU and progress note forms.

b. Military Restricted Reporting Cases. Military Restricted Reporting Cases will be left open 30 days from the date-of service in the event the SM/FM calls back for an additional referral.

c. Progress Reports. DPH staff shall monitor progress of SM/FM on clinical objectives and plans, and document on the Progress Notes forms on the SharePoint site. This constitutes a chronological record of client contacts, as well as any collateral contacts regarding client progress. Monitor inpatient and outpatient services including:
1. Conducting face to face, telephone and/or written-email contacts with the member and therapeutic agency to monitor progress as clinically appropriate.
2. Urging the member and/or therapeutic agency to develop an aftercare/continuing care plan.
3. When appropriate, being available to provide back to work meeting with the member and appropriate NG command to ease the member’s return to work transition after an absence due to treatment participation.

d. Incident Reports (refer to Policy #306 Incident Reports for details): When DPH staff become aware of client behavior that warrants reporting to commanders, RL, or other authorities because of high interest or high profile circumstances, DPH staff are to:
   1. Consult NGPHP Policies on Incident Reporting to ensure proper intake and confidentiality procedures have been followed.
   2. Determine current case acuity, risk factors, safety plan issues (as appropriate), and communicate with appropriate authorities. If in doubt, consult with RL, Deputy Director, or Program Director as available.
   3. Should an incident involving a client involve a high profile event or a fatality, a written SITREP defining the following to the RL, Deputy Director, and Program Director, should be constructed, including the following information:
      (a) What occurred, and the impact on SMs/FMs
      (b) The degree of involvement PHP has had with the SM/FM involved in the incident
      (c) Known precursors of the events
      (d) Forecast of client risk/safety concerns (as appropriate)
      (e) Current response by local authorities to the incident
      (f) Recommendations for short-term response

e. Closing a Case. Cases will not be closed until referral for services has been completed and appropriate post-service follow-up is documented. Open cases may be closed with one follow-up if no further action is indicated. Typically, open cases can be closed within a month of when they were opened. Other variations on case closure include:
   1. Cases with referrals may be closed when the DPH assures that linkage with the referral source has been successful via follow up contact with the SM/FM or when an attempt to follow up has been completed 3 times with no ability to reach the SM/FM.
   2. Cases that resulted in a referral to health insurance, the VA, an MTF, Military One Source (MOS) or community resources may be closed at such time as the DPH and the SM/FM agree that PHP assistance is no longer required and the SM/FM has reported his or her presenting need(s) has been met.
   3. Should there be an unforeseen event that would prevent the DPH to effectively close a case, the DPH RL will assign or delegate a follow-up or case closure to another member of the team; or, will take personal responsibility to follow up the case to ensure the client’s connection to appropriate services.
   4. Under all case closure scenarios, the DPH will document outcome in the Progress Note form. Outcome information includes: changes in condition regarding the presenting issue, a report in changes or impact at work and SM/FMs current condition. Any referrals or recommendations for further action by SM/FM will also be included in the affiliate’s case closure documentation in the Progress Note form.

f. Non-Clinical Follow Up. Any non-clinical matters requiring additional assistance on a closed case may be addressed via opening a new case. After six (6) months, a new SCU and other specific forms will need to be completed in order to provide SM/FMs with additional services.

g. Managing High-Interest Clients.
   1. Clients judged to be at a higher level of risk for psychological decompensating significant maladaptive behavior will be categorized as high interest. The DPH will designate a client as high interest after they have consulted with the RL and reached a consensus that heightened monitoring is indicated and the threshold for proactive intervention is lower than what is required for other clients. This process is internal to
the program for continuity of care. Designate case files involving high-interest clients with red on the label. High Interest clients are those who are categorized as “Orange” or “Red” on the COSC scale.

2. High interest clients include those with any of the following:
   (a) Emergency or urgent referrals to a mental health provider
   (b) Reactivated former high interest clients
   (c) Cases involving alcohol and/or other drug use
   (d) Suicidal or homicidal risk
   (e) Threats or actual acts of violence
   (f) Child, elder, vulnerable individual abuse/neglect, or partner abuse
   (g) Confirmed TBI and/or PTSD cases
   (h) Clients being discharged from higher levels of care
   (i) Significant psychopathology rendering the client unable to provide for their own wellbeing or their dependent children
   (j) Other cases as determined by the DPH or mental health provider

h. The DPH will staff all high-interest cases with the RL and:
   1. High-interest cases will be staffed on a weekly basis or more frequently if needed until the client is no longer deemed at risk or high interest. (RL and the DPH using the COSC)
   2. The DPH will annotate case staffing with the RL in the client case record and weekly report if applicable.
   3. When there is a high interest case, the DPH will attempt to have weekly contact with the mental health provider to ensure continuity and quality of care until there is no longer a risk concern. These attempts will be documented. The DPH will request the mental health provider to contact the DPH in the case of missed or rescheduled appointments or clinical concerns.
   4. If a client voices having suicidal or homicidal thoughts with no immediate intent, the DPH must contact a mental health provider to schedule an urgent appointment while the client is still physically present.
      (a) The DPH will also activate a safety plan with the unit commander and/or first sergeant until the appointment is met.
      (b) The DPH must follow up with the mental health provider within 24 hours of the scheduled appointment to ensure the client attended the appointment.
   5. When the DPH, in consultation with the RL, determines the client is no longer a high-interest client, the follow-up schedule will return to the standard program guidelines for follow-ups.
   6. Under no circumstances should a DPH go to a private residence to attend to a high-interest situation.

7. Release of Information (See Appendix 4 – Release of Information (ROI) Form)
   (a) The ROI Form is utilized to facilitate the exchange of information with third parties.
   (b) The DPH must ensure proper completion of the ROI Form prior to releasing any client information, excluding those exceptions provided for in the NPP.
   (c) The ROI Form must include the nature and scope of the topics and material to be released, to whom the information may be released, the purpose of the disclosure, and the date on which the consent will be terminated.

3-21. Investigations, Inspections, and Legal Proceedings
   a. The DPH is assigned as a direct asset to the NG leadership and therefore is a representative of their assigned military unit for matters pertaining to psychological health.
   
   b. The DPH represents neither the NG nor the client on legal matters and must direct any legal counsel requests to the Staff Judge Advocate (SJA) or other designated military legal counsel for review and await their guidance.
   
   c. In the event of an investigation, either internally or externally driven, pertinent data and
records will only be released upon receipt of a Government-issued subpoena or with a release of information form signed by the client.

d. The DPH will consult with their RL, as needed, to clarify their responsibilities in maintaining the confidentiality of client information through any legal proceedings associated with a client.

e. The NGPHP Program Director or Deputy will inform the appropriate contractor leadership (e.g., Program Manager(s), etc.) of any investigations or legal issues which could potentially involve the NGPHP.

Section VI
Cases with Substance Abuse Concerns

3-22. Policy
ARNG DPHs shall offer SMs who appear, based on preliminary assessment, to manifest a substance abuse disorder, the opportunity to participate in the Army’s Limited Use Program.

Should the SM/FM desire to make a report to the proper authorities or command, it would remain the SM/FM’s responsibility to complete the reporting process or participate in the ARNG Limited Use Policy. If the DPH determines a SM is engaged in the abuse of alcohol or illegal substances, the DPH will explain the benefits of signing the Limited Use Policy (LUP). If the SM agrees to sign the LUP, the DPH will refer the SM to the Prevention Treatment Outreach Coordinator (PTO), Substance Abuse Program Manager (SAP) or other appropriate individuals for follow-up.

3-23. Documentation and Reporting
Documenting and reporting of incidents of domestic violence, alcohol and substance abuse, and sexual assault are disclosed only when state laws or U.S./DoD regulations mandate such action. Where not mandated or allowed, the DPH will keep such information confidential.

In the case of ANG SM, the LUP does not apply. The ANG DPH will explain options according to Air Force regulations or refer the Airman to discuss their options with an ANG representative.

3-24. Procedures:

a. ARNG DPHs engaged in the clinical assessment and referral process with ARNG SMs who determine that the SM is likely to manifest a substance abuse disorder, need to consult with the protocols and resources below to assist the SM to consider his/her options.


d. U. S. Army Fort Sam Houston Army Center for Substance Abuse Programs:

(1) In situations where the ARNG SM is believed to manifest substance abuse disorders, the following form shall be used to document the process of engaging the SM in a discussion of his/her options under Army regulations

(2) ARNG DPH consultation with the local PTO office is highly recommended on cases that appear to meet substance abuse criteria.
3-25. IAW AR 600-85
As of 15 April 2008

1. The Army realizes that treatment for alcohol or other drug abuse will be more effective if soldiers can admit to drug abuse without this important information being used against them. Therefore, the Limited Use Policy was developed.

   SM initials ________

2. The limited-use policy does not legitimize use or possession of drugs- it provides a way for soldiers to admit their problems and get help.

   SM initials ________

3. Information covered by Limited Use includes what you tell the JSAP Staff or your Chain of Command as part of the process of being enrolled about your past use of alcohol or other drugs, or your past possession of drugs for personal use. Limited Use covers PAST events, not events in the future. It does not cover actions related to alcohol or drug use such as an accident while driving under the influence.

   SM initials ________

4. Administrative action is possible if your commander becomes aware of your use or abuse of drugs independently from the information you gave the ASAP Staff.

   SM initials ________

5. The policy applies automatically; it cannot be given or taken away. It is intended to assist soldiers who wish to self-refer to the JSAP or those who have been referred in other ways and want rehabilitation. The policy does NOT protect soldiers who are attempting to avoid disciplinary or UCMJ action.

   SM initials ________

6. The limited-use policy will not protect you from being investigated for criminal activity not directly related to drug use or possession, losing your security clearance, having your MOS reclassified or withdrawn, or having hazardous duty orders suspended or revoked.

   SM initials ________

7. Limited Use is a legal policy. If you have any questions that cannot be resolved by the JSAP Staff or your Chain of Command, then you should consult with the JAG Office.

   SM initials ________

3-26. Communication of Mission Readiness

a. If the ARNG DPH determines the SM poses a risk to mission readiness due to their use and/or abuse of alcohol and/or drugs, the DPH shall consider the completion of the Assessment Form and Release of Information (ROI) form.

b. If the ARNG DPH determines that completing the ROI is the best interest of the SM, the DPH shall explain the benefits, risks, and obligations/duty associated with the ROI form, and have the SM sign the release to forward the appropriate information to the DSS.

c. If the SM refuses to sign the ROI, the ARNG DPH will follow up with a detailed interview as to the reasons why the SM is unwilling to sign and clarify any misunderstandings.
d. If the ARNG DPH determines the SM poses a risk to mission readiness, the ARNG DPH will complete a report for the Commander and DSS. The ARNG DPH should discuss and develop an understanding with his/her DSS the process and content that will be shared with the DSS’s office. This disclosure is separate from standard “Duty to Warn” situations which have their own protocol.

When a SM’s current mental status impacts mission readiness, the ARNG DPH will provide the DSS a report that addresses the following:
1. SM name and contact information
2. COSC rating
3. High interest concerns
4. Referrals
5. Likely time in treatment until green COSC rating

3-27. Referral and Case Management of Substance Abuse Cases
a. The DPH and SM/FM will determine the Initial Assistance Plan (Glossary) and will identify the appropriate resource(s) based on the assessment of needs, and by whether the situation is categorized as emergency, urgent, or routine.

b. The ARNG DPHs shall in all cases involving client substance dependence refer the client to a licensed in- or outpatient substance dependence treatment resource as well as to a self-help group. Should a client prematurely leave a treatment program, the client’s clinical record shall reflect that this has taken place. When SMs who were not referred as the result of a positive drug test are assessed as having substance abuse dependence, ARNG DPHs are to consider if release of information is required on a need to know basis.

c. If a SM is referred by the Command as the result of positive alcohol and/or other positive drug test as part of a substance abuse program, the DPH shall refer the SM to a Substance Abuse Professional (SAP). Management of the case is to be in accordance with DOD, Army, and Air Force policies and procedures as they apply to the NG and Reserves. These include Army Regulation 600-85, The Army Substance Abuse Program, Air Force Instruction 36-810, the NG J-3 Counterdrug Program, Department of Transportation (DOT)/Federal Highway Administration Controlled Substances and Alcohol Use and Testing Rule as amended, or by any overriding NG and Reserves policies and/or programs then existing.

d. The DPH is to immediately notify both the SM's Commander/supervisor and the Medical Review Officer (MRO) if the SM terminates treatment prematurely. Responsibility for referrals resulting from positive drug tests defaults to the NG Prevention Treatment and Outreach (PTO) program where there is a PTO program in existence. DPHs may assist the PTO in making referrals for SMs who have received a positive drug screen. A Release of Information must be signed by the SM in order to ensure proper communication of referral, follow up and treatment completion to the PTO and/or Commander.

e. Clients shall be followed-up for one (1) year in cases involving substance abuse or chemical dependency, threats of or actual violence, or child or elder abuse/neglect. In cases where the SM is subject to a Last Chance Agreement or other settlement agreement, SMs shall be followed-up for the length of the agreement. If the SM is non-compliant with a counselor's recommendations, or wishes to have his/her case closed, the counselor shall notify the proper personnel including Command personnel and Medical Review Officer (MRO) as provided for by regulation, NG policies or signed Releases of Information. The SM will then be discharged from PH-RC, and the case closed.
Section VIII
Incident Reports

3-28. Policy
Incident reports on the behavioral health implications of NG activities are critical for optimal decision-making for both small (i.e., those incident involving only a few individuals) and large incidents (i.e., those events that impact many individuals). Because of the variety of incidents that a DPH may encounter, there are a number of different reporting strategies that are necessary to the operation of the program. These include:
   a. EXSUMs
   b. Behavioral Health Situation Reports (BH-SITREPs)
   c. Behavioral Health Incident Response Needs Assessments and Plans (BH-IRNAP)
   d. Behavioral Health Incident Response Plan (BHIRP)
   e. Behavioral Health After Action Report (BH-AAR)

Incident reports serve the purpose of informing key stakeholders in the NG, medical, and supportive services of the nature and severity of the incident, and the short and long-term needs to respond to the incident. Reports on “Critical Incidents” serve to notify leadership of the most serious events which require the response, in most cases, of DPHs.

3-29. Definition(s)

**Critical Incident:** Any incident which involves a NG SM or FM which requires a rapid response on the part of DPHs. The incidents that are included are (but not limited to):
   a. Death of any NG SM
   b. Suicide of any SM/FM
   c. Attempted Suicide of any SM/FM
   d. NG plane or helicopter crash
   e. Homicide incidents with involvement of SM/FM
   f. Any DPH response to a traumatic event or natural disaster.

The definitions in the Crisis, Emergency, Critical Incident and Disaster Response policy provide for a more comprehensive set of operational definitions and procedures for response. COSC situational ratings of Red or Orange require reporting through a SITREP, while Yellow or Green ratings do not warrant such a report unless there is the likelihood that the situation will escalate to at least the Orange level.

**DPH Service Request (DSR):** The point at which a military POC or authority determines that a critical incident has occurred, and that a behavioral health response is required of a DPH.

3-30. Incident Reporting Protocol

When DPHs become aware of client behavior that is high interest or high profile that warrants reporting to commanders, RLS, or other authorities, DPHs are to:
   a. Ensure proper intake and confidentiality procedures have been followed, if appropriate to the incident. In most cases, the names and identifying information of the SM/FM are NOT to be documented in these reports.
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b. Determine current case acuity based on both clinical and COSC (Attachment X) criteria, risk factors, safety plan issues (as appropriate), and communicate with appropriate authorities. If in doubt, consult with RL, Deputy Director or Program Director, as available.

c. Any incident that does not rise to the level of a “critical” incident but has a high level of visibility in the military or local community requires the completion of an ExSum report. These are often instances where SMs are the subject of newspaper articles or rumors that may involve a potentially negative impact on the NG, the unit, or the SMs family.

3-31 Incident Report Documentation Procedures

I. All critical incidents as defined in 3-29 shall be documented on the Behavioral Health SITREP form.

II. The RL will work with the DPH in preparing the BH-SITREP and shall consult with the Deputy Director or Program Director on the final content.

III. Incidents with a COSC rating of Red, or Emergent, shall be reported to NGB within 8 hours.

IV. Incidents with a COSC rating of Orange, or Urgent, shall be reported to NGB within 24 hours.

V. The critical incident notification process will proceed with the following guidelines:

   A. The notification process is controlled and initiated by a designated state or local military authority. Typically, this authority will be the DSS (for ARNG) or the Wing CC (for ANG) or designated authority. It is the military authority that determines the DPH Service Request (DSR) (see definitions), and is authorized to request the services of a DPH for behavioral health response.

   B. The DPH shall have direct communication with their designated military authority and obtain approval to release notifications of any and all critical incidents.

   C. Once this approval is obtained, the DPH will immediately call their Regional Lead (RL) to facilitate the notification process and conduct a situational review. If the DPH is unable to reach their RL within one (1) hour, the DPH will attempt to contact the Deputy Director or Director to facilitate the notification process.

   D. The RL will immediately call the Deputy Director or Director to report the pertinent details related to the incident.

   E. The Deputy Director or the Program Director will immediately send an email to the COR and the appropriate NG PHP Branch Chief to report the pertinent details of the incident. The remaining notifications for a critical incident will proceed in accordance with the following schedule:

      • Within 8 hours after notification from military authority (POC or ranking officer)
      • Within 24 hours file first follow-up report on BH-SITREP form, labeled “Follow-Up Report #1)
      • Within 72 hours, file second follow-up report, labeled “Follow-Up Report #2)
        o If incident appears to be of prolonged length, include the nature of the incident and the authority’s forecast of the potential length of the incident (e.g., natural disaster that will require at least two weeks for initial response; or, prolonged hostage situation that may last several days, etc.).
      • When situation has stabilized, having reached at least the COSC Yellow level, an AAR is filed after consultation with POC.

   F. Should the initial incident verification occur after DPH duty hours, the initiation time for the development of the BH-SITREP starts at the beginning of the next work day for the DPH.

   G. Should the DPH not be able to reach the RL, Deputy or Director because of technological or communication problems associated with remote locations, contact with any of the branch Regional Leads for consultation is permissible. In such situations, and where the situation warrants a COSC Red rating, the Regional Lead may need to construct the BH-SITREP on behalf of the reporting DPH and follow appropriate protocols from that point onwards.
See Attachment X:
1. Crisis and Disaster Response Communication Guidelines
2. EXSUM Report
3. BH-SITREP
4. Guidelines for Use of the NGPHP Emergency Behavioral Health Incident Response Needs Assessment/Plan
5. NGPHP Emergency Behavioral Health Incident Response Needs Assessment
6. PRELIMINARY RESPONSE ASSESSMENT/ BHIRP
7. BH-AAR GUIDELINES
8. BH-AAR Format

Section IX
Crisis, Emergency Critical Incident and Disaster Response

3-32. Policy
Personnel within the NGPHP shall provide crisis, emergency and critical incident response services to SMs in the NG and their FMs as part of the response to crises, emergencies, critical incidents, and disasters (CECID). Responses will be consistent with best practices models of response, the needs of SMs/FMs, the resources available at the time of the response, and the degree to which DPHs have been trained to respond to CECID.* NGPHP personnel responding to CECID shall respond to CECID incidents in a manner that promotes the safety and welfare of all concerned, and shall not expose themselves to hazards inconsistent with the role of a behavioral health consultant. NGPHP personnel shall work with their local NG POCs and their RL to determine the appropriate role and expectations for a DPH as part of their installation’s emergency management plan per DoDi 6055.17. Initial contacts with clients or potential clients involved in CECID incidents shall focus on emotional and behavioral stabilization and safety. All contacts with clients shall be documented in the clinical record; all critical incidents shall be documented using the NGPHP SITREP form. NGPHP personnel adhere to the Basic Principles of emergency Behavioral Health Response (Attachment 1), and the Core Action of Psychological First Aid (PFA) (Attachment 2). RLs, Deputy Program Directors, and Program Directors may play key roles in orchestrating an effective response to specific incidents, providing for the potential of a need for the accessing of resources and surge support in large-scale emergencies and disasters.

3-33. Definition(s)

a. Behavioral Health Emergency: “…a situation that requires immediate response to avoid possible harm. The three major behavioral emergencies are suicidal behavior, violent behavior, and interpersonal victimization.” (Callahan, J., 2009, page 13)

b. Behavioral Health Emergency Intervention: “An emergency intervention is a single interview conducted on an immediate basis. Its goals are threefold. The first goal is to evaluate the status of the patient and the potential for harm. The second is to intervene in that situation if possible, to reduce the risk of harm. ... The third goal is the plan, or disposition—what should be done next?” (Callahan, 2009, page 4).

c. Critical Incident: “A critical incident is any event or situation that threatens people and/or their homes, businesses, or community. While we often think of floods, tornadoes, hurricanes, or armed assailants as posing critical incidents, the true definition of a critical incident includes any situation requiring swift, decisive action involving multiple components in response to and occurring outside of the normal course of routine business activities.” (Jones, 2000, p. 4)

_The federal public health definition_ (42 C.F.R. Part 51d) includes the following:

“… (the) inability to meet the mental health and/or substance abuse service needs of a local...
community is the direct consequence of a clear precipitating event. This precipitating event must:

(i) Have a sudden, rapid onset and a definite conclusion, such as:
   (A) A natural disaster (including, but not limited to, a hurricane, tornado, storm, flood, earthquake, fire, drought, or other natural catastrophe); or
   (B) A technological disaster (including, but not limited to, a chemical spill, a major industrial accident, or a transportation accident); or
   (C) A criminal act with significant casualties (including, but not limited to, a domestic act of terrorism, a hostage situation, or an incident of mass violence including school shootings and riots); and

(ii) Result in significant:
   (A) Death,
   (B) Injury,
   (C) Exposure to life-threatening circumstances,
   (D) Hardship,
   (E) Suffering,
   (F) Loss of property, or
   (G) Loss of community infrastructure (e.g., loss of treatment facilities, staff, public transportation and/or utilities, or isolation from services);’ …(42 C.F.R. PART 51d.5—Mental Health and Substance Abuse Emergency Response Procedures)

For the purposes of providing incident reports to the NG COR, the definition is:

Any incident which involves a NG SM or FM which requires a rapid response on the part of DPHs. The incidents that are included are (but not limited to):

i. Death of any NG SM
ii. Suicide of any SM/FM
iii. Attempted Suicide of any SM/FM
iv. NG plane or helicopter crash
v. Homicide incidents with involvement of SM/FM
vi. Any DPH response to a traumatic event or natural disaster

d. Critical Incident Plan: “Action plan developed to mitigate, respond to, and recover from a critical incident. Includes steps to guide the response and recovery efforts. Identifies persons, equipment, and resources for activation in a disaster and outlines how they will be coordinated.” (Jones, 2000, p. 37)

e. Crisis: An event or set of circumstances which demands immediate action to preserve public health, protect life, protect public property, or to provide relief to individuals or groups impacted by such occurrences. Usually involves small numbers of individuals, but may be high intensity situations.

f. Disaster: An occurrence of a natural catastrophe, technological accident, or human-caused event that has resulted in severe property damage, deaths, and/or multiple injuries and possibly mass casualties. Per the federal Stafford Act, a “major disaster” is “any natural catastrophe […] or, regardless of cause, any fire, flood, or explosion, in any part of the United States, which in the determination of the President causes damage of sufficient severity and magnitude to warrant major disaster assistance under [the] Act to supplement the efforts and available resources or States, local governments, and disaster relief organizations in alleviating the damage, loss, hardship, or suffering caused thereby.”

1. Types of Disasters: The size and scope of the disaster determine the level of response and the extent of operations, including three broad categories:
   (a) Catastrophic: Widespread destruction and devastation of homes and business and/or infrastructure and public property. The response is beyond the combined capabilities of the state and local governments. The governor is likely to request a presidential disaster declaration, and it is likely to be signed within hours. The event dominates
news worldwide.

(b) Severe or nationally significant: Widespread destruction of homes and businesses and/or infrastructure and public property. The response and recovery is likely to be beyond the capability of the state and local governments. The governor may request a presidential disaster declaration, and it may be expedited for signature within hours or a few days. The event is the subject of ongoing national media coverage.

(c) Localized: Usually characterized by destruction of homes and businesses and/or infrastructure and public property. Occasionally, localized disasters or emergencies may be declared when the impact of a specific event causes undue hardship on an area or population. The response is beyond the combined capability of state and local governments, and is reviewed by FEMA and the White House. A disaster declaration may take anywhere from several hours to a few days or weeks for approval, depending on the nature of the request and the information provided by the state. The event may receive some short-term national media coverage.

g. Emergency: A crisis that impacts a larger networks of individuals, units, communities, etc. Emergencies typically require responses from law enforcement, fire, emergency management, public health, public works, private security, and other similar agencies and organizations. Examples include hostage situations, suicide attempts/completions, assaults, homicides, fires, local floods, local extreme weather incidents, etc.

*Note: The terms “crisis” and “emergency” are often used by unlicensed personnel in a vague manner that may not be consistent with health care nomenclature. DPHs may not be aware of the specific nature and scope of a problem when asked to respond, and may find themselves dealing with a crisis or emergency that rapidly evolves into a critical incident. Should this be the case, documentation should be completed based on the assessment of the situation at the time of the report. Should the nature or scope change, such changes should be reflected in follow up reports.
3-34. Procedures  

a. Process for DPH Responding to Crises/Emergencies

1. Upon receipt of a request for response to a reported crisis situation, the DPH shall:
   (a) Interview the requester, to the extent possible, to determine the nature and scope of the incident, including:
      (1) The names of those involved and their relationships to one another
      (2) The nature of the incident (i.e., the severity of the incident in terms of degrees of harm to those involved and the motives of those involved, if known.
      (3) The reason for requesting behavioral health intervention (compared with law enforcement, security, paramedics, etc.), and the immediate expectations of the requester.
      (4) The degree to which safety measures have been taken that would support an in-person response (e.g., law enforcement, security or healthcare personnel who have secured the scene or are responsible for the physical stabilization of the client(s)).
      (5) The degree to which telephonic consultation would suffice, including telephonic discussion with the identified client(s). This is of particular importance in incidents that are a significant distance from the location of the DPH.
      (6) If the individual is a client of the PHP, documentation shall be made in the clinical files. If the individual is not a client, documentation shall initially be made on a program SITREP form; further documentation should be determined in clinical consultation with the RL.
   (b) If the requestor insists on in-person response, the DPH shall consult with the RL, Deputy Director, or Program Director prior to on-site intervention.

2. If the response is telephonic, the DPH shall utilize the National Suicide Prevention Lifeline crisis response protocols as a guide (Attachment 5).

   The DPH shall use the COSC scale and the Columbia Suicide Severity Risk Scale (CSSRS) to assist in decision-making if there is evidence of an imminent act of suicide or self-destructive behavior.

3. If the response is in-person, the DPH shall, to the best of their ability, utilize the principles of workplace safety as defined by the International Association of Chiefs of Police (IACP) in dealing with potentially violent situations in the workplace (Attachment 3).

   DPHs who encounter clients or potential clients who appear to be engaging in threats of violence or harm towards other shall, to the best of their ability, use standard interview strategies to understand and clarify the elements of the specifics and motivations behind the threatening behavior. When it appears that the behavior is targeting specific individuals, use of the U. S. Secret Services model of “Questions to be Addressed in Case Investigations of Potential Targeted Violence” (Attachment 4) shall be employed subject to the client/potential client’s willingness to participate in the interview.

4. Should any of the results of the interviews indicate a clear threat of harm to self or others, the DPH shall follow local laws and regulations regarding contact with mental health civil commitment authorities, law enforcement, or the targets of violence per duty to warn or protect requirements. Mandated reporting requirements shall also be addressed. Refer to Policy 207 “Duty to Warn/Protect Requirements” for details.

b. Process for DPH Supporting a Critical Incident

1. When notified by local NG leadership that response to a critical incident is required, the DPH will notify the RL, Deputy Director or Program Director for guidance.

2. Unless otherwise specified, DPHs shall employ the policies and practices within the NGPHP Crisis Response Plan.
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3. The RL will assume responsibility for organizing and communicating role expectations for the DPH and will address any needs for enhanced response by other PHP personnel.

4. The DPH may be requested to travel to the incident site, and be able to work a minimum of 8 hours and a maximum of 12 hours per day. Such travel requires the approval from the RL, and consultation with either the Deputy Director or Program Director.

5. If a cross-branch DPH is supporting a DPH during a branch-specific crisis, the supporting DPH will act as support and secondary to the branch DPH. The DPH affiliated with the branch that is experiencing the emergency will take the lead in coordinating DPH crisis response and direct the supporting DPH according to the Branch’s behavioral health support needs.

6. Once on-site at the deployment location, DPHs will report to the Incident Commander/Manager to perform duties including, but not limited to:
   (a) Conduct assessment of situation using Behavioral Health Incident Response Needs Assessment and Plans form, unless local officials have an alternative needs assessment process.
   (b) Coordinating with local NG POC on the needs assessment prior to forwarding the information to RL.
   (c) Communicating the results of the needs assessment to the RL, who in turn will notify NG chain of command.
   (d) Develops preliminary response plan with the Behavioral Health Incident Response Plan form, unless local officials employ other methods.
   (e) Communicates plan with PHP RL after consulting with NG POC. RL forwards to chain of command.
   (f) Providing traumatic stress debriefings for identified groups using Psychological First Aid (PFA), Traumatic Event Management (TEM), and other critical incident response strategies per the individual’s training and as approved through the RL.
   (g) Providing one-on-one critical incident defusing sessions to individuals as needed.
   (h) Holding ad hoc information or support sessions in break-rooms and other areas where the opportunity presents itself.
   (i) Providing assessment and referral to medical counseling/treatment services when appropriate and in consultation with the RL.
   (j) Providing education to groups and one-on-one on the critical stress-related topics specific to the incident, including handing out customized psycho-educational materials to military members and their families.
   (k) Completing case notes and appropriate PHP paperwork by the conclusion of each shift (per PHP Policy 307: PHP Incident Reports).
   (l) Providing immediate response to the RL for information related to the services s/he is providing (daily, weekly or as needed).
   (m) Providing other clinical-related services as directed by the Incident Commander/Manager and/or RL.

3-35. References
   
   
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f. PHP Policy 307: PHP Incident Reports

g. NGPHP Crisis Response Plan (April 2013 Revision)
Attachment 1: Basic Principles of Emergency Behavioral Health Response

The ARNG and ANG PHPs endorse the model of behavioral health emergency and crisis services as defined by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) in their “Core Elements for Responding to Mental Health Crises” practice guideline (http://store.samhsa.gov/shin/content/SMA09-4427/SMA09-4427.pdf), including the following:

1. **Avoiding harm.** “An appropriate response to mental health crises considers the risks and benefits attendant to interventions and whenever possible employs alternative approaches, such as controlling danger sufficiently to allow a period of “watchful waiting.” In circumstances where there is an urgent need to establish physical safety and few viable alternatives to address an immediate risk of significant harm to the individual or others, an appropriate crisis response incorporates measures to minimize the duration and negative impact of interventions used.”

2. **Intervening in person-centered ways.** “Appropriate interventions seek to understand the individual, his or her unique circumstances and how that individual’s personal preferences and goals can be maximally incorporated in the crisis response.”

3. **Shared responsibility.** “An appropriate crisis response seeks to assist the individual in regaining control by considering the individual an active partner in—rather than a passive recipient of—services.”

4. **Addressing trauma.** “It is essential that once physical safety has been established, harm resulting from the crisis or crisis response is evaluated and addressed without delay by individuals qualified to diagnose and initiate needed treatment. There is also a dual responsibility relating to the individual’s relevant trauma history and vulnerabilities associated with particular interventions; crisis responders should appropriately seek out and incorporate this information in their approaches, and individuals should take personal responsibility for making this crucial information available (for instance, by executing advance directives).”

5. **Establishing feelings of personal safety.** “Assisting the individual in attaining the subjective goal of personal safety requires an understanding of what is needed for that person to experience a sense of security (perhaps contained in a crisis plan or personal safety plan previously formulated by the individual) and what interventions increase feelings of vulnerability (for instance, confinement in a room alone). Providing such assistance also requires that staff be afforded time to gain an understanding of the individual’s needs and latitude to address these needs creatively.”

6. **Based on strengths.** “An appropriate crisis response seeks to identify and reinforce the resources on which an individual can draw, not only to recover from the crisis event, but to also help protect against further occurrences.”

7. **The whole person.** “An individual with a serious mental illness who is in crisis is a whole person, whose established psychiatric disability may be relevant but may—or may not—be immediately paramount.”

8. **The person as credible source.** “…an appropriate response to an individual in mental health crisis is not dismissive of the person as a credible source of information—factual or emotional—that is important to understanding the person’s strengths and needs.”

9. **Recovery, resilience and natural supports.** “An appropriate crisis response contributes to the individual’s larger journey toward recovery and resilience and incorporates these values. Accordingly, interventions should preserve dignity, foster a sense of hope, and promote engagement with formal systems and informal resources.”

10. **Prevention.** “…an adequate crisis response requires measures that address the person’s unmet needs, both through individualized planning and by promoting systemic improvements.”
**Attachment 2: Core Actions of Psychological First Aid**

<table>
<thead>
<tr>
<th>Core Action</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Contact and engagement.</td>
<td>To respond to contacts initiated by survivors, or to initiate contacts in a non-intrusive, compassionate manner.</td>
</tr>
<tr>
<td>2. Safety and Comfort</td>
<td>To enhance immediate and ongoing safety, and provide physical and emotional comfort.</td>
</tr>
<tr>
<td>3. Stabilization (If needed)</td>
<td>To calm and orient emotionally overwhelmed or disoriented survivors.</td>
</tr>
<tr>
<td>4. Information Gathering: Current Needs and Concerns</td>
<td>To identify immediate needs and concerns, gather additional information, and tailor PFA interventions.</td>
</tr>
<tr>
<td>5. Practical Assistance</td>
<td>To offer practical help to survivors in addressing immediate needs and concerns.</td>
</tr>
<tr>
<td>6. Connection with Social Supports.</td>
<td>To help establish brief or ongoing contacts with primary support persons and other sources of support, including FMs, friends, and community helping resources.</td>
</tr>
<tr>
<td>7. Information on Coping</td>
<td>To provide information about stress reactions and coping to reduce distress and promote adaptive functioning.</td>
</tr>
<tr>
<td>8. Linkage with Collaborative Services</td>
<td>To assist survivors with warm handoffs to immediate need services.</td>
</tr>
</tbody>
</table>
**Attachment 3: Personal Conduct to Minimize Violence**

Follow these suggestions in your daily interactions with people to de-escalate potentially violent situations. If at any time a person’s behavior starts to escalate beyond your comfort zone, disengage.

<table>
<thead>
<tr>
<th><strong>Do</strong></th>
<th><strong>Do Not</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Project calmness: move and speak slowly, quietly and confidently.</td>
<td>• Use styles of communication which generate hostility such as apathy, brush off, coldness, condescension, robotism, going strictly by the rules or giving the run-around.</td>
</tr>
<tr>
<td>• Be an empathetic listener: encourage the person to talk and listen patiently.</td>
<td>• Reject all of a client’s demands from the start.</td>
</tr>
<tr>
<td>• Focus your attention on the other person to let them know you are interested in what they have to say.</td>
<td>• Pose in challenging stances such as standing directly opposite someone, hands on hips or crossing your arms. Avoid any physical contact, finger-pointing or long periods of fixed eye contact.</td>
</tr>
<tr>
<td>• Maintain a relaxed yet attentive posture and position yourself at a right angle rather than directly in front of the other person.</td>
<td>• Make sudden movements which can be seen as threatening. Notice the tone, volume and rate of your speech.</td>
</tr>
<tr>
<td>• Acknowledge the person’s feelings. Indicate that you can see he or she is upset.</td>
<td>• Challenge, threaten, or dare the individual. Never belittle the person or make him/her feel foolish.</td>
</tr>
<tr>
<td>• Ask for small, specific favors such as asking the person to move to a quieter area.</td>
<td>• Criticize or act impatiently toward the agitated individual.</td>
</tr>
<tr>
<td>• Establish ground rules if unreasonable behavior persists. Calmly describe the consequences of any violent behavior.</td>
<td>• Attempt to bargain with a threatening individual.</td>
</tr>
<tr>
<td>• Use delaying tactics which will give the person time to calm down. For example, offer a drink of water (in a disposable cup).</td>
<td>• Try to make the situation seem less serious than it is.</td>
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<tr>
<td>• Be reassuring and point out choices. Break big problems into smaller, more manageable problems.</td>
<td>• Make false statements or promises you cannot keep.</td>
</tr>
<tr>
<td>• Accept criticism in a positive way. When a complaint might be true, use statements like “You’re probably right” or “It was my fault.” If the criticism seems unwarranted, ask clarifying questions.</td>
<td>• Try to impart a lot of technical or complicated information when emotions are high.</td>
</tr>
<tr>
<td>• Ask for his recommendations. Repeat back to him what you feel he is requesting of you.</td>
<td>• Take sides or agree with distortions.</td>
</tr>
<tr>
<td>• Arrange yourself so that a visitor cannot block your access to an exit.</td>
<td>• Invade the individual’s personal space. Make sure there is a space of 3’ to 6’ between you and the person.</td>
</tr>
</tbody>
</table>

Attachment 4: Questions to be Addressed in Case Investigations of Potential Targeted Violence*

**Question 1:** What motivated the subject to make the statements, or take the action, that caused him/her to come to attention?

**Question 2:** What has the subject communicated to anyone concerning his/her intentions?

**Question 3:** Has the subject shown an interest in targeted violence, perpetrators of targeted violence, weapons, extremist groups, or murder?

**Question 4:** Has the subject engaged in attack-related behavior, including any menacing, harassing, and/or stalking-type behavior?

**Question 5:** Does the subject have a history of mental illness involving command hallucinations, delusional ideas, feelings of persecution, etc. with indications that the subject has acted on those beliefs?

**Question 6:** How organized is the subject? Is he/she capable of developing and carry out a plan?

**Question 7:** Has the subject experienced a recent loss and or loss of status, and has this led to feelings of desperation and despair?

**Question 8:** Corroboration--What is the subject saying and is it consistent with his/her actions?

**Question 9:** Is there concern among those that know the subject that he/she might take action based on inappropriate ideas?

**Question 10:** What factors in the subject's life and/or environment might increase/decrease the likelihood of the subject attempting to attack a target?