DoW Instruction 6490.04

Mental Health Evaluations of Service Members

Originating Component:	Office of the Under Secretary of War for Personnel and Readiness
Effective:	July 27, 2026
Releasability:	Cleared for public release. Available on the Directives Division Website at https://www.esd.whs.mil/DD/.
Reissues and Cancels:	DoD Instruction 6490.04, "Mental Health Evaluations of Members of the Military Services," March 4, 2013, as amended
Approved 07/21/2026 by:	Anthony J. Tata, Under Secretary of War for Personnel and Readiness

Purpose: In accordance with the authority in DoD Directive (DoDD) 5124.02, this issuance:

- Establishes policy, assigns responsibilities, and prescribes procedures for the referral, evaluation, treatment, and medical and command management of Service members who may request or require assessment for mental health concerns, psychiatric hospitalization, and potential of imminent harm to self or others due to a mental disorder.
- Implements Section 1090b of Title 10, United States Code.

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SECTION 1: GENERAL ISSUANCE INFORMATION

1.1. APPLICABILITY.

a. This issuance applies to OSW, the Military Departments (MILDEPs) (including the Coast Guard at all times, including when it is a Service in the Department of Homeland Security by agreement with that Department), the Office of the Chairman of the Joint Chiefs of Staff and the Joint Staff, the Combatant Commands, the Office of Inspector General of the Department of Defense, the Defense Agencies, the DoW Field Activities, and all other organizational entities within the DoW (referred to collectively in this issuance as the "DoW Components").

b. This issuance does **not** apply to:

(1) Required periodic pre- and post-deployment mental health assessments for Service members deployed in connection with a contingency operation in accordance with DoD Instruction (DoDI) 6490.03.

(2) Responsibility and competency inquiries conducted in accordance with the guidelines established in the Rule for Courts-Martial 706 of the Manual for Courts-Martial, United States.

(3) Interviews conducted in accordance with guidelines established for the Family Advocacy Program in DoDI 6400.01.

(4) Interviews conducted in accordance with guidelines established for substance use treatment programs in DoDI 1010.04.

(5) Clinical referrals requested by other healthcare providers (HCPs) as a matter of clinical judgment and when the Service member consents to the evaluation.

(6) Evaluations under authorized law enforcement or corrections system procedures.

(7) Evaluations for special duties or occupational classifications and other evaluations expressly required by applicable DoW issuance or Service regulation that are not subject to commanders' discretion.

(8) Independently requested mental health evaluations (MHEs) brought directly to direct care or private sector care that do not involve a commanding officer or supervisor.

1.2. POLICY.

a. DoW fosters a culture of support and strives to create an environment that promotes help-seeking behaviors and reduces the stigma for help-seeking in the provision of mental healthcare.

b. The use of mental health services is equivalent to the use of other medical and health services. This extends to policy directed at promoting fitness for duty, returning injured or ill

Service members to full duty status after appropriate treatment, and managing medical conditions that may harm the Service member, others, or mission accomplishment.

c. No one may refer a Service member for an MHE as a reprisal for making or preparing a lawful communication of the type described in Section 1034 of Title 10, United States Code, and in DoDD 7050.06.

SECTION 2: RESPONSIBILITIES

2.1. UNDER SECRETARY OF WAR FOR PERSONNEL AND READINESS (USW(P&R)).

The USW(P&R) establishes policy to implement command-directed evaluations (CDEs), self-initiated referrals, and independently requested MHEs.

2.2. ASSISTANT SECRETARY OF WAR FOR HEALTH AFFAIRS (ASW(HA)).

Under the authority, direction, and control of the USW(P&R), the ASW(HA) develops policy for the MHE of Service members and monitors DoW compliance with this issuance.

2.3. DIRECTOR, DEFENSE HEALTH AGENCY (DHA).

Under the authority, direction, and control of the USW(P&R), through the ASW(HA), the Director, DHA:

a. Develops and publishes any necessary policy to implement this issuance, including, to the extent necessary, policy for CDEs, self-initiated referrals, and involuntary hospitalization of active duty Service members at DoW inpatient facilities, including involuntary medication treatment.

b. Develops and implements training for mental health healthcare providers (MH HCPs) and other HCPs who may conduct MHEs.

c. Supports the Secretaries of the MILDEPs, as needed, in the development of education and training programs for leaders and Service members.

d. Ensures records and information established and created in accordance with this issuance are retained in accordance with DoW Instruction (DoWI) 5015.02 and DoW Component records management disposition schedules.

2.4. SECRETARIES OF THE MILDEPS AND COMMANDANT OF THE U.S. COAST GUARD.

The Secretaries of the MILDEPs and Commandant of the U.S. Coast Guard:

a. Develop and distribute any necessary Service-level policies in support of this issuance and the Director, DHA's procedures regarding CDEs and self-initiated referrals.

b. Monitor the ability of commanders and supervisors to meet MILDEP involuntary emergency referral procedures.

c. Promote commander and supervisor proficiency in fulfilling their responsibilities to:

(1) Initiate and follow procedures for both emergency and non-emergency CDEs and facilitate other MHE referrals.

(2) Execute emergency management and precautions in the referral and care of a Service member who meets conditions as described in Paragraph 3.3.g.

(3) Provide Service members with the resources, opportunity, and encouragement to seek mental health, social services, or other assistance for stress-related concerns. This is based on Service members' independent initiatives and consistent with promoting well-being and maintaining Service members' health and readiness.

d. Promote commanding officer and supervisor consultation with MH HCPs assigned to units, or other appropriate HCPs, on self-initiated referrals by Service members to receive an MHE.

e. Develop and implement procedures as necessary, consistent with DoDD 7050.06, to enforce the prohibition on using CDEs to retaliate against whistleblowers and the other provisions in DoDD 7050.06 concerning protected communications.

f. Develop and implement annual training for leaders, Service members, and HCPs under their jurisdiction associated with MHEs.

g. Ensure records and information established and created in accordance with this issuance are retained in accordance with DoWI 5015.02 and DoW Component records management disposition schedules.

2.5. CHIEF, NATIONAL GUARD BUREAU.

The Chief, National Guard Bureau, on behalf of and with the approval of the Secretaries of the Army and Air Force, and in coordination with the State adjutants general:

a. Establishes or modifies any necessary National Guard policy to implement this issuance.

b. Supports and, where practical, implements any Service-level policies and programs.

SECTION 3: PROCEDURES

3.1. DISTINGUISHING CDES, SELF-INITIATED REFERRAL MHES, AND INDEPENDENTLY REQUESTED MHES.

a. Certain procedures are different depending on whether an MHE is command-directed, self-initiated, or independently requested. While all three types have confidentiality protections that are described in DoDI 6490.08, there are differences in the information that HCPs are required to communicate back to command.

b. If a CDE of a Service member is pending and the Service member requests a self-initiated referral, the command will consult with an MH HCP and determine whether the CDE will be canceled in favor of the self-initiated referral.

c Service member patient rights and confidentiality are protected, in accordance with requirements for confidentiality of health information in Public Law 104-191 (also known and as the "Health Insurance Portability and Accountability Act of 1996") applicable privacy laws, and DoW privacy regulations and guidance, including DoD 5400.11-R, DoDIs 5400.11, 6025.18, and 6490.08, and Volume 2 of DoD Manual (DoDM) 5400.11 and DoDM 6025.18.

3.2. SELF-INITIATED MHE.

a. Service members who may self-initiate a referral for an MHE, and are referred to as "Service member(s)" in Paragraphs 3.2.b. through 3.2.c., include:

(1) Service members on active duty.

(2) Service members of the Reserve Components on active duty for a period of longer than 30 days.

(3) Service members of the Selected Reserve in a duty status, which includes those on:

(a) Active duty training;

(b) Inactive duty training;

(c) Orders less than 30 days; or

(d) Full-time National Guard duty in accordance with Title 32, United States Code.

b. Service members:

(1) May request a referral for any reason on any basis including, but not limited to, personal distress, safety concerns, and trouble functioning in activities valued by the Service member that may be attributable to a possible mental disorder. Service members are not required to inform their supervisors or commanders of the reason to self-refer for an MHE.

(2) May request a referral at any time and in any environment including, but not limited to, the continental United States, outside of the continental United States, in a deployed setting, assigned to a temporary duty station, or on leave.

(3) May self-initiate a referral for an MHE by requesting such a referral through their commanding officer, or a supervisor who is in a grade E-6 or above and is in the Service member's chain of supervision.

(a) If a Service member's commanding officer or supervisor is unavailable, the next available Service member who performs the duties of a commanding officer or supervisor, and who is in a grade E-6 or above, will be responsible for following the referral procedures.

(b) If a Service member's immediate supervisor is a civilian employee who is in a grade of GS-12 (or equivalent) or above, then such supervisor will be responsible for following the procedures for self-initiated referrals assigned in this issuance to commanding officers.

(4) Will report duty-limiting mental health issues as required by DoWI6025.19.

c. Commanding officers or supervisors will:

(1) Promote understanding of the procedures for Service members under their command or supervision to request a referral for an MHE.

(2) Refer the Service member to an MH HCP for an MHE as soon as possible when a Service member requests an MHE.

(a) When making the referral, the commanding officer or supervisor will consider the unique circumstances of the timing of the self-initiated referral. This includes the accessibility of military medical treatment facilities (MTFs), and unit-operated and embedded mental health services, as well as the availability of MH HCPs. As applicable, commanders or supervisors should use existing mental health resources and processes to connect Service members with an MHE.

(b) The commanding officer or supervisor will make every attempt to refer the Service member to an MH HCP for an MHE as soon as possible. If an MH HCP is not available in a reasonable time or location, the commanding officer or supervisor can refer the Service member to a non-MH HCP (such as a primary care provider) to perform the MHE within the scope of the non-MH HCP's privileges.

(c) The commanding officer or supervisor will provide the Service member's name, date of birth, DoW identification number or Electronic Data Interchange-Personal Identifier or Social Security Number, and telephone number to the HCP performing the MHE or clinic representative. If voluntarily provided by the Service member, information on the circumstances that led to the Service member requesting the referral will be provided to the mental health clinic by the commanding officer or supervisor. This may include additional information that may be relevant and necessary to the health and welfare of their Service members or mission accomplishment.

(d) Commanders and supervisors will protect Service members' privacy when disclosing information for referral purposes in accordance with applicable privacy laws and associated DoW guidance.

(e) If the Service member discloses that the request for referral is in response to a sexual assault, guidance from DoDD 6495.01 and procedures in Volume 1 of DoDI 6495.02 will be followed in addition to referring the Service member for an MHE.

(f) If the designated commanding officer or supervisor determines the Service member is at risk to harm self or others, the priority will be to maintain that precautions (including escorting) are taken to protect the safety of the Service member and others before the Service member's arrival at the location of the evaluation. If the Service member is exhibiting concern of potential or imminent danger to self or others, the commanding officer or supervisor will follow safety and communication procedures for an emergency evaluation in accordance with this issuance.

(3) Provide the Service member with the date, time, and place of the scheduled MHE made through the established referral process.

(4) Promote stigma reduction for the processes described in Paragraphs 3.2.c.(1) through 3.2.c.(3).

3.3. REFERRAL OF SERVICE MEMBER FOR CDE.

a. A CDE has the same status as any other military order.

b. At the time of the referral, the Service member's commander who is a commissioned officer, or the supervisor who is a commissioned officer in the paygrade O-4 or higher, or a civilian employee in a grade level GS-12 (or equivalent) or higher, in the Service member's chain of supervision will determine whether a referral for a CDE should be made.

c. A senior enlisted Service member, in the paygrade E-7 or higher, may be designated in writing to order an emergency CDE for enlisted Service members under their authority by a commander or supervisor authorized to refer a Service member for a CDE in accordance with Paragraph 3.3.b.

d. Referrals for a CDE can be made to a non-MH HCP who can complete the CDE within the scope of the non-MH HCP's privileges if an MH HCP is not available in a reasonable time or location. Such evaluations may be for a variety of concerns that are thought to be secondary to a mental disorder, including:

(1) Fitness for duty;

(2) Occupational requirements;

(3) Risk of harm to self or others;

(4) Significant changes in performance; or

(5) Other behavior changes that may be attributable to possible mental status changes.

e. For all referrals, emergent and non-emergent, the commander or supervisor may consult with the embedded mental health, outpatient mental health, or other appropriate MH HCP to determine the most clinically appropriate referral mechanism.

f. When the commander or supervisor believes that a Service member requires a non-emergency MHE, the commander or supervisor will:

(1) Promote the message that mental healthcare is healthcare; discuss its importance relative to self-care, mission, and readiness; and safeguard against an environment with a negative stigma for Service members requiring an MHE.

(2) Direct the Service member to an MH HCP for a CDE, providing both name and contact information.

(3) Consult with embedded mental health, outpatient mental health, or other appropriate MH HCP as needed to determine the most clinically appropriate referral mechanism for a Service member.

(4) Inform the Service member of the date, time, and place of the scheduled MHE.

g. The commander or supervisor will make every attempt to refer a Service member for an emergency CDE as soon as possible when any of the following conditions are met:

(1) A Service member, by actions or words, such as actual, attempted, or threatened violence, intends or is likely to cause serious injury to self or others due to a mental disorder.

(2) When the facts and circumstances indicate that the Service member's intent to cause such injury is likely.

h. When the commander or supervisor directs a Service member for an emergency MHE due to concern about potential or imminent harm to self or others, the following principles will be observed:

(1) Safety.

When a Service member is exhibiting the potential to harm self or others, the commander or supervisor will confirm that precautions are taken to protect the safety of the Service member and others, pending completion of an emergency evaluation. In certain operational conditions where hospitalization or medical evacuation may not be immediately available, unit commanders, in consultation with MH HCPs, may establish a time-limited supervision plan. Supervision plans will promote Service member safety until definitive care can be provided.

(2) Communication.

The commander or supervisor will report to the MH HCP circumstances and observations regarding the Service member that led to the emergency referral either before or while the Service member is transported to emergency evaluation.

(3) Stigma.

The commander or supervisor will advise the Service member about the safeguards in place to prevent an environment of negative stigma associated with obtaining mental health services for an emergency MHE. MHEs are similar to treatment for other emergency medical services to the maximum extent possible.

3.4. COMMAND PROMOTION OF CARE SEEKING FOR THE MAINTENANCE OF TOTAL WELL-BEING.

a. Commanders or supervisors may make informal, non-mandatory recommendations for Service members under their authority to seek care from an MH HCP when circumstances do not require a CDE based on safety or mission concerns. Under such circumstances, the commander or supervisor will inform the Service member of the Service member's ability to obtain an independently requested MHE or opt to obtain the assistance of the commander or supervisor to support a self-initiated referral to an MH HCP. The commander or supervisor will inform the Service member that they are not ordering care.

b. Commanders and supervisors will demonstrate leadership and direct unit involvement in developing a culture of total well-being of Service members. This includes providing consistent and ongoing messaging and support for the benefits and value of seeking community wellness services, proactive use of non-medical counseling when needed, and mental healthcare, including voluntary care for substance use.

c. Commanders and supervisors will support Service member awareness of community sources of assistance, including confidential counseling from Military OneSource resources, Military and Family Life Counseling program described in DoDI 6490.06, consultation from chaplains, and options for obtaining assistance with financial, legal, childcare, housing, or educational issues.

d. Commanders and supervisors will not substitute alternative approaches to a CDE when there is significant concern regarding a Service member's safety or an underlying duty-impairing mental disorder.

3.5. MH HCP STANDARDS OF CARE IN MHE REFERRAL.

MH HCPs:

a. Administer an MHE in accordance with access to care requirements for routine medical and mental healthcare. This includes recommending or providing a recommendation of the

necessary care, including treatment, as clinically indicated following clinic communication with the commanding officer or supervisor consistent with DoDI 6490.08 and this issuance. MH HCPs coordinate with the unit-assigned medical assets to discuss treatment support and limitations.

b. Protect Service member patient rights and confidentiality, in accordance with requirements for the confidentiality of health information pursuant to Health Insurance Portability and Accountability Act of 1996 applicable privacy laws, and DoW privacy regulations and guidance, including DoD 5400.11-R, DoDIs 5400.11, 6025.18, and 6490.08, and Volume 2 of DoDM 5400.11 and DoDM 6025.18. In addition to the disclosures to command consistent with exigent circumstances pursuant to DoDI 6490.08, MH HCP disclosures to command are limited to:

(1) Confirming that the MHE was provided pursuant to the referral.

(2) Any other disclosure for which the Service member provided authorization, in accordance with DoDM 6025.18.

c. Promote the process described in Paragraphs 3.2.c.(1) through 3.2.c.(3) to reduce stigma associated with seeking help for mental health concerns.

d. Document all MHEs in the Service member's electronic health record (EHR). Documentation must include:

(1) Any relevant forms, digital copies of additional documentation when determined important to the MHE findings, and final determinations.

(2) Any precautions taken to reduce harm.

e. Assess Service member's medical readiness for duty. When mental health duty limitations are warranted, MH HCPs will initiate duty restrictions in accordance with DoWI 6025.19.

3.6. HOSPITALIZATION FOR PSYCHIATRIC EVALUATION AND TREATMENT.

a. Pursuant to an inpatient referral, only an MH HCP with admitting privileges or, when an MH HCP with admitting privileges is not available, a physician with admitting privileges may admit a Service member for an inpatient MHE.

b. An emergency MHE may result in hospitalization for inpatient clinical evaluation and comprehensive risk assessment via referral to the MH HCP with admitting privileges.

c. The evaluation will be conducted in the most appropriate clinical setting, in accordance with the least restrictive alternative principle.

d. Voluntary inpatient admission is appropriate when an MH HCP with admitting privileges or, when an MH HCP with admitting privileges is not available, a physician with admitting privileges determines that:

(1) Admission is clinically indicated.

(2) The Service member has the capacity to provide informed consent regarding treatment and admission.

e. An involuntary inpatient admission to an MTF is appropriate when the Service member does not consent to admission and an MH HCP makes an evaluation that the Service member has, or likely has, a severe mental disorder that endangers self or others, or poses imminent risk of harm to self or others. When an MH HCP is not available, a physician or another HCP with admitting privileges may also make an involuntary inpatient admission. Guidelines include:

(1) Level of Care.

Placement in a less restrictive level of care would result in inadequate medical care.

(2) Admission Criteria.

Admission is consistent with applicable clinical practice guidelines.

(3) Re-evaluation Following Admission.

The Service member will be re-evaluated, under the purview of the admitting facility, within 72 hours of admission by an independent privileged psychiatrist or other medical officer if a psychiatrist is not available.

(a) The independent medical reviewer will notify the Service member of the purpose and nature of the review and of the Service member's right to have legal representation during the review by a judge advocate. If reasonably available, Service members may choose a civilian attorney at their own expense, provided it is within the required period for the review.

(b) The independent medical reviewer will determine and document in the inpatient EHR whether, based on clear and convincing evidence, continued involuntary hospitalization is clinically appropriate. If so, the reviewer will document the clinical conditions requiring continued involuntary hospitalization and the circumstances required for discharge from the hospital. An additional review will be scheduled within 5 business days.

(c) The independent medical reviewer will notify the Service member of the results of each review.

(4) Medical Record Documentation.

Documentation of the evaluation encounter, findings, disposition, and outcomes must be consistent with applicable standards of care and will:

(a) Document information pertaining to the inpatient admission in the Service member's EHR including, at a minimum, communication of the assessment of potential for harm to self or others, treatment plan, medications, progress of treatment, discharge assessment, and recommendations to commanders or supervisors regarding continued fitness for duty and actions the MH HCP recommends be taken to assist with the continued treatment plan.

(b) Upon discharge, use available healthcare communication tools and processes to provide, consistent with Section 3 of DoDI 6490.08, sufficient clinical information and recommendations to allow the commander or supervisor to understand the Service member's condition and make reasoned decisions about the Service member's health and welfare or mission accomplishment.

(5) Additional Patient Rights.

(a) As soon as the Service member's condition permits after admission to the MTF, the Service member has the right to contact anyone the member chooses including, but not limited to:

1. Relatives.

2. Friends.

3. Chaplains.

4. Attorneys.

5. Any inspector general (IG) office.

(b) DHA will develop policies for involuntary hospitalization of active duty Service members at DoW inpatient facilities, including involuntary medication treatment, that are modeled after guidance prepared by professional civilian mental health organizations. These organizations must serve as credible sources of nationally recognized best practices and standards of care for emergency evaluation, hospitalization, and treatment for adults (e.g., guidance written by the American Psychiatric Association regarding emergency evaluation of adults).

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

(1) Make reasonable attempts to consult with an MH HCP with admitting privileges before and during the admission, such as by telecommunications.

(2) Arrange for transfer to an MH HCP with admitting privileges as soon as practical.

g. In the case of referral for an involuntary inpatient admission to a civilian facility, evidence-based guidelines from authoritative sources, such as the DoW, Department of Veterans Affairs, or Substance Abuse and Mental Health Services Administration, for involuntary civil commitment will be considered, and the process established under the law of the State where the

facility is located will be followed. If in a foreign country, the applicable laws of the host nation will be followed.

3.7. MEDICAL QUALITY MANAGEMENT CASE REVIEW.

Case review requirements will be conducted for patients in accordance with DoDI 6025.13.

3.8. FITNESS AND SUITABILITY FOR SERVICE.

a. MH HCPs will report back to commanders or supervisors who direct a Service member for a CDE. In doing so, they will make the minimum necessary disclosure and, when applicable, will advise how the commander or supervisor can assist the Service member's treatment. Additional information may be disclosed consistent with Section 3 of DoDI 6490.08.

b. The providers will advise the commander or supervisor of any duty limitations, recommendations for monitoring, additional evaluation, or recommendations for treatment, including, but not limited to:

(1) Referral of a Service member to a Medical Evaluation Board for processing through the Disability Evaluation System pursuant to DoDI 1332.18.

(2) Recommendation for administrative separation based on a condition that does not amount to a disability, but renders the Service member unsuitable for continued military service in accordance with DoDI 1332.14 or DoWI 1332.30, as applicable.

c. Any referral for consideration of potential separation from military service will be in accordance with MILDEP separation procedures.

d. In addition to duty to take precautions to protect and warn others from harm, the MH HCP will recommend, as appropriate, referral for evaluation of fitness and suitability for service as described in Paragraph 3.8.b.

3.9. DUTY TO TAKE PRECAUTIONS TO PROTECT OTHERS FROM HARM.

a. In any case in which a Service member has communicated to a privileged HCP an explicit threat to harm a clearly identified or reasonably identifiable person, or to destroy property under circumstances likely to lead to serious bodily injury or death, and the Service member has the apparent intent and ability to carry out the threat, the responsible HCP will make a good faith effort to take precautions against the threatened injury. Such precautions include, but are not limited to:

(1) Notifications.

Privileged HCPs will notify:

(a) The Service member's commander or supervisor that the Service member poses imminent or potential harm to others.

(b) The Service member's commander or supervisor and any identifiable individuals being threatened by the Service member about the Service member's pending discharge from inpatient status to the extent provided in law or the standard of care in the State where the care is being provided.

(c) Military or civilian law enforcement authorities where the threatened injury may occur and of specifically named or identified potential victim(s).

(2) Recommendations and Referrals.

The responsible HCP will recommend as appropriate:

(a) Precautions to the Service member's commander or supervisor.

(b) Admission of the Service member to an inpatient psychiatric or medical unit for evaluation and treatment.

b. The provider will inform the Service member and document the precautions taken in the EHR.

3.10. COMPLAINTS OF REPRAISAL FOR PROTECTED COMMUNICATION.

Any Service member who believes a CDE is a reprisal for the Service member having made a protected communication may file a complaint with the DoD IG Hotline or a MILDEP IG in accordance with DoDD 7050.06.

3.11. TRAINING FOR COMMANDERS, SUPERVISORS, AND SERVICE MEMBERS.

Training for commanders, supervisors, and Service members must be delivered on an annual basis. Training must include how to recognize personnel who may require mental health evaluations on the basis of the individual being an imminent danger to self or others, as demonstrated by the behavior or apparent mental state of the individual. Additional training may be provided with the content, frequency, and type of training based on the rank, responsibility, and duty status of the Service members or associated civilian personnel.

3.12. REPORTING REQUIREMENTS.

a. The Office of the ASW(HA) will provide a template to facilitate report submission.

b. The first report will be due the last Friday in October, 2 years following the publication of this issuance, and the last Friday in October every 2 years thereafter.

c. The report will provide information associated with the previous 2 calendar years. For example, reports submitted October 2026 will provide information associated with calendar years 2024 and 2025.

d. The DHA will provide the following information in its biennial report to the ASW(HA):

(1) A listing of any policy and guidance necessary to implement the CDE and self-initiated referral processes and training requirements in accordance with this issuance and electronic or hard copies of these documents.

(2) Data associated with training completion and the provision of MHEs, including:

(a) The percentage of MH HCPs under the jurisdiction of the DHA that completed an MHE training.

(b) The number of MHEs for Service members conducted by MH HCPs under the jurisdiction of the DHA.

(c) The number of unique Service members who have received an MHE from an MH HCP under the jurisdiction of the DHA.

(d) Any additional explanations that will aid data review, including potential challenges and limitations of data systems and data analysis.

(3) Any recommendations for consideration associated with current policy, including but not limited to:

(a) Lessons learned.

(b) Emerging data.

(c) Metrics for consideration.

e. The MILDEPs will provide the following information in their biennial report:

(1) A listing of any policy and guidance necessary to implement the CDE and self-initiated referral processes and annual training requirements in accordance with this issuance and electronic or hard copies of these documents.

(2) Data associated with training completion, including:

(a) The percentage of Service members who completed MHE training.

(b) The percentage of commanding officers and supervisors who are in a grade E-6 or equivalent and above who completed the training described in this issuance.

(c) The percentage of MH HCPs under the jurisdiction of the MILDEP that completed the training described in this issuance.

(d) Any additional explanations that will aid data review, including potential challenges and limitations of data systems and data analysis.

(3) Any recommendations for consideration associated with current policy, including but not limited to:

(a) Lessons learned.

(b) Emerging data.

(c) Metrics for consideration.

GLOSSARY

G.1. ACRONYMS.

ACRONYM	MEANING
ASW(HA)	Assistant Secretary of War for Health Affairs
CDE	command-directed evaluation
DHA	Defense Health Agency
DoDD	DoD directive
DoDI	DoD instruction
DoDM	DoD manual
DoW	Department of War
DoWI	DoW instruction
EHR	electronic health record
HCP	healthcare provider
IG	inspector general
MHE	mental health evaluation
MH HCP	mental health healthcare provider
MILDEP	Military Department
MTF	military medical treatment facility
OSW	Office of the Secretary of War
USW(P&R)	Under Secretary of War for Personnel and Readiness

G.2. DEFINITIONS.

Unless otherwise noted, these terms and their definitions are for the purpose of this issuance.

TERM	DEFINITION
active duty training	Defined in the DoD Dictionary of Military and Associated Terms.
CDE	An MHE ordered by a commander or supervisor.

TERM	DEFINITION
embedded mental health	The process of placing MH HCPs directly into operational units to increase the availability and utilization of individual and population-level prevention and intervention strategies that enhance mission readiness and fitness for duty.
emergency	Any situation in which a Service member is found to have the potential of imminent harm to self or others or concerns for safety due to a change in mental status.
good faith	A sincere belief without improper purpose.
HCP	Defined in DoDM 6025.18.
inactive duty training	Defined in the DoD Dictionary of Military and Associated Terms.
independently requested MHE	An MHE from a provider or clinic requested by a Service member without any involvement by the member's command.
least restrictive alternative principle	A principle under which a Service member committed for hospitalization and treatment will be placed in the most appropriate and therapeutic setting available: That is no more restrictive than is conducive to the most effective form of treatment. In which treatment is available and the risks of physical injury or property damage posed by such placement are warranted by the proposed plan of treatment.
mental health	An individual's psychological, emotional, and social well-being that influences how a person feels, thinks, and acts. It establishes a person's capacity to pursue and maintain constructive relationships and cope with life's stressors.
MHE	An evaluation of a Service member's mental health by an appropriately privileged HCP, including MH HCPs or other HCPs whose credentials for practice have been verified and have been granted permission to practice within the scope and defined limits of their current licensure, relevant education, and clinical training.
MH HCP	A psychiatrist, clinical psychologist, licensed clinical social worker, psychiatric nurse practitioner, or other licensed clinical mental health provider who is credentialed and privileged by the DHA or MILDEPs.

TERM	DEFINITION
Reserve Component	Defined in the DoD Dictionary of Military and Associated Terms.
Selected Reserve	Defined in the DoD Dictionary of Military and Associated Terms.

REFERENCES

DoD 5400.11-R, "Department of Defense Privacy Program," May 14, 2007

DoD Directive 5124.02, "Under Secretary of Defense for Personnel and Readiness (USD(P&R))," June 23, 2008, as amended

DoD Directive 6495.01, "Sexual Assault Prevention and Response (SAPR) Program", January 23, 2012, as amended

DoD Directive 7050.06, "Military Whistleblower Protection," April 17, 2015, as amended

DoD Instruction 1010.04, "Problematic Substance Use and Gambling Disorder," January 17, 2025, as amended

DoD Instruction 1332.14, "Enlisted Administrative Separations," August 1, 2024

DoD Instruction 1332.18, "Disability Evaluation System," November 10, 2022

DoD Instruction 5400.11, "DoD Privacy and Civil Liberties Programs," January 29, 2019, as amended

DoD Instruction 6025.13, "Medical Quality Assurance and Clinical Quality Management in the Military Health System," July 26, 2023, as amended

DoD Instruction 6025.18, "Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule Compliance in DoD Health Care Programs," March 13, 2019

DoD Instruction 6400.01, "Family Advocacy Program (FAP)," May 1, 2019

DoD Instruction 6490.03, "Deployment Health," June 19, 2019

DoD Instruction 6490.06, "Counseling Services for DoD Military, Guard and Reserve, Certain Affiliated Personnel, and Their Family Members," April 21, 2009, as amended

DoD Instruction 6490.08, "Command Notification Requirements to Dispel Stigma in Providing Mental Health Care to Service Members," September 6, 2023

DoD Instruction 6495.02, Volume 1, "Sexual Assault Prevention and Response: Program Procedures," March 28, 2013, as amended

DoD Manual 5400.11, Volume 2, "DoD Privacy and Civil Liberties Programs: Breach Preparedness and Response Plan," May 6, 2021, as amended

DoD Manual 6025.18, "Implementation of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule in DoD Health Care Programs," March 13, 2019

DoW Instruction 1332.30, "Commissioned Officer Administrative Separations," May 11, 2018, as amended

DoW Instruction 5015.02, "DoW Records Management Program," June 26, 2026

DoW Instruction 6025.19, "Individual Medical Readiness Program," July 13, 2022, as amended

Manual for Courts-Martial, Rule for Courts-Martial 706, United States, current edition

Office of the Chairman of the Joint Chiefs of Staff, "DoD Dictionary of Military and Associated Terms," current edition

Public Law 104-191, "Health Insurance Portability and Accountability Act (HIPAA)," August 21, 1996

United States Code, Title 10

United States Code, Title 32