### Chapter 7: Emergency and Command Directed Evaluations

**Overview:**

The POD’s primary focus will be emergent evaluations. By the time one assumes the role of POD much of the emergency evaluation process should be familiar from one’s PCLS rotation. The main objectives are:

1. To determine whether a patient warrants direct admission to a psychiatric unit or not.
2. If admission to another unit is more appropriate (i.e. to the ICU/medicine for detox or neurology for seizures) to provide relevant psychiatric recommendations for care in that setting (e.g. sleep, delirium, 1:1 sitter).
3. If psychiatric admission is warranted, to coordinate psychiatric admission either on 7W, FBCH, or outside facility.
4. If admission is not warranted, to arrange appropriate outpatient follow-up.
5. To provide command directed evaluations.

**Admission Determination:**

The following factors are often cited as reasons to recommend psychiatric admission:

1. Suicidal or homicidal ideations
2. Psychosis creating high likelihood of harm to self or others
3. Inability to care for one’s self because of one’s mental illness
4. Severe behavioral disturbance that fails outpatient management

**Other Guidelines for Admission:**

There is no universally agreed upon “criteria” for admission. Some criteria are based on reimbursement by Medicare or Medicaid; where as others (e.g. APA and DoD/VA guidelines) are based on clinical experience. The following are a collection of justifications included in previous POD guides. Although some factors such as “imminently suicidal with intent and plan” or “severely psychotic and unable to care for themselves” are straightforward reasons to admit a patient; the presence of any single criteria may not necessarily mean that a patient *has* to be admitted. However the more criteria that apply to a particular patient, the stronger the case for admitting that patient becomes.

1. Recent (72 hours) suicide attempt.
2. Evidence of suicidal intent and plan requiring suicidal precautions.
3. Assaultive behavior as a result of psychiatric illness.
4. Psychiatric illness lading to self-mutative or dangerous impulsive behaviors (serious impulsive substance use, sexual behavior, reckless driving).
5. Substance withdrawal delirium. Consider initial admission to medicine or ICU if patient is at risk for complicated withdrawal (high tolerance or history of seizures or hallucinations associated with alcohol withdrawal).
6. Acute exacerbations of psychosis that interfere with ability to care for themselves.
7. Inability to comply with psychiatric medication regimen (in a patient who has a chronic history of decompensation off medication) in a patient who can be reasonably expected to improve with hospitalization (< 14 days).
8. Imminent hazard to life in patient with psychiatric illness impairing ability to comply with medical regimen (e.g. insulin administration; transplant rejection); that will likely improve with hospitalization.
9. Acute onset of inability to care for self or attend to activities of daily living; and documentation of reasonable expectation that resumption of self-responsibility will occur following appropriate treatment.
10. Recent self-mutative behavior or active threat with likelihood of action on the threat and there is absence of appropriate supervision or structure to prevent self-mutilation. Non-suicidal self-injurious behavior that is out of proportion to that expected and creating a high risk of “accidental” death (cutting deeper or closer to arteries than expected) are contemplated by this.
11. Active hallucinations or delusions likely to lead to serious harm (e.g. command auditory hallucinations).
12. Severe eating or substance abuse disorder which requires 24 hour observation or supervision. If the patient is at risk for refeeding syndrome or seizures then consider sending patient to medicine or specialized network eating disorders unit (e.g. Shepperd-Pratt);
13. Significant clinical deterioration from baseline impairment.
14. Evaluation and treatment cannot be carried out safely or effectively in other settings due to severely disruptive behaviors or environment (e.g. diagnostic clarification).
15. There is no less restrictive environment to treat this patient’s psychiatric illness (e.g. failure of outpatient treatment).

**Command Directed Evaluations:**

Commanders have the prerogative to send subordinate service members for psychiatric evaluation. The regulations governing this process is Department of Defense Instruction 6490.04. It is the same instruction that governs involuntary psychiatric admissions. The POD’s independent evaluation is a vital safeguard of the service member’s due process rights. As such, PODs should not feel obligated to admit patient’s simply because of command’s influence. PODs should ensure that a command representative until the evaluation is complete and the POD has determined whether the patient warrants admission or not. Otherwise, the service member will become a difficult disposition problem. Regardless of outcome, command is entitled to information – as outlined in DoDI 6490.04. The most efficient means of communicating the proper amount of information that balances a patient’s privacy and commanders’ need for actionable intelligence is through Department of the Army Form 3822 (DA3822). This is available as a fillable PDF in the folder. Although it is an Army form, it is modeled after DoDI 6490.04. Naval and Marine commands may accept this form (and *all* commands at Ft Meade need this form), however may also ask for a memo. A sample memo is provided in the Chapter 7 Folder, and as is essentially DA3822 in sentence form. For the memo, do not change formatting or allow word to auto format. The current format is in accordance with Navy Correspondence Guidelines. You should also be directly communicating your recommendations to the representative at the bedside and/or calling the unit leadership. A current DA3822 is also found as a PDF in the Chapter 7 Folder.

**Suicidal Patients**

Walter Reed has a specific administrative instruction on the management of suicidal patients (WRNMMC-AI 6490.01). The full text of this instruction is available on the following pages and can be found at [https://www.wrnmmc.intranet.capmed.mil/DocumentCenter/WRBINST.](https://www.wrnmmc.intranet.capmed.mil/DocumentCenter/WRBINST) There is also a copy in the POD binder in the Chapter 7 folder. All staff members (including residents) must be familiar with this instruction – as it instructs the integration of various disciplines throughout the hospital.

The instruction requires that the POD to assess with the PHQ-9 (see rating scales section); and coordinate follow- on care for the patient. This includes either inpatient or outpatient care.

**Safety Assessment:**

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| DoD/VA Suicide/Homicide Risk Factors |
| **Suicide Risk Factors** | **Protective Factors** |
| [ ] History of Suicide Attempts: | [ ] Sense of Responsibility to Family: |
| [ ] History of Self-Directed Violence: (state “no self-directed | [ ] Positive Social Support: see Safety Plan |
| violence in the past 6 months” if applicable) | [ ] Positive Therapeutic Relationship: |
| [ ] History of Suicidal Ideation/Plans/Intent: | [ ] Positive Coping and Problem-Solving Skills: see Safety Plan |
| [ ] Current Suicidal Ideation: | [ ] Religious Beliefs: |
| [ ] White, Native American, Male, <25yo, and/or Elderly: | [ ] Reality Testing Intact: |
| [ ] Single/Divorced/Separated/Widowed: | [ ] Pregnancy: |
| [ ] Psychiatric Disorders: |  |
| [ ] Substance Use Disorder: (state “no substance use in the past | **Homicide Risk Factors** |

[ ] History of Unsanctioned Violent Acts: [ ] Recent Threatening Statements:

[ ] Current Homicidal Ideation:

[ ] Identified Target or Specific Plan: [ ] Access to Firearms:

12 months” if applicable)

[ ] CNS Disease, Pain Syndrome, Terminal Illness, and/or Functional Impairment:

[ ] History of Childhood Sexual or Physical Abuse: [ ] Family History of Suicide or Mental Illness:

[ ] Significant Psychological Pain, Stress, Agitation,

Hopelessness, and/or Self-Hate: see CAMS [ ] Access to Firearms:

[ ] Significant Impulsivity, Aggression, and/or Cognitive Impairments:

The risk stratification system contemplated by the DoD/VA Clinical Practice Guidelines on the Assessment and Management of Suicide define the various risk-levels as follows:



**Columbia Suicide Severity Rating Scale (C-SSRS):**

The Directorate of Behavioral Health uses the Columbia Suicide Severity Rating Scale (C-SSRS) form as a means of addressing suicidal ideations as an independent problem rather than simply a symptom of underlying illness. The C-SSRS form integrates multiple leading approaches in the field of suicidology into a single tool that provides an opportunity for both the patient and provider get beyond the initial awkwardness that surrounds discussions of suicide. Although the original form contemplated variations on the initial screening form completed over a series of visits – this is not practical for PODs. PODs will typically only see the patient once before coordinating care with an outpatient provider – who could continue the CSSRS work, started with the POD during the consult.

PODs may find the screening and full version of the C-SSRS found as additional attachments in the Chapter 7 folder. These should be completed in a *collaborative* manner and are meant to be a tool for assessment of suicide risk, however is not the exclusive way. This means simply giving the form to the patient – as one would do with a rating scale – is insufficient. Moreover, when done that way, patient’s often fill in the form incorrectly or incompletely – which squanders an opportunity to capture the patient’s state of mind and driving forces in the moment. PODs should be available while the patient is filling the form out and ensure the form is being completed correctly. By the time the patient follows-up they will not likely be able to accurately recall their level of distress or feel pressure to minimize their symptoms. Many times the short screening version of the C-SSRS is completed by the emergency room staff and will be placed in the patient’s chart in the ED.

**Safety Planning:**

A patient’s ability to articulate and compose their own safety plan is both practical and diagnostically helpful – it at least demonstrates the patient’s ability to think rationally, consider coping skills, and demonstrate support. Although the ability to write out a safety plan is not a safeguard against suicide or deceit; the inability to articulate a credible or practical safety plan should be a significant warning sign.

According to the DoD/VA Clinical Practice Guidelines for the Assessment and Management of Patients at Risk for Suicide, the following should be taken into account when planning for safety:

* 1. Safety planning that is developed collaboratively with the patient should be part of discharge planning for all patients who were evaluated with high acute risk for suicide before being released to a lower level of care.
	2. For patients at intermediate acute risk for suicide, the safety planning process can be abbreviated to recognizing signs of elevating safety concerns and listing of practical steps for individual coping, safety precautions and support-seeking.
	3. For patient at low risk, provider should discuss signs that the patient can use to recognize escalating stress or risk, provide key phone numbers and resources for help, and educate about lethal means restriction. A handout can be used to reinforce the discussion.
	4. A Safety plan should be:
		1. Collaborative between the provider team and the patient
		2. Proactive–by explicitly anticipating a future suicidal crisis
		3. Individually tailored
		4. Oriented towards a no-harm decision
		5. Based on existing social support
	5. The Safety plan should include the following elements, as appropriate:
		1. Early identification of warning signs or stressors
		2. Enhancing coping strategies (e.g., to distract and support)
		3. Utilizing social support contacts (discuss with whom to share the plan)
		4. Contact information about access to professional help
		5. Minimizing access to lethal means (as, weapons and ammunition or large quantities of medication)
	6. The development of the safety plan with the person, family/unit members, should anticipate and discuss contingencies to address possible obstructions to plan implementation and where to keep the plan.
	7. The safety plan should be reviewed and updated by the health care team working with the patient as needed and shared with family/unit members and other related if the patient consents.
	8. Safety plans should be updated to remain relevant during changes in clinical state and transitions of care.
	9. Providers should document the safety plan within the medical record or reasons for not completing such a plan (i.e. “Patient

admitted. Inpatient provider to complete safety plan at time of discharge.”)

The CPGs also recommend that the POD provide education about actions to reduce associated risks and measured to limit the availability of means with emphasis on more lethal methods available to the patient:

1. Fire Arms (military or privately owned): For patients at highest risk, exercise extreme diligence to ensure firearms are made inaccessible to the patient. For all patients at intermediate to high acute risk of suicide, discuss the possibility of safe storage of firearms with the patient, command, and family (e.g., lock firearms up, use trigger locks or store firearms at the military armory, at a friend’s home, or local police station. Store ammunition separately. )
2. Medications: When clinically possible, include limiting access to medications that carry risk for suicide, at least during the periods when patient is at high acute risk for suicide. This may include prescribing limited quantities, supplying the medication in blister packaging, providing printed warnings about the dangers of overdose, or ensuring that currently prescribed medications are actively controlled by a responsible party.
3. Household Poisons: Educate how to secure chemical poisons, especially agricultural and household chemicals, to prevent accidental or intentional ingestions. Many of these chemicals are highly toxic.

The C-SSRS screening version and full version can be found in the Chapter 7 Folder. There is also a copy of the VA/DoD Safety Planning worksheet in the folder.

**Resident Walk-In Clinic:**

The Resident Walk-In Clinic is a special option reserved for PODs in light of the difficulty associated with obtaining follow-up for patients after hours. Each PGY-3 in the outpatient clinic has a dedicated Walk-in Clinic day and time – found in the spreadsheet in the Resident Acute Clinic folder on the S: Drive. Only one patient should be scheduled for each walk-in slot.

When booking a patient for the walk-in slot please ensure you send an email to the resident whom you are sending the patient to, the resident clinic supervisor, the clinic manager, and the chief of the Outpatient Behavioral Health Clinic. Please see the folder regarding the Resident Acute Clinic for a list of people to email, as well as an Excel document with the schedule.

Please note the following limitations on patients eligible to be sent to the walk-in clinic:

1. Primed to WRNMMC – this would be evident on the “Demographics” page in AHLTA;
2. Not currently engaged with behavioral health - otherwise patient should follow-up with their provider or clinic in which they are already established;
3. Eligible for care at WRNMMC Outpatient Behavioral Health (at various times clinic policies may lead to closure to certain groups – retirees, dependents, etc.).

Note that the Resident Walk-In Clinic is NOT the same thing as the Triage Clinic. The triage clinic is for unexpected walk-ins to the clinic. Neither the POD nor any other provider should be sending patients to the triage clinic.

**PCLS Walk-In Clinic:**

The Psychiatry Consult and Liaison Service offers an ad hoc walk-in clinic for gap coverage in the event that patient cannot receive follow-up within 5 days of being discharged from the emergency room. This situation will typically arise if the Resident Walk-In slots are filled for the next 5 calendar days. Patients must be otherwise eligible for care (TriCare) and not have an established provider. If the patient does have an established provider then the patient should be following up with that provider. Unlike the resident walk-in clinic, the patient does not have to be primed to WRNMMC.

To establish an appointment do the following:

1. Complete detailed assessment and safety plan determining that patient does not warrant a level of treatment higher than outpatient.
2. Instruct the patient to come to Building 10, 7th Floor Center, Room 7124 and look for Corina Miller at 1000 the next regular work day. Provide them with the number (301) 400-2070 so they can inform Ms. Miller if they are running late or not coming.
3. Inform the patient that this is only to be a temporary measure (ideally no more than two or three visits) until the patient can get into an established clinic.
4. Place a referral to outpatient behavioral health in your AHLTA note or in CHCS to begin the process of engaging the patient in regular care.
5. Obtain good contact information for the patient – preferably at least two numbers.
6. Document this in your note and provide a printed copy of the full note to PCLS at sign out so they know to expect the patient. If another provider will be evaluating the patient then they will contact the patient through the information you provide.

If you do not think your patient can make it until the next business day, then you should reconsider whether the patient warrants a higher level of care.

**Suicide and Crisis Hotlines:**

PODs will provide each patient sent out from the ED with the following numbers:

National: (800) 784-2433

DC: (888) 793-4357

Maryland: (240) 777-4000

Virginia: (703)527-4077

Veterans Affairs: (800)273-TALK (8255)

**Alcohol Related Events:**

All patients seen in the emergency department for alcohol-related incidents should be referred to Addiction Treatment Services (ATS) for evaluation. PODs are recommended to notify patients of this referral. Although they can be referred, non-active duty patients cannot be compelled to attend their ATS evaluation.

\*CHCS Consult For: “**Behavioral Health MTF BE**” and write “FOR ATS” in the consult information.

**Outpatient MEDEVAC:**

Patients being medically evacuated (MEDEVAC) for outpatient level care are designated 5C (Charlie). These patients are brought in to the hospital via the regular MEDEVAC process similar to those who are intended to Remain Over-Night (RON) or inpatient MEDEVAC. As with RON or inpatient MEDEVAC patients, these patients should have Patient Movement Record (PMR) sheets available from the MEDEVAC Office, which is collocated with Patient Administration (PAD).

The role of the POD is to evaluate these patients in the Emergency Department and assess the patient’s safety and

plan of care. If the POD concurs with continued outpatient level treatment then:

1. The POD should instruct the appropriate service liaison (e.g. Army, Navy, Air Force) to escort the patient to the Adult Behavioral Health Clinic, America Building (Building 19), 6th Floor NLT 0800 for intake and assessment on the next business day. The POD should obtain and document in their note good contact information for the service member and/or at least for the contact information appropriate service liaison.
2. The POD should notify CDR Del Sesto via email at Barbara.s.delsesto.mil@mail.mil

If the patient arrives during a long weekend and the POD feels that the patient is suitable for outpatient treatment but needs follow-up before the next business day, they can instruct the patient and Navy liaison to return to the ED or 7W for interim safety check.

If the POD feels that the patient warrants inpatient admission, or does not feel comfortable with the plan in place to maintain patient’s safety/accountability, then the patient can be admitted to 7W.

**Limits to Confidentiality:**

Reporting could include, but not be limited to the following:

1. To avert a serious and imminent threat to the health or safety of yourself or others, such as suicide, homicide, or other violent action. This includes disclosures regarding child abuse or domestic violence consistent with DoD Instruction 6400.06.
2. Harm to mission. The provider believes there is a serious risk of harm to a specific military operational mission. Such serious risk may include disorders that significantly impact impulsivity, insight, reliability, and judgment.
3. The Service Member is in the Personnel Reliability Program or is in a position that has been pre-identified by Service regulation or the command as having mission responsibilities of such potential sensitivity or urgency that normal notification standards would significantly risk mission accomplishment.
4. Inpatient Care. The Service member is admitted or discharged from any inpatient mental health treatment facility as these are considered critical points in treatment and support nationally recognized patient safety standards.
5. Substance Abuse Treatment Program. The Service Member has entered into, or is being discharged from, a formal outpatient or inpatient treatment program consistent with DOD 1010.6 for the treatment of substance abuse or dependence.
6. Command-Directed Mental Health Evaluation. The mental health services are obtained as a result of a command-directed mental evaluation consistent with DoDI 6490.04 (see most recent instruction in Chapter 7 folder of POD binder)

In making a disclosure, health care providers shall provide the minimum amount of information to satisfy the purpose of the disclosure. In general, this shall consist of:

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