Guideline for Forward Management of Acute Behavioral Health Conditions by Non-Specialty Medical Personnel

16 Jan 2024

By the Psychological Health Center of Excellence

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Introduction

This clinical practice guideline (CPG) describes strategies for general medical personnel (e.g., medics and general physician assistants (PAs) who do not have extensive education and training in behavioral health. Increasingly in modern warfare, units find themselves in environments where medical evacuation is delayed or not possible and embedded medical personnel must assess and manage conditions with limited resources. Given these demands, these guidelines lay out basic principles and strategies for assessment and management of a wide range of behavioral health conditions in a resource-scarce environment. Therefore, the primary audience for this guideline is non-specialty personnel (e.g., general physician assistant or operational medical personnel), corpsmen, and medics at far-forward locations when specialty behavioral health care or consultation is not immediately available. The text is meant to be an informative consolidation of resources that would benefit a range of medical personnel from medics to credentialed providers who may not have had specialty training but must contend with the reality of emergent behavioral health needs. The term, non-specialty medical personnel (NSMP), is used throughout the text to refer to this broad audience. When providing care for the service members, it is essential to keep in mind that medical personnel make recommendations, but command makes the decisions. Commanders are responsible for the health and well-being of service members in their command and all interventions are dependent on the mission, operational environment, and operational conditions.

Each role of care in the deployed environment during the past two decades has been associated with a specific level of behavioral health support (discussed in Chapter 1). At Role 1, facilities (such as battalion aid stations) typically received direct support from behavioral health technicians and rotational support from behavioral health officers. Role 2 facilities provided direct support through uniformed behavioral health officers (BHOs) or through combat stress control (COSC) prevention teams. From these Role 2 facilities, uniformed providers conducted battlefield circulation and outreach to address behavioral health needs at smaller bases and Role 1 facilities. Large, fixed facilities with direct support from a division psychiatrist typically were available at Role 3 facilities. These Role 3 facilities often were co-located with combat stress restoration clinics that provided three-to-five-day respite and treatment programs.

The future of 21st century warfare will likely prevent several aspects of behavioral health support that have been relied upon in previous wars. Contested airspace and advanced air defense likely will delay medical evacuation of low-priority behavioral patients. The same factors that disrupt patient movement also will prevent regular battlefield circulation, particularly in large-scale combat operations and areas of operation that are larger than in previous wars. Fixed behavioral health and combat stress facilities at Role 3 may also not be available due to requirements for rapid movement in a changing battlespace. Although telehealth has significant capability in delivering behavioral health services, disruption of network infrastructure by adversaries may prevent the systematic use of telehealth in future combat environments.

Gaps in Research & Practice: Far Forward Behavioral Health Care

The provision of far-forward medical care in the combat theater is essential to both mission success and the well-being of individual service members. The changing nature of conflict and future multi-domain operations likely will prohibit forward staging of definitive specialty care support in all operating areas due to wide geographic dispersion of high numbers of small teams/units performing operations of varied intensity. Far forward care in such operations would thus

rely on organic resources at Role 1, including combat medics or health care specialists in addition to self or buddy care.[1] While the U.S. military has made tremendous strides in medical advancement for providing best possible medical care in austere environments, behavioral health care guidance is lagging behind as evidenced by an increasing number of service members being evacuated to higher levels of care due to combat and operational stress. To this end, combat and operational stress control (COSC) interventions have proliferated in the past decades since initial formalized requirements in 1999.[2] Although principles of intervention such as proximity of care, immediacy of contact, expectancy of return to duty, and simplicity of intervention (PIES) have been applied in a number of forward contexts,[1] there is still debate over what types of behavioral health interventions are useful in a deployed environment. [3,4]

Ongoing research and training are underway to prevent, identify, and initiate early treatment for behavioral health casualties at the frontlines of conflict. Challenges in tracking behavioral health data coupled with limited resources in austere environments hamper research efforts and achievement of optimal patient outcomes in austere environments. Scoping reviews and focus groups with boots on ground have identified several research gaps that need to be addressed.[5,6] Domains that need additional research include:

- Guidance in prolonged field care of service members with combat and operational stress and other behavioral health conditions
- Training of organic resources and leadership in recognition and management of emergent behavioral health conditions
- Guidance on strategies and resources to mitigate psychological impact and operational stressors in austere environments.
- Objective real time behavioral health data and use of wearables as well as long term outcomes of combat and operational stressors

Current capabilities for intervention are situated at Role 2 and above. Limited behavioral health resources for Role 1 in forward locations necessitates battlefield circulation of behavioral health technicians from Role 2. Battlefield circulation may not be a viable option in multi-domain operations and there is a need to train organic resources to provide behavioral health care. Most studies are not rigorous enough to understand whether or not an intervention will work in other contexts. Large scale reviews of studies note that most programs lack the necessary outcome data to demonstrate effectiveness. [7,8,9] For example, some published reports on forward interventions only describe the satisfaction ratings by participants, but do not include whether or not symptoms improved, or medical evacuation reduced for individuals who received an intervention. The clearest outcome data come from controlled studies prior to deployment and after deployment, or in clinical settings like restoration clinics. There have been recent calls to organize and understand Department of Defense (DOD) COSC research through a public health lens, considering levels of interventions (for example, universal prevention, selective intervention, indicated intervention, and clinical treatment).[10] By this lens, medical personnel cannot assume that techniques used to treat mental health disorders might also work to prevent their onset.

NSMPs should consider applying basic outcomes measurement and tracking during far-forward care to ensure that their interventions are working in their specific environments. The following chapters apply similar principles that informed the creation of various COSC programs. Each chapter pulls from treatment principles that are demonstrated as effective in other contexts and adapted for the forward environment. Until treatment programs show more rigorous outcome data, medical providers must rely on adapting basic principles to austere environments.

Finally, it should be noted that this guideline is intended to be aspirational and is not intended to create a requirement for practice. The guidelines are not intended to be mandatory or exhaustive and may not be applicable to every professional and clinical situation. The guidance provided is not intended to take precedence over the judgment of medical personnel or command.

***NOTE**: Introduction references can be found with Chapter 1 references.*

Chapter 1

Behavioral Health Assets Typically Available in the Deployed Environment

The focus of this chapter is to provide a brief background on the need for behavioral health assets during deployment as well as an overview of available behavioral health resources and their capability in the far-forward environment. Combat and operational stress accounts for up to half of battle casualties,[1] significantly contributing to the loss of fighting forces and negatively impacting military readiness. Replacement personnel, specifically service members with highly specialized military occupational specialty (MOS) training are hard to come by, wherein, preventing and managing stress-related injuries in theater provides a timely and cost-effective way to conserve combat power.

The imperative for the development of service-wide combat and operational stress control programs was based on the 1999 DOD Instruction 6490.5 on Maintenance of Psychological Health in Military Operations, providing guidance to implement such programs and minimize the impact of combat stress reactions.[11] Behavioral health assets in deployed settings play a vital role in providing the necessary support to ensure the health of the service member and the mission. Consequently, it has become increasingly evident that there is a need for behavioral health providers to employ a "battlefield rotation" in order to provide care nearest to the point of injury as well as to help mitigate behavioral health problems and combat stress-related injuries among deployed service members. Joint Mental Health Advisory Team-7 (MHAT-7), in its 2010 report to the Office of the Surgeon General, identified some of the specific barriers to care in deployed settings, which included lack of knowledge of available resources of care and limited availability of behavioral health services.[12]

Control and management of combat and operational stress necessitates the utilization of embedded and forward deployed behavioral health personnel. Each service branch has worked to independently meet this requirement with personnel and service packages tailored to meet the operational needs of their forces. While the Army utilizes behavioral health teams embedded at the level of the Brigade Combat Team, the Navy has established shipboard, submarine, and special operations embedded mental health teams, and the United States Marine Corps has developed the Operational Stress Control and Readiness program with behavioral health providers and technicians embedded at the regimental level and combat stress platoons (CSPs) within the logistics element. Air Force mental health personnel typically deploy in smaller groups and attach to Army units.

It is also important to note that embedded behavioral health providers fulfill many roles beyond their clinical activities. While there are service-specific variations, some of these assets may spend a significant amount of time working as a special staff officer providing command advisement on unit resilience, morale, or in liaison with other medical resources for disposition planning. Further, in special operations communities, the embedded behavioral health providers serve in special roles assisting with assessment and selection for certain programs.

ECHELONS OF CARE IN THE DEPLOYED ENVIRONMENT

The triage process (described here and expanded in detail in Chapters 2 – 4) for COSC is used to sort service members depending upon the symptoms/needs, capabilities available, and location where they can best be managed. The COSC management principles are expressed in the memory aid—**B**revity, **I**mmediacy, **C**ontact, **E**xpectancy, **P**roximity, and **S**implicity (BICEPS), and described more in Chapter 2. These principles apply to all COSC interventions or activities throughout the theater and are adhered to by COSC personnel in all behavioral health and COSC elements. These principles may be applied differently based on a particular role of care and other factors pertaining to mission, enemy, terrain and weather, troops and support available, time available, and civil considerations. This is accomplished by a proactive preventive medicine program and a phased health care system (levels of care) that extends from actions taken at the point of injury or illness to evacuation from theater for treatment at an appropriate facility. The primary objective of embedded and forward deployed behavioral health assets is to make behavioral health care available at the point of need in order to conserve the fighting strength of the military.

Each service's behavioral health team has a distinctive composition and capability which is task organized to meet the needs of its mission. Therefore, this chapter applies a common framework for comparison in order to offer value in describing best practices. Embedded and deployed behavioral health forces do not always fit cleanly into the Health Service Support (HSS) model of Role 1 (battalion aid stations), Role 2 (limited field hospital), and Role 3 (combat support hospital). Nonetheless, it is a useful framework to describe the roles and capabilities which are available in an operational environment. A basic characteristic of organizing and planning for HHS support is the distribution of medical resources and capabilities to facilities at various levels of command, diverse locations, and progressive capabilities, referred to as roles of care. For medical planners to effectively provide mission support to the commander, they need to understand the full breadth of these roles of medical care. Different levels denote differences in capability, rather than the quality of care. Each level has the capability of the level before it and expands on that capability, with level 4 referring to care in a fixed facility outside the forward environment. Given that the focus of this guidance is on far-forward capability, description of assets in this chapter is limited to Roles 1 to Role 3. Additionally, it should be noted that the capabilities at each level in a forward operation can be joint. For example, support provided at a Role 3 hospital could include an Army Division psychiatrist, a Navy or Air Force behavioral hospital team, and a combat stress control restoration center. Thus, service members can leverage tri-service assets. Table 1.1 provides a snapshot of behavioral health assets and capabilities across services in forward environment.

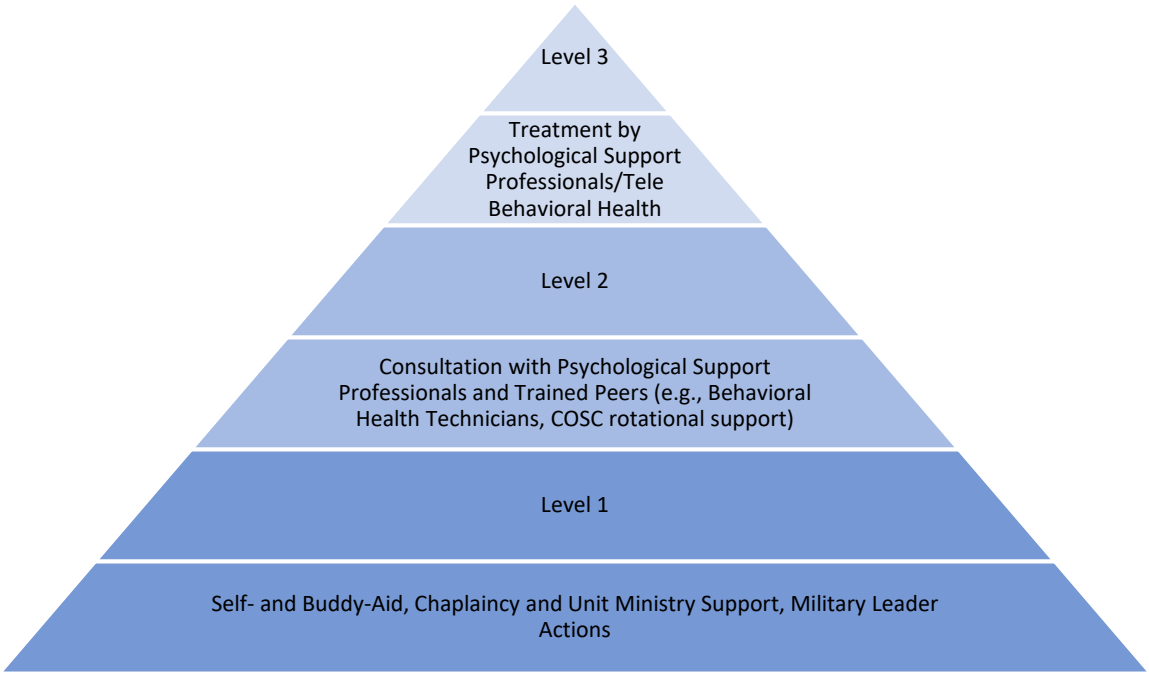
Table 1.1. Snapshot of Tri Service Behavioral Health Assets and Capabilities during Deployment.

Role/ Capability	Service Branch	Behavioral Health Assets	Team Composition
Role 1 Immediate and short-term care Primary care management of routine behavioral health concerns	Army	Self-Aid/Buddy Aid, Combat Medic, Religious Support teams	Depends on unit mission and size. Training and number of members trained varies by service. Many service members trained in self/buddy aid during basic training. Chaplain and unit ministry team support available. Rotational support provided by behavioral health officers from Role 2.
	Navy	Self-Aid/Buddy Aid, Navy Corpsman	
	Marine Corps	OSCAR Teams	
	Air Force	Self-Aid/Buddy Aid, Medical Technician	
Role 2 Outpatient specialty behavioral health services available Limited patient hold capability	Army	Brigade Combat Team Combat and Operational Stress Control	Team composition varies depending on unit size and mission but includes a provider (psychiatrist or psychologist or social worker or behavioral health nurse practitioner or behavioral health
	Navy/ Marine Corps	Operational Stress Control and Readiness Team, OSCAR Combat Stress Platoon (CSP)	

	Air Force	The Combat and Operational Stress Control (COSC) detachment or clinics	registered nurse) and an enlisted behavioral health specialist. Chaplain and unit ministry team support available.
Role 3 Residential care	Army	Combat and Operational Stress Control Restoration Centers, Combat Support Hospital	Specialty care including psychiatrist, psychologist, social worker, behavioral health nurse practitioner, behavioral health registered nurse and tele behavioral health chaplain and unit ministry team support available.
	Navy/Marine Corps	Hospital Ship	
	Air Force	Combat Support Hospital	

Potential levels of support available in austere environments are depicted in the figure below. Level 1, the fastest and most frequently readily available resource, focuses on unit member and leader actions. Given that ministry or chaplains also deploy with service members, this is an additional capability that could be leveraged. This support involves self-help, buddy help, support from unit ministry as well as leader actions. Level 2 interventions involve more formal actions that may be carried out by trained peers and/or in consultation with trained behavioral health professionals (e.g., behavioral health technicians). Finally, Level 3 interventions, the capability of which might be rather limited in far-forward environments, but important for command to consider as additional tools in maintaining unit readiness, include treatment by specialty behavioral health providers.

Figure 1.1. Role 1: First Aid/Emergency Medical Care and First Responder Capability



The definition of Role 1 care is broad. Role 1 for all services begins with some form of self-aid or leadership intervention. Command involvement through good leadership and fostering a supportive environment is crucial to mitigating stress in austere environments. This merits a more elaborate discussion and has been captured in detail in Chapter 6. Self-Aid or Buddy Aid includes multiple aspects of battlefield care from basic first aid performed by all combatants to medical care provided at the battalion aid station (BAS). Behavioral health capabilities are provided by self and peers as well as by the combat lifesaver.

Self-Aid and Buddy Aid are interventions delivered by service member to either self or buddy during instances of crisis, such as acute stress reactions and panic attacks. While many service members are trained in self/buddy aid during basic

training, the number of members trained and the type of training received varies by service. Additional description of self-aid and buddy aid capability in the present as well as modifications that might enhance the capability in the future are provided below.

Leadership actions include removing or adjusting duties required by individual service members based on guidance from medical personnel. There are some basic models for preventive care, including the ability to rest and recover, which are often dictated by leadership and mission. Commanders and other leaders are also able to employ unit-wide assessments and tailor their decisions based on that information. Behavioral health and other medical personnel often become the primary educators and consultants to command on how to respond to individual and unit-level mental health concerns.

Self-Aid

The changing nature of conflict will result in an increase in the behavioral health stress faced by troops on the battlefield. With diminished reliance on battlefield circulation, troops will no longer be able to rely on external medical support, enhancing the need for real-time self-management of behavioral health stress and distress. A primary domain through which self-aid may be implemented is with the increased use of mobile applications for the self-management of behavioral health symptoms in military settings. Many of these apps (e.g., Breathe2Relax, Virtual Hope Box, PTSD Coach) have undergone rigorous empirical evaluations and have been found to be effective for self-management of symptoms [13,14] and may be appropriate for use in deployed settings [15] Importantly, many of the mobile applications which have been developed specifically for use in military populations have already addressed critical domains, such as the use of data-at-rest encryption, the ability to be pre-loaded onto devices, and standalone capacity or no need for reliance on consistent internet access.[16]

Additional training for the enhancement of self-aid may come through updating existing training which is already in use for the enhancement of psychological well-being and resilience, in order to reflect the changing nature of conflict. One such initiative is Master Resilience Training (MRT).[17] MRT has been implemented into the force for the past decade and aims to develop upon an individual's natural resiliency and capability for stress management.[18] Although MRT has been found to be effective in both the short- and long-term,[18,19] the training will need to be updated to reflect the unique stressors present in austere multi-domain operations (MDO) and prolonged field care (PFC) environments.[18] Furthermore, preliminary investigations of stress inoculation training using simulated combat scenarios has shown mixed but promising results. Further development and widespread implementation of these trainings will allow troops to more readily self-identify and briefly self-treat their own behavioral health care in real time.

Buddy Aid

In conjunction with an increased expectation for troops to engage in self-aid, buddy intervention will be similarly essential in addressing acute stress reactions. Peaks in behavioral evacuations frequently precede or follow a significant operational event.[20] Buddy aid may be trained to and applied by any available troop and will serve to increase the availability of immediate interventions. Two well-supported uses of buddy interventions for acute stress reactions are the Israeli Defense Forces intervention YaHaLOM[21] and the U.S. forces adaptation, iCOVER[22], which are further described in Chapter 4. These are brief 30- to 60-second procedures which are easily taught to and implemented at the squad level with a 90-minute training and are associated with return to functioning during dangerous situations when implemented on front lines.[23] Both YaHaLOM and iCOVER may be employed by any available troop, greatly increasing access to immediate buddy intervention.[22] While YaHaLOM and iCOVER function to address immediate acute stress reactions, the Marine Corps OSCAR program trains select leaders to identify and assist Marines affected by chronic operational stress problems and requires that 20% of all unit members receive Operational Stress Control and Readiness (OSCAR) training. This program relies on the concept of buddy care through the promotion of early recognition of more chronic combat stress.[24] More widespread use of iCOVER, Master Resilience Training, OSCAR, and related programs across branches will

be critical to promoting front-line coping as well as early recognition and management of combat stress in the far-forward environment.

Combat Lifesaver

The combat lifesaver is a bridge between the self-aid/buddy-aid and combat medic and functions in the role of supportive buddy aid. The combat lifesaver is a non-medical service member who provides lifesaving measures as a secondary mission as allowed by the primary (combat) mission. The combat lifesaver may also assist the combat medic in providing care and preparing casualties for evacuation when the combat lifesaver has no combat duties to perform. In the Army, one member of each squad, crew, or equivalent sized unit will be trained as a combat lifesaver. Examples of lifesaver roles include providing combat and operational stress preventive measures such as behavioral health and resiliency training, assisting with iCOVER, and coordinating with external behavioral health services, etc.

Medics and Role 1 Medical Providers

Access to specialty behavioral health providers or technicians at Role 1 facilities will be greatly diminished with decreased battlefield circulation. Furthermore, while tele-behavioral health models have historically been utilized to support Role 1 facilities, concerns with bandwidth and signal interruption will likely result in the downgrade in frequency of and reliance on such access to care. Thus, medics and other battalion-level medical personnel will become the frontline responders for behavioral care, necessitating greater training in psychological concerns typically addressed by behavioral health providers. Currently, medics receive limited training in behavioral health, therefore enhanced training for Role 1 providers must emphasize the most common and most serious differential diagnoses of behavioral health presentations (see Chapters 3 and 4). Furthermore, training must also encapsulate basic initial behavioral and symptom treatment (Chapter 2 to 4), as well as ongoing management of behavioral health concerns. Short-term behavioral symptom management will be critical as Role 1 medical providers will need to rely on the limited prescription drug formulary available at front-line locations (as outlined in Chapter 5), with limited access to psychotropic medications.

Behavioral Health Options

Behavioral health providers cannot replace the invaluable support provided by fellow service members. The single most important factor in organizational resilience is unit cohesion. All operational behavioral health assets provide training to their units on protective factors related to behavioral health, as well as teaching some form of psychological first aid that includes five core steps, namely: listen, protect, connect, model, and teach. Buddy care is critical in order to prepare teams to support each other when under pressure, prevent behavioral health casualties when possible, and help bridge people into care if they become a behavioral health casualty. Additionally, peer support (buddy care) can help facilitate reintegration of service members when symptoms have subsided. These trainings may be given by a behavioral health provider or technician. The trainings provided within each service branch are doctrinal and developed at the highest echelons of command rather than grown at the unit level in order to ensure consistency. Rotational behavioral health support can be obtained through battlefield circulation from (BHOs based at Role 2 facilities.

Behavioral Health Technicians

Behavioral health technicians (Military Occupational Specialty 68Xs in the Army, L24A in the Navy and 4C0X1 in the Air Force) serve a unique role as immediate access points of care among their organic unit, and their innate familiarity with the unit culture allows them to establish trust more readily with other enlisted service members.[25] They are a critical

asset[26] in the recognition of and treatment for unhelpful coping in individual soldiers, such as through the interruption of impaired reactions at the point of injury. Furthermore, the nature of their embedded status ensures that technicians are uniquely established to identify patterns of unit needs in order to increase and sustain performance and motivation and promote positive behavioral health. However, a recent report demonstrated inconsistent utilization and underutilization of enlisted behavioral health technicians in garrison,[25] to include relegation to administrative and clerical tasks. With appropriate training and adequate oversight, technicians may function semi-autonomously to conduct such tasks as implementing therapy protocols, conducting group interventions, and maintaining a therapeutic caseload.[27] Improved training for technicians must include more accurate recognition of early signs of maladaptive coping in individual service members, increased opportunity to work with service members after the initial triage/assessment, as well as enhanced coping within units. Furthermore, technicians will be more readily utilized at Role 1 treatment facilities if aligned at the battalion (or equivalent) level.

Chaplaincy

Additional resources that are organic to the unit and could be leveraged at roles 1 and 2 include chaplaincy services. A chaplain is more likely to be physically located closer to a deployed/forward location than a behavioral health specialist. Most chaplains are trained in basic counseling and are usually familiar with common behavioral health conditions from having worked closely with behavioral health counselors in prior duty assignments. The broad nature of confidentiality afforded by Chaplains may appeal to personnel who perceive limits of confidentiality as being a deterrent to help seeking.

Role 2

Care at the Role 2 is rendered by the area support squad and medical treatment platoon of medical companies. The primary goal of Role 2 is to provide "forward resuscitative care." The Role 2 Military Treatment Facility (MTF) has the capability to provide combat and operational stress control, preventive medicine, and physical therapy services. The Role 2 MTF provides a greater capability than is available at Role 1. Those patients who can return to duty within 72 hours (1 to 3 days) are held for treatment. This role of care provides medical evacuation from supported Role 1 MTFs and also provides Role 1 medical treatment on an area support basis for units without organic Role 1 resources. The primary function of Role 2 is to stabilize and prepare casualties for strategic aeromedical evacuation. Role 2 is the "home base" of uniformed BHOs from which battlefield circulation is derived. Examples of Army and Navy capabilities at Role 2 have been highlighted below. It should be noted that in forward operations, in view of limited availability of resources, services leverage available resources. For example, service members from the Air Force or Navy could avail help at the Army Combat and Operational Stress Control detachment.

Behavioral Health Officers

As indicated earlier, individual and unit behavioral health promotion will be more readily facilitated through organic unit assets such as self-aid, buddy aid, medics, and embedded behavioral health technicians. However, in instances where additional support might be needed, rotational support from Role 2 could be leveraged. In these situations, the behavioral health officer/licensed provider role will develop from hands-on provision of care to that of a clinical, supervisory, and training consultant. In garrison, the behavioral health officer should be providing realistic, experiential training to all troops to include Role 1 medical providers; trainings such as pre-deployment stress inoculation training have demonstrated positive effects by mitigating the future development of posttraumatic stress disorder (PTSD), particularly within the hyperarousal cluster of symptoms.[28] In deployed settings, the primary role of the behavioral

health officer is to provide supervision and consultation to Role 1 assets, assessing for the implementation fidelity of treatment protocols.

Army Role 2

Combat Operational Stress Control (COSC): The Army COSC detachment has been the primary means for providing behavioral health care in theater since Operation Enduring Freedom.[29,30] These COSC clinics exclusively focus on specialty behavioral health care services, often operating independently from other medical services. COSC operates in a "hub and spoke" manner such that the COSC clinic is established at a forward operating base (FOB), and the behavioral health teams travel to other FOBs from their "home base" as part of battlefield circulation.[31] COSC clinics utilize traveling teams of behavioral health providers and technicians or telemedicine equipment to reach patients in remote areas. COSCs in some instances might also be co-located at large, permanent restoration centers at Role 3.

Army Brigade Combat Teams: Combat and Operational Stress Control (COSC) support is provided by behavioral health sections assigned to the brigade support medical company of the brigade support battalion. If required, these resources can receive direct support from the behavioral health personnel assigned to the medical detachment (Combat and Stress Control Clinic or Restoration Clinics), if augmentation is required.

Organic assets (i.e. providers and paraprofessional technicians) are typically aligned at the brigade/battalion level and provide clinical care to soldiers within their organic units. Typically, organic behavioral health personnel are uniformed, but in certain circumstances may be government civilians or contractors. Personnel live, train, and fight within the units they serve and are generally housed within the unit's organic behavioral health clinic within one FOB. This allows for BHOs to build rapport with soldiers and effectively assess, treat, and impact individual and organizational needs. Responsibilities include providing consultation and advisement to commanders regarding behavioral health needs and trends at the individual as well as unit level. The behavioral health technicians thus serve a unique role and are a critical asset[25] aiding in the recognition of and treatment for maladaptive coping in individual soldiers, such as through the interruption of maladaptive reactions at the point of injury. Furthermore, the nature of their embedded status ensures that technicians are uniquely established to identify patterns of unit needs in order to increase and sustain performance and motivation and promote positive behavioral health.

The level of care provided best meets and does not exceed the level of care required in the area of responsibility. The interventions are intended to be brief, time limited, and more resource efficient than specialty behavioral health care. The focus is more on functional impairment and symptom reduction, as compared to specialty care that focuses on pathology, diagnosis, and intervention.

Composition of Team: Teams are typically made up of one to two licensed behavioral Health Officer BHOs (social worker and/or psychologist) and two to four 68Xs (behavioral health technicians). They may also rely on COSC and/or COSC resources to supplement/help support their unit, especially when troops are dispersed across wide geographic domain or when availability/accessibility issues arise. Members engage in continuous and predictable battlefield circulation – travelling through the unit area of operations (AO) on a regular basis to access as many soldiers/units as possible. Multi-day visits might be scheduled to varied Combat OutPosts (COPs) and FOBs.

Navy Role 2

Behavioral health care at this level will be provided through the combined efforts of behavioral health assets embedded within the unit, as well as behavioral health assets assigned to forward medical units. It is not expected that an operational unit's organic behavioral health asset will always be sufficient to meet the demands of every situation and therefore is expected to be augmented periodically with additional support. The activities at this level include interventions such as behavioral health triage, brief supportive counselling, group intervention, disaster postvention,

short-term evidence-based psychotherapy, or medication management. These providers may work as part of a team where providers are paired with behavioral health technicians or may be individually assigned within a unit.

The OSCAR program. The OSCAR program was designed to bridge the cultural gap between warfighters and behavioral health professionals by drawing care providers as fully as possible into the culture and life of the Marine units they supported—making them members of the "family" rather than outsiders. OSCAR capabilities have been extended down to the infantry battalion and company levels, without requiring additional behavioral health resources, by providing special OSCAR team training to existing medical and religious ministry personnel (OSCAR extenders) as well as selected enlisted warfighters (OSCAR mentors).[32] As special staff officers, OSCAR providers are able to evaluate and advice on the behavioral health well-being of individuals and units while also being able to provide preventive care. These OSCAR providers are organic to the unit and thus are assigned so that they fall under the direct command of the unit that they are serving.

In their primary role as special staff officer,[32] the OSCAR provider is expected to spend a significant amount of their time providing support services and consultation to command level leadership designed to improve the command's behavioral health readiness and safety. Responsibilities include being present at and participating in all command and staff meetings, Force Preservation Councils, as well as providing unit behavioral health surveillance, serving as command liaison, providing preventive behavioral health and resiliency training, and coordinating with external behavioral health services. In addition, the OSCAR providers are expected to fully immerse themselves in the culture of the Marine units including participating in unit-level training, pre-deployment exercises, and pre- and post-deployment briefings. As part of their role, the OSCAR provider is expected to provide behavioral health services in forward-deployed operational environments where services would otherwise be unavailable.

Role 3

The mission of deployment behavioral health care is to optimize war fighters and keep them in the fight. Medical evacuation from theater to Role 3 or above is utilized for personnel who are at serious risk of harm to self or others, or are otherwise not mentally fit for their area of responsibility. In Role 3, a service member is treated at large, fixed facilities with direct support from division psychiatrists. Services include short-term psychiatric medical hold capabilities. For the Army and Air Force, these are often co-located with restoration clinics staffed by combat stress control (CSC) detachment personnel.

Restoration Centers

Restoration centers, which are typically short-term advanced COSC care facilities, are generally co-located with Role 3 facilities. Services provided at the restoration centers are similar to a community behavioral health model and provide service members with the 4 Rs (**R**est, **R**eassure, **R**eplenish, **R**estore).[33] The primary mission of these centers is to promote individual and unit readiness by enhancing adaptive stress reactions, preventing maladaptive stress reactions, and providing higher level care for combat and operational stress reactions as well as other behavioral health disorders. They are doctrinally structured and provide multi-day (typically three days to two weeks) programs of education/monitoring/supervision/treatment with the focus on increasing return to duty rates for combat-stress-related casualties.[34] Examples of referrals to the restoration centers include service members experiencing deployment-related issues resulting from combat, conflicts with their chain of command, duty assignments, or other adjustment issues. Treatment framework is organized around three components: sleep hygiene, temporary separation from service member unit, and psychoeducational individual or group therapy sessions.

Composition of Teams

Restoration centers are staffed by COSC personnel, plus psychiatrists, psychologists, social workers, nurse practitioners, registered nurses, occupational therapists, and 68Xs. Support might be provided by COSC clinic comprising psychiatrist, clinical psychologist, social worker, behavioral health nurse practitioner, and behavioral health registered nurse if needed. An example from the Navy is described below.

Navy Role 3

This level of care in Navy behavioral health includes providers and technicians assigned to the T-AH Hospital Ships, and can also be manned by providers who traditionally work at a Role 4 medical center but are co-assigned to casualty receiving and treatment ships (CRTSs). The CRTS typically a line ship such as a landing helicopter assault (LHA) or landing helicopter dock (LHD) class amphibious aircraft carrier. In time of conflict, when the need arises, the provider who is assigned to a particular hospital will be rapidly re-assigned to duty aboard ship. The providers are periodically trained as a part of that CRTS team, so that they are prepared to quickly adapt when assigned to immediate duty at sea. The activities at this level include interventions such as psychotherapy, supportive counselling, group intervention, disaster postvention, or medication management.

In addition to maritime platforms, Navy behavioral health providers are also periodically deployed to expeditionary medical facilities (EMF) to provide contingency support. These facilities may be outside the continental United States (OCONUS), such as the Role 3 EMF in Kuwait which operated from 2004-2011, or may also be within continental United States (CONUS), such as the EMFs which were established in 2020 as a part of national COVID-19 response efforts. These providers are typically sourced from Role 4 medical treatment facilities.

Moving Beyond Traditional Roles

Over the last two decades of conflict, the U.S. Military has experienced air superiority and freedom of movement across the active battlespace, allowing for quick evacuation casualties to advanced medical support. However, the military anticipates that in future conflicts, access to advanced medical decision-making and patient stabilization may be restricted or significantly delayed due to distance or adversary denial to freedom of movement. Consequently, there will be increased need to access the capabilities (particularly the expertise) of the multidisciplinary medical team in more austere, severely resource limited, pre-hospital environments at or near the point of injury. Recent natural disasters and mass casualty events such as COVID-19, across the United States and abroad spotlight the challenges of delivering health care in austere contexts.

Tele-behavioral Health

Tele-behavioral health is an emerging consultative capability that extends the reach of behavioral health providers and adds fluidity, continuity, and expanded capability to the previously established roles. With the use of telehealth, a behavioral health provider and a Role 4 Medical Center could also function as a Role 2 or even Role 1 provider near the front line of a conflict. Telehealth is utilized as a force multiplier and allows for access to care in locations/during times when embedded behavioral health/behavioral health officer teams are unable to make walkabouts/battlefield circulations. The guiding principle for telehealth services are described below.

General Considerations for Telehealth in Operational Environments: The overarching principle of virtual health in an operational setting is that the interaction is always in a consultative posture. Some of the general principles that need to be understood when utilizing reach back capabilities are listed below:

- Virtual health in the operational environment should always be arranged with the medical assets on the ground and never directly with the patient.
- Unit providers are ultimately responsible for the care of the service member in their area of operations, and need to:
  - Be familiar with what medical care is available in the area of operations
  - Know what other circumstances need to be considered that may affect the patients care
  - Understand the logistics of evacuation out of the geographical area when necessary (see Chapter 7 for medevac considerations)

Recent innovations in battlefield telehealth have allowed for more robust communication between and across various echelons of care in Garrison settings. With extended conflicts and engagements, including Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF), deployment behavioral health care has expanded and been positively received.[34,35] However, there is less empirical support of particular models of care in a deployed environment. Additionally, access to this resource might be limited in far-forward settings where technology and connectivity might be a challenge. The Services have initiated expansion of tele-behavioral health capability in forward environments. Exemplars of recent initiatives that have shown promise are showcased below. While approaches such as the Pacific Asynchronous TeleHealth (PATH) system[36] serves users widely throughout the fleet as well as shore-side duty stations in Central and South America, Europe, Asia, and the Pacific, models like the Advanced Virtual Support for Operational Forces (ADVISOR) are still in pilot phase[37] and are not available for all far-forward environments. Given the nascent nature of this capability, the provider is encouraged to explore and rely on available organic assets before engaging or resorting to telehealth service options.

Examples of Telehealth Capabilities

Evaluation and treatment of behavioral issues of service members in the operational environment are initially provided by organic assets described earlier. Additional counseling assets that include military family life counselors (MFLC) can be reached at FOBS such as Camp Aachen, Powidz, and Poznan, to name a few. Referral and/or consultation for behavioral health emergencies and/or evacuations should be coordinated with an organic BHO. If a BHO is not available, then coordination should be made with the division surgeon (DIV SURG) or equivalent regarding how to proceed (Chapter 7). In instances where the operational environment does not possess sufficient behavioral health assets to fully support the service member under the area of responsibility, tele-behavioral health options need to be considered. The options include virtual deployment of behavioral health teams to address acute issues, provide 2nd level operational and technical support to the austere providers, or provide coaching and mentorship to the team in the austere setting. An Alternatives to telephone consult that has been gaining traction include the Pacific Asynchronous Tele Health (PATH) system. Some additional tele-behavioral health models that can be leveraged are detailed below. Asynchronous telehealth such as those offered by Health Experts online Portal (HELP) or PATH enables discussion between multiple consultants and the primary care provider, who fittingly remains at the center of medical decision-making. In this way, the platform is a 21st century workaround to the challenges faced by the military in the form of wide geographic fragmentation and limited specialist availability.

BHO to Medical Provider Consultation

The ADVISOR program, currently piloted in the European Theater, was designed specifically for the deployed remote medical asset who needs quick advice to manage a severely injured patient in an austere location with limited resources. Examples where this resource might be applicable include instances where the service member requires management by multiple specialties due to complicated symptoms such as acute stress reaction and concussion following exposure to blast, with preexisting sleep disturbance and migraine attacks exacerbated by the stress. The ADVISOR line is available 24/7/365 and is manned by staff who can direct callers to the right specialist in a timely, efficient manner. It is important to note that sensitive operations may make it impossible for medics or docs to reveal patient location or service member identification. Additionally, this option might also be used for calls relating to local national patients that medics or physicians might find themselves caring for.

The HELP and PATH platforms are web-based, 'email a doc' systems that represent options for non-urgent care. Both HELP and PATH are important foundational virtual health platform for routine consults from anywhere, both garrison and deployed settings, and represent most of the virtual consults (75%). The consultant or consultants who answer the online requests are most often in the normal care continuum at the Role 4. However, if there are gaps in coverage, the consult will be forwarded to the appropriate specialty anywhere in the Military Health System (MHS). The main pool of consultants that comprise HELP are the larger medical centers (MEDCENS) along the care continuum, namely Tripler Army Medical Center, Naval Medical Center San Diego, Landstuhl Regional Medical Center, and Naval Medical Center Portsmouth. In operational settings, the online portal helps in initiating provider to provider specialty consultation with the potential to transition to virtual video visits. If the specialty provider determines that a virtual video visit or patient travel is necessary, the medic would need to coordinate with command for assistance with medical travel and/or referral placement (refer to Chapter 7 for medevac planning and procedures). If there is a determination for medevac, a medic would need to provide a warm handoff to the receiving provider and the unit and enter the patient into Transcom Regulating and Command & Control Evacuation System (TRAC2ES). Finally, if the patient is evacuated, discharge paperwork needs to be forwarded to a unit provider if they are returned to duty. The platform, which by design is unsophisticated, is cognizant of low or no communication operational missions and thus utilizes very low bandwidth. This option can be accessed at https://help.nmcp.med.navy.mil/

Behavioral Health Provider to Patient

Virtual video visits provide a real time encounter with a specialty provider via video conference. As mentioned earlier, virtual health in operational environments should always be arranged with the medical assets on the ground and never directly with the patient. The provider from the distant site reaching into an operational setting will always be in a consultative posture.

Virtual video visits are the most challenging in terms of connectivity, therefore it might not be a viable option in deployed or remote units utilizing low or no communication technologies. Additional considerations for virtual video visits include virtual health privileging. Deployable, deployed, or remote providers need to complete virtual health training. Upon completion of training, a copy of the training certificate will be forwarded to the primary privileging authority to be placed in the providers inter-facility credentials transfer brief (ICTB). Remote providers need to be privileged at both the remote site as well as the originating site if there is a privileging body present. The credentialing needs to be completed prior to deployment. For more detailed discussion on virtual health privileging and privileging by proxy, please refer DHA PM 6025.13 Vol.4. All virtual encounters include either written or verbal consent from patient for virtual health. Paper and printers and sometimes even electronic health records may not be available in austere environments, so verbal consent with a note on the chart is acceptable in these instances. Verbal consent with a note is in the new COVID virtual health guidance and is likely consistent with future Department of Human Services (DHS) guidance.

Finally, audio visual privacy is another consideration for synchronous encounters. This needs to be a consideration whether in a tent or hard facility. Some of the key elements include:

- Avoid cluttered background and check proper lighting.
- Use picture-in-picture feature to get a self-view.
- Speak clearly and distinctly. When speaking, pause to allow transmission delay. Avoid abrupt movements.
- Display an appropriate sign when virtual encounter is in session.
- Have an alternate communication plan in case of loss of audio/video connection.
- Know specialty specific virtual health emergency protocol. Specific to behavioral health patients, it is recommended to have larger screen so as to capture more than just the head and shoulders for a better situational assessment.

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Chapter 2

Basic Assessment and Intervention Principles for Forward Behavioral Health Care

Exposure to operational stress during deployment increases the risk of developing a range of behavioral health conditions, including PTSD, major depression, and substance misuse.[1-3] While the extant literature has focused primarily on the diagnosis and treatment of behavioral health disorders following a return from deployment,[4,5] these symptoms often present in theater, creating an additional burden for medical personnel and negatively impacting readiness during critical operations. Service members with existing behavioral health diagnoses in particular may be at increased risk for developing acute symptoms requiring behavioral health care in a deployed setting. Frontline behavioral health principles center on assessing and intervening quickly, simply, and as close to the original stressors as possible. These principles are captured in the BICEPS approach (Brevity, Immediacy, Centrality or Contact, Expectancy, Proximity, Simplicity).[6] An interview with a mental status examination and brief screeners are at the core of basic screening and assessment for behavioral issues and safety. Stress is a modifiable and important component across all presenting behavioral health issues. Therefore, brief simple interventions focused on stress management and restoring basic needs can improve severity of symptoms across presenting issues. Disposition will include immediate return to duty, rest in place near the unit, treatment/intervention near the unit (see Chapter 4 for common issues and interventions), evacuation to Role 2, or evacuation to Role 3 (see Chapter 1 for roles of care and behavioral health capabilities, Chapter 3 for most severe issues and safety interventions; see Chapter 7 for medical evacuation; Chapter 6 for command consultation). As noted in the Introduction, the term NSMP (non-specialty medical personnel) is used throughout this CPG and chapter. It is intended to describe the range of medical personnel providing services or engaging service members who will likely and often do encounter behavioral health conditions without available specialty services. Whereas behavioral health providers ideally intervene for needed services, the reality of far-forward care is that they are often are not available. As a reminder, this CPG is intended to equip NSMPs with the tools that they need for the reality of far-forward environments.

Considerations for Pre-Existing Conditions

Pre-deployment assessment and medical clearance for service members with existing diagnoses is a rigorous process, and it should be noted that these individuals have passed through several “checkpoints” before being cleared to accompany their unit on deployment. However, they are still at an increased risk of developing acute symptoms during prolonged exposure to operational stress.[7] The acclimatization period following arrival in theater is an optimal time to check in on service member’s current functioning and an opportunity to collect baseline data—making it easier to monitor for concerning changes for the remainder of the deployment. In order to reduce the burden on medical

personnel, members of unit leadership could be trained to identify common risk factors and meet with members of the medical staff periodically to provide updates, express concerns, and note any identified changes in baseline behavior. Non-commissioned officers (NCOs) and staff non-commissioned officers (SNCOs) have rapport and working knowledge of members within their squad or platoon that make them especially well positioned to assess for potential risk factors and monitor for changes that may require intervention.

There are a multitude of factors that may cause an exacerbation of symptoms in a deployed setting. When conducting assessments, or training non-medical personal to assess, it may be useful to consider these factors under two categories: 1) symptoms present prior to deployment; and 2) operational and combat stressors organic to the deployed environment. For example, nearly 60% of all deployed service members are married and over 40% have children.[4] In addition to the stress of being separated from family, financial hardships and substance use issues are often exacerbated during deployment. In some cases, these issues may be addressed in theater (i.e., tobacco withdrawal). However, operational and combat stressors are often much better targets for intervention in a deployed environment. Operational stressors include a lack of privacy, reduced quantity and quality of sleep, prolonged exposure to extreme geographic environments, and reduced quality of life for extended periods of time. Combat stressors include personal injury, killing combatants, witnessing the injury or death of a unit member, and repeated blast exposures. While it should be noted that acute symptoms of combat stress have been treated using exposure techniques in theater,[8-10] these treatments must be provided by a qualified behavioral health professional. Conversely, operational stressors lend themselves to brief and often self-guided treatments that may be implemented by a variety of non-medical personnel. Behavioral health interventions available in theater are often restricted due to a lack of resources and personnel. In determining how to proceed when developing a treatment plan for service members in theater, it is important to consider which treatments would be most effective, efficient, and feasible given the available resources.

Assessment and Screening

Screening involves identifying possible problem areas, and assessment is the process of understanding the specific problems further, leading towards possible diagnosis and a specific treatment plan. The process of triage and planning starts with screening and should include assessment principles as well. This section describes broad and specific techniques and tools for these processes. Considering the approach and manner of engaging the service member is important. Techniques such as active listening and motivational interviewing can: 1) yield more accurate clinical information; and 2) make the assessment process itself therapeutic and stress-relieving.[11]

Self-Reported versus Observed Information

A person's insight about their own behavioral health functioning varies widely according to individual characteristics, cognitive functioning, and specific condition. Therefore, an accurate and effective assessment process includes self-report, which could be both collateral and observed information taken into the context of the person's known history. The Mental Status Exam (MSE) covers mostly observed behaviors whereas brief screeners are primarily self-reported by the service member. More important than a specific diagnosis, the combined use of appropriate interview questions, clinical judgment, MSE, and brief screeners will guide decisions on medical evacuation and appropriate interventions. Physical vital signs, like pulse and temperature, offer a rough index of the overall health of a person and the urgency of any necessary intervention. Likewise, there are certain behavioral health measures that offer important information about overall behavioral health functioning, which are supplemented by the MSE (described below).

Brief Clinical History

It is helpful to gather a brief clinical history to understand the person's context and further clarify their presenting issue and possible causes. Appendix A includes some basic clinical interview questions that cover basic demographics, stress and recent trauma exposure, substance use, violence or suicide history, history of behavioral health, and history of neurological/other medical issues.

Techniques and Interview Style

The manner of asking the questions and responding are as important as the content of the questions. Active listening is an approach to communication that emphasizes the listener's attempt to understand the speaker's perceptions of events without making their own interpretations and conclusions. This approach can be helpful to: 1) de-escalate a person in crisis and 2) get more accurate clinical data. Some specific techniques involve paraphrasing (i.e., attempting to summarize what the person said), reflection (i.e., repeating back what the person said), and clarification (i.e. asking follow-up questions about specific phrases or comments). In addition, motivational interviewing,[12] a style of asking questions and engaging a person to elicit their internal motivation to change, is also a useful framework for conducting an interview. Using this framework is particularly important for agitated or generally untrusting service members who may be resistant to answering questions. It is important to avoid engaging in confrontation as that leads to less information and can further agitate the person. Consider using the acronym OARS:[13]

- **O**pen Ended Questions: What things do you have on your plate right now? What are you dealing with?" rather than "Do you have stress right now?"
- **A**ffirming: "No wonder you feel overwhelmed. That is a lot to manage at home from so far away."
- **R**eflective Listening: "What I hear you saying is that the argument you had with your squad leader is making it hard to do your job now."
- **S**ummarizing: "Let me see if I've got this straight. You've not been able to sleep more than two to three hours per night and are still really shaken by the fire fight you were in two weeks ago. On top of that, your medically ill mother is at home and you're not sure if she will survive until you get back. That is a lot to manage."

Screener Administration

Consider routinely using behavioral health vital signs screeners. As described in the following minimum, better, and best section, screeners are not considered minimally necessary. Upfront use of the BASIS screener, as it includes questions about general distress and suicide, is considered better and use of all the described screeners is considered best. The measures themselves can also be administered item by item in a conversation with the service member. Alternatively, you might print them out for the service member to complete by hand. Self-report screeners provide some information about what the presenting issues might be but are not meant to result in diagnosis. The screener results must also be taken into context of the service member's comprehension of their own symptoms and willingness to honestly report them. Therefore, it is important to follow-up with the service member on specific, relevant items for clarification and further understanding. For example, a service member responds affirmatively to "I feel hopeless," then it is helpful to talk further about what that item means to the service member and use active listening skills. See Appendix B for each full screener.

Generalized Anxiety Disorder Scale

Generalized Anxiety Disorder Scale (GAD-7) is a self-reported questionnaire for screening and severity measuring of GAD.[14-16] Respondents are asked how often, during the past two weeks, they have been bothered by each of the seven core symptoms of GAD, such as having trouble relaxing or feeling afraid, as if something awful might happen.
See Table 2.1 for details on the GAD-7, and Appendix B for the full screener.

Table 2.1. Generalized Anxiety Disorder Scale.

Generalized Anxiety Disorder Scale (GAD-7)	Screener Details
What it measures	A self-reported questionnaire for screening and severity measuring of generalized anxiety.
Number of items	7 items
How long to administer	Under 5 minutes
How to score	Scores are calculated by assigning scores of 0, 1, 2, and 3 to the response categories, respectively, of "not at all," "several days," "more than half the days," and "nearly every day." Scores are summed across all items. Scores can range from 0 to 21, and higher scores indicate higher levels of anxiety. The score ranges are: 0 – 4 = minimal anxiety 5 – 9 = mild anxiety 10 – 14 = moderate anxiety 15 – 21 = severe anxiety
What's considered a "high" positive score	Scores greater than or equal to 10 are categorized as having probable GAD.

Patient Health Questionnaire - 9

Patient Health Questionnaire – 9 (PHQ-9)is a standard brief measure of depression that ascertains how many days in the past two weeks service members experienced common depressive symptoms, such as feeling down, depressed, or hopeless; had trouble falling or staying asleep, or sleeping too much; and had little interest in doing things.[17,18]
See Table 2.2 for details on the PHQ-9, and Appendix B for the full screener.

Table 2.2. Patient Health Questionnaire – 9.

Patient Health Questionnaire – 9 (PHQ-9)	Screener Details
What it measures	A self-reported questionnaire for screening and severity measuring of depression severity.
Number of items	9 items
How long to administer	Under 5 minutes
How to score	Scores are calculated by assigning scores of 0, 1, 2, and 3, to the response categories of "not at all," "several days," "more than half the days," and "nearly every day," respectively. Scores are summed across items. Scores can range from 0 to 27, and higher scores indicate higher levels of depression. The score ranges are: 0 – 4 = none 5 – 9 = mild depression 10 – 14 = moderate depression 15 – 19 = moderately severe depression 20 – 27 = severe depression
What's considered a "high" positive score	Scores greater or equal to 10 are categorized as probable major depression.

Patient Health Questionnaire – 4

Patient Health Questionnaire – 4 (PHQ -4), comprising of the first two items of GAD -7 and PHQ -9, could be administered as an ultra-brief screener for both anxiety and depression when the provider is hard pressed for time.[19-22] PHQ-2 and GAD-2 sub scores of the PHQ-4 provide separate depressive and anxiety scores and can be used as screeners for depression and anxiety. The recommended cut points for each when used as screeners is a score of 3 or greater. When used together, they are referred to as the PHQ-4 a four-item screening measure. The score for PHQ-4, ranges from 0 – 12, with scores greater than 6 indicative of probable depression and/or anxiety and warrants additional evaluation. See Table 2.3 for details on PHQ-4, and Appendix B for the full screener.

Table 2.3. Patient Health Questionnaire – 4.

Patient Health Questionnaire – 4 (PHQ-4)	Screener Details
What it measures	Ultra-brief screener for both anxiety and depression.
Number of items	4 items
How long to administer	Under 5 minutes
How to score	Scores are calculated by assigning scores of 0, 1, 2, and 3, to the response categories of "not at all," "several days," "more than half the days," and "nearly every day", respectively. Scores are summed across all items. Scores can range from 0 to 12, The scores on first two items provide sub-score for depression and the last two items provides sub-score for anxiety.
What's considered a "high" positive score	Scores greater than or equal to 6 are categorized as having probable depression and or anxiety. Sub-scores greater than or equal to 3, on the anxiety or depression items are indicative of probable anxiety or depression respectively.

Couples Satisfaction Index

Couples Satisfaction Index (CSI-4)[23] is originally a 32-item scale reduced to four items that most represent relationship satisfaction, which are positively related to a variety of other couples' indices, including self-reported positive communication, sexual chemistry and negatively related to hostile conflict, perceived stress, and ineffective arguing. This index might provide helpful insight into the presence of psychosocial stressors at home, which is further described in Chapter 4. See Table 2.4 for details on the CSI-4, and Appendix B for the full screener.

Table 2.4. Couples Satisfaction Index.

Couples Satisfaction Index (CSI-4)	Screener Details
What it measures	A self-reported questionnaire measuring relationship dissatisfaction.
Number of items	4 items
How long to administer	Under 5 minutes
How to score	Scores are summed across all items. Scores can range from 0 to 21. Higher scores indicate higher levels of relationship satisfaction.
What's considered a "high" positive score	Scores below 13.5 suggest notable relationship dissatisfaction. .

Epworth Sleepiness Scale

Epworth Sleepiness Scale (ESS) is a self-administered eight-item questionnaire which asks respondents to rate on a four-point scale (0-3) their usual chances of having dozed off or fallen asleep while engaged in eight different activities.[24,25] The total ESS score (the sum of 8 item-scores) gives an estimate of a more general characteristic, the person's 'average sleep propensity' or ASP, across a wide range of activities in their daily lives. See Table 2.5 for details on the ESS and Appendix B for the full screener.

Table 2.5. Epworth Sleepiness Scale (ESS).

Epworth Sleepiness Scale (ESS)	Screener Details
What it measures	A self-reported questionnaire measuring an individual's 'daytime sleepiness'
Number of items	8 items
How long to administer	Under 5 minutes
How to score	Scores are summed across all items. Scores can range from 0 to 24, and higher scores indicate higher levels of daytime sleepiness. The score ranges are: 0 – 5 = Lower Normal Daytime Sleepiness 6 – 10 = Higher Normal Daytime Sleepiness 11 – 12 = Mild Excessive Daytime Sleepiness 13 – 15 = Moderate Excessive Daytime Sleepiness 16 – 24 = Severe Excessive Daytime Sleepiness
What's considered a "high" positive score	Scores of ranging from 11 – 24 represent increasing levels of 'excessive daytime sleepiness.'

Primary Care PTSD Screen for DMS-5

Primary Care PTSD Screen for DMS-5 (PC-PTSD-5is a five-item screen that was designed for use in primary care settings.[26,27] Preliminary results from validation studies suggest that a cut-point of 3 on the PC-PTSD-5 (e.g., respondent answers "yes" to any three of five questions about how the traumatic event(s) have affected them over the past month) is optimally sensitive to probable PTSD. See Table 2.6 for more information on the PC-PTSD-5, and Appendix B for the full screener.

Table 2.6. Primary Care PTSD Screen for DMS-5.

Primary Care PTSD Screen for DMS-5	Screener Details
What it measures	A self-reported questionnaire designed to identify individuals with probable PTSD.
Number of items	5 items
How long to administer	Under 5 minutes
How to score	Scores can range from 0 to 5. Scores are summed across all items, and higher scores indicate higher probability of PTSD.
What's considered a "high" positive score	Scores greater than or equal to 3 may detect probable PTSD.

COLUMBIA-SUICIDE SEVERITY SCALE

Columbia-Suicide Severity Scale (C-SSRS) is self-report or provider-administered and includes questions about suicide-related thoughts, intensity of thoughts, and behavior.[28] See Table 2.7 for details on the C-SSRS and Appendix B for the full screener.

Table 2.7. Columbia-Suicide Severity Scale (C-SSRS).

Columbia-Suicide Severity Scale (C-SSRS)	Screener Details
What it measures	A clinician-administered interview used to identify and assess individuals at risk for suicide.
Number of items	18 items
How long to administer	Under 5 minutes
How to score	The C-SSRS is made up of 10 categories, all of which maintain binary responses (yes/no) to indicate a presence or absence of the behavior.
What's considered a "high" positive score	There are no specified clinical cutoffs for the C-SSRS due to the binary nature of the responses to items. When an item is endorsed, the clinician must pose follow-up inquiries to obtain additional information.

BEHAVIOR AND SYMPTOM IDENTIFICATION SCALE

Behavior and Symptom Identification Scale (BASIS-24) is a 24-item self-report measure that ask questions across five domains: depression, anxiety, suicidality, impulsive and addictive behaviors, and psychotic symptoms.[29] As noted, this screener can be used for every encounter upfront as part of a better assessment approach. See Table 2.8 for details on the BASIS-24 and Appendix B for the full screener.

Table 2.8. Behavior and Symptom Identification Scale (BASIS-24).

Behavior and Symptom Identification Scale (BASIS-24)	Screener Details
What it measures	A self-reported questionnaire designed to assess behavioral health treatment outcomes. Scores can be computed for the overall BASIS-24, as well as for six subscales: depression and functioning, interpersonal relationships, psychosis, substance abuse, emotional lability, and self-harm.
Number of items	24 items
How long to administer	Under 15 minutes
How to score	Scores can be calculated as an overall score, or individual subscale scores. The 24 questions are scored on a 5-point scale (from 0 to 4) and each subscale, and overall mean scores also range from 0 to 4, with 0 being the lowest severity of symptoms and 4 being the highest severity of symptoms.
What's considered a "high" positive score	Scoring algorithm is only available in electronic administration; reviewing by domain and item is recommended.

Observed Behaviors: Mental Status Examination

The Mental Status Exam (MSE) is a commonly used structure for health care professionals to get a sense of an individual's current functioning. Appendix C (adapted from Norris et al., 2016) shows the mental status domain, the definition, things to look for, and questions to ask the service member within those domains.[30] Abnormalities within any of these domains can come from a variety of sources and conditions and offers a clue to possible dysfunction. For example, if the service member has a disheveled appearance and disorganized way of speaking, they might be under the influence of a substance, experiencing depressed mood, experiencing a manic episode, experiencing delirium, sleep deprived, or a combination of these conditions. Typically, issues within one or more of these domains suggests increasing severity as they are broad indices of basic functioning. Chapter 3 offers more specific insight regarding assessing and intervening on the most severe behavioral health conditions that might present in a far-forward environment.

Minimum, Better, and Best Assessment Approaches

The clinical example below follows SPC Miller across what minimum, better, and best interventions would look like: The Squad Leader walks SPC Miller into the tent. The squad leader shares that SPC Miller is 24 years old, married with one child, and is infantry with no prior deployments.

Minimum:

- **Brief interview questions and provider observes parts of the service member's Mental Status Exam (MSE**) - (may not be full MSE).

  Provider: *What's been on your plate lately?*

  Service member: *My partner will not answer my calls and the service is spotty anyway. The last time this happened, she was on a bender and had relapsed.*

  MSE Observations: *SPC Miller is disheveled and appears un-showered. His eyes are slightly blood shot. He avoids eye contact while talking. His speech is a bit pressured. All of these observations are consistent with an ongoing experience of stress or anxiety.*

  Provider*: I imagine that's stressful for you to not know if your partner is okay. How long has this issue been going on?*

  Service member: *She hasn't answered me in three weeks. It's felt like forever. I haven't been able to sleep because I keep trying to call her during the day or catch her at other times.*

- **Interpretation and follow-up steps:** From the information gathered above, SPC Miller's primary issues seem to stem from worry and anxiety related to his partner at home and her well-being. The provider might consider using strategies from the "psychosocial stressors" subsection in Chapter 4 and general stress management.

Better:

- **More thorough interview questions, full MSE, and use of BASIS screener.**
- **Stress and Recent Trauma Exposure**: SPC Miller said that this deployment has been stressful. It feels like there are long, boring periods where he's just left to think and worry about his partner and then other times when there's no time for phone calls and they have day long duties. He said that they have not encountered any enemy fire, which is also a source of stress because he enlisted to "get in the fight." He said that not hearing from his partner makes him feel helpless and out of control.

- **Substance Use**: SPC Miller shares that he was drinking approximately three to four beers per night and one to two energy drinks during the day prior to the deployment. He continues to drink two to three energy drinks per day. He says he hasn't used other drugs and does not think he's ever really had an alcohol problem.
- **Violence or Suicide**: SPC Miller says that he used to get into fights in high school but "hasn't really done that anymore." He says that sometimes he wishes he were dead when he feels hopeless about his partner and has thought "seriously" about suicide before. He has not acted on his thoughts and has not attempted to harm himself.

Best:

- **Full interview, MSE, and use of all screeners beforehand:**

  Couples Satisfaction Index -4 (Score=13). SPC Miller's CSI - 4 falls below the 13.5 cutoff and suggests relationship dissatisfaction; the provider already has a sense of what's going on in SPC Miller's relationship and these specific items may provide an opportunity for follow-up questions and clarifying the history of the relationship.

  Behavior And Symptom Identification Scale-24. The provider reviews SPC Miller's responses to the BASIS by domain (listed below) and then specific item. There are a few things that the BASIS-24 revealed that SPC Miller did not directly state in the interview: 1) he experiences significantly low social support; 2) he is experiencing some depression in addition to anxiety; 3) he feels largely unable to function.

  Depression/Functioning (items 1-3, 9-10; 4-6 are reverse scored): SPC Miller reports "half of the time" for most of the items, suggesting that he is both experiencing some depression and has had trouble functioning.

  Relationships (reverse scored; items 4-8): SPC Miller indicated 0 "none of the time" or 1 "little of the time" for all items, suggesting that he might experience more loneliness and lack of social support than he reported in conversation.

  Psychosis (14-17): Reported 1 "rarely" on 15 (hear voices of see things) and 2 "sometimes" on 16 (think people are watching you). Upon clarification, there was no evidence of psychotic symptoms. SPC Miller says that his squad leader has been more on him to complete tasks and watches more closely. He said that sometimes in the middle of the night he hears his partner's voice in his head.

  Substance use (21-24): SPC Miller responded 2 "sometimes" to item 21 (urge to drink alcohol or take street drugs) and 0 "never" to items 22-24, suggesting that substance use may not currently be an issue

  Emotional lability (18-19): SPC Miller responded "sometimes" for mood swings and "rarely" for feeling short-tempered. Upon clarification, SPC Miller said that sometimes he will get excited or hopeful about something and then quickly shift when he's disappointed.

  Self-harm (11, 20): SPC Miller respond 0 "never" to both self-harm questions.

- **Additional interview information collection:**

  History of behavioral health issues: SPC Miller says that he has not engaged in behavioral health before and doesn't think he has behavioral health problems.

  History of neurological/other medical issues: SPC Miller says that he was diagnosed with attention deficit hyperactivity disorder in elementary school but hasn't sought treatment for it and didn't tell Military Entrance Processing Stations (MEPS).

  Resources and support: SPC Miller says he likes his squad leader and is close with a couple other guys in his unit. He said that he doesn't really have any friends or family that he stays in touch with back home.

Overview: Far Forward Interventions

As stated above, most effective interventions are non-specific and center on modifying stress. Experiencing stress that exceeds a person's resources exacerbates any pre-existing behavioral health condition and often can trigger an apparent behavioral health issue. There are times when medical evacuation is necessary; it is important to balance a consideration for the negative impact of removing the service member from their unit and their role as this transition can further exacerbate behavioral health issues. Interventions should follow a stepped approach as much as possible to ensure the lowest appropriate level intervention for the presenting issue. First, elements of a service member's organic leadership should play an integral role in monitoring for changes from their baseline behavior and ensure that further assessment and treatment is sought when necessary. Second, interventions applied in theater should be brief and focused on skills learned prior to deployment as well as common presenting issues in a deployed setting. Finally, a thorough understanding of when presenting symptoms require a higher level of care is needed to avoid unnecessary burden on the already limited capacity to provide care in a forward deployed setting.

Chapters 3 and 4 outline a framework for forward intervention that draws on prolonged field care principles. Utilizing this "minimum," "better," "best" framework to focus on the most common and most serious behavioral health conditions that emerge in far-forward environments provides NSMPs a range of potential options to intervene when specialty care is not available.

Considerations for Pre-Existing Conditions

The overarching goal of providing behavioral health treatment in theater is to keep service members in the fight and maintaining unit readiness for the duration of the deployment period. In accomplishing this goal with limited resources and often in austere environments, it is vital that interventions be brief and focused on high yield treatment goals. Treatment planning and intervention in a forward operating environment can be approached along the same lines of symptom evaluation, where prior history (e.g., interventions that the service member had undergone prior to deployment) is considered along with the direct impact of deployment.

First, service members with an existing diagnosis were likely receiving behavioral health services prior to deployment and have likely developed skills over the course of therapy in garrison. In some cases, they may have developed something resembling a crisis plan or skills toolbox with coping strategies tailored for the deployed environment. If they have not worked with their previous provider on this issue, it may be a useful starting point. In addition to leveraging previously developed skills, education and intervention targeted at problems commonly faced during deployment – including sleep related issues, lack of adequate self-care, and education about normal stress responses – provide additional targets for intervention that may be implemented by non-medical personnel. Second, when considering how to implement treatments it is important not only to make note of which resources are available now (see Chapter 1), but perhaps more importantly, what is the lowest level from which these interventions can be implemented? In some cases, treatment may be self-administered by the service member with or without intermittent monitoring by a peer, unit leadership, a member of a combat stress operational control team, or a medical or behavioral health provider. It should also be noted that 40% of service members receiving a treatment plan in theater were prescribed medication, with 75% of those receiving antidepressant medication,[31] although availability of psychotropic prescription medications in the far-forward theater remains uncertain. Finally, it has been found that providers considered or recommended medical evacuation for approximately 4% of all service members presenting with behavioral health issues.[31] While relatively infrequent, it is vital to understand the medical capabilities as well as the medical evacuation chain within the deployed setting (see Chapter 7).

Stress Management

Most individuals under normal but stressful circumstances are able to cope with the stress load and return to functioning without adverse outcomes downrange. Potential impact and negative effects of stress can be mitigated through adaptive stress coping. The components of adaptive coping include the 5 Rs described below.

1. Reassurance of normality
2. Rest – break from combat or work
3. Replenish bodily needs – heat, water, food, hygiene, sleep
4. Restore confidence – with purposeful activities and unit contact
5. Return to duty and reunite with unit

As indicated earlier, the overarching principles of interventions should follow a stepped approach as much as possible to ensure the lowest appropriate level of intervention for the presenting issue. At the minimum, stress reactions could be addressed by self or with help by peer by establishing "buddy" systems for informal support. Additionally, sources of support include chaplains, military police, and medics that can facilitate access to resources. Detailed description of behavioral health resources and self /buddy interventions are described in Chapter 1 as well as in the chapters 3 and 4, addressing behavioral health conditions.

Leadership plays an important role in mitigating stress as well as promoting healthy behaviors. This is accomplished by creating an open culture free of stigma towards behavioral health conditions, leading by example e.g., reminding service members to care for themselves, and attending to basic needs including personal safety, hydration, sleep, and restoration as well as ensuring that service members are supported through stressors such as disciplinary action or relationship difficulties. Additional actions by leadership are detailed in the Chapter 6 on command consultation.

Finally, described below is the overarching guidance on the stepped approach for minimum, better, and best interventions to address some of the behavioral health conditions that some of the service members might experience in a forward environment. Chapter 3 and 4 provide descriptions of the interventions tailored to specific conditions.

Minimum, Better, Best Rating

Minimum:

At a minimum, interventions for all behavioral health conditions should focus on safety management and de-escalation of the crisis or presenting symptom. For example, when a service member is displaying symptoms of acute stress as evidenced by increased palpitations and panic, a peer or buddy could help by reassuring the service member, providing support, and ensuring that the service member is out of harm's way.

Better:

Better than minimum interventions include actions taken to ensure the safety of the service member as well as provide help with stress management. Some of the approaches which are also described in detail in later sections of this guidance include tactical breathing, help with problem solving, etc.

Best:

The interventions identified as the best approach are tailored interventions for the presenting symptoms which have been described in detail in Chapters 3 and 4. In addition to helping the service member cope with stress, these interventions also help with managing the presenting problem by leveraging behavioral health resources where available.

Conclusion

Deployments can be psychologically taxing for all service members, and this may be especially true for service members who deploy with an existing behavioral health diagnosis. To make matters more challenging, far-forward deployments often lack the behavioral health resources necessary to provide traditional outpatient therapies. In order to effectively and efficiently assess and treat behavioral health issues of service members with or without a history of behavioral health diagnosis in theater, several strategies should be considered. First, incorporating elements of a service member's organic leadership team can reduce the burden on medical personnel while adding the invaluable insights of someone with a working relationship with the individual who is more likely to notice early warning signs. Second, interventions applied in theater should be brief and focused on skills learned prior to deployment as well as common presenting issues in a deployed setting. Finally, a thorough understanding of medical capabilities and evacuation procedures may assist in determining when the necessary level of care exceeds the current resources of the medical team. With service members deployed all over the world, there is no one size fits all approach to providing behavioral health treatment in a deployed setting. However, preserving resources by providing brief, targeted interventions that are delivered at the lowest possible level of care can serve as a force multiplier in nearly every deployed setting, from shipboard to ground combat operations.

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Chapter 3

Management of Serious Behavioral Health Conditions That May Manifest in Forward Environments

This chapter focuses on the most severe behavioral health conditions that might emerge in a far-forward environment. Prevalence of behavioral health disorders in the military has increased over the last few years and account for significant morbidity and attrition from service. In 2022, mental health disorders accounted for almost a third (33.5%) of all hospital bed days.[1] The most frequent behavioral health conditions requiring hospitalization were mood disorders (49,830 personnel), substance use disorders (29,829 personnel), adjustment disorders (91,571 personnel), and psychotic disorders (2,059 personnel).[2] Most of the conditions discussed are grounds for medical evacuation (see Chapter 7). Due to delays and flying restrictions, these conditions might require management and safety interventions for a prolonged period while awaiting evacuation. Key steps to take are:

1. De-escalate and ground the service member.
2. Take steps to maintain safety.
3. Make a brief, targeted evaluation, and screen for behavioral health conditions.
4. Triage as appropriate for medical conditions.
5. Use available assets, including tele-behavioral health if possible.
6. Apply prolonged field care principles prior to medical evacuation.

These steps are integrated into each chapter section. Of note, psychotic symptoms, agitation, suicide risk, and homicide risk are presenting issues that cut across a variety of disorders and events. This chapter starts with behavioral management of acute safety issues that often present with severe conditions and then discusses longer term assessment and management of specific conditions. As noted in the introduction, NSMP is intended to describe the range of medical personnel providing services or engaging service members who will likely and often do encounter behavioral health conditions without available specialty services. Again, behavioral health specialty providers are preferred for assessing and managing serious behavioral health conditions; however, the reality of far-forward environments means that NSMP often need to know and be trained in strategies to manage acute mental health issues without the help of specialty behavioral health providers.

Assessment and Triage of Acute Agitation

Agitation is typically a change in behavior that is associated with an underlying medical or psychiatric condition. Acute agitation in forward combat environments requires immediate intervention. Agitation, as defined by the 1st International Experts' Meeting on Agitation,[3] includes:

- Inability to stay calm or still.
- Motor or verbal hyperactivity.
- Emotional tension.
- Difficulties in communication.

Agitation presents clear immediate safety issues in addition to conveying potential medical issues that require immediate intervention. Agitation includes nonspecific, unrelated behaviors and the "feeling of irritability or severe restlessness" with a fluctuating course.[4] Agitation is a symptom that is associated with both medical (generalized infection, exposure to toxins, electrolyte abnormalities, traumatic brain injury (TBI), etc.) as well as behavioral conditions (drug/alcohol intoxication or withdrawal, bipolar disorder, psychotic disorder, etc.).[4] Management of agitation thus necessitates assessment of presenting symptoms and evaluation of underlying causes. For example, the Joint Trauma System Clinical Practice Guideline for Acute Traumatic Brain Injury Management in Prolonged Field Care indicates that the most common signs of patients with non-convulsive seizures include agitation and or blank stare.[5] The following table (Table 3.1) describes factors, need for medical intervention, and differential diagnoses associated with agitation.[6,7]

Table 3.1. Differential Diagnoses Associated with Agitation.

Possible Contributing Factors & Differential Diagnoses	Possible Medical Origins
▪ Abnormal vital signs ▪ Focal neurologic findings ▪ Evidence of head injury ▪ Substance intoxication ▪ Substance withdrawal ▪ Exposure to toxins or drugs ▪ Decreased awareness with attentional problems ▪ Acute Psychotic Episode	▪ Alcohol or drugs (e.g., opioids, amphetamines, cannabis) ▪ Prescription meds (benzodiazepines, anticonvulsants, opioids etc.) ▪ Head trauma ▪ Delirium ▪ Electrolyte disturbance ▪ Hypoxia ▪ Seizure/postictal state ▪ Environmental toxicity

Management of Agitation & Acute Safety Issues

Though medication interventions may differ across presenting issues, behavioral strategies for management of safety issues related to agitation and distress may be very similar across diverse underlying conditions. The primary initial approach is to ensure safety of surroundings, verbally de-escalate, and leaving the patient in a quiet, unlocked room (if feasible).[6] Treatment approaches should ensure the safety of the patient, staff and all others in the area, help stabilize the patient, avoid restraints when at all possible, and avoid coercive interventions that will probably escalate the agitation.[6]

Minimum:

- Consult and coordinate with Command to remove the service member's weapon. Ideally, the service member would voluntarily hand over their weapon.
  - *"I see that you're upset. It's our policy here to place your weapon on the rack when you walk in. Will you place it over there?"*

- *"Please hand your weapon to me. I will put it over here for safe keeping."*

- If the patient is not willing to voluntarily surrender their weapon, then assistance from Military Police or the Chain of Command may be needed.
- Crowding, bright lights, noise, and waiting with others can further agitate a patient. When possible, move the patient to a low-simulation environment which is safe for both the patient and staff.[6]

Better:

- Consult and coordinate with Command to remove the service member's weapon AND respond to agitated service members with assessment for underlying medical conditions. Also take a stepped approach to de-escalation with a focus on safety.
- This stepped approach to agitation includes non-violent and behavioral approaches before relying on pharmacological intervention or physical restraint. If necessary, the provider might include an action plan and spatial layout of the area for use of seclusion or separation, with a team approach to the agitated service member and rehearsals for these situations.
- Use verbal de-escalation skills.[6]
  - Respect the personal space of the patient.
  - Have one designated medical staff engage the patient by introducing themselves.
  - Provide the patient with concise, simple instructions (repeat instructions multiple times).
  - Appeal to the patient's wants and needs (listen for anything you might be able to offer them, such a comfort item or psychotherapy).
  - Set limits and reinforce appropriate behavior (such as safety, mutual respect).
  - Offer choices (provide choices between medications or route of administration, when possible).
- Pharmacological Intervention for agitation:

  Pharmacological intervention can be administered to agitated service member to reduce the risk of harm to self or others. This option might not be viable in far-forward environments due to limited resources. Medications commonly used for pharmacological intervention are available at Role 1. However, pharmacological intervention may require an order by a medical professional who is authorized to prescribe medication when a service member is incompetent to make medical decisions for self, or if the behavior of service member poses a risk to either self or others. See Chapter 5 for additional details.
- Physical restraint:

  If the patient continues to threaten staff, others, or themselves, as a final resort, physical restraints might be necessary to keep them and others safe. However, physical restraints need to be administered under the supervision or guidance of trained professionals. Continue to use a regulated, calm approach and converse with the patient throughout any period of restraint. Consider:

  1. Why the restraint is being used.
  2. What type of restraint will be used.
  3. Length of time for which restraint is intended to be used.

Best:

- Use the strategies above and gather information about patient clinical history and collateral information about possible causes of the agitation.

- Refer to Chapter 2 for additional information on basic assessment principles. Beyond removing the patient's weapons and using de-escalation strategies, it is ideal to also gather basic information about the service member's medical background to help clarify what might be causing the agitation or altered consciousness and inform next steps. A targeted clinical history includes:
    1. Basic demographic characteristics – age, gender, and occupation.
    2. History of behavioral health conditions.
    3. History of physical and neurological issues.
    4. History of substance use.
    5. History of violence or suicide.

Substance Use Disorders: Prevalence & Etiology

Unique military culture, combined with stressors such as deployment, offer both risks and protective factors related to substance use among active-duty personnel. Research has indicated an association between unhealthy drinking, drug use, smoking initiation, and risky behaviors with deployment. In 2021, surveillance data found a range of 0.9% to 2.1% of all active -duty branches had an alcohol use disorder.[8]

Alcohol use disorders are the most prevalent form of substance use disorders among military personnel. Combat exposure, involving violence and trauma experienced by those who serve, result in an increased risk of problematic drinking. As reported by the 2015 Health Related Behaviors Survey,[9] 5.4% of military personnel were heavy drinkers. The survey also indicated that one in three service members are binge drinkers. Additionally, more than one in three service members met criteria for hazardous drinking or possible alcohol use disorder, with rates higher among men than women.

Alcohol dependence is a severe form of alcohol use disorder where withdrawal symptoms manifest after cessation of alcohol intake. Alcohol is a central nervous system (CNS) depressant. Chronic use is associated with changes in CNS neurotransmitters that excite (glutamate) and inhibit Gamma-Aminobutyric Acid (GABA) as well as dopamine. Sudden cessation of chronic alcohol use results in CNS excitation. Clinical symptoms of alcohol withdrawal can manifest as tachycardia, tremors, sweating, delirium, hallucinations, and seizures. The degree of symptom severity and duration vary based on the length of alcohol dependence among other factors (e.g., age, comorbid medical conditions, past history, dehydration).

In extreme cases, service members with undiagnosed alcohol dependence might ingest *non-beverage ethanol* (NBE) to stave off withdrawal symptoms or achieve intoxication. Associated medical conditions vary based on the substance ingested (e.g., paint removers, cough syrup, and mouthwash). NBE should be considered when evaluating a service member who appears to be intoxicated. Medical conditions associated with NBE vary based on the substance ingested (e.g., paint removers, cough syrup, and mouthwash). If a patient is not forthcoming in reporting the type of NBE injected, the type of NBE ingested might be determined by smell. While the NBE ingested may contain predominately ethanol, the NBE also contains toxics which could cause acute medical conditions and, in some cases, death. For example, antifreeze contains ethylene glycol, which can cause some inebriation, but also can cause severe metabolic acidosis, renal failure, and at high doses hypocalcemia and death.[10] Due to the appearance of acute intoxication, NBE can often be misdiagnosed and should be considered when evaluating a service member who appears to be intoxicated.

A disorder that has a close relationship with alcohol withdrawal is *alcohol-induced psychotic disorder* (AIPD). AIPD manifests immediately after the consumption of a large quantity of alcohol. Patients will likely have intact orientation and stable vital signs paired with symptoms including delusions, hallucinations, depression, and mania. AIPD usually resolves within 18-35 days but can persist for up to six months. AIPD may end through alcohol abstinence and may return at next alcohol consumption.[11,12]

Use of *anabolic steroids* and performance enhancing drugs in the military presents a public health concern. Surveys indicate use of human performance drugs among active-duty service members, with research suggesting increased use of these drugs during deployment.[13] The DoD Health Related Behaviors Survey reported a 4% increase in the use of anabolic steroids between 2002 and 2011.[9] Image enhancement and coping with deployment stress, specifically combat, have been cited as the most frequent reason for continued use and abuse of performance and image enhancing drugs (PIEDs). Anecdotal reports from service members indicate use of PIEDs linked to peer pressure as well as enhancing aggression to better engage in combat. PIEDs are associated with adverse physical and behavioral health effects such as severe liver injury, insomnia, headaches, panic attacks, extreme aggression, negative self-image, disturbing thoughts, and behavioral changes all of which impact the readiness.[14]

Lastly, *opioids* have the potential for abuse. Opioids are natural or synthetic chemicals that reduce feelings of pain. Common prescription opioid pain relievers include hydrocodone (Vicodin), oxycodone (OxyContin), oxymorphone (Opana), methadone, and fentanyl. In the military, the number of service members diagnosed with opioid drug dependence or opioid abuse is very low (less than 1%) and decreased by 38% between 2012 and 2016;[9] likewise, opiate positive drug tests among service members also has declined. The number of opioid-related deaths in the military is also lower than that of the civilian population.

Substance Use Disorders: Assessment & Rule-Outs

It is not uncommon for service members to horde alcohol and other substances when deployed. Command might need to determine if a service member is concealing any substances. When triaging suspected substance use-related health concerns, medical personnel need to be able to distinguish between alcohol withdrawals, alcohol-induced delirium, alcohol-induced psychosis, and opiate withdrawal.

Alcohol Withdrawal [15]

- Symptoms start several hours after alcohol cessation and can last between 24 to 48 hours with mild withdrawal and up to 72 hours to two weeks for severe cases. The degree of symptom severity and duration vary based on the length of alcohol dependence, among other factors (e.g., age, comorbid medical conditions, past history, dehydration).
- Signs include elevated blood pressure, tachycardia, elevated body temperature, sweating, tremulousness of body/increased hand tremor, dilated pupils, disorientation, hyper arousal, and seizures.
- Symptoms include anxiety, insomnia, hallucinations, paranoid delusions, nausea, and irritability.
- In moderate withdrawal, hallucinations can develop after 12 hours of abstinence.
- In severe withdrawal, delirium tremens can develop and typical begin 48 to 96 hours after abstinence, lasting up to two weeks.

Alcohol-Induced Psychotic Disorder [11]

- In differentiating AIPD from hallucinations sometimes associated with alcohol induced withdrawal, AIPD does not occur during alcohol induced intoxication or withdrawal but manifests immediate after the consumption of a large quantity of alcohol and may not be related to alcohol dependence.
- A diagnosis of AIPD cannot be made until the individual has clear consciousness.
- Patient should not have another psychotic disorder.

Opioid Withdrawal Symptoms [16]

- Symptoms of opioid withdrawal include anxiety, nausea, vomiting, or abdominal pain.
- Presenting symptoms might include pain in the muscles and/or gastrointestinal symptoms include diarrhea, vomiting, or nausea.

- Service members might experience restlessness or sweating combined with changes in mood such as general discontentment or anxiety.
- Additional common presentations are cramping abdominal pain, fast heart rate, excessive yawning, goose bumps, insomnia, or tremor.

Substance Use Disorders: Interventions

Minimum:

- Make sure patient is not in acute withdrawal that might be life threatening.

Better:

- Determine which substance is causing symptoms.
- Monitor patient for safety and health for 24 to 48 hours or as long as symptoms last.
- Regularly check mental status until patient is oriented to person, place, and time.

Best:

- Short-term psychopharmacological management of symptoms in consultation with physician (when available).
- Telehealth consultation with substance use disorder specialist.

Mania & Bipolar Symptoms: Prevalence & Etiology

Bipolar disorder is a chronic and complex mood disorder that is characterized by alternating mania (bipolar 1) or hypomania (bipolar 2) and depression episodes. Subsyndromal symptoms are common between episodes. Those with bipolar often have comorbid medical and behavioral disorders. Bipolar 1 involves at least a single episode of mania whereas bipolar 2 includes at least one hypomanic episode and one major depressive episode.

Bipolar disorder is hypothesized to be caused by a variety of factors. These include genetic, neuroanatomical, biogenic amines, hormone related imbalance, immunological, and psychosocial (significant life stressor) factors. Bipolar 1 disorder is considered one of the most heritable behavioral disorders.[17]

The mean onset of bipolar disorder is generally between 15-19 years old but with three different peak age groups at average age of 18 years, middle 25 years, and late-onset at 29.4 years.[18] At least 0.4% of women (0.4% lifetime) and 0.1% of male (0.2% lifetime) service members were diagnosed with bipolar in 2021.[2] Diagnoses of bipolar disorder were generally found among service members less than 20 years of age. In 2021, 19% of hospitalizations for active-duty populations was for bipolar disorder.[2]

Mania and Bipolar Symptoms: Assessment

Consistent with the criteria noted above, assessment of a manic episode should include the presence and severity of elevated mood, agitation, energy/activity level, goal-directed behaviors, self-confidence, talkativeness, rapid thought processes, as well as a decreased need for sleep. Assessment measures for the symptoms of mania or agitation are the Mood Disorder Questionnaire;[19] See Appendix B for full screener) and briefer self-report tools such as the five-question Altman Self-Rating Mania Scale;[20] See Appendix B for full screener), which assesses the presence and severity of positive mood, self-confidence, need for sleep, talkativeness, and activity level. For the ASRM, the individual rates whether they

are experiencing symptoms constantly to not at all (e.g., being happy or cheerful, needing less sleep). The six-item Rapid Mood Screener (See Appendix B for full screener) also evaluates possible bipolar disorder.[21] The RMS asks about both manic and general bipolar features. Items measure daily functioning, specifically if mood or activity level are different from usual or are causing disruption within their unit. These items include:

- Have you ever had to stop or change your antidepressant because it made you highly irritable or hyper?
- Have you ever had a period of at least one week during which you were more talkative than normal with thoughts racing in your head?
- Have you ever had a period of at least one week during which you felt any of the following: Unusually happy, unusually outgoing, or unusually energetic?
- Have you ever had a period of at least one week during which you needed much less sleep than usual?

Mania and Bipolar Symptoms: Rule Outs

Mania:

Mania is often identified as abnormally elevated, expansive, or irritable mood. Manic patients can appear excessively friendly and talkative. Grandiose delusions are generally present regarding self-worth or beliefs about one's power and influence. A decreased need for sleep is present. Speech is pressured. Easy distractibility can be noted with a rapid flow of ideas, racing thoughts, and increased goal-directed activities. Psychomotor agitation can appear as restless, constant movement.[22] *Manic patients are usually oriented to person, place, and time* but some orientation impairment might be noted. Gross memory and cognition problems are also likely at intake. Manic patients can be threatening and assaultive. Insight is usually impaired, and they are highly unreliable in information provided about themselves and symptoms. These symptoms usually last one week and are present most of the day, nearly every day.[22]

Hypomania:

A period of persistent abnormally elevated or irritable mood with increased goal-directed behavior that lasts at least four full days. Three or more of the symptoms associated with mania are present. Hypomania likely does not cause significant occupational or social impairment as would be seen with mania.[22]

Major Depressive Episode:

Low mood for at least two weeks and significant social and occupational impairment. Individuals will experience at least five of the following symptoms: low mood (e.g., feeling empty, hopeless), loss of interest in pleasurable activities, weight loss or gain, hyper or hypersomnia, psychomotor agitation or retardation, difficulty concentrating, suicidal ideation, feelings of guilt or worthlessness.[22]

Also evaluate:

- Presence of suicidal or homicidal ideation, intent, or plan.
- Access to means for harm to self or others.
- Presence of command hallucinations or other psychotic symptoms.
- Presence of alcohol or substance use.

Interventions for Mania/Bipolar

In far-forward environments, the primary objectives of interventions are to assess the safety of patients, the potential impact on the unit, and appropriate interventions. Exact diagnosis is not necessarily the goal. For brief assessment and intervention, see below.

Minimum:

- Disarm and make sure patient is in quiet, safe place.
- Observe patient to ensure safety to self and others.
- Determine suicidal or homicidal ideation, intent, or plan.
- Do not challenge the veracity of hallucinations or delusions.
- Minimize consequences of manic symptoms and channel excess of energy in productive tasks (e.g., ditch digging).

Better:

- Rule out possible substance misuse (i.e., alcohol)
- Determine and stabilize influence of alcohol or substance use that might cause symptoms.
- Minimize ability to act on command hallucinations or other psychotic symptoms.

Best:

- Acute short-term psychopharmacological management (see Chapter 5) until symptoms abate.
- Injectable form of an antipsychotic with a benzodiazepine might be needed in case of acute psychosis with harm to self or others where hospitalization is not yet possible.

Psychosis: Prevalence and Etiology

Psychosis is a composite of many behavioral health symptoms characterized by a loss of contact with reality and can be seen in several different behavioral health and medical disorders. It is the primary feature of schizophrenia spectrum disorders and other psychotic disorders as well as a secondary feature of co-occurring mood and substance disorders. Psychosis can also be found as a complicating symptom in many neurologic and medical conditions. Psychosis is often highly distressing to patients and should be a primary target of treatment.[23]

A first episode of psychosis can be preceded by a prodromal phase (period of early incubation when symptoms first start) that lasts for six months. Prodromal changes include gradual, non-specific changes in mood, thoughts, perceptions, behaviors, and functioning (e.g., sleep, eating, hygiene, job performance, and sociability). During the prodromal stage, patients have yet to clearly manifest psychotic symptoms (e.g., hallucinations or delusions).

According to the VA/DoD Clinical Practice Guideline for Management of First-Episode Psychosis and Schizophrenia,[24] early warning signs of psychosis include:

- Worrisome drop in grades or job performance.
- New trouble thinking clearly or concentrating.
- Suspiciousness, paranoid ideas, or uneasiness with others.
- Social withdrawal or more time spent alone than usual.

- Decline in self-care or personal hygiene.
- Difficulty telling reality from fantasy.
- Confused speech or trouble communicating.
- Serious homicidal ideation or aggressive or violent behaviors, or both.
- Serious suicidal ideation (e.g., suicidal ideation with plan or intent, history of suicide-related behavior).
- Self-harm or behavior that might be preparatory for suicide.
- Command hallucinations that might impair safety (e.g., commands to harm oneself or others or to engage in dangerous activities).
- Catatonia or grossly disorganized speech or behaviors.
- Serious self-neglect or apparent inability to meet basic needs.

During 2021, psychoses had the highest hospitalization rate (28%) for service members hospitalized due to behavioral health conditions.[1] One of the disorders most frequently diagnosed within the first six months of service was psychotic disorders (10.5%). Total diagnoses of schizophrenia during the same 10-year period were less than psychotic disorders (2,867 at a rate of 2.3%).[2] In 2021, rates of psychoses in active duty military for both men and women was 0.1%.[1]

According to the American Psychiatric Association Diagnostic and Statistical Manual, psychotic disorders are characterized by abnormalities in one of five domains:[22,25]

- **Delusions:** Fixed, false beliefs that an individual believes even in the face of disconfirming evidence. Various types of delusions include: persecutory, referential, grandiose, erotomanic, nihilistic, somatic, bizarre, and non-bizarre.
- **Hallucinations**: Perceived experiences without external stimuli to evoke the experience. Hallucinations can be experienced in any sensory modality (e.g., auditory, visual, olfactory, gustatory, proprioceptive, and tactile). They are not under the voluntary control of the patient. *Auditory hallucinations are the most common in schizophrenia spectrum disorders and are experienced as voices "outside" a patient's head. Visual and tactile are most predominant in alcohol withdrawals*.
- **Disorganized thought**: A patient exhibits loose association of thoughts with a non-linear, tangential pattern. They often include an excess of unnecessary details, meander from one topic to the next, never returning to the original point, and cannot directly answer a question. Word salad (unintelligible jumble of words), neologism (made up words), and perseveration (repetition of words) are often noted.
- **Disorganized behavior**: A patient might be found performing nonsensical actions that are often considered socially inappropriate. They also can display unpredictable and inappropriate emotional responses to situations. They may lack impulse control.
- **Negative symptoms**: Often seen in the prodromal phase of schizophrenia and present as inexpressive or emotionally blunted affect. They may also display simplistic or prosodic speech and alogia (poverty of speech). Psychomotor retardation might be noted. *Negative symptoms can be confused with a depressive disorder*.

PSYCHOSIS: ASSESSMENTS

Psychosis is a symptom of multiple behavioral disorders including schizophrenia, schizophreniform disorder, brief psychotic disorder, schizoaffective disorder, delusional disorder, bipolar disorder, but also depressive disorder with psychotic features, and substance use intoxication or withdrawal.[22] Assessing for the symptoms of psychosis can be somewhat complicated by the nature of the service members symptoms or their level of insight about what they are experiencing. For example, a service member exhibiting grandiose or persecutory delusions might not recognize,

understand, or accept that they need help. Thus, an assessment for psychosis may occur either through self-report of the service member, or the observation, report, or rating by fellow service members or unit leadership.

The assessment tool suggested for use by the VA/DoD Clinical Practice Guideline for Management of First-Episode Psychosis and Schizophrenia is the Structured Interview for Psychosis-Risk Syndromes. [24,26] However, a brief tool more easily used in the field and included in the CPG is the Early Psychosis Screener-26 (EPS-26).[27] The screener is a self-report survey that can be administered in 8 minutes and can be taken anywhere with internet access, without the help of a clinician. A two-minute version of the survey is accessible at http://www.eps.telesage.com/ . A simplified paper version is also available for download at the above link.

PSYCHOSIS: RULE OUTS

Early identification of and interventions for psychotic disorders can reduce the future burden of care associated with such disorders.[24] Early detection can occur through differential diagnosis and recognizing prodromal changes in a patient.

- **Differential diagnosis** [23]: To differentiate between primary psychotic disorders and psychotic disorders associated with medical or neurologic conditions, consider the following factors:
  - **Age of onset**: Primary psychotic disorders usually present between late teens and early 30s. Men typically present with this disorder at younger ages than women. Psychotic disorders associated with medical conditions are more likely to occur after the age of 40.
  - **Pattern of onset**: In the prodromal stage of a psychotic disorder, symptoms are often subtle and can be confused with other disorders (e.g., schizophrenia can be confused with depression). If psychotic symptoms are acute, they are likely due to medical or neurologic psychosis.
  - **Genetic**: It is common for patients with non-medical psychotic disorders to have a family history of psychotic disorders.
  - **Presentation**: Primary psychotic disorders often first manifest in times of high/significant life stress.
  - **Hallucinations**: *Primary psychotic disorders are often synonymous with auditory hallucinations.* Psychosis due to medical conditions are often accompanied by other forms of hallucinations (e.g., visual, tactile).

PSYCHOSIS: INTERVENTIONS

The primary objective of interventions is to assess the safety of patients in prodromal stages of psychosis. If observing psychosis, most psychotic states are not violent. If psychosis is drug induced, violence is more likely to be observed.

Minimum:

- Disarm and make sure patient is in quiet, safe place.
- Observe patient to ensure safety to self and others.
- Do not challenge the veracity of hallucinations or delusions.
- Determine suicidal or homicidal ideation, intent, or plan.
- Minimize consequences of psychotic symptoms and help minimize patient anxiety related to symptoms.

Better:

- Rule out possible drug use (i.e. hallucinogens).

- Determine and stabilize influence of alcohol or substance use that might cause symptoms.
- Minimize ability to act on command hallucinations or other psychotic symptoms.

Best:

- Utilize short-term psychopharmacological management (see Chapter 5) until symptoms abate. Options include:
  - Haloperidol lactate 5 MG IM, preferably combined with diphenhydramine 25 MG IM is the recommended approach.
  - A dose of Lorazepam 2 MG IM to counter the side effects of haloperidol can be added.
  - The use of olanzapine ODT 5 MG in the mouth is an effective alternative. It is fast acting and does not need the addition of any other medication to it.
  - An injectable form of an antipsychotic with a benzodiazepine might be needed in case of acute psychosis with harm to self or others where hospitalization is not yet possible.

SUICIDE RISK

Suicide is a condition with a complex etiology, yet it can also be prevented. Suicide-related events (SREs) occurring in deployed settings include suicide deaths, suicide attempts, and suicidal ideation with a plan and intent to die. Suicidal behavior across this spectrum of severity can impact the health and wellbeing of military units, including helping professionals, peers, and leadership. In far-forward environments, consequences of suicidal behavior include loss of personnel, commander's preoccupation with the issue, impact on service member morale, and threats to lethality and mission readiness of the unit.

Medics, peers, chaplains, and leaders each serve a specific and a collaborative role in the decision-making process regarding management of SREs in deployed settings. Medics conduct assessments and provide therapy and/or medication; peers serve as support; chaplains counsel service members on religious and moral issues; and leaders collaborate and consult with the team to identify at-risk service members needing referrals and ultimately decide on a course of action. Prevention efforts include risk assessment, referral, and hospitalization for management by specialty care, if needed. The focus of this section is to provide an overview of suicide risk assessment and recommendations on management in far-forward environments.

SUICIDE RISK: RULE OUTS

Service members may express thoughts about dying without any true desire to be dead. They may also engage in non-suicidal self-injury such as cutting or burning their skin, without an intent to die. However, such self-injurious behaviors can still unintentionally result in death or the need for medical attention, and should be taken seriously. It is possible that suicidal thoughts or behaviors could be related to symptoms of psychosis (e.g., command hallucinations), other co-occurring behavioral health condition (e.g., PTSD), or substance use, but this can be difficult to determine without a more thorough assessment or appropriate training. As previously mentioned, in many cases of suicide, there is not a known underlying behavioral health condition.[28,29] Thus, even in the absence of depression or other behavioral health issues, stressors and crises (e.g., relationship problems, legal issues, physical health issues, job/financial concerns) should be taken seriously and attended to as potential risk factors for suicide, and taken into consideration regarding supportive services.

SUICIDE RISK: ASSESSMENT

When it is suspected that a service member might be having suicidal thoughts or is contemplating suicide, one of the immediate responses should be a risk assessment. There are several purposes for suicide risk assessment: It provides information on current risk, it allows for monitoring of risk over time, and it facilitates de-escalation of risk by having the service member feel socially connected and talk about options for care, thus serving as a type of preventive intervention. There exists a misperception that asking someone about suicide will increase the chances of or directly lead to their attempting suicide; however, the research has not supported this concern and even shown that disclosure has positive benefits.[30]

Suicide-related thoughts (suicidal ideation or thoughts of killing oneself), behaviors (planning, self-harm with intent to die), and self-harm (harming self to regain emotional control/provide emotional release) are often associated with a diagnosis of depression, and it is one of the symptoms included under the criteria for a major depressive episode. However, it is important to note that many factors contribute to suicide (e.g., relationship problems, current crisis, alcohol and substance use, physical health problems, job/financial problems, legal issues), including in those individuals without a known behavioral health condition.[28,29] Research indicates that suicide risk is higher when service members are experiencing multiple stressors (e.g., transitions, relationship concerns and career or personal setbacks).

In assessing for suicide, several factors should be taken into consideration to better understand the service member's current mindset and functioning, inform communication to relevant personnel, and aid in decision making regarding intervention, treatment, or any further disposition. At a minimum, a basic assessment should evaluate for current suicidal thoughts/ideation, suicide-related plans or preparations, any stated intent to die, and history of past suicide attempts. Although it can be difficult to predict who will die by suicide, a prior history of a suicide attempt has been found to be a strong predictor.[31,32] It may also be beneficial to assess protective factors, such as family members, community ties, or religious beliefs that would prevent them from harming themselves. Typically, a thorough assessment of suicidality requires a skilled, trained behavioral health provider to accurately assess the relevant factors noted above. However, in far-forward environments, this may not be feasible and may necessitate a more streamlined assessment.

There are several screening tools that have been developed to assess suicidal thoughts, intent, and behavior including the Columbia Suicide Severity Rating Scale (C-SSRS), Patient Safety Screener (PSS-3), Ask Suicide Screening Questions (ASQ).[33-36]

The C-SSRS consists of six questions with affirmative response to suicidal ideation, plan, and acting on the plan indicate a high risk for suicide.

Table 3.2. C-SSRS Questions.

Thought/Behavior	Past week
1. Have you wished you were dead or wished you could go to sleep and not wake up?	Yes/No
2. Have you actually had any thoughts about killing yourself?	Yes/No
If YES to 2, answer questions 3, 4, 5 and 6. If No to 2, go directly to question 6	
3. Have you thought about how you might do this?	Yes/No
4. Have you had any intention of acting on those thoughts of killing yourself, as opposed to you have thoughts but you definitely would not act on them?	**High Risk**
5. Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?	**High Risk**
Always Ask Question 6	
6. Have you done anything, started to do anything, or prepared to do anything to end your life? *Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, held a gun but changed your mind, etc.*	**High Risk**

SUICIDE RISK: INTERVENTIONS

One of the most important aspects of behavioral health triage that medics or peers need to know in forward environments is how to manage acute suicidal thoughts and behaviors. As indicated earlier, suicide risk assessment could serve as a preventive intervention by de-escalating the risk and helping the service member feel connected with fellow service members. Assess for suicide risk by directly asking suicide assessment questions noted above (e.g., *"Are you thinking of harming yourself?" "Are you thinking about ending your life?"*). High risk for suicide is indicated if service member indicates plans for acting out on ideation.

Table 3.3. Suicide Prevention Intervention Matrix.

Level of Risk			Management Recommendations	
	Risk Indicators	Minimum	Better	Best
Low Acute Risk	- Occasional suicidal ideation - No intention to act, no plan or rehearsal of a suicide act - No history of prior attempt	- Reflective listening to de-escalate - Encourage self-management through involvement in activities to control stress (e.g., relaxation techniques, journaling, communication)	- Address ongoing stressors (e.g., relationship concerns, lack of sleep, thoughts of self-harm) - Provide reassurance and supportive counselling - Provide resource education/awareness (e.g., ministry or spiritual resources)	*For low and high acute risk, in addition to the minimum and better strategies: - Monitor for any changes in symptoms - Provide safety plan combined with unit watch and lethal means safety. The Safety Plan should: 1. Identify signs of a crisis, suicidal ideation, or maladaptive behavior 2. Help with coping strategies for grief, trauma, and stress 3. List people, social settings, or objects that provide distraction from the stressor 4. List people and identify professional resources the service member can contact for help 5. List steps the service member can take to make the environment safe (e.g., reducing lethal accessibility)
High Acute Risk	- Persistent suicidal thoughts, ideation or intrusive, disruptive thoughts - Strong intention with plan to act on suicidal ideation - Recent suicide attempt - Service member/service member's unit exposed and impacted by a suicidal event	- Means safety, secure access to lethal means such as weapons, medication etc. - Place service member on limited duty - Provide Buddy Aid and consider unit watch	QPR strategy : 1**. Question**: Ask direct questions. C-SSRS can assist with triage process 2**. Persuade**: Listen without judgement, show you care, persuade service member to seek help 3. **Refer**: Do not leave at-risk service member alone! After removing lethal means, escort service member to a medic, chaplain, or trusted leader	

SUICIDE RISK: COMMAND INTERVENTIONS

Suicide prevention starts with simple, ongoing efforts to promote psychological health and a sense of community. Commanders can proactively plan for crisis intervention, address the process for identification, actively support referral, and prompt access to care for at-risk service members, as well as those affected by a suicide.

Reports of a service member expressing suicidal ideation, coupled with having a suicide plan, and thoughts of acting on that plan are indicative of high acute risk of suicide. Occasional thoughts without a specific plan or thoughts of acting on the plan are indicative of low acute risk for suicide. Whether the risk is low or high, the safety of the unit and the service member is the responsibility of the Command; below are a few recommended actions to consider.

Table 3.4. Suicide Prevention Intervention Matrix (Command Interventions).

Level of Risk		Management Recommendations		
	Risk Indicators	Minimum	Better	Best
Low Acute Risk	- Occasional suicidal ideation - No intention to act, no plan or rehearsal of a suicide act - No history of prior attempt	- Reflective listening to de-escalate - Encourage self-management through involvement in activities to control stress - Foster a command climate that supports and promotes behavioral health, overall wellness and unit cohesion	- Address ongoing stressors (e.g., relationship concerns, lack of sleep, thoughts of self-harm) - Provide reassurance and supportive counselling - Provide resource education/awareness (e.g., ministry or spiritual resources)	*For low and high acute risk, in addition to the minimum and better strategies: - Compile a list of on-base resources and their contact details (e.g., health providers, chaplains, local resources, etc.) - Collaborate with behavioral health providers on crisis response plan. - Ensure a well-written and current Crisis Response Plan is in place. - Post Crisis Response Plan and other resources in easily accessible areas such as drill floor, chow hall, living quarters etc. - Provide safety plan combined with unit watch and lethal means safety. - Recommend buddy watch responsibility to a peer who is comfortable fulfilling that duty - Verify absence of negative interactions between "buddy" and distressed service member - Collaborate with provider and monitor changes in symptoms. - Consider unit health promotion activities.
High Acute Risk	- Persistent suicidal thoughts, ideation or intrusive, disruptive thoughts - Strong intention with plan to act on suicidal ideation - Recent suicide attempt - Service member/service member's unit exposed and impacted by a suicidal event	- Means safety: secure access to lethal means such as weapons, medication etc. - Place service member on limited duty - Assume "line of sight" control: Remove potential lethal means (e.g., weapons, belt, bootstraps, drawstrings, razors) - Provide Buddy Aid and consider unit watch	- Ensure all personnel are familiar with ACE (Ask, Care, Escort) - Include Crisis Response Plan recommendations: Remind Responders to remain calm and non-judgmental; initiate conversation with service member to gain insight on possible critical stressors and facilitate access to appropriate resources - Situations involving perceived safety threat to individual or others should contact security immediately	

HOMICIDE RISK

In a retrospective cohort study examining 3.9 million U.S. service members between 2002 and 2007, the rates of homicide mortality were lower than a U.S. population comparison.[37] The authors speculated that in the Operation Enduring Freedom and Operation Iraqi Freedom cohort, after separating from the military, drug use was associated with homicide, suicide, and other external causes of death.[38] It is also not uncommon that suicide and homicide risk are often approached similarly as the initial assessment and management are very similar. The presentation of this acute issue in a deployed setting is particularly problematic as resources and options for interventions are limited. If a deployed service member is found to have homicidal thoughts and/or behaviors (i.e., planning, preparation), it is imperative that immediate assessment and intervention be implemented to mitigate the crisis as well as ensure the safety of both the perpetuator and at-risk unit/service members, protect potential victims, and maintain the mission capabilities of the unit. Security forces, military police, or other appropriate security personnel should handle potential homicidal individuals, not medical personnel. The specific security personnel to intervene when a service member exhibits homicidal thoughts or behaviors should be determined by command before a potential incident. Currently there is limited guidance regarding threat assessment and management of violent behavior in far forward settings.[38] Adapting examples provided by the Coast guard approach to management of aggressive and violent behavior, the remainder of this section is to provide guidance regarding assessment and intervention in cases of homicide risk.[38]

HOMICIDE RISK: ASSESSMENT AND RULE-OUTS

During the initial assessment, safety should be the priority. Medical personnel and the command team should ensure there is no access to the potential victim and means of harming others. The assessment should serve as an aid in making decisions in an operational environment, such as evaluating the need for law enforcement engagement (if any), the manner in which to execute administrative action, recommendations for victim security, and the appropriate type of management plan for dealing with the situation at hand. Threat assessments are neither intended nor suitable for inclusion in testimonial or evidentiary documents, nor are they a substitute for a thorough, comprehensive investigation.[37] In addition, the evaluation should rule out potential suicide risk, as it is commonly co-morbid with homicide risk. Please see the previous section regarding suicide risk for additional information. Subsequent management should then be determined after a thorough assessment of the variables.

HOMICIDE RISK: THE INITIAL ASSESSMENT

Medical personnel and the command team should ensure there is no access to the potential victim and means of harming others. The evaluation should rule out potential suicide risk as it is commonly co-morbid with homicide risk.

Table 3.5. C-SSRS Questions.

Thought/Behavior	Past week
1. Have you had difficulty in relationships in your work or family?	Yes/No
2. Have you had thoughts about harming or killing someone with whom you have had difficult relationship?	Yes/No
If YES to 2, answer questions 3, 4, 5 and 6. If No to 2, go directly to question 6	
3. Have you had thoughts about to whom and how you might do this?	**High Risk**
4. Have you had any intention of acting on those thoughts of harming others, as opposed to you have thoughts but you would definitely not act on them?	**High Risk**
5. Have you started to work out the details of how to harm others? Did you intend to carry out this plan?	**High Risk**
Always Ask Question 6	
6. Have you done anything, started to do anything, or prepared to do anything to harm or kill those with whom you have troubled relationships?	**High Risk**

Additional information to collect when possible. (Adapted from The Violence Screening and Assessment of Needs[38]):

Table 3.6. Violence Screening and Assessment of Needs (VIO-SCAN).

Domain	Item	Response	Score
Financial instability	Do you and your family generally have enough money each month to cover your expenses?	Yes = 1 No = 0	
Combat experience	Did you personally witness someone (from your unit, an ally unit, or enemy troops) being seriously wounded or killed?	Yes = 1 No = 0	
Alcohol misuse	Has a relative or friend, or a doctor or other health care worker, been concerned about your drinking (alcohol), or suggested you cut down?	Yes = 1 No = 0	
History of violence or arrests	Have you ever been violent toward others or arrested for a crime? (Excludes controlled aggression conducted while deployed in combat). * If "yes," ask about type, severity, frequency of past violence	Yes = 1 No = 0	
Probable PTSD plus anger	In the past week, how many times have you been irritable or had outbursts of anger?	≥4 times + probable PTSD = 1 Other = 0	
		Total Score:	

***NOTE**: The VIO-SCAN is not an actuarial tool or a complete risk assessment of violence. Instead, it provides a rapid procedure for 1) prompting NSMP to consider at least five empirically supported risk factors; 2) guiding NSMP to investigate individual or combinations of risk factors in greater detail to gauge level of clinical concern; 3) identifying SMs who may be at high risk of violence; 4) prioritizing referrals for a comprehensive violence risk assessment; and 5) assessing needs and dynamic factors to develop a plan to reduce risk. The VIO-SCAN should neither be used alone nor replace fully informed clinical decision making that investigates risk and protective factors beyond the five items in the screen. The screen does not designate whether a service member is at low, medium, or high risk. Rather, the VIO-SCAN can structure a part of the evaluation of longer-term violence risk, not imminent danger. The screen does not have perfect accuracy, so false negatives and false positives will occur. A service member with a score of 5 may never be violent, and one with a score of 0 may be violent. Please note that the VIOSCAN needs to be replicated in other samples by other researchers and may be modified in the future as new research emerges.*

Interpreting scores

A. Individual items: A score of one should prompt follow up questions about this risk factor. For example, if a service member endorses a history of violence, the NSMP should ask about the type, severity, frequency of violence.

B. Multiple items: Combinations of endorsed risk factors should be examined.

C. Total score: Higher total scores generally indicate a higher probability of problem with violence. A service member with a high score may be a good candidate for a comprehensive risk assessment. However, take into consideration individual items (e.g., if a service member scores a 1 due to recent severe violence, a full assessment is warranted despite the low total score).

HOMICIDE RISK: INTERVENTIONS

As mentioned previously, the level of risk will dictate the most appropriate level of intervention. Furthermore, the recommendations or strategy should be structured to deter or mitigate the potential for disruptive behavior, with the ultimate goal of prevention. The prevention strategy should integrate organizational, social, psychological, physical, and technical methods to positively influence the SMs behavior, enhance potential victims' security posture and establish relationships that may encourage early reporting of change in SMs behavior as well as plan for precipitating events.[37] Hence, the following recommendations will be separated into high and low risk interventions. However, irrespective of level of risk, appropriate consultation with command should occur, along with notification of the potential victim when feasible.

- **If the level of risk is low**: Occasional homicidal ideation, with no intention to act on the ideation, along with not having a plan or rehearsal of the homicidal act and having no prior history of violence. Address with the service member the underlying stressors contributing to the service member's current crisis. Provide ongoing support and monitoring. Engage the service member with additional support (i.e. chaplain) opportunities to more frequently engage with their primary support system. Engage the service member with a behavioral health professional if available.
- **If the level of risk is high**: Multiple ongoing stressors, along with persistent disruptive homicidal thoughts or ideation with a homicidal plan coupled with a strong intention to act on the homicidal plan, as evidenced by rehearsals or prior anger and/or violent episodes, indicate high acute risk. Address the underlying stressors contributing to the service member's current crisis. Engage the service member with a behavioral health professional via telehealth if available.
- If the aforementioned recommendations are inadequate to reduce risk for high-risk service members, provide 24-hour watch which will require the service member to be in line of sight of a designated observer so that any indication of harmful behaviors is addressed immediately.

Table 3.7. Minimum/Better/Best Intervention Recommendations.

Level of Risk		Management Recommendations		
	Risk Indicators	Minimum	Better	Best
Low Acute Risk	- Occasional Homicidal Ideation - No Intention to act, no plan or rehearsal of homicidal act - No history of prior attempt	- Reflective listening to de-escalate - Provide 5 Rs, rest reassurance, replenish, restore confidence, and return to duty - Encourage self-management of stress (e.g., tactical breathing, mindfulness etc.)	- Address ongoing stressors (e.g., relationship concerns, lack of sleep, financial management) - Provide reassurance and supportive counselling - Provide resource education/awareness (e.g., Ministry or spiritual resources)	*For low and high acute risk, in addition to the minimum and better strategies: -Monitor for changes in symptoms -Command consult if appropriate (e.g., potential victim identified, and service member has worked out a plan to act on the ideation)
High Acute Risk	- Persistent intrusive homicidal thoughts and/or ideation - Strong intention with plan to act on homicidal ideation - Recent anger and/or violent episodes	- Means safety, secure access to lethal means - Initiate command consult and notify potential victim - Place service member on limited duty - Provide Buddy Aid and consider unit watch	- Means safety and command consult if needed - Notification of warning to potential victim if feasible - Problem solving approaches by medic or buddy (e.g., reflective listening, de-escalation and challenging negative thinking)	- Provide warning notification to the victim - Safety planning for the at-risk person - Provide additional support and help resources such as chaplaincy or tele-behavioral health

Minimum:

Command Consultation (see Chapter 6) along with Safety and De-Escalation of Crisis Situation

The provider is encouraged to inform the command of both high as well as low risk homicidal service members through a command consultation when a service member is identified as being either a high or low risk for homicidal ideations or attempt. To effectively manage and monitor service members contemplating homicide, the command consultation should be followed by removal of access to lethal means along with unit or buddy watch where feasible.

Below are a few scripts to help with removal of lethal means:

- *"I see that you're upset. It's our policy here to place your weapon on the rack when you walk in. Will you place it over there"?*
- *"Please hand your weapon to me. I will put it over here for safe keeping."*
- If the service member will not offer the weapon voluntarily, request assistance from the Military Police.
- Additionally, if there is a determination of high risk for homicide, limited duty disposition should be recommended. The service member should not engage in regular duties at this time and ongoing monitoring is required. The command consultation chapter elaborates more on this guidance in Chapter 6.
- However, in instances where there is a determination of low homicidal risk, duty restrictions may not be needed. The service member may engage in regular duties but would still need to be monitored for changes in intent and homicidal risk.

Better:

Command Consult + Means Safety + Problem Solving and Buddy Aid

- As indicated earlier, irrespective of level of risk, any indicator of homicidal risk should involve notification of command, followed by command consult and notification of warning to potential victim if feasible. Interventions that would be better than the minimum recommended involve the addition of problem solving and use of buddy aid in addition to the minimum recommended guidance.
- If level of risk is high, use de-escalation techniques, such as verbal de-escalation including the "talk down" approach in combination with the removal of all means of harm. Separate the service member from the potential victim and provide appropriate warning of potential harm as appropriate to the operational environment. Problem solving approaches by the medic or buddy could involve asking questions to clarify the concern and also help resolve the issue as described below.
- Invite the service member to talk to you and use the suggested questions help clarify the concerns of the service member.
    - Ask what's happening using open-ended questions.
      Example: *"What's upsetting you right now?"*
    - Offer help and re-orient the person to who you are, who they are, and where you are.
      Example: *"I see you're angry and maybe scared. I want to help. I am LT Johnson, the PA. We are at FOB XXX. We met before in the DFAC."*
    - Repeat back to the person what you heard to ensure accurate information and indicate that you are listening.
      Example: *"I hear you saying that you think that you're angry at your platoon leader and you think that he is out to get you. Is that right?"*
- Resolve: Request/ask politely (do not command).
  Example: *"I would like to talk with you more about this issue. Do you mind if we sit down, grab some water, and I ask follow-up questions?"*
- Give reasons for requests and be genuine/honest.
- Make an apology or change if necessary.
- Offer choices and options, so the service member can feel empowered.
  Example: *"Do you want to sit in this chair over here or would you prefer to go outside the tent?"*
- Be flexible, negotiate, compromise, and avoid power struggle.
- If level of risk is low, provide support and ongoing assessment.
- Allow the service member to engage in additional self-care (i.e. additional time for rest).

Best:

Command Consult + Means Safety + Problem Solving and Buddy Aid + Chaplaincy or Behavioral Health Support

Similar to minimum and better recommendations, in any instance of homicide risk, the first step involves informing command followed by command consult and if applicable warning notification to any at risk victims. The interventions that might work best include providing support and resources from chaplaincy or tele-behavioral health in addition to de-escalating the situation by talking to the service member, clarifying their concerns, and helping with resolving conflict by challenging unhelpful thoughts.

The following is a sample script of asking questions that could help with challenging unhelpful thoughts:

- *"I see you're angry and maybe scared. I want to help. I am LT Johnson, the PA. We are at FOB XXX. We met before in the DFAC."*

- Repeat back to the person what you heard to ensure accurate information and indicate that you are listening. Example: *"I hear you saying that you think that you're angry at your platoon leader and you think that he is out to get you. You think that the way he looks at you is evidence that he is thinking negatively about you. Is that right?"*
- For challenging the unhelpful thought, the buddy or medic could help the service member to differentiate if the thought is a fact or opinion. Below are few suggested conversation tips.
  - Is there any evidence that it is true?
  - Can it be disproved?
  - If your buddy is in a similar situation, what would you advice your buddy?
- Finally, help the service member to try and look at the situation differently.
  For example: if you were not one of the people involved, how do you think the situation would look to a bystander? Are there better options that you could use or suggest?

If the level of risk is high, then in addition to techniques recommended for Minimum and Better levels of intervention, also address the underlying stressors contributing to the service member's current crisis. When possible, modify the service member's work schedule and responsibilities to reduce stress and allow time for self-care. Engage the service member with a behavioral health professional via telehealth if available.

If the level of risk is low, then in addition to techniques recommended for Minimum and Better levels of intervention, address with the service member the underlying stressors contributing to the service member's current crisis. Provide ongoing support and monitoring. Engage the service member with additional support (i.e. chaplain) and/or opportunities to more frequently engage with their primary support system (i.e. phone calls and/or access to technology to speak with friends and family). Engage the service member with a behavioral health professional via telehealth if available.

If the aforementioned recommendations are inadequate to reduce risk for high-risk service members, provide 24-hour watch. 24-hour watch will require the service member to be in line of sight of a designated observer so that any indication of harmful behaviors is addressed immediately.

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CHAPTER 4

MANAGEMENT OF MOST COMMON BEHAVIORAL HEALTH CONDITIONS THAT MAY MANIFEST IN FORWARD ENVIRONMENTS: SLEEP DISRUPTION AND DEPRIVATION

Sleep disruption and deprivation are common for service members due to factors including mission demands, deployment across time zones, shift work, and watch duty. Unfortunately, individuals who do not obtain sufficient sleep over days or weeks become desensitized to feeling sleepy and are poor at judging their own performance capabilities.[1] As a result, command cannot rely on service members to self-report sleep deprivation and its consequences. Rather, implementation of, and adherence to, recommended sleep guidelines across the services is critical to maintain unit health and readiness.

IMPACT OF SLEEP DEPRIVATION

Insufficient sleep degrades cognitive, emotional, and physiological functioning—all of which can negatively impact a service member's performance and readiness. Cognitively, acute sleep deprivation results in decreased alertness, problem-solving ability, situational awareness, reaction time, and memory.[1] The behavioral health impacts of sleep deprivation include increased irritability, a heightened risk for PTSD, depression, and suicide, as well as stalled recovery following a TBI.[2,3] Physiologically, chronic insufficient sleep is associated with diabetes, dementia, cardiovascular disease, weight gain, and decreased immune function, among other illnesses and concerns.[4]

The cognitive, behavioral health, and physiological deficits caused by sleep deprivation can have dangerous consequences for individual service members and the unit. This is further highlighted in the following research study of a combat platoon deployed to Afghanistan in 2013, in which 14.6% of soldiers reported accidents that affected the mission, with half of these (51%) attributed to sleepiness. In addition, 34.1% of soldiers reported falling asleep while on guard duty, 69.7% while riding in convoys, and 31.9% while sitting in briefings. Both the accidents and unintentional sleep periods were significantly associated with the number of hours that soldiers received per day.[4]

CONSIDERATIONS

Given these findings, it is unsurprising that sleep deprivation is associated with lower perceived unit readiness.[3] The following considerations are important with regard to sleep:

- **Current sleep duration does not equal sleep need:** Many service members report that they have "adapted" to need less sleep; a provider might then incorrectly assume that the service member's current reported total sleep time is sufficient to meet their sleep needs. However, as described above, persons experiencing sleep deprivation lack subjective insight into the severity of their impairment. Actual sleep need can be determined by consistent total sleep time in ad lib (i.e., individually determined) situations, with an optimal sleep environment and verified by a sleep log.[5] Less than 3% of the population naturally needs 6 or fewer hours of sleep, and the majority require seven to nine hours - meaning a service member's sleep need may actually be more than eight hours. It is not typically feasible to determine actual sleep need in operational settings, so assume 8 hours as the minimum necessary sleep need. Note that a need for more than eight hours of sleep is not a sign of 'weakness' or 'incompetence,' but rather a normal result of hardwired and fixed physiological differences.[6]
- **Role of environment:** The sleep environment plays a key role in providing what is termed "sleep opportunity," or the chance to get the maximum quality and quantity of sleep. A poor sleep environment will disrupt sleep by causing brief, often undetected, arousals, resulting in the deficits in waking function described above. Factors that contribute to a poor sleep environment include loud noise, the presence of light, physical discomfort, and a high-threat, hyper arousing environment.[7] To the maximum extent feasible, providers should facilitate the setup of an optimal sleep environment.[7] Specifically, this includes a quiet, dark, safe, undisturbed setting at a comfortable temperature with comfortable bedding. If a sleeping area is communal, no activities other than sleep should be performed during allotted sleeping hours, and intrusions should be minimized or eliminated. Individuals may find noise and light abatement methods helpful, such as ear plugs and eye masks. When a poor sleep environment is present, anticipate that service members will have their sleep disrupted, and thus, will not have performance and health equivalent to when an optimal sleep environment is available.
- **Role of circadian timing**: The human circadian rhythm is attuned to a 24-hour day with maximal alertness during daylight hours, except for a temporary afternoon "dip," and sleep-promoting mechanisms during nighttime hours, with the lowest point or "trough" in the circadian rhythm falling between 0200-0400. During the trough, risk for performance deficits and accidents is greatest. Additionally, persons engaging in long-term nighttime wakefulness, as in shift work, typically experience ongoing consequences such as reduced cognitive performance, impaired physical health (e.g., reduced muscle strength and disruption of hormone regulation), and difficulty sleeping during shifted periods of sleep, resulting in sleep deprivation.[8] Years of research have documented that it is not possible for this rhythm to adjust to either frequent changes or even to long-term shift work. While there is innate individual variability in circadian elasticity, overall there is no treatment that can reverse the harmful impact of shift work situations. Providers should facilitate schedules that best align with the endogenous circadian rhythm, where possible, to include identifying individuals most negatively impacted and those who may have preferences for later or earlier shift times. When shift work is not assigned by best individual fit, anticipate that alertness and cognitive efficiency will be significantly compromised particularly between the hours of 2300 – 0800. In these cases, it is recommended that low-level tasks, with extra time allotments and redundant oversight, be assigned.[7] Napping prior to a shift should be recommended (See Appendix D, Tactical Napping). When shift work is not a factor, individuals can maximize their circadian rhythm by maintaining a consistent sleep schedule for both on- and off-duty days.
- **Differentiation of sleep opportunity vs sleep ability**: Sleep duration can be reduced below an individual's required sleep need by loss of either sleep ability or sleep opportunity. In this text, we address poor sleep opportunity -- that is, sleep deprivation due to external sources. Poor sleep ability occurs when internal factors hamper sleep or when an individual has an adequate (or optimal) sleep context with eight or more hours available for sleep, meeting the criteria of Role of the Environment and Role of Circadian Timing, and is still

unable to sleep for a sufficient amount to meet their needs (known colloquially as insomnia). Management strategies for poor sleep ability differ from those for poor sleep opportunity. When a provider identifies the presence of insufficient sleep time, despite adequate opportunity, apply evidence-based strategies for insomnia (e.g., cognitive-behavioral therapy).

- **Recognition of sleep as only "cure" for sleep loss:** Given the cognitive impairments of sleep deprivation, as well as amount of time required and environmental and circadian considerations for adequate sleep, service members may attempt to abate the need for sleep with substances or behaviors. For example, use of caffeine and nicotine, standing, loud noise, or use of cold air are used to promote wakefulness. However, research has conclusively demonstrated that there is no replacement for sleep.[7] The brain has a physiological need for sleep to maintain function. If sleep is not obtained, the brain will eventually lapse into sleep without voluntary intent. No treatment for sleep deprivation, other than getting sleep should be recommended. After periods of sleep deprivation, up to 14 hours of recovery sleep may be necessitated to restore the body.[6] Providers should discourage sleep deprivation, to the extent possible, and recognize that sleep management in other than "best" conditions should be considered temporary and may result in adverse outcomes for the individual and the unit.

Minimum, Better, and Best Interventions

MINIMUM

Self Care and Rest and Restoration

During short term periods of sleep restriction *below six hours, sustain performance with napping and appropriate caffeine dosing*. Under unavoidable conditions of reduced nighttime sleep with six hours or less time in bed due to operational demand, the primary management approach should be adjunctive napping when feasible.[7] Due to the afternoon "dip" in alertness described above, afternoons represent an optimal time to nap without dampening nighttime sleep. Napping prior to shift work may also be beneficial. Under a predictable schedule, short, infrequent naps may be sufficient. When the next available sleep opportunity is unpredictable, a nap of a long a duration, if feasible, may be warranted. Additionally, judicious use of caffeine may help maintain alertness, but will not impact cognitive function. However, caffeine should be avoided on a regular basis due to rapid tolerance.[9] The optimal dose is 200 mg per use, once upon awakening and again four hours later.[7] The last dose should not occur within six hours of the subsequent sleep period. Note that these recommendations do not apply to voluntary restriction of sleep time despite adequate time off duty to obtain more sleep. In these cases, assuming no impairment in sleep ability, providers should recommend the development of a sleep schedule allowing for eight or more hours of sleep.

BETTER

Self Care and Psychoeducation and Sleep Hygiene

Eight non-consecutive hours of sleep per 24-hour period OR eight consecutive hours in a minimally adequate environment or during daytime is recommended. Under operational conditions where periods of continuous sleep are not available, but sufficient down time exists for multiple, shorter periods of sleep, providers should facilitate service members' planning for eight total hours of sleep per 24-hour period in as long a blocks of time as is possible. The human sleep period is composed of a series of cycles through varying stages of sleep intended to flow continuously until complete after four to five cycles. Interrupted sleep and shorter periods of sleep prevent persons from obtaining full amounts of deep, restorative sleep, as well as rapid eye movement (REM) sleep, a stage that contributes to learning and memory processing. Since each cycle takes approximately 90-120 minutes, four two-hour blocks of sleep or two four-hour blocks of sleep are preferable to a series of one-hour naps or sleep chunks of varying durations. Because sleep is not continuous, even if the total duration reaches eight hours, anticipate that performance and alertness will be suboptimal and consider recommendations to duty type and capacity accordingly. Alternatively, in conditions in which periods of eight or more continuous hours of sleep are feasible, but the sleep environment is not fully adequate (e.g., loud, lighted, or uncomfortable/disturbed sleep circumstances), similarly expect that performance and alertness will be

suboptimal and proceed accordingly. Recall that for optimal cognitive and physical function, both sufficient sleep quantity and sleep quality is required.

BEST
8 Consecutive Hours of Sleep per 24-hour Period with Optimal Environment During Nighttime.

The best sleep management strategy facilitating maximum cognitive and physical performance is eight or greater hours (dependent on individual need) of uninterrupted, continuous sleep in an optimal sleep environment at a consistently timed sleep schedule across both on and off duty days to leverage the circadian rhythm.[7] The factors of sufficient *available time*, appropriate *environment*, and appropriate *circadian timing* constitute the ideal context for best sleep opportunity. Note that, in this context, individuals who experience difficulty falling and staying asleep may lack adequate sleep ability as described above with insomnia, which requires separate treatment and management.

Augment with Sleep Banking and Restorative Sleep

In operational environments, temporary periods of sleep deprivation may be unavoidable. In these cases, when such periods are anticipated, proactive use of sleep banking can somewhat mitigate, but not substantially reduce or eliminate, negative consequences. Sleep banking refers to increasing the opportunity to sleep several days to a week prior to a period of sleep deprivation, generally up to 10 hours.[7] This is best accomplished via an earlier bedtime, if sufficient sleepiness is present, in order to maintain a consistent wake time. The use of restorative sleep after sleep deprivation can also aid recovery. Restorative sleep refers to allowing for similarly increased sleep opportunities afterward. In practice, several days of up to ten hours of post-deprivation sleep provides benefit while not dampening sleep drive long term. However, research studies suggest that, in prolonged cases, up to fourteen hours of sleep may be necessary for the brain to physiologically readjust.[6] More recovery time will, generally, be needed for periods of sleep deprivation lasting several days than it would for just a single day of sleep loss. These strategies can be used to augment the minimum, better, best practices described above or when such practices are not feasible.

Caution Regarding Wake-Promoting Substances

Readily accessible alerting agents are widely used among military populations, largely consisting of caffeine in drinks and other forms, and nicotine. Prescription alerting agents are available as well. Alerting agents have not been shown to be an effective substitute for sleep.[10] Caution should be taken regarding use of these substances; alerting agents may serve to sustain wakefulness, to an extent, but do not reverse the accrued deficits in cognitive and physical function. Performance of duty will still be reduced. Additionally, alerting agents may interfere with subsequent sleep and, as a result, the ability to recover from periods of sleep deprivation. At a minimum, they should not be used within six hours of attempted sleep.

Recommendation against Periods of Sleep Deprivation Exceeding 16-24 Hours

Cognitive and physical abilities begin to deteriorate when individuals are deprived of sleep for 16-24 hours. In this period of acute sleep deprivation, performance decrements are observed in attention, reaction time, and focus, while an increase in both errors of commission and omission are observed. Extended wakefulness of this nature produces impairment in psychomotor tasks equivalent to moderate alcohol intoxication (0.05-0.10% BAC).[11] After 24 hours of sleep deprivation, the following abilities, critical to operational readiness, are significantly impacted:[12]

- Acquiring, assigning priorities, allocating, and using resources.
- Anticipating and solving problems.
- Managing and exploiting change.
- Acting decisively under pressure.
- Establishing position.
- Requesting fire.

- Coordinating squad tactic.
- Monitoring environment (vigilance).
- Attending to preventive maintenance.

These impairments increase as individuals sustain multiple nights of sleep deprivation.[11] Consequently, we recommend against periods of sleep deprivation exceeding 16-24 hours, as the deficits resulting from greater deprivation increase the likelihood of errors and decrease the likelihood of success in a deployed setting. Please see Appendix D for a list of resources (e.g., Sleep Checklist and Tactical Naps) developed by Walter Reed Army Institute. While this tool references warfighter, the tips are applicable across services.

Coping with Psychosocial Stressors

Problems at Home: Case Example

MAJ Morales, currently assigned to 5SFG and deployed to Afghanistan for five months, has become increasingly disengaged from his occupational responsibilities. He has failed to complete several critical taskings and has been distractible, even during mission briefings and other essential meetings. His appetite has diminished, and he has become more and more reclusive. Commander LTC Champ has directly observed concentration difficulties and irritability and has heard from other service members about some public outbursts.

MAJ Leo Morales, a 37-year-old Hispanic male, has been married for 13 years and has three young children (ages 6, 9, and 10) with his wife, LTC Marianne Morales. MAJ Morales has been active duty for 12 years and is a 90A (logistics officer). While his marriage has been generally positive, he and his wife sought couples' counseling through MFLC in 2014 for several months and through his embedded behavioral health provider in 2016. Two of their three children have special needs and are enrolled in the Exceptional Family Member Program (EFMP): their oldest daughter has significant learning disabilities and is on an Individualized Education Program (IEP), and their youngest daughter has cystic fibrosis.

His wife remained at Ft. Campbell with their three children. While MAJ Morales has ensured near-daily phone calls with his family since arrival in country, both his peers and subordinates have noticed that he has appeared increasingly distressed following these calls. When asked, MAJ Morales has stated that things are "falling apart" at home and he feels "helpless." He stated that it seems that every time he speaks to his wife, he learns about a new stressor. Over the past month, he stated that his youngest child has had a significant health scare with possible exposure to COVID-19 (which could be fatal given her diagnosis of cystic fibrosis), his oldest child is reporting severe bullying at school and was observed by a teacher to have apparent self-inflicted scrapes on her arms, and his middle child is "acting out" at daycare and has been suspended from the Child Development Center until his behavior is managed. He and his wife spend their phone and video calls arguing about interventions for each of their children. Furthermore, his wife told him that she may be unexpectedly deploying within 60 days.

Impact and Considerations

Coping with various psychosocial stressors in a deployed/forward environment is challenging because these often contribute the most to common behavioral health conditions, but service members have the least amount of control over these situations. Prior to the internet and advancements in digital communications, deployed service members were often unaware of psychosocial stressors occurring on the home front or in garrison. Most communications from the home front were from hand-written letters, which limited the amount of information that could be exchanged. Although this slow mode of communication could itself be a stressor, it provided a natural barrier between the deployed service member and the various stressors from home. This ability to communicate easily and frequently online with the home front, for many, serves to decrease stress levels, and, for some, increases stress (as showcased in the case above). This stress is worsened when service members perceive a lack of control to mitigate the stressor(s).

MINIMUM, BETTER, AND BEST INTERVENTIONS

Minimum: Use the 5 Rs, Basic Listening and Validation, Tactical Breathing

Problem-focused coping is generally preferred to emotion-focused coping because it is associated with positive health outcomes.[13,14] However, because of the lack of ability to directly mitigate psychosocial stressors in a deployed/forward environment, emotion-focused coping strategies are a preferred front-line intervention. These interventions are individually based and focus on the service member regulating her or his negative emotional reactions to a stressor.[15]

As indicated at the outset, the initial approach for management of behavioral health issues in forward environment should, at a minimum, include the 5 Rs, followed by additional strategies that are described in context of the case vignette.

In the example of MAJ Morales, the commander, as well as peers, observed changes in the behavior of the service member. MAJ Morales also expressed feelings of distress. The first line of support for coping with psychosocial stress includes self-help and "buddy" support. A few self-care strategies that encourage adaptive coping that could be used by either a buddy or leader are described in the 5 Rs described below:

- Reassurance of normality.
- Rest – break from combat or work.
- Replenish bodily needs – heat, water, food, hygiene, sleep.
- Restore confidence – with purposeful activities and unit contact.
- Return to duty and reunite with unit.

Some of the most common self-help, emotion-focused coping strategies include reflective listening and help with de-escalation of stress through use of techniques such as diaphragmatic breathing ("tactical breathing"), meditation, mindfulness, positive imagery, and progressive muscle relaxation.

De-escalation and Reflective Listening

1. **Delimit**

   Buddy or leader can use a series of verbal de-escalation strategies including a "talk down" approach from the Safewards Model.[16] The first step is to approach the service member and initiate a conversation to both provide support and to get a better understanding of the issue. Move to a quiet place and invite MAJ Morales to sit down.

2. **Clarify**

   - Return to duty and reunite with unit.
   - Ask what is happening using open-ended questions.

     Example: *"What's upsetting you right now?"*
   - Offer help and re-orient the person to who you are, who they are, and where you are.

     Example: *"I see you're angry and maybe scared. I want to help. I am LT Johnson, the PA. We are at FOB XXX. We met before in the DFAC."*
   - Repeat back to the person what you heard to ensure accurate information and indicate that you are listening.

     Example: *"I hear you saying that you think that you're angry at your wife, and you think that she is out to get you. Is that right?"*

3. **Resolve**

   - Request/ask politely (do not command).

     Example: *"I would like to talk with you more about this issue. Do you mind if we sit down, grab some water, and I ask follow-up questions?"*

   - Give reasons for requests and be genuine/honest.
   - Make an apology or change if necessary.
   - Offer choices and options, so the service member can feel empowered.

     Example: *"Do you want to sit in this chair over here, or would you prefer to go outside the tent?"*

   - Be flexible, negotiate, compromise, and avoid power struggle.
   - Resist the urge to offer immediate solutions or advice; instead listen, paraphrase to indicate that you are listening and reflecting, and encourage service member to problem solve.

     Example: *"I hear you saying that you are having issues at home, and you are having difficulty sleeping. Is that right?"*

     "You also think that the issues at home are bothering you, and those thoughts are interfering with work, making you irritable?"

     "What do you think could help you manage the situation? Have you tried some of the techniques that were taught to us during Basic training to help with stress?"

     "Would you like me to help you work on those techniques?"

Tactical/Belly Breathing

Ideally a service member will be familiar with these interventions and have practiced them with some positive benefit.

- Get to a place where both the provider and the service member have the best opportunity to actually feel the stomach move in and out while breathing.
- Ask service member to place one hand right above belly button and to place the other hand on chest. Demonstrate or help service member with the actions if needed.
- Next, ask service member to take a big breath in, then breathe out, to feel the diaphragm at work. Instruct service member to begin breathing in with a closed mouth doing their best to keep chest level stationary. Instructions include:

  "Keep your mouth closed and start breathing in to the count of four. Focus on feeling your breath fill up your belly area. Try to keep your chest level stationary and fill your belly with air by feeling your hand on your belly getting pushed out further and further."

- Ask the service member to pause for a count of four.

  "Feel your belly full of air."

- Next ask the service member to exhale through mouth to the count of 4.

  "Now, begin to exhale through your mouth, feel your stomach moving towards you as you breathe out."

- Ask service member to repeat exercises five times or until breathing is stabilized.

  There are many apps available for free download to a smartphone such as the Defense Health Agency's Connected Health Branch (formerly the National Center for Telehealth & Technology or T2) apps like "Tactical Breather," "Breath2Relax" and "Mindfulness Coach" (https://8tharmy.korea.army.mil/site/assets/doc/newcomers/medical-care/Mobile-Apps.pdf). Once

downloaded, these apps can be accessed off-line (no cell serviced needed) at a service member's convenience. These apps provide visual and verbal cues to guide a member through basic emotion-focused coping strategies. Some also include the ability to track changes in mood or sleep and contain various educational material as well.

Additional Techniques

These techniques could be used include the practice of meditation or yoga that includes mindfulness. Mindfulness comprises mental training that helps with focusing attention to the present. (See Appendix E) This approach has been trained, implemented, and found effective in the U.S. Military.[17] Below is an example of the steps involved:

1. Take a moment to get comfortable.
2. Feel free to close your eyes.
3. Settle in and let go of any unnecessary tension in your body and mind.
4. Take three deep and slow breaths; now let your breathing return to normal pace.
5. Focus your attention on where you feel the breath most – that's the target of your attention. For example, it could be your nostrils, your chest, or your shoulders. Select what is most salient for you and focus on it.
6. Notice when your mind wanders away from the target, and when it does, return it back gently to the sensation.
7. Practice this exercise for two to three minutes.
8. Gently bring movement back into the hands and feet as you complete the practice and return to everyday life.

Help by buddy includes identification of the stress through active listening and use of the 5 Rs namely Reassure, Rest, Replenish, Restore, and Return. Active listening can be used to identify concerns of the service member as well as developing strategies to resolve the concerns.

Better: Buddy Aid

In addition to the de-escalation and self-care comprising the 5 Rs, a service member may benefit from available social support. In a deployed/forward environment, social support often comes from other unit members. Called by various names such as "buddy care," "battle buddy," or "buddy aid," these interventions involve leveraging other unit members as a source for listening and offering moral support. Ideally unit members have been exposed to basic training or knowledge on active listening as a preferred method for social support (i.e., listening, paraphrasing, reflecting, and resisting the urge to offer immediate solutions or advice). A provider might consider helping the service member identify a low-level stressor that might be easier to address and therefore build confidence. Alternatively, they might want to break down a larger stressor into components. Using the example of MAJ Morales, some strategies for identifying and addressing low level stressor is described below.

Buddy or leader (LTC Champ) should first reach out to MAJ Morales and check if MAJ Morales would like to discuss his issues with them. If MAJ Morales agrees to discuss, move to a place that is quiet and initiate the conversation. Reflect on the concerns expressed by MAJ Morales. Paraphrase to indicate that you are listening as well as obtain clarity on the stressors faced by MAJ Morales.

- Ask what's happening using open-ended questions.

  Example: *"What's upsetting you right now?"*

- Offer help and reorient the person to who you are, who they are, and where you are.

  Example: *"I see you're angry and maybe scared. I want to help. I am LT Johnson, the PA. We are at FOB XXX. We met before in the DFAC."*

- Repeat back to the person what you heard to ensure accurate information and indicate that you are listening.

Example: *"I hear you saying that you think that you're angry at your wife and you think that she is out to get you. Is that right?"*

- Resolve.
- Request/ask politely (do not command).

  Example: *"I would like to talk with you more about this issue. Do you mind if we sit down, grab some water, and I ask follow-up questions?"*

  - Give reasons for requests and be genuine/honest.
  - Make an apology or change if necessary.
  - Offer choices and options, so the service member can feel empowered.

    Example: *"Do you want to sit in this chair over here, or would you prefer to go outside the tent?"*
  - Be flexible, negotiate, compromise, and avoid power struggle
  - Resist the urge to offer immediate solutions or advice; instead listen, paraphrase to indicate that you are listening and reflecting and encourage service member to problem-solve.

    Example: *"I hear you saying that you are having issues at home, and you are having difficulty sleeping. Is that right?"*

    "You also think that the issues at home are bothering you, and those thoughts are interfering with work, making you irritable?"

    "What do you think could help you manage the situation? Have you tried some of the techniques that were taught to us during basic training to help with stress?"

    "Would you like me to help you work on those techniques?"

    "What else do you think you can do to help with the situation? Can you share your tasks with a buddy? Is there any other support back home who could provide help in managing the concerns with your children?"

Additional strategies that could help include motivational interviewing and encouraging the service member to reach out for help from additional sources, such as a chaplain.

Best: Problem Solving Therapy

Problem Solving Therapy (PST) is a similar, more structured approach to managing stressors. PST is similar to the Military Decision-Making Process (MDMP), with which many service members are already familiar. Primary goals for PST include:

1. changing thoughts or appraisal of the stressors.
2. implementing specific behaviors and strategies to address the stressors.[18]

The specific approaches involve changing the nature of the situation, altering unhelpful views of the stressor, or a combination of both. For example, SPC Hill described in Chapter 2 was worried that his partner had relapsed because she had not responded to his calls for weeks. As shown in his responses to the BASIS-24 (a self-report measure of stress), he had a low sense of his ability cope with his current stress. In PST, a negative problem orientation (i.e. unhelpful views) includes: a) perceptions that problems are threats or are unsolvable; b)doubts about one's own ability to cope, and c) low frustration tolerance. The loose structure of PST includes the following four steps:

1. Define the problem.

   "I can't get in touch with my partner, and she might be in danger."

2. Generate alternatives.

   "I could call her sister."

"I could stop calling and let her contact me. I could trust that she is resourceful."

3. Make decisions.

   "I think I could call her sister first. I might be worried if her sister doesn't know either. Maybe I could try that and then, if she doesn't answer, I can use some relaxation exercises."

4. Implement solutions and verify.

   Check in with SPC Hill as he attempts some alternative approaches.

Chaplain/Command-Level Interventions

In addition to individual service member coping strategies and leveraging available social support, a service member may benefit from additional support resources, including engagement by the chain of command. For example, a chaplain is more likely to be closer to a deployed/forward location than a behavioral health specialist. Most chaplains are trained in basic counseling and are usually familiar with common behavioral health conditions, based on working closely with behavioral health counselors in prior duty assignments. Chaplains have the additional benefit of complete confidentiality, which makes this a less stigmatizing resource than traditional behavioral health. Senior members of the chain of command are better positioned to facilitate home-front communication as the operational mission allows and within the constraints of available technology. These deployed resources may be able reach back and mobilize garrison resources to assist the service member's loved ones. For example, a Navy ombudsman may be able to reach out to a spouse and connect them with legal or financial services to actively engage the issue causing the stress on the deployed service member.

Depressive Episodes: Impact and Considerations

Depression is one of the most common behavioral health conditions in our society, affecting almost 20 million Americans (7.8% of the population) each year.19 As an all-volunteer force, base rates of depression in the military population mirror that of the general public, with some estimates that rates of depression are higher (e.g., 12-13%) in certain segments of the military population, such as currently or formerly deployed service members.[20,21] Because of the continued stigma of behavioral health, it is likely that there are many more service members experiencing sub-clinical depression or perhaps even suffering from untreated clinical depression. Ideally, a service member suffering from depression will self-identify during the pre-deployment phase (e.g., via the Pre-Deployment Health Assessment or the annual Periodic Health Assessment/Mental Health Assessment). However, it is not uncommon for service members who are motivated to deploy to under-report or completely deny behavioral health symptoms on these pre-deployment screens. In addition, it is equally possible that a service member with no prior behavioral health history may develop a depressive episode on an extended deployment/forward environment.

In response to hostile and traumatic events exposure during combat environment, some service members might be vulnerable to stressors that affect their behavioral health. Stressors might include occupational/operational stressors, exposure to death of peers, loss of peers due to injury or combat, and killing of combatant, which might lead to feelings of moral injury, guilt, and/or depression. Additional stressors that might exacerbate depression include fatigue, sleep disturbance, anxiety, and home-front issues.

Minimum, Better, & Best Interventions

Minimum: Use the 5 Rs, Basic Listening, and Validation

One of the best interventions for any behavioral health condition, to include depression, is prevention. To that end, a good front-line intervention is to encourage service members to practice good self-care to the extent that the

deployed/forward environment permits. Good self-care is comprised of adaptive coping and includes the 5 Rs: Reassurance of normality, Rest, Replenishment of bodily needs, Restoration of confidence, and help with Return to duty.

Initial evaluation as indicated for other behavioral health symptoms should include assessment of risk to service member and unit. Additionally, *medic check is recommended for prior episodes of depression and details of medication adherence. If there are indicators of risk to self and expressions of suicidal ideation, peer or medic should ensure that all lethal means are secured* and follow the guidance provided for suicidality in Chapter 3. In the absence of suicidal ideation and/or low suicidal risk level, minimum interventions include:

1. providing support and listening to the concerns of the service member.
2. encouraging the service member to rest.
3. allowing time for uninterrupted sleep far from enemy contact.
4. reassuring the service member that there is support and help for the problem situation, and, if applicable.
5. working with command to enable modifications to duties to ensure rest and restoration for the service member.

Self-help skills also can be used, such as tactical breathing, relaxation exercises, and apps such as Breathe2Relax. Reflective listening described below will help with problem-solving the issue.

- Appreciate MAJ Morales for his contribution to the unit and indicate that you notice that he is currently looking upset. Follow-up by asking what is happening using open-ended questions.

  Example: *"I see that you are angry and maybe sad after talking to your wife."*

- Repeat back to the person what you heard to ensure accurate information and indicate that you are listening.

  Example: *"I hear you saying that you think that you're angry at your wife and you think that she is out to get you. Is that right?"*

The next step involves helping with problem-solving by challenging the negative thoughts. This could be accomplished by the following:

- Request/ask politely (do not command).

  Example: *"I would like to talk with you more about this issue. Do you mind if we sit down, grab some water, and I ask follow-up questions? Why do you think your wife is out to get you?"*

Better: Behavioral Activation

Behavioral management of depression methods that are better than the minimum interventions include practicing self-care, buddy care, and behavioral activation. Behavioral activation is a brief psychosocial approach to managing depressive thoughts and behaviors. It is based on the premise that problems in the service members' lives and behavioral responses reduce the ability to experience positive reward from their environment. The steps in behavioral activation help to systematically increase activation and enable greater contact with sources of reward, as well as problem-solve issues that the service member might be experiencing. Behavioral activation could be used to help a service member understand how behaviors influence emotions and connect the dots between thoughts and emotions. Monitoring daily activities to increase an understanding of the relationship between the thoughts and actions linked to depression is one of the steps of behavioral activation.

Specific techniques of behavioral activation include:

1. **Self-monitoring of activities and mood.** Example: Continuing with the case vignette provided earlier, MAJ Morales could be encouraged to maintain a record of activities and changes in mood. The service member can be encouraged to keep a diary of daily activities and events that trigger changes in mood, identify goals and values, build an upward spiral of motivation and energy, problem solve potential barriers to activation such as avoiding stressful situation. Some of the commonly reported indicators among service members with depression

include decreased physical activity, passive/avoidant style coping (e.g., not speaking up or lack of assertiveness), and absence of positive mood states, coupled with a lack of future oriented thinking.

2. **Activity-scheduling and problem-solving**. Activity-monitoring could help to identify triggers of changes in mood. Example, MAJ Morales gets upset every time he has video call with his wife. Following the call, he becomes more withdrawn from others, skips meals, and prefers to go back to his barracks and avoid work. Problem-solving could include help with social-skills training, such as assertiveness, resolution of issues with his wife, and encouragement of physically healthy behaviors needed, such as exercising instead of feeling lethargic and skipping meals. Example: MAJ Morales could be encouraged to create an activity list that uplifts his mood or activities that distract him from feeling depressed. Some of the activities possible in deployed environment are exercising, taking photographs, listening to music, talking to a buddy, cooking a meal, or writing in a journal that might be shared with a loved one on return from deployment.
3. **Psychoeducation.** Educate the service member that anxiety and depression arise from part of the brain that is trying to protect by getting the service member to avoid or isolate. Reinforce that exercise can produce healthy chemicals in the brain that lift mood and also provide positive experiences that mitigate depression.

Self-care activities that are often possible in this environment include exercising, reading, listening to music, praying, watching movies, nutrition/eating a balanced diet, and playing games (especially social games that can build comradery, such as cards). Quality social support will often serve to enhance mood, boost morale, and, at times, help a service member who is feeling down to establish some perspective. Psychological support, encouragement, and active listening by a buddy or peer could help boost morale of a service member. If technology and operational mission permits, a service member experiencing depression will also likely benefit from practicing some of the emotion-focused interventions on the smartphone apps such as "Tactical Breather," "Breath2Relax," and "Mindfulness Coach." Once downloaded, these apps can be accessed offline (no cell serviced needed) at a service member's convenience. These apps provide visual and verbal cues to guide a member through basic emotion-focused coping strategies. Some also include the ability to track changes in mood or sleep, as well as various educational material.

Buddy Aid with Suicide Risk Assessment

Because a symptom of depression is suicidal thoughts, forward/deployed medical personnel should always assess for acute suicide risk level (described in Chapter 3) for any service members with suspected depression. This recommendation is consistent with the most recent.[22] Another symptom of depression (as well as many other conditions, such as stress and anxiety) is sleep problems, including insomnia and hypersomnia. Forward deployed providers should educate service members experiencing sleep problems about good sleep hygiene habits such as avoiding caffeine, practicing relaxation strategies at bedtime, and avoiding lying in bed for long periods of time without falling asleep.

Best: Challenging Thoughts/Negative Beliefs

In addition to building individual service member coping strategies and leveraging available social support, a service member may benefit from accessing organic resources, such as a chaplain or rotational behavioral health support from Role 2. Furthermore, strategies such as challenging thoughts/negative beliefs could help the service member problem-solve, as well as overcome, feelings of depression. Below is a brief example of challenging negative thoughts:

- Appreciate that the service member has documented daily activities and triggers. Follow up by asking what is happening using open-ended questions.

  Example: *"I see that you are angry and maybe sad after you had a video call with your wife. Can you tell me more on what happened?"*

- Repeat back to the person what you heard to ensure accurate information and indicate that you are listening.

  Example: *"I hear you saying that you think that you're angry at your wife and you think that she is out to get you. Is that right?"*

- The next step involves helping with problem solving by challenging the negative thoughts. This could be accomplished by the following:
- Request/ask politely (do not command).

  Example: *"I would like to talk with you more about this issue. Do you mind if we sit down, grab some water, and I ask follow-up questions?"*
  "Why do you think your wife is out to get you?"

  "I heard you say that she was irritated with you and yelled at you. Is that right?"
- Generate Alternatives.

  Example: *"Could it be that the your wife was having a bad day and expressing her frustration at you?"*

  "Could it be that your she is unaware of the other stresses that you are undergoing?"

  "What could you have done to clarify the situation?"
- Make decisions.:

  Example: *"I can follow up with my wife and help clarify the situation. Check what I could do to help with the situation."*

  "Was the irritation reasonable and due to a task that you were unable to complete? What were barriers to you not being able to keep up with what you had promised to do? Were you multitasking? Can you get help, perhaps talk to your siblings for help with the task?"
- To sum up, the best intervention in remote austere settings uses*:*
  - Self-help combined with buddy aid.
  - Active listening.
  - Tips to problem-solve.
  - Leveraging of command level resources.
  - Consultation with behavioral health experts, when possible, either synchronously or asynchronously.

Elevated Risk Considerations

If a service member's depression worsens to the point of affecting a service member's occupational performance or if their suicide risk level worsens to the point of becoming an acute, high risk for self-harm, then the forward deployed medical asset should strongly consider evacuation from theater. The first-line treatment for even uncomplicated, mild to moderate depression includes evidence-based psychotherapies -- e.g., cognitive behavioral therapy (CBT), acceptance and commitment therapy (ACT), and interpersonal therapy (IPT) -- and/or evidence-based pharmacotherapy (e.g., selective serotonin reuptake inhibitors) delivered by a qualified and appropriately privileged behavioral health specialist. As such, a service member's depression that has worsened after a robust trial of the various self-care and problem- and emotion-focused interventions mentioned above will likely require a higher level of care that can only be delivered at a higher role of care (i.e. Role 3 or higher).

Acute Stress Reactions & Panic Attacks: Impact & Considerations

All service members have hardwired survival reactions, which are often functional in the wake of trauma or severe stress. Some service members will have involuntary, temporary reactions that overwhelm their ability to function, called "acute stress reactions," that include physical, cognitive, behavioral, and emotional effects. These reactions become a problem when they stop service members from functioning, particularly during a combat situation. Combat stress reactions (CSRs), as one type of acute stress reaction (ASR), and panic attacks are overwhelming reactions to actual and perceived threats to life, respectively. Table 4.1 displays shared experiences of ASR and panic attacks according to the International Classification of Disease Manual, 10th edition[23] and distinguishes features specific to ASR or panic attack. Rule-outs for other, urgent medical ailments are also identified. *Interventions, such as tactical breathing, grounding exercises and iCOVER for both ASRs and panic attacks, are immediately important as they can return service members to functioning. Immediate interventions can buffer against behavioral health disorders that may develop as a result of loss of function and stress.*

Table 4.1. Overlap and Distinctions of ASR Symptoms and Panic Attacks.

Shared Presentation of ASR and Panic (ICD-10) Symptoms		
Arousal	Chest and Abdomen	Brain and Mind
Palpitations or pounding heart	Difficulty breathing	Feeling dizzy, unsteady, faint or light-headed
Sweating	Feeling of choking	Feelings that objects are unreal, or that oneself is distant or "not really here"
Trembling or shaking	Chest pain/discomfort	Fear of losing control, going crazy, or passing out
Dry mouth	Nausea or stomach distress	Fear of dying

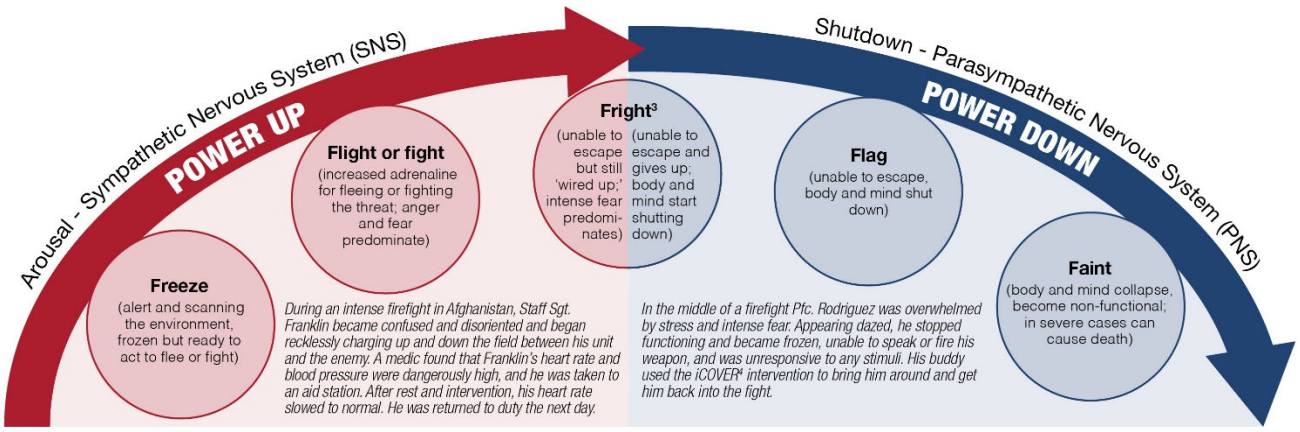
ASR Specific	**Panic Attack Specific**
Originates from an "exceptional" mental or physical stressor (e.g., combat)	Originates from bodily sensations (fear of bodily symptoms) without external threat; triggered by excessive carbon dioxide inhalation
Occur in environments where there is a known, life-threatening stressor (e.g., firefight)	Can occur in many routine environments (e.g., DFAC, training scenario)
Typically longer in duration (0 -48 hours)	Shorter in duration (20-30 minutes)

Rule-out	
Other physical injury; service members may have a head injury or gunshot wound	Heart attack or other heart arrhythmia

Acute Stress Reactions

The stress reaction is commonly described as "fight, flight, or freeze" as a natural response to a threatening situation.[24] The stress response is a process, rather than a specific reaction, that is shaped by the "dose" of the stressor (e.g. length of exposure, severity). As an example shown in Figure 1 below, one proposed sequence of response to traumatic stress (e.g., combat), called the "defense cascade," starts with "freeze" to identify the threat, escalates to "flight or fight" , peaks with "fright" (i.e. tonic immobility), and leads to a "flag" and/or "faint" shutdown responses as the mind and body become overwhelmed.[25]

Figure 4.1. Combat Stress Reaction Process; Figure Developed by PHCoE based on Schauer and Elbert's (2015) Illustration



Three recent survey studies have provided useful data on the frequency and impact of acute stress reactions (ASRs). A survey of 621 U.S. Army soldiers who reported combat experience in Iraq or Afghanistan revealed that 8% admitted that they had been "so mentally stressed during combat that they were unable to function for a period of time," and 45% reported that they had encountered a team member in that state.[26] A subsequent study with two cohorts yielded 52% who reported witnessing an ASR in the post-deployment group, and 42% who reported witnessing an ASR in the currently deployed group.[27] Similarly, an Israeli Defense Force study surveyed 560 soldiers from 12 combat battalions, of whom 74% reported experiencing a combat-related event and a subset of 29% reporting being exposed to acute stress reactions in fellow service members.[28]

Table 4.2. Service Members Report of Witnessing an ASR Across Three Samples.

Witnessed ASR 'During a significant combat-related event I encountered a service member who was so mentally stressed that…'	Adler 2019 N=621	Adler, Svetlitzky et al., 2020 Post-deployed, N=176	Adler, Svetlitzky et al., 2020 Current Deployed, N=497
Total	45%	51.7%	42.4%
They were unable to function for a period of time during the event.	31	39.8	39.2
Their difficulty in functioning increased risk to themselves and/or fellow service members.	38	33.5	31.4
They were detached from what was happening (such as being 'frozen', not responding, having a thousand-yard stare).	33	39.8	33.5
They were erratic and agitated (such as dropping gear/weapon, running without regard to danger, or firing without purpose).	19	21.6	19.3
They were emotionally overwhelmed (such as yelling, crying or gasping).	31	31.2	31.6
They were extremely confused (such as repeating phrases, speaking in fragments or speaking without regard to sequence of events).	24	26.3	25.0

Panic Attacks

Panic attacks are, by definition, a fear of one's own panic symptoms and can happen alongside trauma symptoms and independent of any other behavioral health issue.[29] Specifically, panic attacks occur when individuals perceive bodily sensations as life-threatening; for example, increased inhalation of carbon dioxide can provoke panic attacks as it can trigger perceived suffocation.[30] Panic attacks include similar sensations to an ASR or CSR and might look similar to the outside observer. They are driven by a physical and cognitive reaction to stress-related sensations that, essentially, spiral into a dysfunctional state. ASR and panic attacks have a similar presentation and can be linked, as past exposure to significant stressors can predispose a person to panic attacks. Autonomic nervous system dysfunction has been reported in adults with anxiety and panic attacks.[31] Panic attacks are also common among service members, particularly in those with combat-related exposure.[32,33] During unfamiliar or threatening environments, military personnel who experienced ASRs in the past may be more likely to experience panic symptoms in the future.[34]

Importance of Intervening

Helping service members restore to function in the midst of a CSR or panic attack has important effects on the individual service member and unit, as well as imparting confidence moving forward in continued demands of an operational environment. CSRs and panic attacks look similar in the moment and are most observable by an inability to function. CSRs might happen in the midst of a firefight, whereas a panic attack can happen in any non-threatening or mildly stressful setting, as it is a reaction to physical sensations, rather than the environment itself. Regarding individual effects, whereas most service members with ASR do recover, service members who have experienced previous CSRs are at higher risk for both short-term and long-term psychopathology, such as acute stress disorder, posttraumatic stress disorder, and panic disorder.[35] Addressing stress reactions early helps prevent downrange psychopathology, by thwarting or slowing the development of the disorder.[36] Therefore, ASRs may be a window to intervene and prevent further deterioration. Regarding unit effects, interventions for CSR and panic are primarily peer-based; when fellow service members are empowered to intervene when a teammate loses ability to function, the entire unit will perform better and experience increased safety.[27]

Because of the overlap of ASRs and panic attacks, similar interventions can be used to help reorient a person in the moment. ASRs occur during or directly after exposure to a stressor. Panic attacks are, by definition, reactions without any real danger. Therefore, ASRs and panic attacks likely occur in different environments, and as time passes, may require different approaches. This chapter focuses on using brief, immediate interventions during an ASR or panic attack. We also offer a brief description of panic disorder and the development of other stressor-related issues that require consultation with a behavioral health asset.

Helping a Service Member Return to Function During a Combat Stress Reaction or Panic Attack

The methods of grounding (minimum), tactical breathing (better), and iCOVER (best) are ordered according to how comprehensive the intervention is. Because the stress process and panic attacks involve both physical and cognitive components, methods taught to purposefully regulate autonomic systems and their arousal usually include cognitive and physical components. The cognitive component usually encourages some way to focus thought into a neutral, non-emotional path to reduce cognitively mediated arousal. This focus may include self-talk or more benign activities, such as counting respirations, visualizing relaxing situations, a focus on sound, and/or the repetition of some other sensory stimulus. The physical component of this intervention usually includes abdominal breathing, with intentional relaxation of various muscles in a systematic way.

MINIMUM, BETTER, AND BEST INTERVENTIONS

MINIMUM

Self /Buddy Aid with Techniques such as Grounding

Grounding exercises are about using the five senses -- namely sight, hearing, smell, taste, touch – to reconnect mind and body in the present. It is our basic human senses that remind us that we are here now. Grounding exercises are helpful for many situations where an individual might feel overwhelmed or distracted by distressing thoughts, images, feelings, or memories. Examples include getting caught up in strong emotions like anxiety or anger, engaging in stressful circling thoughts, experiencing strong painful memory or a flashback, or waking up from a nightmare with a pounding heart (nocturnal panic attack).

The most frequently used grounding approach is the 3-3-3 rule that comprises the following steps: [37,38]

1. Name three things you can see: *"Look around you and name three things you can see."*
2. Name three things you can hear: *"Pay attention to the sounds around you, and name three that you can hear."*
3. Move three parts of the body: *"That was good that you could identify the sound of rain; now can you move your right foot, left arm and nod your head?"*

Another option that might be more applicable to when the service member is not in a combat setting is the 5-4-3-2-1 technique that engages all five senses.[37,38] Below is a description of the steps, as well as a sample script that could be used:

1. Engage memory and attention by having them count backwards from five.

   "MAJ Morales, I need you to count backward from 5."

2. Have them identify them four, then three, then two, then one sensory object, in any order of sense. Here's one example of that process:

   "Good job! MAJ Morales, can you now pay attention to the sounds around you and name four that you can hear?"

   "Very well done buddy. Now can you identify and tell me the names of three smells around you?"

   "Awesome that you were able to pick up the smell of coffee brewing. Now feel things around you and name two things that you can feel, is it hot? Is it soft?"

   "Take a sip of this mug and tell me what you are tasting."

BETTER

Self/Buddy Aid Along with Techniques for Relaxation, such as Tactical Breathing

As we are unable to consciously and directly slow our heart rate, we can use tactical breathing, which acts to slow heart rate from a stress-induced high to a normal resting rate within a few minutes. Abdominal/belly breathing promotes slow and deep breathing by encouraging expansion of the abdomen rather than the chest. This technique is easily taught by having the individual place a hand on their chest and abdomen while breathing in slowly. Belly breathing can be done either while lying down on the floor or by sitting down on the floor or on a chair. Instructions are described below:

- Get to a place where both the provider and the service member have the best opportunity to actually feel the stomach move in and out while breathing.
- Ask the service member to place one hand right above belly button and to place the other hand on the chest. Demonstrate or help service member with the actions if needed.

- Next, ask the service member to take a big breath in, then breathe out, to feel the diaphragm at work. Instruct the service member to begin breathing in with a closed mouth doing their best to keep the chest level stationary. Instructions include:

  "Keep your mouth closed and start breathing in to the count of four. Focus on feeling your breath fill up your belly area. Try to keep your chest level and stationary and fill your belly with air by feeling your hand on your belly getting pushed out further and further."

- Ask the service member to pause for a count of four: *"Feel your belly full of air."*
- Next, ask the service member to exhale through mouth to the count of four.

  "Now, begin to exhale through your mouth, feel your stomach moving towards you as you breathe out."

- Ask service member to repeat the exercises five times or until breathing is stabilized.

BEST: iCOVER

iCOVER is a rapid, peer-based protocol that applies grounding concepts.[39] iCOVER is a six-step protocol that can be completed in under 60 seconds.[40] Providers (medical, non-medical or peers) need to be trained in the intervention, which includes a 60-minute didactic module and a 30-minute practical exercise that is delivered as part of resiliency training. The intervention involves the following six steps:

1. **I**dentify the team member who is experiencing an ASR, and make sure that there is no physical reason for their behavior.
   a. Is the service member in shock and immobilized?
   b. Is team member appearing frozen dissociated or agitated?
   c. Is the team member behaving erratically, such as dropping equipment or acting without regard to danger?
2. **C**onnect to bring them to the present moment (eye contact, touch, hearing).
   a. Ask the service member to look at you; make eye contact.

      "MAJ. M, this is LTC. C, look at me."

   b. Ask if they can hear you, state that you are going to squeeze their arm and request the service member to squeeze your arm.

      "MAJ M, this is LTC C, can you hear me? I am going to squeeze your arm - can you feel it? Can you squeeze my arm?"

3. **O**ffer commitment to reduce sense of isolation.

   Indicate to the team member that you are with them, that you are not going anywhere, and that the service member is not alone.

   "MAJ M, we are here at xx, we are under fire, I am here with you and will be here with you, you are not alone."

4. **V**erify facts with simple questions to get the thinking brain back in gear.

   Ask two to three simple, fact-based questions, such as what mission that the service member is currently on and who the team lead is.

   "MAJ M, tell me what mission we are on. Who is your chief?"

5. **E**stablish order of events to reorient the individual.

   "We are here in X mission. We are under attack."

   "Do you understand?"

6. **R**equest action to re-engage in purposeful action.

   "Can you stand watch at X place?"

Appendix F provides additional description of the iCOVER protocol developed by the Walter Reed Army Institute of Research.

Recurrent Panic Attacks and Panic Disorder

Recurrent panic attacks are best treated by a behavioral health professional via telehealth or in-person. Panic attacks are primarily a fear reaction to bodily sensations; therefore, it is important to ask the service member directly about the source of their fear and anxiety. Often first panic attacks happen outside the home environment and tend to happen when individuals feel pressure about the impact of bodily reactions.[41] Especially in a combat environment, service members may feel increased anxiety about their stress reactions (e.g., freezing) and the impact on their ability to engage in combat effectively. After the initial panic attack, panic attacks can continue because of two factors:[41]

1. Learned, automatic fear of internal "cues" of panic (e.g., increased heart rate, rapid breathing).
2. Unhelpful beliefs about the sensations in the moment (e.g., "I am dying.").

Interventions focus on the two factors described above: panic tracking, exposure, and challenging beliefs about panic and body symptoms, which can be supported and implemented by a behavioral health specialty provider.

Anger Management: Impact and Considerations

Stress reactions in a forward environment are a physical and behavioral health response to the combat events. One of the expressions of stress could include anger. Anger is a complex system of survival mechanisms that are orchestrated by cognitive processes, physiologic arousal, environmental stimuli, and behavioral reactions to perceived threatening events.[42] Anger may not only be an acute response to a certain social event, but also co-occur with other emotions as part of a disorder symptomatology (e.g., major depression or PTSD).[43] According to the 2016 Millennium Cohort Study, 15,600 (17.3%) service members had problematic anger.[44] Given the accessibility of numerous weapons in the combat zone and the potential impact to the safety of other service members and other personnel in the unit, anger in an operational setting is an important problem.[45,46]

Compared with those without problematic anger, service members who experienced a type of life or military stressor (e.g., childhood trauma, being married, financial problems, deployment with high levels of combat experience, austere physical environment, interpersonal struggles or disputes, difficulty with leadership, legal problems, and separation from the military), probable behavioral health disorder (e.g., PTSD), or problems with drinking were more likely to report anger.[44,47] Conversely, service members with problematic anger had lower mean scores for positivity and self-mastery compared with those who did not report problematic anger.[44] Service members may express anger subjectively (i.e. symptoms) and/or objectively (i.e., signs). Symptoms of anger may be self-reported by service members as follows: feelings of difficulty with temper or impulses, depression, guilt, crying, tiredness, withdrawal, irritability, fatigue, or being accident-prone in the combat zone.[47] Signs of anger which are observed by the clinical team may include physiologic manifestations: clenched fists, hyperactivity, difficulty focusing, and/or pressured speech.[47] In unique operational contexts, such as deployment to a combat zone, service members are trained to maintain vigilance, which can exacerbate anger. Therefore, the clinical team, in collaboration with the command, should establish effective interventions to mitigate anger in deployed environments.[27]

Behavioral Management and Recommendations on Minimum, Better, and Best Interventions

The primary and initial approach to management of anger issues is to de-escalate irritability, as well as calm the service member. The continuum of minimal, better, and best interventions is described below.

Minimum

De-escalation and Self Aid

When a service member presents with signs and symptoms of anger, the clinical team should consider a risk management approach and, if possible, complete a behavioral health evaluation to obtain the following information: a) biopsychosocial history, b) family history of expressing anger, c) prior violence, d) general health (e.g., pain, low blood sugar), e) habits (e.g., sleep, diet, recreational drugs), f) environmental stimuli (i.e. factors that may trigger anger), and g) current precipitating factors.[47]

As indicated earlier, safety of the service member and unit should be the primary focus. If there are indications of risk to self or others, command would need to be consulted and command consultation (as described in Chapter 6) initiated. Expressions of anger and irritability without homicidal or suicidal intent should, at the minimum, be managed using the 5 Rs: Reassurance of normality, Rest, Replenishment of bodily needs, Restoration of confidence, and help with Return to duty.

Depending on the severity of the anger, and if anger has been expressed in overt aggression (i.e. physical harm towards the self or others), the following safety measures and actions need to be considered:

- Removal of weapon access.
- Assignment of one-to-one escort or a buddy (typically of the same rank) to monitor movements.
- Providing a "no-contact" order against any targeted individual.
- In extreme cases, additional actions that are beyond the purview of medical staff, and more in the lane of military police and command, include administering the Uniform Code of Military Justice action or place in a detention facility as needed.
- Warning the targeted individual if a homicide threat had been made by the angry member (i.e. the Supreme Court of California case Tarasoff vs Regents of University of California, indicating that a mental health professional has a duty not only to a patient but also to individuals who are specifically being threatened by a patient).[47]
- Finally, self-help aids, such as use of mobile applications. For example, Breate2Relax and PTSD Coach, as well as breathing exercises such as tactical breathing, can also help in regulating anger.

BETTER

De-escalation + Buddy Aid + Problem Solving

Manifestations of anger are influenced by one's physiologic hyper-arousal. For service members with deployment stressors, the flight-or-fight response is constantly activated, resulting in high physiologic arousal. Signs of arousal may include increased blood pressure, tightened muscles, increased speech volume and rate, and quickened respirations.[42]

When a service member presents with signs and symptoms of anger, the clinical team should consider a risk management approach and, if possible, complete a behavioral health evaluation to obtain the following information:

- Biopsychosocial history.
- Family history of expressing anger.

- Prior violence.
- General health (e.g., pain, low blood sugar).
- Habits (e.g., sleep, diet, recreational drugs).
- Environmental stimuli (i.e., factors that may trigger anger).
- Current precipitating factors.

Interventions that are better than the minimal approach include managing anger effectively to prevent the release of anger in the form of verbal or physical aggression. Suggested approaches include an initial de-escalation of the stress by talking to the service member and helping the service member to relax using breathing exercises, followed by help with problem-solving. The medic or buddy can help by asking clarifying questions and guiding the service member in problem-solving. A few guiding tips are described below:

- Ask what's happening using open-ended questions.

  Example: *"What's upsetting you right now?"*

- Offer help and re-orient the person to who you are, who they are, and where you are.

  Example: *"I see you're angry and maybe scared. I want to help. I am LT Johnson, the PA. We are at FOB XXX. We met before in the DFAC."*

- Repeat back to the person what you heard to ensure accurate information and to indicate that you are listening.

  Example: *"I hear you saying that you think that you're angry at your platoon leader and that he is out to get you. Is that right?"*

On identifying the issue, help-with problem solving and resolving the issue by using the following suggestions:

- Request/ask politely (do not command).

  Example: *"I would like to talk with you more about this issue. Do you mind if we sit down, grab some water, and I ask follow-up questions?"*

- Give reasons for requests and be genuine/honest.
- Make an apology or change if necessary.
- Make an apology or change if necessary.
- Offer choices, help with identifying the triggers of anger and alternate ways of controlling anger.

  Example: *"I hear you saying that your platoon leader wants to speak to me, so I am going to be in trouble? You saw him looking at you and think that he is laughing or thinking something negative about you?"*

- Be flexible, negotiate, avoid power struggle, and compromise and talk through the issue.
- A medic can help challenge the unhelpful thoughts and identify ways in which service member can better cope with the issue -- for example, helping with clear communication with the platoon leader and being assertive when needed.

For service members with a diagnosed behavioral health disorder (e.g., depressive/anxiety disorder or PTSD), the clinician may recommend up to three days of restorative hold. This hold allows for the service member to receive individual or group therapy and medication management (e.g., selective serotonin reuptake inhibitors (SSRI) or serotonin-norepinephrine reuptake inhibitors (SNRI)) with the goal of targeting any problematic behavioral health symptom.[47]

BEST

De-escalation + Self/Buddy Aid + Problem Solving + Chaplain or Behavioral Health Support.

Because anger is a common emotion, and manifestation of anger (e.g., aggression) may be learned behavior, one can be taught to behave in a nonaggressive manner.[47,42] Once safety has been established and physiologic hyper-arousal is under control, the clinician may challenge cognitive distortions associated with the service member's anger. For example, service members can be taught to respond to an irritable unit leader by having them think in a different way, "I wonder why my sergeant yelled at me? He must be dealing with problems himself or stressed about something. The next time I have an opportunity to talk with him, I'm going to ask how I can help." Providing the service member an alternative perspective may lessen his anger and increase empathy towards fellow deployed service members.

Additionally, a medic could encourage the service member to maintain a diary to record triggers of anger, as well as to use strategies to manage or resolve the issue, to help with problem-solving and prevention of issues downrange.

Finally, increasing the service member's protective factors as a prevention strategy should be considered as one of the best "treatments" for anger. Protective factors such as a) engaging in self-care activities (e.g., exercise, meditation, sleep, or spiritual activity, such as prayer), b) providing team support, and c) having positive leadership behaviors are associated with decreased behavioral problems and may effectively reduce the severity of anger reactions.[48] Where possible, connecting the service member with chaplaincy or additional behavioral health resources could also help in preventing and managing anger issues.

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Chapter 5

Psychopharmacological Interventions in Forward Locations

The US Army Field Manual 4-02 (2020) consolidates all materials related to combat operational stress control (COSC), behavioral health, and neuropsychiatric treatment aspects under Chapter 7.[1] In that chapter, it defines the responsibilities of COSC as "a program developed and actions taken by military leadership to prevent, identify, and manage adverse combat and operational stress reactions in units. This medical function optimizes mission performance; conserves the fighting strength; and prevents or minimizes adverse effects of combat and operational stress reaction on service members and their physical, psychological, intellectual, and social health. Its goal is to return service members to duty expeditiously." Accordingly, combat operational stress control promotes service members and unit readiness by:

- Enhancing adaptive stress reactions.
- Preventing maladaptive stress reactions.
- Assisting service members with controlling combat and operational stress reactions.
- Assisting service members with behavioral disorders.
- Teaching warrior resiliency skills.

The chapter goes on to emphasize a distinction between combat and operational stress reactions and behavioral health disorders: "It is both inappropriate and detrimental to treat Soldiers with combat and operational stress reactions as if they are behavioral health disorders." Additionally, it discourages the use of medications in combat so not to "foster the patient role."

On the other hand, Schneider et al, in a paper published in Military Medicine (2007) noted the impact of increased dependence of National Guard and Reserve service members on the availability of medications in the forward areas of operation.[2] This was clarified later by the same group in the Textbook of Military Medicine: Combat and Operational Health (2011) to indicate that "the Army was receiving personnel who were treated according to civilian community standards rather than military readiness standards concerning prescriptions for selective serotonin reuptake inhibitors (SSRIs), atypical antidepressants, and antianxiety medications. This resulted in an increased requirement for available medications in theater."

Accordingly, the primary focus of this chapter will be on the pharmacological interventions for all mental health conditions that might more commonly be experienced by service members in forward positions, whether due to an emergent acute issue, psychological trauma, intoxication from alcohol or illicit drugs, or due to complications from a preexisting medical concern that may or may not be adequately documented and waivered.

Because the following conditions and behaviors could be initially expressed as a medical emergency, we will cover medication treatments for those who display the following conditions:

- Psychosis.
- Mania.
- Alcohol withdrawal.
- Substance intoxication.
- Delirium.
- Suicidal ideation, gesture, attempt, or high risk for suicidal behavior.
- Catatonia.
- Conversion disorders.

As noted in the introduction, the term Non-Specialty Medical Personnel (NSMP) is used throughout this CPG and chapter. It is intended to describe the range of medical personnel providing services or engaging service members who will likely and often do encounter behavioral health conditions without available specialty services. This particular chapter offers broader context for available resources as well as mentions what NSMPs can do to bridge gaps between resources.

Deployment Actions

Psychiatric Medication Clearance for Deployment

Prior to deployment, a primary care provider should assess the behavioral health status of each deploying service member. In certain cases, referral to a military psychiatrists or a qualified behavioral health providers is made. This assessment would include completed waivers, if necessary, the service member medication needs during the deployment cycle, and other emergency psychotropic medications (as allowed in theater in a deployment status).

How Waivers are Managed, Processed, or Considered

While not usually a consideration in the acute setting, medical waivers are required for certain diagnoses in the U.S. Central Command (CENTCOM) Area of Responsibility (AOR). Modification of the Operational Order Seventeen (MOD17) is the current version of the CENTCOM Individual Protection and Individual-Unit Deployment policy. MOD17 has a published date of April 2023. MOD17 applies to all military services and branches, including service members, DOD civilians, contractors, sub-contractors, volunteers, and third country nationals working for the DOD. MOD17 – TAB A (US Central Command, 2023) defines the diagnoses requiring a medical waiver and the process for waiver submission.[3]

Behavioral health diagnoses are included in MOD15, especially if chronic medication treatment is required. MOD15 outlines the behavioral health diagnosis and treatments that require an approved waiver in order to deploy. Note that certain conditions, including psychotic disorders and bipolar spectrum disorders, are strictly disqualifying. If an acute or new behavioral health condition is diagnosed while deployed and the provider assesses the patient as stable, the patient is able to remain in theater. MOD15 Section H #17 states that behavioral health disorders "newly diagnosed during deployment do not immediately require a waiver or redeployment.[4] Disorders deemed treatable, stable, and having no impairment of performance or safety by a credentialed mental health provider do not require a waiver to remain in theater." Otherwise, a medical waiver needs to be completed. The final approval for entry into or remaining in theater rests with the CENTCOM Surgeon. If a medical waiver is required, local medical personnel are responsible for informing the individual and their respective commander or supervisor about the waiver process. Any of the following are "authorized agents" to submit a waiver for adjudication: the local medical provider, the commander or supervisor, or a delegated representative.

New or additional behavioral health diagnoses requiring waiver(s) should be a factor in the evaluation of patient stability. Cronrath and colleagues (2017) found that service members deployed with waivers are at higher risk for medical evacuation out of the CENTCOM AOR.[5] Results were statistically significant across all categories. However, the subcategories of neurology and mental health waivers had the highest risk of redeployment with a relative risk (RR) of 3.81 and 3.03, respectively. In other terms, the risk of medical evacuation increased 203% while deployed on an approved mental health waiver. A redeployed service member could cause a mission capability gap, therefore presenting risk to mission or risk to force, and should be a planning factor for commanders.

Psychopharmacologic Planning for Deployment

In the planning for psychotropic medications for the deployment, the brigade surgeon consults with the appropriate behavioral health provider to proactively plan for the deployment needs. This process would take into account the information accumulated in the psychiatric medication clearance and the waiver process. Also, theater assessment based on preceding deployments or similar theater conditions should be taken into account. Therefore, it is highly recommended that incoming providers communicate closely with medical personnel already in theater and on a regular basis throughout the planning phase of pre-deployment. Consultation with the pharmacist is also essential to match the planned deployment needs with the approved formulary. We will use the CENTCOM formulary as an example later in this chapter.

Dispensing Psychiatric Medications in Theater

NSMPs at the front line have ready access to trauma meds. Generally psychotropic medications are not available, with the exception of Narcan (naloxone) being available in theater for the management of overdose on opioids.

Emergency psychotropic medications are available at Role 2, and a broader selection at Role 3. Planning factors include the proper storage of medications in accordance with (IAW) manufacturer specific guidance, including medications which require refrigeration, also known as temperature sensitive medical products (TSMP). Medication storage can be challenging, possibly due to the theater climate, availability of electricity for refrigeration, and safe securing of controlled substances. Consistent and proper inventory assessment will assist in the supply and resupply of medications throughout the deployment.

Medication History

It is essential to obtain an accurate and thorough medication history, in order to assess for possible drug interactions with any new treatment, or to determine if current medications are aggravating the behavioral health condition. This can include illicit substances service members acquire through alternate sources, to include civilian contractors, host nation markets, or the postal system. It also includes use of over-the-counter (OTC) medications, which are readily available in local post exchanges (PX) and, in extreme doses, could lead to delirium or hallucinations (dextromethorphan). PXs and the postal service can also be a source of numerous nutritional supplements, such as pre-workout or protein powders. While usually benign, pre-workout supplements can contain an excessive amount of caffeine, 200-300 mg per dose. Service members over usage of these supplements can also be compounded by the extreme heat of deployed locations. If a product contains the term “Proprietary blend” in its nutrition facts, the manufacturer is not obligated to provide the ingredients of the blend; as a result, the true ingredients are unknown. These proprietary blends therefore present risk to the service member for potential drug interactions, symptom or condition aggravation, or unknown substances which could also affect drug urine analysis. For all these reasons, it is a good practice to recommend service members avoid supplements with a “Proprietary blend.”

Formulary

The CENTCOM formulary,[3] managed by the CENTCOM Pharmacy and Therapeutics Committee (PTC), is a targeted and precise formulary for medical operations in a kinetic theater and a theater of transition. EUCOM and AFRICOM do not currently have their own respective deployment formularies.

The CENTCOM formulary is reviewed quarterly by service component surgeons, and contains CPG-supported behavioral health medications such as SSRIs, antipsychotics, benzodiazepines (BZD), and CNS stimulants. However the CENTCOM formulary does not have the same breadth and depth of these classes as a Continental U.S. (CONUS) MTF formulary or a retail pharmacy. This needs to be taken into account as a planning factor in the treatment of both acute and chronic behavioral health conditions. Additionally, in accordance with MOD15, medication resupply for service members requiring ongoing behavioral health medications is executed by the Tricare Mail Order Program (TMOP), not deployed pharmacies. As a result, Role 3 pharmacies may have limited quantities of behavioral health medications on hand.

There are limited behavioral health medication options at most Role I or aid stations far-forward in the deployed theater. Role 1 Capabilities are usually constrained to trauma care and forward resuscitation. The Army recently published a new health systems doctrine with a more expeditionary, modular organizational structure. This includes psychiatric care in hospital augmentation detachments and a medical company area support (MCAS) battalion psychiatrist, which are considered Role 2. However Joint Doctrine still aligns behavioral health treatment as a theater hospitalization or Role 3 capability. Given the cold-chain storage requirements for injectable lorazepam, olanzapine ODT (Zyprexa Zydis) disintegrating tablet (which would be first line if verbal redirection is not effective for agitation), Haldol intramuscular (IM) injectable (second line if verbal redirection ineffective and patient refuses olanzapine ODT) with Benadryl IM (to potentially be given with Haldol for increased sedation and decrease likelihood of dystonia) may be the only options for acute pharmacological intervention. These items may not be stocked at Role 1 though. If necessary, the Medical Logistics (MEDLOG) representative can assist with ordering approved medications, with the reminder that chronic, ongoing behavioral medications should be resupplied to the service member through TMOP and require a MOD15 waiver. If a controlled substance is required for chronic care, TMOP requires that a hardcopy prescription is mailed to them in CONUS, along with the approved MOD15 waiver.

Aid Bag

There is no standard list of medications for an aid bag that is carried by the combat medic or Navy corpsman. There are several references medics use to inform their medication selection list to carry. A conventional force combat medic is likely to carry Joint Trauma Services Clinical Practice Guideline (JTS CPG) compliant medications. These usually include ketamine, tranexamic acid (TXA), calcium, acetaminophen (Tylenol), ibuprofen, morphine, diphenhydramine (Benadryl), midazolam (Versed), some antibiotics, and other medications. Every combat medic (conventional force and special operations medics) is likely to have ketamine, and may have BZD like midazolam in accordance with the JTS CPGs. This list is not standardized beyond the references mentioned.

Accordingly, many medics will try to balance medication choices against the limited space they have in their very small aid bag, and medications that are perceived to serve two purposes are better than medications that serve a single purpose. Additionally, reports from the field indicate that ketamine and midazolam are being used for behavioral intervention in the field, which is not their primary indication. Ketamine has the potential of causing dissociation and midazolam may cause disinhibition while attempting to stabilize an agitated patient with these two medications. The potential risk of using a midazolam, a BZD, if the service member has alcohol or opioids in their system is respiratory arrest and death. Accordingly, it is highly recommended that an antipsychotic is included in the aid bag for cases of severe agitation. As mentioned earlier, olanzapine ODT disintegrating tablets, or haloperidol IM would be good candidates for inclusion.

Treatments

Pharmacologic treatment of any condition anywhere has a risk of inducing side effects, which might be unpleasant or might put the treated service member in danger. Consequently, and especially in a far-forward situation, this balance between benefits and side effects needs to be assessed carefully before starting medications. Oftentimes, behavioral interventions might work adequately enough until either the underlying condition has resolved or the service member has been transferred to a higher role. Generally, it is preferred that the decision to initiate any psychiatric medications are made in consultation with the behavioral health prescriber.

Acute Agitation

There are multiple reasons, both medical and psychological, where a service member might become acutely agitated. In a far-forward location, the options for a medical workup are limited. Consequently, decisions for controlling the situation need to be weighed carefully. When the acute agitation is not severe enough to put anybody's life at risk and there is no evidence of psychosis (disturbed ability to test reality), the preferred approach is to use is hydroxyzine, taking into account the risk of causing sedation and delayed neurological reflexes.

In cases of severe agitation or agitation accompanied by psychosis (disturbed ability to test reality), then the use of antipsychotics is recommended.[6] Olanzapine ODT 5mg disintegrating tablet would be first line if verbal redirection is not effective for agitation. It is fast acting and does not need the addition of any other medication to it. Haldol IM would be second line if verbal redirection is ineffective and patient refuses olanzapine ODT, potentially to be used with diphenhydramine IM. This addition is useful to counter the side effects of haloperidol, and/or to induce sedation to control the situation or facilitate transfer. Although olanzapine IM has been recommended not to be given with BZDs for at least one hour, no such warning exists for the ODT formulation. However, it would be prudent to check the history of any medications in use before the administration of olanzapine ODT – or for any other medication for that matter.

Restraint

The use of physical restraint should be an option of last resort,[7] as highlighted in Chapter 3, and discussed below under Ethical Issues.

Suicide Risk

Behavioral interventions and supportive psychotherapy are best indicated in situations like these, while at the same time maintaining the safety of the service member. No pharmacologic treatment is available for acute treatment of suicidal risk. The use of an antihistamine anxiolytic or even a BZD might be warranted in case of agitation or to facilitate transfer.[8] If appropriate, refer to the paragraphs on acute stress reactions or acute agitation for detailed medicinal intervention steps.

Homicide Risk

Similar to suicidal risk, no pharmacologic treatment is available for acute treatment of homicidal risk. The use of an antihistamine anxiolytic or even a BZD might be warranted in case of agitation or to facilitate transfer. If appropriate, refer to the paragraphs on acute stress reactions or acute agitation for detailed medicinal intervention steps.

Substance Use Disorders (SUDs), Substance Intoxication, and Substance Withdrawal

The long-term treatment of SUDs is beyond the scope of this manuscript since it involves long-term medicinal and behavioral interventions, usually in specialized centers.

As stated by Deady et al (2013), "Substance intoxication and withdrawal can induce a variety of mental health symptoms and disorders, such as depression, anxiety, and psychosis.[9] For example, alcohol use and withdrawal can induce symptoms of depression or anxiety; manic symptoms can be induced by intoxication with stimulants, steroids or hallucinogens; and psychotic symptoms can be induced by withdrawal from alcohol, or intoxication with amphetamines, cocaine, cannabis, Lysergic acid diethylamide (LSD), or Phencyclidine (PCP). In the majority of cases, these effects subside and eventually disappear with abstinence. For some, however, psychiatric symptoms may continue even after they have stopped drinking or using drugs."

Subsequently, in a far-forward setting, the main goal is to stabilize the service member while maintaining safety for all. This can be done by withdrawing the offending agent (alcohol, PCP, etc.), maintaining vital signs, and managing the behavior based on the condition as stated in this chapter, while awaiting transfer to a higher role.

Bipolar Disorder/Mania and Psychosis

These conditions require evacuation from the combat zone. The treatment of both acute mania and psychosis is similar and consists of the use of antipsychotics. The protocol listed above under Acute Agitation should be followed.

Insomnia

The formulary offers two antihistamines that may be used for insomnia; their side effects may cause drowsiness or a hangover feeling the next morning with some sluggishness.[10] Certain psychotropics that are indicated for other reasons could also be used in small doses, such as trazodone (an antidepressant), or quetiapine (an SGA). BZDs and the z-class of hypnotics generally work well, however the risks involved in co-administration with other medications or alcohol should be taken into account, in addition to their potential for addiction when taken regularly over time. An over-the-counter substance, melatonin, is a naturally occurring chemical in the brain, that can be taken orally. In spite of their common use for this reason, the benefit of this approach is not well established. Additionally, melatonin is not regulated by the U.S. Food and Drug Administration (FDA), with no assurance of dose or the purity mentioned on the label.

Coping with Psychosocial Stressors (e.g., Relationship, Family, Financial)

Usually, behavioral interventions and supportive psychotherapy are best suited to deal with situations like these. However, in case of severe distress or impairment of functioning, one can use interventions covered under the paragraph for acute stress reactions.

Acute Depressions/Major Depressive Disorder/Dysthymic Disorder

There are several medication groups that are helpful in the long-term management of these conditions. Currently, SSRIs are most commonly used to their general overall safety and tolerability.[11] No blood tests or electrocardiogram (ECG) is required before the institution of treatment. For acute depressive episodes, care needs to be paid to the risk of suicidal ideation or plans, and measures should be taken to ensure safety. Similar to what was covered earlier, and in case of sever distress or impairment of functioning, one can use interventions covered under the paragraph for acute stress reactions. On the other hand, if a service member is known to be on an antidepressant and develops symptoms of the serotonin syndrome (see below), steps should be taken to maintain safety. First step should be to discontinue all medications that increase serotonin in the brain – not just the antidepressants. Next step is the transfer of the patient to a higher role.

Acute Stress Reactions and Panic Attacks

The treatment for acute stress reactions and panic attacks is different from long term treatment of panic disorder. In an acute situation, BZDs work promptly and effectively. However, as mentioned earlier, this should be weighed against the situation the service member is in on the field, and impact of their side effects on the service member. Alternatively, adrenergic agents could be used, again with care paid to their side effects, mainly lowering the blood pressure.

Recurrent Panic Attacks and Panic Disorder

Serotonin acting medications (SSRIs and SNRIs) are very effective medications for the treatment of panic disorder and for decreasing and ameliorating the frequency and severity of the panic attacks. However, it will take several weeks of regular use to get the desired effects, which would also require continuous use over time. Care should be given to dosing of these medications in the case of panic disorder. Medications should be started at a significantly lower dose than when used in other conditions and titrated up slowly over several weeks.

Anger Management

Anger is a common emotional state that all humans experience, and it is commonly expressed and dealt with in an appropriate, safe, and constructive manner. Occasionally, some individuals are not able to manage or deal with their anger in a healthy way and can place their or others' wellbeing or lives at risk. These severe cases of dysfunctional behavioral symptom might have an underlying psychological or medical cause, or can be precipitated by an acute event: behavioral, psychological, or medical. The focus of management of acute bout of anger, is to maintain safety of service member and others while keeping in mind any and all underlying conditions that might require a transfer to a higher Role. The protocol for management of acute agitation should be followed.

MEDICATIONS CLASSES

Antidepressants

The majority of the antidepressant medications approved for use in the United States exert their effect by modulating one or more of the three monoamines in the brain: serotonin, norepinephrine and dopamine.[12] The more recent ones with a different mechanism of action are not on the formulary and thus will not be covered. With the exception of the tricyclic antidepressants (TCAs), which were approved in the 1960s and tend to have a harsher and potentially dangerous side effect profile, newer antidepressants approved in the late 1980s and onwards tend to be well tolerated and have a benign side effect profile. Common side effects include gastrointestinal (GI) disturbance and sexual side effects. Of note here is that the FDA has placed a black box warning for all antidepressants due to concern over increased risk of suicidality.

Indications

Major depressive disorder is the main indication. These meds are also used to treat depression associated with bipolar disorder. Of note here is that the subgroup that acts on Serotonin (SSRIs and SNRIs) is also very effective in long-term treatment of anxiety without the risk of addiction associated with the benzodiazepines.

Serotonin Syndrome

A rare but important risk of being on medications that increase serotonin in the brain.[13] Usually, it is a combination of multiple medications. These would include most antidepressants, but also a score of other medications that are not commonly associated with brain disorders (e.g., anti-migraine medications, pain medications, anti-nausea medications, some cough syrups, illicit drugs, and herbal supplements). Signs and symptoms include restlessness, agitation, confusion, hypertension, tachycardia, pupillary dilation, heavy sweating, diarrhea, and headache. In severe cases, the serotonin syndrome can be life threatening, with signs including high fever, seizures, arrhythmia, and unconsciousness. Generally, the signs and symptoms subside once serotonin levels return to normal by stopping all serotonin agents and providing supportive medical intervention at a higher Role level. Severe cases that are not treated can lead to death.

Antipsychotics

These medications are generally divided into two groups: first generation antipsychotics (FGAs), also known as typical antipsychotics, which tend to cause serious immediate neurological side effects, such as akathisia—a movement disorder that makes it hard to stay still—and extrapyramidal side effects (EPS), with tremors and stiffness similar to having Parkinson's disease.[14] Second generation antipsychotics (SGAs), also known as atypical antipsychotics, tend not to carry such a high risk. However, some of the SGAs do carry the risk of causing or worsening a "metabolic syndrome" (i.e. obesity, hypertension, and diabetes).[15]

Indications

These medications are effective in treating psychosis, acute mania, mood instability, severe agitation, and augmentation strategies for depression. In a deployed setting, antipsychotics are almost always reserved for emergency use. Psychotic disorders are strictly disqualifying, and antipsychotics used for other purposes (such as augmentation for depression) would require a waiver.

Anxiolytics, Sedatives, and Hypnotics

These classes are some of the most widely used and abused medications. In the U.S., the benzodiazepines (BZDs) and hypnotics (Z-class) are classified as controlled substances and require a prescription. However, they can be bought without a prescription in certain countries overseas. The main concern of their use and abuse is that they impair both mental and physical responses and reflexes, causing sedation and sluggishness, and consequently may put the lives of those who are using them, and of others, in danger.[16] Occasionally, patients who are given a BZD might exhibit symptoms of psychological disinhibition, whereby they may behave in an inappropriate manner.

Indications

BZDs are mainly indicated for the acute treatment of anxiety and as hypnotics.[17] However, they are contraindicated for use in patients with PTSD. They are also indicated for use in cases of agitation, either alone or in conjunction with an antipsychotic. The non-benzodiazepine group of hypnotics (usually referred to as the Z-class), are not effective for anxiety nor agitation. Their only use is to induce and/or maintain sleep. Generally, they are safer than the BZDs, however, they still carry a lower risk of addiction. The use of medications in this class requires a waiver.

Non-benzodiazepine anxiolytics are divided into two groups, the former includes buspirone, which has been on the market for over 30 years, and the latter includes two antihistamines: hydroxyzine and diphenhydramine, which are commonly used for their nominal indication.

Buspirone is approved for use in generalized anxiety disorder.[18] It needs to be taken on a daily basis and its benefit might take a few weeks to be felt. However, it is well tolerated overall and, unlike BZDs, it is not sedating and does not carry a risk of addiction. Hydroxyzine and diphenhydramine are used off-label for short term treatment of anxiety. They are non-addicting but do cause drowsiness and might impair both mental and physical responses and reflexes. Diphenhydramine is also used to counter certain immediate neurological side effects (such as extrapyramidal side effects (EPS)) of FGAs.

Anticonvulsants

The four compounds in this list were all initially approved as anticonvulsants.[19] Each belongs to a different chemical group and has a unique mode of action. All are widely used both in psychiatry and neurology and are generally well tolerated.

Indications

Carbamazepine is not indicated by the FDA for any psychiatric diagnosis; however, it is used off-label for the treatment of bipolar disorder and manic episodes. Divalproex is approved by FDA and is indicated for the treatment of bipolar disorder, manic, or mixed episodes. Gabapentin is not indicated by FDA for any psychiatric diagnosis; however, it is used off-label to treat anxiety and for reducing the symptoms of alcohol withdrawal. Gabapentin does not appear to provide any benefit for bipolar disorder. Topiramate is not indicated by the FDA for any psychiatric diagnosis, however it is used off-label used to treat alcohol use disorder and for the treatment of antipsychotic-induced weight gain. In spite of evidence to the contrary, it is also used off-label to treat bipolar disorder. The use of medications in this class requires a waiver.

Cerebral Stimulants

Most of the medications in this group are stimulants and are classified as controlled substances due to the associated risk of addiction. Amphetamine and its derivatives come in different formulations and durations of action, with the earliest compound discovered and used recreationally since the late 1800s. Similarly, methylphenidate has been on the market since the 1950s and comes in different formulations and durations of action. Since the early 1970s, both groups have been classified as Schedule II controlled substances due to their high risk of addiction. Modafinil is not a classical stimulant,[20] but is scheduled as a Schedule IV controlled substance due to some concern over its addictive qualities. Atomoxetine is neither a stimulant nor is scheduled as a controlled substance. Post-marketing reports indicate that atomoxetine can increase the risk of seizures in adults with a history of seizure disorder or those with high risk of having a seizure.[21]

Indications

Amphetamine formulations listed in the table, in addition to atomoxetine, are all approved for the treatment of attention deficit hyperactivity disorder (ADHD). Alternatively, amphetamine and modafinil are approved for the treatment of narcolepsy. The use of medications in this class requires a waiver.

Opiate Antagonists

Naloxone temporarily and rapidly reverses the effects of opioids on the brain in case of an overdose. Examples of opioids include heroin, fentanyl, oxycodone, hydrocodone, codeine, and morphine. Naloxone is available in three formulations: intramuscular injectable, intravenous injectable, and as a nasal spray.

Indications

Naloxone is indicated for the treatment of suspected opioid overdose when the breathing has slowed or stopped.[22] It can quickly restore normal breathing caused by an opioid overdose; however, naloxone has no effect on someone who does not have opioids in their system and thus is safe to use in case of a suspected overdose. Additionally, due to its temporary effect, it is critical to obtain medical intervention as soon as possible after administering naloxone. Note that naloxone is not a treatment for opioid use disorder.

Adrenergic Agents

These agents exert their effect by acting on the adrenergic (norepinephrine) system in the brain, each through distinct mechanisms. Clonidine stimulates the alpha-2 receptors and is mainly used for treatment resistant high blood pressure, while prazosin blocks the alpha-1 receptors, and is used to lower blood pressure and treat enlarged prostate. Propranolol and propranolol ER block the beta receptors, mainly used to lower blood pressure. None of them carry the risk of addiction.

Indications

Clonidine is indicated for use in ameliorating withdrawal symptoms from alcohol, BZDs, and opioids.[23] Prazosin is used for the treatment of PTSD, mostly to ameliorate nightmares.[24] Propranolol is used for the treatment of generalized anxiety and performance anxiety and to counter certain immediate neurological side effects (akathisia) of FGAs.

Ethical Issues

Restraint

Issues related to pharmacological intervention vs. physical restraint should be resolved before implementing physical restraint. Whenever possible, trained military personnel should be considered for restraint. Sometimes this is the only option in an austere environment. Otherwise, medical personnel can and should also be trained in basic restraint so as not to injure themselves or another service member. Physical and chemical restraints should be utilized in accordance with local theater policies and procedures. These devices are heavily regulated based on situation and location. Each policy should identify and elaborate on consent, competence, and restraint, thereby allowing the provider to protect their patient safely and legally.

Table 5.1. CENTCOM Formulary 2023 - Behavioral Health Medications.

Antidepressants	Generic	Brand	Doses	Comments
TCAs	Amitriptyline	Elavil	10MG, 25MG	
	Nortriptyline	Pamelor	10MG, 25MG	
DNRI	Bupropion SR	Wellbutrin SR	100MG, 150MG	
SSRIs	Citalopram	Celexa	20MG, 40MG	
	Escitalopram	Lexapro	10MG	
	Fluoxetine	Prozac	10MG, 20MG	
	Paroxetine	Paxil	20MG	
	Sertraline	Zoloft	50MG, 100MG	
	Trazodone	Desyrel	50MG	
SNRIs	Venlafaxine	Effexor XR	37.5MG, 75MG	

Antidepressants	**Generic**	**Brand**	**Doses**	**Comments**
	Duloxetine	Cymbalta	30MG	
Alpha-2 Agonist	Mirtazapine	Remeron	15MG, 30MG	
Antipsychotics	**Generic**	**Brand**	**Doses**	**Comments**
Typical (FGAs)	Haloperidol	Haldol	1MG, 5MG	Detainee, Role 2 & 3 only
	Haloperidol INJ	Haldol	5MG/ML	
Atypical (SGAs)	Olanzapine ODT	Zyprexa Zydis	5MG	Role 2 & 3 only
	Quetiapine	Seroquel	25MG	Detainee, Role 2 & 3 only
	Risperidone	Risperdal	1MG	Detainee, Role 2 & 3 only
Anxiolytics / Sedatives / Hypnotics	**Generic**	**Brand**	**Doses**	**Comments**
Antihistamine	Diphenhydramine	Benadryl	25MG, 50MG	
	Diphenhydramine INJ	Benadryl	50MG/ML	
	Hydroxyzine	Vistaril	10MG, 25MG	
	Hydroxyzine	Vistaril	50MG/ML	
BZDs	Diazepam	Valium	5MG	CS
	Lorazepam	Ativan	1MG	CS
	Lorazepam INJ/IV	Ativan	2MG/ML	CS
	Midazolam INJ/IV	Versed	1MG/ML, 5MG/ML	CS
	Temazepam	Restoril	15MG, 30MG	CS
Hypnotics	Eszopiclone	Lunesta	1MG, 2MG	CS
	Zaleplon	Sonata	10MG	CS, Restrict for use to Air Crews
	Zolpidem	Ambien	5MG, 10MG	CS
Miscellaneous	Buspirone	Buspar	5MG, 10MG	
Anticonvulsants	**Generic**	**Brand**	**Doses**	**Comments**
	Carbamazepine	Tegretol	200MG	
	Carbamazepine Oral Suspension	Tegretol	100MG/5ML	
	Divalproex ER	Depakote ER	250MG, 500MG	
	Gabapentin	Neurontin	100MG, 300MG	
	Topiramate	Topamax	25MG, 100MG	
Cerebral Stimulants	**Generic**	**Brand**	**Doses**	**Comments**
	Dextroamphetamine & amphetamine salts IR	Adderall IR	5MG, 10MG, 30MG CS	CS
	Dextroamphetamine & amphetamine salts XR	Adderall XR	5MG, 10MG, 20MG,30MG	CS
	Dextroamphetamine	Dexedrine	5MG	CS
	Modafinil	Provigil	200MG	CS
	Atomoxetine	Strattera	40MG, 60MG	
Opiate Antagonists	**Generic**	**Brand**	**Doses**	**Comments**
	Naloxone INJ/IV	Narcan	0.4ML/ML,1MG/ML	
	Naloxone Nasal Spray		4MG	
Adrenergic Agents	**Generic**	**Brand**	**Doses**	**Comments**
	Clonidine	Catapres	0.1MG	
	Clonidine INJ		100MCG/ML	
	Prazosin	Minipres	1MG, 2MG, 5MG	
	Propranolol	Inderal	10MG, 40MG	
	Propranolol ER	Inderal LA	80MG	

CS= Controlled Substance

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CHAPTER 6

COMMAND CONSULTATION

The purpose of command consultation related to behavioral health is to maximize the readiness and performance of the unit/organization and to facilitate individual and collective health, resilience, wellbeing, and performance. In all consultations, the purpose is to make clear and actionable recommendations to command regarding the behavioral health of an individual or group and to assist command in implementing interventions.

To effectively perform command consultations, it is essential for the Non-Specialty Medical Personnel (NSMP) to understand roles and responsibilities and to build relationships. The NSMP must integrate into the unit upon assignment; understand the unit culture, language, organizational and power structures; and build relationships within the unit. They must understand the roles of command and medical support services, as well as the rules and regulations that guide command consult such as DOD Instruction (DODI) 6490.04, Mental Health Evaluations of Members of the Military Services[1] (See Table 6.1 for details on all policies relevant to this chapter). The NSMP needs to be familiar with the nature of command and commanding, medical and non-medical/chaplain services, resources such as the sexual assault response coordinator (SARC), and interventions available in that environment. Moreover, they are mandated to practice medical ethics with appropriate disclosure of confidential information. Finally, NSMPs must understand dual agency and balance the needs of the patient versus the organizational mission, keeping in mind that they make recommendations, but command makes the decisions.

This chapter complements previous topics of individual service member assessment and clinical interventions covered throughout Chapters 2-4, and will refer back to those skills and principles. This chapter focuses on the unique contributions of command consultations, including unit-wide assessment and interventions, command monitoring procedures, and individual service member issues in which command can take appropriate actions.

Table 6.1. Chapter Relevant DOD Policies.

- Department of Defense (2022). DODI 1020.03 Harassment Prevention and Response in the Armed Forces. Change 2 effective Dec 20, 2022
- Department of the Army (2020). Disclosure of Protected Health Information to Unit Command Officials (Army Directive 2020-13).
- Department of Defense (2011). Command Notification Requirements to Dispel Stigma in Providing Mental Health Care to Service Members (Department of Defense Instruction 6490.08).
- Department of Defense (2020). Mental Health Evaluations of Members of the Military Services (Department of Defense Instruction 6490.04, incorporating Change 1).
- DA Form 3822. Report of mental status evaluation. Office of the Surgeon General (Jun. 9, 2019).

Three Command Consultation Tasks

Individual Service Member Consult: Advise Commander on Individual Service Member Cases of Concern, Risk, or Adverse Mission Impact.

Monitor, Detect, and Assess

Monitor the Health and Well-being of Service Members and Detect Concerning Issues

Command and NSMP work jointly to monitor the behavioral health status of service members. They are familiar with baseline conditions for service members and the unit and are open and watchful for any changes. Information may be obtained in multiple ways and from various sources, including general observations, casual conversations, active questioning, discussions with the chaplain, concerning reports received from service member peers or enlisted leaders, attention to excessive sick call behaviors or misconduct, or other awareness of changes in mood, behavior, or performance. The NSMP and command should be in continuous communication regarding any perceived changes and together strive to better understand and problem-solve the situation.

Determine Best Way to Further Assess or Address a Concerning Situation

When concerns are identified, the NSMP and command discuss the situation and agree on the best way to proceed with addressing or further assessing the service member. Options to handle the concerning situation vary depending on the severity of the concerns and the nature of the larger situation, and include less serious concerns that involve minimal or informal intervention, and more serious concerns that require a higher level of intervention.

For situational awareness, the NSMP should be familiar with the DODI 6490.04, Mental Health Evaluations of Members of the Military Services, which provides guidelines for command-directed mental health evaluations (CDEs) as well as rules for both routine and emergency CDEs.[1] Because CDEs are formal evaluations that must be conducted by a behavioral health provider, neither routine nor emergency CDEs are practical or likely to occur in an austere environment with limited resources. For emergent situations, actions by forward medical personnel to ensure safety supersede actions regarding a formal evaluation by a behavioral health professional. The NSMP will take medical actions to ensure safety until the service member is evacuated to a higher echelon of care, where a CDE can be subsequently performed by a behavioral health provider. A non-emergent ("routine") CDE is typically ordered by command to determine the service member's fitness for duty, but would not need to be conducted during deployment if the service member is seeking care voluntarily. If the service member exhibits potential behavioral health concerns and declines voluntary care, the NSMP should pursue other options, which may include transferring/evacuating the service member to a higher level of care that has behavioral health assets or proceeding with a CDE assisted by a tele-behavioral health provider.

The consult request can be broached by either command or by the NSMP but should represent a joint decision. The NSMP will clarify the "ground rules" with command and help to "shape" the consultation by specifying referral questions and goals and explaining roles, expectations, and limitations (what NSMP can and cannot do), and the limits of confidentiality.

Assess the Service Member within the Organizational Environment

Depending on the time available, gathering collateral information prior to interviewing the service member can help guide the NSMP's interview with the service member and provide a more complete picture of the individual and their situation. Sources may include the pertinent observations, information, opinions from command, other unit members' and leaders' knowledge of the service member's personal and performance issues, and any available medical, performance, or administrative records. This background information may help guide the NSMP's interview with the service member.

When interviewing the service member, the NSMP should ensure that the service member voluntarily agrees to the evaluation. The NSMP should explain to the service member the consultation questions and scope of consult, who requested the consult, what information is being gathered and what will be done with the information, confidentiality,

any legal/ethical issues, potential consequences, and how/to whom to refer. It is critically important for the NSMP to understand the unit structures and functions and the service member's specific job duties and role in the unit, and to consider how that may relate to command-related actions to minimize risk and/or to maximize performance.

Clinical assessment guidelines and behavioral health screening tools for the NSMP are described in Chapters 2-4.

Analyze Potential Interventions and Develop Actionable Recommendations

Overall, the NSMP will consider four general disposition options: return to duty, return to duty with short-term limitations, medical hold, and refer. The NSMP must determine what options/resources are available in the current environment to include potential duty limitations, availability of behavioral health specialty providers (such as through tele-behavioral health intervention or restoration clinic; see Chapter 1), prescription medications (see Chapter 5), medical hold (see Chapter 1), medevac (see Chapter 7), and practical actions that command can take. For clinical conditions, the NSMP may apply the recommended "minimum/better/best" interventions from Chapters 3 and 4 and may consult with a tele-behavioral health NSMP as needed.

For many presenting concerns, command can take immediate and practical actions to ameliorate the underlying issues and stressors or to provide safety for a service member at risk. These wide-ranging command-related actions include altering the mission rest times to increase sleep opportunity; ensuring the service member can voice relevant concerns to command; referring the service member to a chaplain, judge advocate general (JAG), or the inspector general (IG), depending on the nature of the problem; ensuring that a unit mentor meets regularly with the service member to assist with relationship, financial, or occupational problems; and ensuring contact between a victim of sexual assault and the unit's victim advocate and SARC. Safety interventions include instituting appropriate unit watch procedures and firearms/weapons/medications safety limitations. See Table 6.2 for a detailed NSMP guide to match specific problems to immediate interventions on which command can take action.

Table 6.2. Command Consultation Tool for Evaluation and Command-Related Interventions for Individual Service Member Concerns.

Concerning Issues	Command-Related Interventions
Sleep	
Is the service member sleeping less than 4 hours per 24-hour period for a duration of more than one month?	Revisit planned mission rest times to ensure eight hours of downtime for intended sleep. Provide sleep hygiene training. (See Chapter 4 for clinical recommendations)
Self-harm/Suicidal Risk	
Has the service member recently expressed thoughts of self-harm or made attempts to harm self?	Establish appropriate unit watch procedures and firearms and other safety limitations (e.g., restrict medication access, if appropriate) until the service member can be medically evacuated at the earliest opportunity. (See Chapter 3 for clinical recommendations and Chapter 7 for Medevac guidance)
Anger/Homicidal Risk	
Has the service member had any significant outbursts or times when the service member might be considered "out of control"?	Ensure that the service member has adequate opportunity to voice frustrations to command. Consider referral to Chaplain. NSMP to monitor service member for outbursts at least weekly. (See Chapter 4 for clinical recommendations)

Is the service member expressing specific threats of violence toward any individuals (including local nationals)?	Establish appropriate unit watch procedures and firearms/weapons limitations until the service member can be medically evacuated at the earliest opportunity. (See Chapter 3 for clinical recommendations and Chapter 7 for Medevac guidance)
Substance Misuse/Acute Intoxication	
Is the service member using alcohol or drugs, and/or is the service member currently under the influence or intoxicated?	Establish appropriate unit watch procedures and firearms/other safety limitations until the service member can be medically evacuated at the earliest opportunity. (See Chapter 3 for clinical recommendations and Chapter 7 for Medevac guidance)
Relationships	
Is the service member pending and/or planning a divorce/breakup or experiencing other relationship problems (e.g., frequent arguments with spouse/partner, isolation from family, or loss of child custody)?	Ensure contact between the service member and a unit mentor who has been through similar relationship problems until the service member achieves the benchmarks set up by the mentor. Ensure the service member has adequate opportunity to meet with the chaplain, or attend tele-behavioral health provider appointments. (See Chapter 4 for clinical recommendations)
Is the service member a victim of a sexual assault during deployment who chooses to file an unrestricted report?	Coordinate with SARC for confirmation on report classification. Ensure contact with the unit's victim advocate. Keep service member updated regarding status of legal case. Command to consider removal of perpetrator from AOR. Ensure bi-weekly contact with tele-behavioral health provider for follow-up care. Consider referral to chaplain. NSMP to monitor service member's state closely. (Follow guidance for clinical symptom presentation in Chapters 3 and 4)
Has there been a recent death among the service member's close relatives or friends (whether or not the service member took emergency leave)?	Ensure that the service member has the opportunity to speak with the unit chaplain or other support figures. If a service member has been denied requested emergency leave, ensure that the service member has the opportunity to meet directly with the company commander and/or first sergeant in order to discuss the specific reasons for denial. (See Chapters 3 and 4 for clinical recommendations)
Financial and Administrative	
Financial Problems: Does the service member have significant difficulties paying bills or demonstrate obvious signs of poorly considered purchases (e.g., car, home) well outside known estimated income?	Ensure contact between the service member and a unit mentor familiar with the service member's individual situation until the service member achieves the benchmarks set up by the mentor. Ensure the service member has adequate opportunity to attend financial guidance.
Discipline/Legal Problems: Is the service member currently under military or civilian investigation for any suspected violations or pending Uniform Code of Military Justice/Article 15 action, administrative separation/elimination, or bar to re-enlistment?	Ensure adequate contact between the service member and support assets (inspector general, judge advocate general, trial defense service, chaplain). Ensure the service member receives written criteria, unit plan of support, and minimum of weekly feedback for how to meet requirements/standards until the service member achieves the requirements/standard identified. If applicable, ensure the service member has full awareness of command's intention to initiate administrative separation/elimination.
Occupational Problems: Is the service member pending any adverse action (e.g., flag, reduction in rank, removal from position of responsibility, poor performance review, or non-selection for promotion or attendance to schools), or receiving repeated corrective counseling statements without alterations in problematic behavior?	If pending separation/elimination, provide the service member with full access to transition services. Ensure the service member receives written criteria, unit plan of support, and minimum of weekly feedback for how to meet requirements/standards until the service member achieves the requirements/standard identified. Ensure contact between the service member and a unit mentor familiar with the service member's individual situation until the service member achieves the benchmarks set up by the mentor.

The NSMP should determine clinical and command-related COAs in order of recommendation, provide the rationale for each COA including an analysis of the advantages/disadvantages and level of risk for each, and provide a list of step-by-step instructions/guidelines to discuss with command.

Provide Feedback and Collaborate with Command to Determine Intervention Plan

After the NSMP has completed the assessment and developed clinical and command-related recommendations, the NSMP should brief command on his/her findings within 24 hours, adhering to confidentiality requirements. These requirements include only "need to know" information regarding diagnosis, prognosis, fitness for duty and duty limitations, and a realistic intervention/treatment plan, accompanied by clear, actionable recommendations (for confidentiality policy, see DODI 6490.08, *Command Notification Requirements to Dispel Stigma in Providing Mental Health Care to Service Members*).2

NSMP and command should work to determine the best plan to prevent, manage, fix, or remove the problem as much as possible, depending on the situation and circumstance. The NSMP should complete a written report of the command consultation within 24 hours (see Appendix G, *Non-Specialty Medical Personnel Behavioral Health Communication Form*). Feedback to the service member should be delivered verbally by the NSMP and should include clear, simple information regarding diagnosis, prognosis, duty limitations, recommendations, and plan.

Implement Plan, Evaluate and Adjust as Necessary

When the intervention plan has been determined, it can be implemented, evaluated, and adjusted as necessary. The intervention plan may be relatively simple or more complex, with several components, key personnel, and/or stages that require coordination and tracking. A coordinator of the plan should be designated, as agreed by the NSMP and command. As the plan is implemented, it will be evaluated as needed to determine its effectiveness. This requires the NSMP to check back with the service member and re-evaluate their status and to continue to gather relevant information from pertinent sources such as peers, medical staff, and chain of command. The plan should be adjusted to best suit possibly changing circumstances, such that if the service member fails to improve or worsens, stronger measures should be taken, and conversely, if the service member improves rapidly, the service member may return to duty sooner than expected.

Individual Service Member Consult Case Vignette

Presenting Issues

Staff Sergeant Brown's performance had suddenly declined, and she began making excessive mistakes in her work as a helicopter mechanic. Her concentration and memory were poor, she appeared slow and unmotivated, and she had several temper outbursts when asked about her performance.

Assessment

Staff Sergeant Brown voluntarily agreed to be evaluated, and the NSMP proceeded with basic interview and assessment skills from Chapters 2 – 4. Findings indicated that Staff Sergeant Brown was sleeping less than two hours a day. This represented a change in her sleep, which followed her assignment to night shift work. Staff Sergeant Brown explained that she was unable to sleep during the day due to the extreme heat. In addition, as her sleeping area was shared with daytime operation personnel, space was being used for mission-related tasks, such as obtaining keys or log books, and was not adequately blacked out to ensure darkness. Operational stressors such as excessive noise due to colocation near the airfield also contributed to the disrupted sleep.

Interventions

The commander re-located personnel such that all night shift workers were housed in one tent, which was reinforced to black out daylight and provided with a white noise machine and a fan (commandeered from the officer barracks); all night shift workers were given ear plugs and eye masks; and the NSMP reviewed sleep hygiene tips with them, with a specific focus on shift work.

UNIT CONSULT: PROVIDE PREVENTION/MITIGATION ACTIVITIES FOR UNIT AS REQUESTED OR INDICATED

Monitor, Detect, and Assess

Monitor the Health and Well-Being of the Unit and Detect Concerning Issues

Just as command and NSMP work jointly to monitor the behavioral health status of individual service members, they also monitor the unit as a whole, being familiar with baseline conditions and watchful for any changes. Information may be obtained from general observations, casual conversations, active questioning, concerning reports received from service members or chain of command, excessive sick call behaviors or misconduct, or other changes in cohesion, morale, behavior, or performance within the unit. When operational and/or combat stressors are evident, the NSMP and command should proactively ask questions and investigate how unit members are faring.

Determine Best Way to Further Assess or Address a Concerning Situation

Upon detecting unit concerns, command or the NSMP can request unit consultation and intervention and will meet to discuss the concerns and brainstorm the best path forward. The need for the consult may be obvious, for example, if the unit has endured harsh environmental conditions and their morale and performance are flagging. In this case, the NSMP may recommend and conduct an appropriate unit health promotion intervention or training. However, if the reasons for poor unit morale or performance are not fully known, the NSMP must assess the situation.

Throughout the unit consultation process, the NSMP should identify who in the unit is at risk – if the entire unit was affected by a unit-wide stressor or if certain parts of the unit were more affected by a particular stressor. For example, if a service member attempts suicide and is medically evacuated, his/her platoon members will be most affected, while the battalion as a whole may be affected but to a lesser degree. These two populations may merit different assessment and intervention approaches.

Assess Unit Morale, Climate, and Performance

The NSMP and command should be continuously communicating and should collaborate on assessment plans and possible interventions. NSMP and command should determine if the concerns involve 1) the whole unit, 2) groups who have experienced an event and are at risk, or 3) individuals who are identified with an issue. Assessment and intervention plans should be tailored to the concerning issues and target population. The NSMP may utilize all sources of relevant information and employ methods that are less formal and rigorous (e.g., spot checks, interviewing key personnel) or more rigorous (unit survey). Some assessment options include:

Review Available Data

- Analyze behavioral trends such as high rates of behavioral health referrals, sick call, misconduct, service member suicide, sexual assault, fratricide, or disciplinary actions.
- Review policy documents, such as standard operating procedures.

Collect New Information

- Interview service members to hear their perceptions and concerns, such as through informal walkabouts.
- Interview key unit personnel, such as chain of command, chaplain, other medical.
- Conduct unstructured or structured group interviews, such as focus groups.
- Administer anonymous surveys, such as the Unit Survey – Individual Questions (Unit-IQ; see Appendix H).

There are a wide range of possible issues affecting the unit, and it is important to consider that variables often interrelate or may have underlying causes. For example, recent traumatic events in the unit may give rise to unit-wide poor sleep, lack of motivation, and depressed mood; or cancellation of rest and recuperation (R&R) can lead to

increased irritability and problem behaviors. The Unit-IQ survey (Appendix H) categorizes broad areas of concern across the unit: trauma experiences, clinical conditions, sleep problems, family stressors, combat and operational stressors, unit aggression/problem behaviors, decreased unit cohesion/morale/performance, and toxic leadership concerns. Administering unit surveys to assess concerns can act as an intervention in and of itself, because it demonstrates that 1) the problem is noticed, and 2) someone is willing to do something about it.

The Unit-IQ serves as a flexible resource designed to cover a wide range of issues in a brief format, but it does not need to be administered in its entirety; NSMPs may choose to include only certain selected items relevant to their immediate concerns. Additionally, the Unit-IQ is split into three sections, so that NSMPs may administer clusters of related questions to understand a particular concern. These three sections include 1) Behavioral Health and Sleep Indicators, 2) Combat and Operational Stressors, and 3) Unit Climate and Leadership Concerns. The survey should be both anonymous and voluntary. The NSMP may announce the survey request at formation or at the DFAC, and arrange a secure pick up and drop off point. However, it is important to ensure that an adequate and representative number of the target population of service members are surveyed; otherwise, survey results may be misleading. Reviewing the demographic information on the Unit-IQ will shed light on the nature of the sample in terms of rank and MOS.

When the NSMP has received all completed surveys, they should calculate the results, form opinions, and may follow up with voluntary "walkabout" interviews, paying special attention to rounding out the sample to ensure its representativeness. For additional information or guidance, the NSMP may consult with the tele-behavioral health NSMP and/or chaplain as needed.

Analyze Potential Interventions and Develop Actionable Recommendations for Command

If the NSMP suspects that toxic leadership may play a role in unit morale and performance, the NSMP should follow steps in the Command Monitoring section (below). Otherwise, the NSMP verbally briefs command on their assessment of the unit issue and their recommendations for intervention.

In broad strokes, recommendations may include 1) practical actions that command can take to address the situation, 2) unit health promotion interventions and trainings, including Traumatic Event Management (TEM) if indicated, and 3) command after action reviews. Command can implement a wide-ranging number and type of actions, e.g., altering planned mission rest times, taking actions to mitigate environmental concerns, imposing curfew, limiting electronics use, conducting unit assessments (UAs), increasing monitoring, establishing zero tolerance policy, affirming an open-door policy, and so on. As indicated, command will conduct after action reviews following significant events.

The NSMP may conduct unit health promotion interventions and trainings as command consultation interventions to mitigate behavioral health issues. However, they may not be trained or experienced in conducting some specialized behavioral health trainings. When indicated, the chaplain or JAG can conduct specialized training.

The NSMP should be equipped to provide basic trainings/interventions:

- Sleep hygiene in a deployed setting.
- Basic self-care (rest/diet/exercise).
- Healthy coping skills.
- Stress management/solution focused skills.
- Morale promoting events, such as team building events.
- Q&A sessions to discuss unit concerns in an open forum.
- Access to relevant resources.

Acute Behavioral Health Care by Non-Specialty Medical Personnel

Depending on the experience, training, and comfort level, the NSMP or the chaplain can provide the following trainings/interventions:

- Interpersonal communication/conflict resolution.
- Anger management/emotional regulation.
- Combat and operational stress control.
- Traumatic event management (TEM).
- Ethics training (can be provided by JAG also).

See Table 6.3 for more detailed examples linking unit concerns with interventions.

Table 6.3. Command Consultation Tool for Unit-Wide Evaluation and Interventions.

Unit-Wide Concerning Issues	Interventions (Assess with Unit-IQ Items as needed; consult with tele-behavioral health provider as needed)
Unit Psychological Distress	
Has the unit been exposed to a traumatic event e.g., KIA, WIA, MASCAL, service member suicide or suicide attempt?	Recommend that command conduct after action review with unit. Request that chaplain provide TEM training. Provide stress management and tangible/solution focused skills training. (See Chapter 8 for additional recommendations)
Does the unit appear to show signs of depression, anxiety, or acute stress?	Assess for unit type and level of behavioral health distress, and determine underlying variables for these conditions. Provide feedback to command and advise on actions command can take to mitigate the contributing factors. Select appropriate health promotion activity or training to address the concerns.
Unit Sleep	
Does the unit have sleep issues?	Determine unit sleep status and explore underlying variables, e.g., operational factors. Provide feedback to command and advise on actions command can take to mitigate any contributing variables. Revisit planned mission rest times to ensure 8 hours of downtime for intended sleep. Provide sleep hygiene briefing/sleep psychoeducation tailored to the deployed setting. (Refer to Chapter 4 and Appendix D for specific sleep interventions for individuals) Monitor monthly changes on Unit-IQ.
Family Stressors	
Is there evidence of unit-wide family stressors, such as lack of communication stateside, cancellation of R&R, extension of deployment, etc.?	Assess all contributing variables and their impact on morale and performance, provide feedback to command, strategize possible mitigation options. Conduct training for common themes and variables that affect families/resources for families, conflict resolution, and other health promotion trainings as needed.
Combat Stressors	
Has combat intensity or trauma been high?	Assess all contributing variables and their impact on morale and performance, provide feedback to command, strategize possible mitigation options. NSMP to conduct stress management and tangible/solution focused skills training.
Operational Stressors	
Is the operational tempo high for prolonged periods of time?	Assess all contributing variables and their impact on morale and performance, provide feedback to command, strategize possible mitigation options. Conduct stress management and tangible/solution focused skills training.
Is the physical environment harsh or does it contain challenges such as lack of privacy, chemical smells/exposure, isolation, sensory overload, etc.?	Identify specific issues and their impact on behavioral health and morale. Advise command to mitigate any environmental conditions when possible. Conduct health promotion trainings such as rest/exercise/diet; basic self-care; stress management.

Is there evidence of other operational issues such as boredom, repetitive work, insufficient materials for job, working outside of MOS, unclear or confusing messages and missions?	Identify specific issues and impact on behavioral health and morale, provide feedback to command. Strategize practical solutions. Conduct relevant trainings such as stress management, solution- focused skills training.
Unit Aggression & Problem Behaviors	
Is there increased incidence of irritability and conflict in the unit?	Determine level of irritability, note any contributing issues (such as lack of sleep, high operational tempo, harsh conditions, etc.) and follow up on those issues with command. Provide anger management/emotion regulation training.
Does the unit seem to be engaging in unhealthy or addictive behaviors (e.g., excessive video-gaming, gambling), or is there a high level of risky behaviors (e.g., recklessly approaching IEDs)?	Determine problem behavior status and explore any underlying causes (e.g., high op tempo or toxic leadership) and brief command on findings. Problem-solve actions command could take to mitigate problem behaviors (e.g., consider limiting access to electronics, establishing curfew, conducting UAs and/or random searches for contraband) and to mitigate any underlying causes. Conduct healthy coping skills training. Recommend that chaplain/JAG provide Ethics training.
Does the unit climate seem unsafe due to attacks, sexual assaults, hazing, or bullying?	Determine problem behavior status and explore any underlying causes (e.g., high op tempo or toxic leadership) and brief command on findings. Problem-solve actions command could take to promote a safe environment, such as zero tolerance policy, open-door policy with command, increased/improved monitoring, and traveling in pairs (especially at night), etc. NSMP to conduct relevant unit trainings, as indicated, such as anger management/emotion regulation training. Chaplain or JAG to conduct Ethics training. Coordinate with SAR for additional trainings or actions.
Unit Cohesion/Morale/Performance	
Does the unit seem to be experiencing low morale/poor unit cohesion (e.g., psychosocial conflict or avoidance, lack of teamwork, poor performance)?	Determine level of problem, note any contributing issues to low morale/poor unit cohesion and follow up on those issues with command. Consider morale promoting events. Provide interpersonal communication/conflict resolution trainings.
Unit Climate/Leadership	
Are toxic leadership issues suspected?	Monitor the health and wellbeing of commanders and leaders. Review Unit-IQ results regarding unit morale and leadership, note other contributing variables such as combat trauma, etc. Consult tele-behavioral health/or chaplain for guidance. Provide feedback to command. If needed, report concerns to higher echelon leadership through the chain of command.

Provide Feedback and Collaborate with Command on Intervention Plan

After the NSMP has completed the assessment and developed clinical and command-related recommendations, the NSMP should discuss these findings with command and together they will determine the best plan for the situation and circumstance. As discussed above, the unit and its sub-populations may be differentially affected by stressors and may require different intervention approaches. When the detailed plan has been determined, it can be implemented, evaluated, and adjusted as necessary.

Implement Plan, Evaluate and Adjust as Necessary

The intervention plan may be relatively simple or more complex, with several components, pertinent key personnel, and/or stages that require coordination. As the intervention plan is implemented, it will need to be evaluated to determine its effectiveness. This requires the NSMP and command to monitor the unit and re-evaluate its status and to

continue to gather relevant information from pertinent sources. If selected items from the Unit-IQ were administered and showed cause for concern, the same items can be re-administered to track the effectiveness of the intervention(s). The plan should be adjusted to best suit changing circumstances, such as increases or decreases in operational tempo or environmental stressors.

Unit Consult Case Vignette

Presenting Issues

An infantry platoon was highly irritable with much conflict and some fighting, motivation and performance were poor, and morale seemed low. The platoon had suffered a casualty in a firefight during a recon patrol ten days ago. The company commander had immediately conducted an after action review, but the platoon continued to show signs of stress.

Assessment

The NSMP administered the Unit-IQ survey (see Appendix H and Table 6.4 below) and received 21 anonymous responses from the platoon of 27 service members (see full results, below). To obtain a better understanding of the survey results, he conducted walkabouts and engaged in conversations with platoon members. As expected, survey results (scores range from 0-4) showed high levels of irritability (3.4), combat stressors (3.2), and poor unit morale (3.6). The survey also revealed a previously unknown issue of officer leadership concerns (3.7). Functional impact was high for behavioral health indicators (3.0), combat stressors (3.3), and highest for leadership climate concerns (3.7). Comments on the survey and follow-up conversations with service members demonstrated that unit members believed that their second lieutenant had unfairly blamed them for the casualty and was highly critical of individual service members and the team as a whole. Additionally, the second lieutenant had markedly increased their training time and had restricted their phone time with their families.

Table 6.4. Unit-IQ Survey Results.

Section I – Behavioral Health and Sleep Indicators	
Posttraumatic stress	2.2
Depression	1.3
Anxiety	1.2
Suicidal	0.2
Irritability	3.4
Behavioral health indicators functional impact	3.0
Sleep obtained	2.1
Sleep opportunity	2.6
Sleep functional impact	2.2
Section II - Combat and Operational Stressors	
Combat stressors	3.2
Combat functional impact	3.3
Operational stressors	2.9
Operational functional impact	2.7
Section III – Unit Climate and Leadership Concerns	
Unit morale	3.6
Unit morale functional impact	3.2
Sr. Enlisted climate	1.3
Officer climate	3.7

Leadership climate functional impact	3.7
Total morale/leadership score	3.6

Score Interpretation (range 0-4) and Examples			
0-0.9 Little Concern	1.0-1.9 Concern	2.0-2.9 Risk	3.0-4.0 High Risk
Not at all-Once/week	1-3 times/week	3-5 times/week	5-7 times/week
Not at all-A little bit	A little bit-Moderately	Moderately-Quite a bit	Quite a bit-Extremely
Very-Moderate Low	Moderately Low-Neutral	Neutral-Moderately High	Moderately-Very High

Interventions

The NSMP briefed the company commander, and they agreed on a number of actions. The commander temporarily relieved Second Lieutenant Green of his responsibilities and referred him for a command consult (see command consult case vignette below). He directed the senior NCO to supervise training, re-instated phone privileges for the platoon, and conducted a stand down to build morale and increase resiliency. Additionally, the chaplain conducted a traumatic event management (TEM) training, and the NSMP facilitated a morale-promoting and team-building exercise.

Command Consult: Provide Command Monitoring to Ensure Leadership Wellbeing

General Introduction to Command Consult and Monitoring

Healthy and sound leadership in general and command in particular are critical to mission success and unit wellbeing. Occasionally leaders suffer from stress, fatigue, and other conditions that may compromise their functioning. Medical providers monitor leadership's wellbeing and functioning to support unit and mission success, regardless of rank and position. Early detection, assessment, and intervention are intended to help those in leadership positions, preserve command climate, improve vertical unit cohesion, and support mission accomplishment.

Command monitoring can be a delicate process, as it might be viewed as a challenge to command's authority that could potentially threaten the mission, and unfortunately, also threaten the commanding officer's ego. Moreover, commanding officers (COs) hold a unique position of power that can be intimidating to those of lower rank, or cause problems for those under their command who may raise issues that command doesn't want to hear or address. In consideration of these possible dynamics the NSMP must understand the importance of their command monitoring function, as the safety of the unit and the success of the mission depend on optimal performance by leaders; therefore, they must be confident and stand firm in their role notwithstanding possible difference in rank issues (e.g., the NSMP is of lower rank than the commander). To this end, it is essential that the NSMP has strong, respectful relationships with the chain of command and remains objective and professional.

Additional care should be taken if the leader in question is in the NSMP's direct chain of command. These situations can be especially delicate because the leader may see the NSMP's concern as insubordination. NSMPs should consult with other peer professionals familiar with the situation (other medical, chaplain, or helping professionals) within the unit, staff the situation with a NSMP at a higher level in the organization (such as a brigade or wing surgeon), etc. These peer or technical consultations can help the NSMP sort out personal perceptions and opinions from true professional concerns.

Monitor, Detect, and Assess

Monitor the Health and Well-Being of Commanders and Leaders and Detect Any Issues

In order to effectively monitor leaders' behavioral health status, the NSMP must know the baseline status of all unit leaders and be aware of any changes. As with all monitoring actions, the NSMP can obtain information in multiple ways and from various sources, including general observations, casual conversations, active questioning, concerning reports

received from unit members and leaders, or changes in mood, behavior, or performance. The NSMP should exercise discretion in the collection of information. When the NSMP suspects behavioral health concerns in leaders and desires additional information, they may confidentially approach other senior leaders and the chaplain for their insights and observations.

Determine Best Way to Further Assess or Address a Concerning Situation

Typically, the NSMP would work most closely with the company or squadron commander in regard to behavioral health concerns with individual service members or the unit. For a command consult, if the affected leader is ranked below the commander, the NSMP may proceed with command consultation steps outlined above for individual service members and collaborate with the commander throughout the process, as is customary.

However, if it is the company or squadron commander who demonstrates concerning changes, the NSMP must proceed differently and more carefully, as they can no longer consult and collaborate with that individual, but must consult with their superior, the battalion or group/wing commanding officer. Similarly, if the battalion or group/wing commanding officer demonstrates concerning changes, the NSMP must consult with their superior, who may operate outside of the area of operation.

If the leader in question is in the NSMP's direct chain of command, prior to briefing/consulting the leader's commanding officer, it is best to pre-brief that officer's main medical advisor to garner their concurrence and support. If possible, that individual should also attend the briefing/consultation with that higher-level commander. Usually, in order to maintain proper order and discipline, the higher-level commander and the medical advisor will take over further assessment and intervention at that point. However, this depends on the situation, the environment, time, and resources available.

When concerns are identified, the NSMP and the affected leader’s commanding officer will discuss the situation and agree on the best way to proceed with addressing or further assessing the leader. If needed, the NSMP should consult with the tele-behavioral health provider at this point and share those recommendations with command.

Assess Behavioral Health and Well-Being of Commanders and Leaders

A strong, respectful relationship between NSMP and command is critical and may be leveraged for further assessment and intervention. In many cases, the NSMP can initiate a conversation with command, expressing their concerns, sharing their observations, and asking questions to obtain further information. If needed, the NSMP can refer to the clinical assessment guidelines and behavioral health screening tools for the NSMP described in Chapters 2-4.

However, if command is not receptive or responsive to the NSMP’s questions, the NSMP should discuss their concerns with the individual’s commanding officer and consult with the tele-behavioral health provider to obtain guidance on assessment options. If not contraindicated, the NSMP should speak with other senior leaders and the chaplain for additional information regarding the commander’s behavioral health status and its impact on the unit and mission. Due to the sensitive issues involved and the possible impact on the mission, the commanding officer will determine if the NSMP conducts a behavioral health evaluation with the leader in question, or if the commanding officer takes other actions to address the situation, such as mentoring the leader or coordinating resources with the medical team. If the NSMP proceeds to evaluate the leader, they will ensure the interview is voluntary, adhere to confidentiality mandates, and follow other procedures described in the individual service member consult.

If toxic leadership concerns are suspected that may be affecting unit morale and performance, the NSMP may administer relevant items to unit members from the anonymous Unit Survey – Individual Questions (Unit-IQ; Appendix H), particularly Section III – Unit Climate and Leadership Concerns, and gather survey data regarding unit concerns. If indicated, this could be followed up by walkabout voluntary interviews with service members and synthesized with the information previously gathered from the chaplain, other senior leaders, and medical personnel. If needed, the NSMP should consult with the tele-behavioral health provider for interpretation of the survey results and interview findings.

Analyze Potential Interventions and Develop Actionable Recommendations

The intervention plan will depend on several factors, including the nature of the concerning issues (e.g., simple, straightforward and situationally dependent, vs. complex and more long-standing), the attitude and receptivity of the leader with concerning issues, the rank and duties of the identified leader, the operational status of the mission, the

impact on the unit, and the availability of resources. The NSMP and the commanding officer will collaborate together and consider these factors in their development of the intervention plan.

Simple situations might involve a lack of sufficient sleep leading to increased irritability and some mild attention or memory problems, which could potentially be resolved by the commanding officer ensuring the affected leader has sufficient time to catch up on and maintain adequate sleep. A step further might entail that the affected leader take a few days to rest and replenish close to, but outside of, the unit, and be re-evaluated by a NSMP prior to return. For other relatively simple clinical conditions, the NSMP may apply the recommended "minimum/better/best" interventions from Chapters 3 and 4, consulting with a tele-behavioral health provider as needed. Additionally, command can take a host of practical actions to mitigate the underlying operational issues and stressors.

However, if the affected leader is resistant to these interventions, then the seemingly simple situation becomes complex. Other situations may start out as more complex, for example, command might experience excessive, debilitating guilt and impaired functioning after the unit suffers heavy losses in a mission.

As a rule of thumb, any complex situation involving command consultation for leaders requires that the NSMP consult with the tele-behavioral health provider and/or the chaplain for guidance, sharing observations, survey data, and related findings with them and developing feasible recommendations for action.

Provide Feedback and Collaborate with the CO to Determine Intervention Plan

After the NSMP has gathered relevant information, consulted with the tele-behavioral health provider if needed, and developed clinical and command-related recommendations, the NSMP should brief the commanding officer on their findings within 24 hours, adhering to confidentiality requirements outlined above.

The NSMP and the affected leader's commanding officer should discuss the NSMP's assessment and recommendations and determine the best plan to manage the problem, depending on the situation and circumstance. For serious concerns, the NSMP should complete a written report of the command consultation within 24 hours (see Appendix G, NSMP Behavioral Health Communication Form).

Feedback to the leader with behavioral health concerns should be delivered verbally by the NSMP and should include information regarding diagnosis, prognosis, duty limitations, recommendations, and plan. If the NSMP and commanding officer agree that it would be helpful, the NSMP may also share additional feedback such as general and anonymous observations by unit members, leaders, and medical staff; unit survey results; and the suspected impact of the leader's behavioral health issues on the unit. If desired, the NSMP may enlist the support of the chaplain or a trusted officer to accompany them to share feedback. The NSMP should employ basic communication strategies such as active listening and motivational interviewing discussed in Chapter 1.

Implement Plan, Evaluate and Adjust as Necessary

The delicate area of intervening with command may bring up special and possibly unforeseen circumstances, depending on the receptivity of the leader with behavioral health concerns and the commanding officer, as well as the nature of the presenting concerns and available intervention options. The intervention plan may include clinical and command-related interventions and may be relatively simple or more complex, with several components, pertinent key personnel, and/or stages that require coordination. As the plan is implemented, it will be evaluated as needed to determine its effectiveness. This requires the NSMP and command to monitor the leader and re-evaluate their status and to continue to gather relevant information from pertinent sources. If selected items from the Unit-IQ were administered and showed toxic leadership concerns, the same items can be re-administered to track the effectiveness of the intervention(s) and the resulting impact on the unit. The intervention plan should be adjusted as needed to suit changes in the leader's behavioral health status, such that if the leader fails to improve or worsens, stronger measures should be

taken; conversely, if the leader improves rapidly, they may resume duties sooner than expected. The NSMP should remain observant, objective, and flexible in order to quickly assess and adjust the plan.

If command monitoring and suggestions to address problematic leader behavior are met with resistance, or fit into serious categories such as hazing, etc., then the NSMP should report concerns to the higher echelon leadership through the chain of command.

Command Consult/Monitoring Case Vignette

Presenting Issues

Findings from the unit consult above indicated that Second Lieutenant Green's behavior had changed after he led a recon patrol ten days earlier in which a service member was killed in a firefight. Second Lieutenant Green became over-harsh with his platoon in words and actions, which affected their morale and performance. His extreme irritability and subsequent actions were an example of toxic leadership. The commanding officer referred him for a command consult and temporarily relieved him of his duties, pending evaluation results.

Assessment

Second Lieutenant Green voluntarily consented to be evaluated, and the NSMP followed interviewing principles from Chapter 1 such as active listening and motivational interviewing. He also shared pertinent information from the Unit-IQ survey with him. As the interview unfolded, Second Lieutenant Green broke down and admitted that he blamed himself and felt guilty for leading his platoon into the firefight. He was sleeping very poorly and had frequent nightmares of the event. Clinical screening tools indicated that Second Lieutenant Green was experiencing posttraumatic stress and sleep problems and showed signs of moderate-severe depression; however, he was not suicidal.

Interventions

After the NSMP briefed command, the commanding officer and the chaplain each met with Second Lieutenant Green to address his concerns and provide support. However, with Green's lack of sleep and general distress, the NSMP and command agreed to evacuate Second Lieutenant Green to a Role II Restoration Center, where he could rest and replenish. There, a behavioral health provider would evaluate him to determine if he could return to duty or if he required further intervention.

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Chapter 7

Behavioral Health Medical Evacuation (MEDEVAC)

Non-battle related behavioral issues are a major cause of medical evacuations from theater, behavioral health considerations play a role in all evacuations, and return to duty is less likely with increasing echelon of care. Behavioral health evacuations are common,[1,2] and in recent years were the largest proportion compared to any category of illness.[3,4] Behavioral health evacuees are commonly young, male, enlisted, first-time deployers and are often seen by behavioral health within the first six months of deployment.[5] The most common diagnosis linked to evacuation is adjustment disorder.[6,4] Secondary behavioral conditions are not as well documented, and medical conditions often involve behavioral health components. Medical transport is also an inherently stressful experience. Mental health principles and interventions are useful in every medical evacuation and particularly in behavioral health cases.

Overview of Logistical Process

Upon disposition, service members will typically be transported from Role 1 to Role 3 facilities (see Chapter 1 for available behavioral health assets at each Role). However, NSMPs may decide to transport to a Role 2 facility, if accessible, where there may be COSC assets for a holding period and restoration for low-level stress reactions. Though non-ambulance vehicles are preferred for transportation (e.g., supply vehicles), service members with behavioral health disorders are typically transported by medical vehicles (ground ambulance or medical evacuation). Service members may also be transported only if approved via casualty evacuation (CasEvac) and/or host nation medical vehicles as a last resort. For evacuation from Role 1 to Role 3 in a far-forward environment, aeromedical evacuation is preferred, but often not available due to mountainous terrain, approved airspace requirements, and landing requirements. With these limitations, far-forward assessment and intervention described in Chapters 3 and 4 and ground evacuation become the primary goals.

The majority of behavioral health MEDEVACs are considered routine. Whereas behavioral health MEDEVACs are more commonplace in non-austere environments, austere environments pose the possibility of multiple constraints that, when possible, should be considered in advance of austere far-forward troop deployment. Appropriateness, communication, and efficiency are the primary factors for quality and safety of non-emergent transport of patients,[7] particularly when there may be an unpredictable timeline for evacuating routine service members. Note that some specific requirements in certain theaters of operation may require the use of physical restraints or other measures during patient transport. Medical staff at all levels should be familiar with these processes specific to each area in order to provide accurate information to patients. Use the following steps to ensure a safe and quality evacuation:

1. Ensure the condition reaches the threshold of evacuation and could not be treated in the same location.
2. Plan for tailgate medicine and creative strategies.
3. Select appropriate escort(s).
4. Use effective communication strategies for all MEDEVACs to ensure:
    a. Commander understands their role and responsibilities.
    b. Service member understands the process.
    c. Escort understands their role and responsibilities.
    d. Receiving provider has an awareness of the presenting issues.
5. Use "tailgate medicine" for waiting periods.
6. Apply en-route behavioral health considerations for common safety challenges.

Table 7.1 includes a decision making guide that follows these steps.

Table 7.1. Decision Making Guide to Medical Evacuation.

	Decide to evacuate	
Psychosis, significant suicide risk, and/or substance dependence?	Yes	--
	Evacuate to Role 3; use strategies from Chapter 3 to maintain safety while waiting for evacuation.	Consider using strategies described in Chapter 4 before deciding to evacuate to Role 3 for any lags or delays in evacuation.
	Select an Escort	
Two non-medical attendants (NMAs) available?	Yes	No Two medical escorts are recommended for severe behavioral health issues; discuss with Command. One escort can be acceptable if there's low or no suicide/homicide risk and no agitation.
NMA is appropriate?	Yes NCO or officer of equal or greater rank, same gender (if possible), Emotionally mature, responsible, and capable.	No
	Communicate	
COMMAND understands their responsibilities and your responsibilities?	Yes	No
SERVICE MEMBER can describe the evacuation process back to you?	Yes	No
	Aware of possible timing (e.g., could take a few days), where they are going, how they are getting there, and who is going with them.	Explain to the service member until they have an understanding. If mental status is in question, ensure mature NMA is able to explain process to service member.
	Identify possible stressors en-route (e.g., boredom and uncertainty).	
NMA can describe roles and responsibilities back to you?	Yes	No

	Aware of possible timing, where they are going, when and how they return.	Discuss with NMA(s) and ensure understanding. Use back brief technique and consider having a printed NMA plan.
	Can describe service member's safety or coping plan and has a copy if possible. Aware of any buddy watch responsibilities	
RECEIVING PROVIDER can describe presenting issues and unique concerns back to you?	Yes	No Make an effort to establish contact with receiving facility or provider.
	Plan for en-route safety	
Suicide intent and/or plan?	Yes Use means restriction during waiting period and transport. -Turn weapon(s) into unit immediately. -Consider removing strings, laces, and belts. -Constant one-on-one supervision.	No Continue to monitor intent and plan; take into account past behavior.
Agitation and/or aggression?	If service member becomes agitated and verbal de-escalation fails, consider pharmacological intervention. Yes Work with service member and escort to identify triggers. If agitation is severe, consider pharmacological intervention (see Chapter 5). If agitation is severe, and pharmacological intervention not available or failed, consider physical restraint during transport.	If ambulatory and cooperative, pharmacological intervention is not needed. No Identify potential for agitation/aggression.
Substance dependence?	Yes Ensure service member is stabilized before transportation. Coordinate with Role 3 facility for stabilization medications to be administered.	No
Sedation?	Yes Monitor respiratory status (including pulse oxygen) for signs of over sedation.	No

Ensure the Condition Reaches the Threshold of Evacuation and Could not be Treated in the Same Location

The primary goal for all frontline care is return to duty, which can be accomplished using interventions discussed in Chapters 2-4. Frontline care can lead to high rates of return to duty for behavioral health issues.[8] When service members are evacuated from theater, they are unlikely to return to duty and may be more likely to separate from the military.[9] Be aware of the possible negative impact of a service member assuming a role as a patient,[10] which leads to worsening symptoms, decreased performance, and lessened likelihood of return to duty. Decision to evacuate and how to manage the service member in the meantime is a careful balance of service member need and available resources.

Medical personnel are required to inform command (IAW DODI 6490.08) when there is potential risk for harm to self, harm to others, and harm to mission. In addition to these considerations, available resources are also important. There are certain behavioral health conditions that cannot or should not be managed effectively in theater, regardless of available resources, due to continuous need for long-term evaluation and treatment:

- Psychosis not related to PTSD.
- Suicidal gesture, attempt, or high risk for suicidal behavior.
- Severe addiction and substance dependence.

Plan for Tailgate Medicine and Creative Strategies

Especially in an austere environment, service members may experience long wait times or inability to evacuate as medically necessary. Chapters 3 and 4 discuss a variety of approaches to reduce stress and improve behavioral health functioning.

Select Appropriate Escorts

Commanders are responsible for providing appropriate escorts for medical evacuations. For behavioral health issues specifically, escorts must have certain traits and characteristics. In a far-forward environment, there might be limitations with available personnel.

Course Corrections

Commanders should not select a NMA with known behavioral health concerns. At times, it might appear more efficient to send service members who experience behavioral health-related readiness issues together. However, this strategy can lead to significant obstacles to safety planning. In the event that the NMA may present with physical and/or behavioral health concerns at any time throughout the escort process, he/she will need to advise command as well as the NSMP(s) in the event that the NMA will need to be switched out.

Use Effective Communication Strategies for all Medical Evacuations

Effective communication can lead to better health outcomes, including patients managing their emotions better, making more accurate assessments, and making better medical decisions.[11,12]

The Commander Understands their Role and Responsibilities

Commanders must acknowledge and complete patient paperwork for all service members who have concerns that require higher echelon(s) and complete all medical documentation in advance of transportation for each service member. Command should be in direct contact with the higher role of care (ROC) to establish ongoing status of patient, concerns, etc. The ROCs must also communicate with command in a timely manner with regard to any status changes, concerns, etc.

The Service Member Understands the Process

Ensure that the service member understands that they are being medically evacuated and generally what to expect as they move through the process. If service members have behavioral health concerns, they may also be especially likely to experience deficits in processing information and understanding verbal information. To reduce distress and ensure a smoother transport, the NSMP should be intentional about using specific communication strategies to ensure the service member understands.

Use Kind Words and Straightforward Language

Remember that the medical evacuation may be positive news for some service members and negative news for others.

NSMP: *Our primary goal is that you and the unit remain safe. It has become clear that we need additional resources to support you. We are medically evacuating you, or transferring you, to another facility so that you can receive the support you need. What are your questions?*

Service member: *I don't think I have any.*

Back Brief

NSMP: *Okay. I need you to repeat back to me what I shared with you, just so I know we're both on the same page. Where are you going next?*

Service member: *To a different facility.*

Handout or Simple Written Information

- The escort understands their role and responsibilities.
- The receiving NSMP has an awareness of the presenting issues.

Apply En-Route Behavioral Health Considerations for Common Safety Challenges

Chapter 3 describes strategies and interventions for the most severe behavioral health issues that might emerge and also addresses agitation and suicide risk. Refer to that chapter for more detailed information on safety management.

Suicidality

Refer to Chapter 3 for risk assessment and management of service members with suicide-related thoughts, intent, or behavior. For any elevated risk, it is important to create a realistic safety plan that incorporates the escort during service member transport. At no time should a patient with behavioral health concerns be left alone. The escort and/or NSMP must remain with the patient until released for safety reasons.

Agitation and Aggression

Emergency stabilization can be used under certain conditions before and during transport to a Role 3 facility where there are more resources for full stabilization. Use the following escalation of strategies for severely agitated, or potentially violent service members. Keep in mind that physical restraint is a last resort, but it is sometimes necessary for safety.

1. Verbal reassurance and grounding (see Chapters 3 and 4).
2. Medication: Psychiatric medications can be used to effectively treat agitation, which is a short-term condition. Medications ideally strike a balance between calming and sedating effects.
3. Physical restraint: Physical restraint should be used as a last resort and only by individuals trained in safe use of physical restraint.

Substance Dependence

Ensure that the service member is medically stable before movement. See Chapter 3 for more information on intervention for acute substance intoxication and withdrawals.

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CHAPTER 8

BEHAVIORAL HEALTH IMPACT OF MASS CASUALTY INCIDENTS

The role of the military planner is to predict potential future conflicts with near peer adversaries that are likely to result in high casualty volumes. Such conflicts not only challenge the current standing of the United States as a global power but may also negatively impact our ability to adequately care for our military forces. In anticipation of being contested in all domains-- to include air, ground and cyberspace -- the concept of what is being described as the multi-domain battlefield is established.[1,2] As a result, it is essential that forces are capable of providing prolonged casualty care to potentially higher casualty numbers while also anticipating delays in medical evacuation platforms.[1] The current situational constraints of providing medical care in austere environments is often extremely difficult based on location, time constraints, and available resources. Given the many constraints of remote locations/austere environments, the previous expectation of evacuating patients within the "Golden Hour" is now nearly impossible to impossible altogether.[3] The first 60 minutes after traumatic injury which is the most crucial period that determines the patient's outcome has been termed the 'golden hour.' However, timely and adequate patient care and evacuation continue to be stressed as the primary goal. These factors are expected to result in multiple mass casualty incidents (MCIs) that NSMPs (e.g., non-specialized doctors and nurses as well as medics) will essentially be required to effectively manage while making difficult medical decisions in austere, resource limited combat zones. While much of this guidance focuses on preparing for the psychological impact of mass casualty incident in combat zones at the individual NSMP level, training in triage and mass casualty management for the entire unit is crucial to conserving force strength and lethality as well as mitigating the psychological impact of mass casualty (MASCAL) on the service members.

MCIs occur when the number of casualties and injuries exceed the available resources, requiring the implementation of triage procedures that are used to rapidly identify patient needs and distribute resources, allowing for optimal level of care to be provided to the most patients.[4,5] Examples of MCIs include school shootings such as the Sandy Hook Elementary School shooting,[4] the September 11 terrorist attack, and the recent COVID-19 pandemic. Though rare, the unpredictable nature of these events, creates a multitude of logistical challenges and presents a variety of psychological stressors and ethical challenges. Preparation for such events through rehearsals and trainings, thorough understanding of available behavioral operations resources, and coordination with leadership are crucial for providing timely care and conserving force strength.

Some of the challenges in management include difficult decisions that need to be made by the medics. For example, due to triage guidelines, attempting to maximize the overall group outcome/survival rate and ensuring mission success, it may be necessary to withhold care from likely casualties who would otherwise receive care and potentially survive in less constrained situations. Peterson, Baker, and colleagues[6] concluded that while the combat stress might make most service members vulnerable to developing Posttraumatic Stress Disorder (PTSD), military medical personnel are at an even greater risk of developing PTSD due to being exposed to a high level of significant medical and psychological

stressors in addition to combat-related stress. This additional medical stress encountered by deployed military medical personnel appears to have an even greater impact on the NSMP than combat stressors. Anywhere from 5–10% of NSMPs are considered at risk for clinically significant levels of PTSD.[6] MASCAL scenarios may intensify this risk through combat exposure and resource allocation to the most viable casualties, while withholding treatment from others in order to save the most lives. The primary objective of this chapter is to provide guidance on potential actions that could be taken by the NSMPs to prepare for and manage behavioral issues among service members and unit in the event of MASCAL events. It is also necessary for them to discuss the behavioral health impact that traumatic injury in MASCAL situations has on NSMPs in far-forward locations when specialty behavioral health care or consultation is not immediately available. Recent conflicts, such as Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF), and documents of NSMP experience have provided lessons learned that could be leveraged for this guidance. Much of the focus is on the psychological impact on the service member and secondary trauma stressors experienced by caregivers responsible for providing first-line care for service members. It is also necessary to understand and prepare for combat stress and lowered resilience, commonly encountered by military caregivers – particularly in austere environments where resources may be severely limited. For example, meeting the "Golden Hour" of patient medical evacuation to higher roles of care may not be possible. It is therefore essential that caregivers develop confidence in their decision-making skills as related to their job expectations. It is also vital that they provide effective means to allow themselves to build resilience and recognize signs of becoming overwhelmed, enabling them to seek behavioral health assistance and overcome combat stress and fatigue (prior to it becoming problematic).

Managing Impact on Traumatic Injury Survivors versus "Observers"

PTSD is one of the most common behavioral health disorders resulting from combat experience.[7] In fact, the U.S. Army Medical Materiel Development Activity estimates that 10-15% of U.S. combat-deployed service members will develop PTSD.[7] Between 2001 and 2013, an estimated 118,829 service members that deployed in support of OEF, OIF, and Operation New Dawn (OND) were diagnosed with PTSD.[7] However, while exposure to extreme traumatic experiences can elicit extreme behavioral health distress in individuals that have directly or indirectly experienced a traumatic event, it is important to note that such responses are not inevitable, as research has shown that traumatic events do not always result in adverse behavioral health outcomes. In fact, the vast majority of individuals exposed to traumatic events do not develop PTSD.[8] According to Riffle, Lewis and Tedeschi (2020),[9] some individuals that have experienced a traumatic event may become more resilient and may even experience posttraumatic growth (PTG) in response to the experience of the traumatic event. While one's military service likely offers a vast amount of different traumatic experiences than the average individual faces during their lifetime, ongoing research is continually being conducted in consideration of military populations in an effort to promote service member resilience and foster growth and to effectively manage the potential adverse impact that trauma can have on service members. This is particularly important for maintaining unit readiness.

Managing Impact on Command & Unit Readiness

Front-line NSMPs and their associated procedures, knowledge, skills, and abilities have developed significantly in the past decades thereby ensuring a medically ready force during MCIs and other emergency situations. Recent decades have seen considerable advances in trauma care (i.e. tactical combat casualty care (TCCC). More specifically, the TCCC principles were found to be "responsible for saving the lives of more than 1,000 US Service Members."[10] Similarly, the management of behavioral casualties (e.g., combat stress reactions) has improved dramatically since the 21st century.

Embedded NSMPs are uniquely placed to influence behavioral health readiness and have several advantages over specialty medical NSMPs. First, NSMPs are embedded in far-forward locations with access and trust of key unit leaders.

This proximity engenders a greater degree of buy-in from unit command and increased collaboration and provides a valuable opportunity to increase unit-level resilience, screening, and prevention measures to ensure long-term behavioral health readiness.

In far-forward locations, the access to specialty behavioral health services is limited (see Chapter 1). This section will discuss the command and unit factors, which influence the behavioral health functioning role of the NSMP in ensuring long-term unit readiness through their interaction with their units. Relatedly, trauma and the associated behavioral health impact does not discriminate between the unit's command, medical personnel, and frontline service members. It is highly probable that embedded NSMPs must make efforts to mitigate the behavioral health impact of MCIs for their command, peer service members, and for themselves. Fortunately, embedded NSMPs are well placed to provide or advise preventative measures to mitigate the impact on their formation.

Every service member experiencing trauma due to a combat event triggers a triage or sorting to align available resources with needs. However, when these needs overwhelm or surpass available resources, it becomes a mass casualty event that necessitates the launch of a series of rehearsed strategies to achieve the greatest benefit for the maximum number of affected individuals. Intensity, number of casualties, location of the unit, and the environment contribute to the estimate of caregiving capacity load. In austere environments, a single complex injury, such as blast injury with behavioral impact evidenced by panic attack and agitation as well as multiple fractures or open wound requiring surgery, can eliminate a unit's ability to deliver additional casualty care, while more than two such patients needing surgical and behavioral health care has the potential to max out unit capabilities.

Barriers to NSMPs Seeking Mental Health Care

MCIs may have a disastrous impact on a unit's readiness to accomplish its mission, through both the catastrophic damage to medical readiness and the commitment of operational resources to meet the overwhelming medical demand.[11] During MCIs, front-line NSMPs (e.g., medics, corpsmen, physician assistants) must manage limited time and inadequate resources while maximizing care for the greatest number of people. A complementary objective for NSMPs in far-forward locations is to identify soldiers who can be treated rapidly and return to duty (RTD).[4] NSMPs are a critical force multiplier in enhancing medical readiness, whether it be their assistance in evacuation of service members to specialty care NSMPs or the utilization of brief, evidence-based interventions to facilitate RTD.

Psychiatric casualties during an MCI have both short-term and long-term consequences for the medical health readiness. In the short term, the loss of experienced service members from the immediate battlefield could directly impact the success of the mission. The loss of key unit leaders at the frontline would not only directly hamper immediate operational performance, but the lag time for resupply and retraining of these leaders would reduce performance for weeks. Long-term consequences of psychiatric casualties are related to service-related disability, long-term specially care, and adverse impact on military families, including social, economic, and other quality of life impacts.[8] Despite the importance of behavioral health care, service members may be reluctant to seek such care. Reasons for the reluctance to seek care include the commitment of NSMP to serving the mission and the unit and failing to notice or ignoring functional impairments in themselves. Additional reasons include stigma and career concerns. Service members may also purposely avoid behavioral health care due to concerns about how others might view them or the potential impact on their career.

Managing Impact on Service Members and Medical NSMPs – Preventative Levels of Care

Preventative care is defined as taking place at the primary, secondary, and tertiary levels. Primary preventative strategies are interventions to mitigate the occurrence of the disease/disorder. An example of this would be the use of an immunization to increase one's resistance to a pathogen. This level of preventative care also applies to behavioral health. Military-wide initiatives to foster resilience are designed to act as primary intervention strategies to foster well-being and reduce impact on mission accomplishment. An embedded NSMP has numerous advantages to traditional specialty behavioral health services in providing primary and secondary preventative care. Primary preventative care involves interventions designed to mitigate the potential of behavioral health distress interfering with performance of the mission. Secondary preventative care involves interventions tailored to reduce the likelihood of a more severe, chronic condition developing. The final level of care, tertiary prevention, addresses a known behavioral condition, aiming to reduce symptoms and manage the condition. The following sections review the relevant domains in which an NSMP can support their unit command before, during, and following an MCI.

Pre-MCI: Primary Preventative Care

That traditional paradigm for behavioral health services has been at large hospitals centralized in outpatient clinics. This system is primarily geared towards tertiary preventative care through identification of a diagnosable behavioral condition. Trainings, as well as conducting test exercises so as to make personnel aware that their roles will change during a MASCAL, would help both service members and NSMPs be prepared in the event of a MASCAL.

Embedded NSMP Proximity: The proximity of these medical personnel to the unit's daily operations provides a comprehensive perspective in the challenges facing their formation and ample opportunity to intervene.

MCI: Secondary Preventative Care-- Early Diagnosis and Prompt Treatment. Identifying Individuals Struggling during the MASCAL

Effective management of MASCAL event requires planning, coordination, and communication. Goals of responding assets are to bring medical and other essential resources to casualties when the system within the area of operations is overwhelmed and unable to provide the desirable standard of care to all affected. Individuals, teams, units and the entire community need to be prepared to respond quickly and efficiently to prevent, moderate, or avoid both the physical and psychological impact of the MCI.

Key preventive and management steps include the 5 Rs.[12] The following section reviews the 5 Rs to prepare both the NSMP as well as the unit for successful trauma response-- namely resources, rehearsal, response, route (described in Chapter 7, MEDEVAC), and rest. Given that features of route, namely transport and accountability have been covered in Chapter 7, it will not be expanded in this chapter.

> **1. Resources:** The primary concern in the event of MASCAL is the safety of the unit. Although security of the service members is not a medical responsibility, it needs to be addressed by NSMPs at all echelons of care. Avoidable injuries to the unit, including NSMPs, can have significant impact on mission readiness. Ensuring security, e.g., confirming effective enemy action has ended before rushing to treat affected individuals, is one of the foundations of safe and effective care. The current military casualty triage and evacuation system uses a model of echelons of care described in Chapters 1 and 7. Being familiar with available resources and local host nation capabilities, which could be leveraged to augment a unit's MASCAL response, is critical. Also, having trained and ready personnel is an invaluable asset in austere environments. Since units most often have limited time together before deployment, common training can enhance cohesive unit response in theater as well as identify capable people whose skills could be leveraged in the event of a MASCAL. Finally, familiarity with medevac procedures (chapter 7), as well as competent cultural assistance, is crucial in international trauma response.

2. Rehearsal: Engaging all stakeholders to analyze and plan for the mission and choreograph a shared response which is flexible to match unique events would help in preventing chaos and facilitating coordinated care. Mnemonic MASCAL expanded as Minimize chaos (remain calm and confident), Assess (perform screening and triage described in Chapter 2), Safety (ensure safety of both affected individuals as well as taking care of self), Communication (communicate with command, peers, and affected individuals in a clear and concise manner), Alert (be on the alert for more casualties, reconstitute, and resupply; watch out for warning signs of behavioral distress in fellow service members and NSMPs) and Lost (do not lose patients or staff; maintain accountability for staff and tracking system for patients) is a useful guide in understanding the principles of management during MASCAL.[13]

3. Response: As indicated earlier, successful response depends on a prepared team that is familiar with available resources, a MASCAL plan that has been well rehearsed, and service members who can communicate effectively. It is recommended that key personnel who would be providing care have close proximity to the area of operations to help with accelerated response times. Organic resources like chaplains are an invaluable asset for the response team, especially to help with managing behavioral as well as spiritual concerns during MASCAL event. A chaplain is more likely to be physically located closer to a deployed/forward location than a behavioral health specialist. Most chaplains are trained in basic counseling and are usually familiar with common behavioral health conditions based on working closely with behavioral health counselors in prior duty assignments. Chaplains have the additional benefit of complete confidentiality, which makes this a less stigmatizing resource than traditional behavioral health. Senior members of the chain of command are better positioned to facilitate home front communication as the operational mission allows and within the constraints of available technology. These deployed resources may be able reach back and mobilize garrison resources to assist the service member's loved ones.

Behavioral health casualties during MCIs can significantly disrupt the functioning of the NSMP team by diverting resources from physically or critically injured service members. A MASCAL plan that incorporates disruptive behavioral health individual in the practice sessions will help the team to be prepared for such emergencies. Additionally, it should be remembered that members of the unit who bring in their battle buddies for care might very likely be unaware of their injuries due to the adrenaline of battle. Care NSMPs need to watch out for the warning signs and follow guidelines as indicated in Chapters 3 and 4. Having a designated behavioral health professional such as a behavioral health technician, if available, as part of the standard MASCAL response is recommended.

4 and 5. Route and Rest: Given the potential for large number of casualties in a MASCAL event, another crucial element in management of behavioral health concerns includes accountability and transport. Patient transfer guidance and associated considerations has been described in Chapter 7. However, having dedicated staff to meticulously record every patient's movement from the triage and treatment areas during MASCAL events would help with mitigating confusion and losing track of personnel or patients downrange. Additionally, a unit commander or supervisor needs to be informed on any movement of military or contract personnel. Finally, caring for the service NSMPs, especially during the reset phase when the emergency situation has ceased and the impact of the event is felt by the NSMPs, is crucial and essential. Some of the frequent or common responses include inappropriate outbursts of anger, sleep disturbance, and symptoms of depression.

Post-MCI: Tertiary Preventative Care: Managing Impact on Medical NSMPs

Multiple trauma events are stressful, not only for the injured but also for the NSMPs. Thus, care for the responding team members is essential for reset. Sleep rest cycles and meals cannot be neglected. Compassion and awareness are essential for the recovery process of the NSMP team, due to the emotional distress and potential moral injury perceptions resulting from MCIs. Unit ministry can also help with addressing the emotional, moral, and spiritual issues faced by the NSMPs. NSMP stress and burnout is described in detail in Chapter 9.

Host Nation Considerations

Of particular importance when faced with reduced medical resources and capacity is the possibility of utilizing local host nation resources whenever feasible. While this subject will not be discussed in-depth here, it is important to mention some of the significant planning considerations for general awareness. These include the host nation's respective political atmosphere and local laws or legal constraints which must be considered.

Several concerns may arise when dealing with medical and behavioral health concerns while located in another country. For example, the subject of behavioral health is often considered to be highly sensitive or taboo subject and is commonly considered unacceptable or even illegal. It is highly recommended that when researching another country's laws and health care system possible differences or concerns are noted and planned for in advance – prior to moving to the respective location. This is particularly true of austere environments, which may have views on behavioral health that are considered very traditional or outdated. As a result of prevalent stigmas or beliefs in some countries with regard to behavioral health care treatment, behavioral health care treatment is commonly shunned, nonexistent, or greatly differs from behavioral health care in the United States. As of October 2020, Human Rights Watch (HRW) indicates that 60 countries located in Asia, Africa, Europe, the Middle East, and the Americas continue to imprison or confine individuals with behavioral health concerns. One common practice is through shackling (i.e. chaining or locking individuals in confined spaces under inhumane conditions).[14]

Medical planners must also determine which medical evacuation platforms (e.g., MEDEVAC and/or CASEVAC platforms) will be used based on the capabilities and local laws (e.g., Is ground and/or airspace approved for U.S. force capabilities to perform ground or air evacuations in theater? Is the use of the host nation ground and/or air evacuation platform capabilities approved? Will "green"/military evacuation platforms be used and/or are contracted evacuation platform services available? Are there any border crossing constraints due to COVID-19 or any other concern which prevents patients being transferred from austere environments to areas with readily available and higher levels of medical response (e.g., Saudi Arabia to Camp Arifjan, Kuwait medical support/ hospital facility for further patient evacuation to Landstuhl, Germany as needed)?). In the event a geographic location is not already built up with evacuation capabilities due to troops moving into the location, it is highly recommended that U.S. military planners collaborate whenever possible with host nation liaisons and host nation medical assets and location considerations (e.g., the use of medical facilities and helipads).

Collaboration with host nation counterparts may also include contracted organizations for the use of contracted medical assets (e.g., medical personnel, evacuation platforms, etc.) and/or host nation military counterparts in the event that the host nation military assets are planned for use for MEDEVAC or air evacuation, etc. It should be noted that in the event that host nation contracted services and/or military assets will be used to assist with 9-Line requests, personnel from these assets will require advance training in English on the proper 9-Line format, and they must be trained by participating in walk-through and practical exercises before service are approved and made available for later use. The approval to use contracted and/or host nation assets would only be granted after all parties feel that this is the most viable and safest option for everyone involved.

Forward Palliative Care and Considerations Regarding Deceased

Military health care workers may be challenged by ethical issues and decisions during deployments. Often deployments were considered a departure from one's usual health care job to a foreign location. With the advent of the COVID-19 pandemic and response to other disasters such as hurricanes, floods, etc. where inclusion of military health care NSMP's has been essential, deployments now come in various environments with a multitude of mission focuses. The current health care arena has created situations where ethical issues are probably even more likely to occur and can arise when clinicians face a substantial disparity between the medical capabilities of their own medical system and that of the indigenous health system of the country in which they are deployed[15,16] identified the following six themes or ethical situations faced by military nurses during war which can be applied to any health care discipline while on deployment:

1. **Resources/allocations:** relates to the number and types of casualties, severity of injury, humanitarian efforts, and resources used to care for enemies and civilians. An ethical conflict may arise when resources are scarce, used on enemies, or used at all costs.
2. **Core values:** prioritizes the mission and needs of the military and adhering to military core values might create an ethical dilemma if the individual feels these come first over patients' needs or suffering.
3. **Code of ethics:** can provide guidance and principles for the health care NSMP to adhere to and may help prevent ethical dilemmas while deployed.
4. **Caring for the enemy:** one of the biggest sources of conflict for those who have to care for them. Showing compassion for an enemy or prisoner who may mistreat the health care NSMP, or who may be alongside an injured military member, may prove challenging for the NSMP and test them in ways like never before.
5. **Caring for civilians:** Civilians injured due to the MASCAL event, may lead to conflicts to provider, due to lack of resources, culture differences, and time commitments. This care can be taxing and may seem futile to the deployed health care NSMP.

There is a need for follow-up/closing the loop after behavioral health care NSMPs care for severely injured service members and speculate outcomes. This unknowing can create doubt and speculation of responsibility for less than optimal care outcomes. For some behavioral health care NSMPs, it is helpful to seek "the rest of the story" to come to terms with the care they provided.

Palliative care is an area of health care which often is associated with health care NSMP stress. Relieving suffering and improving quality of life are the foundational tenets of all health care NSMPs and often cause the most personal suffering. Recently, COVID-19 has exacerbated palliative care issues in military health care. In response, a group of experts have created a military health care NSMPs toolkit for addressing palliative care needs.

The final category of triage in MASCAL events involves the deceased service members. During MASCAL events, it is very likely that there may be limited or no access to a morgue. A MASCAL plan needs to include training and guidance on where to transfer the deceased and define space for the dead. It is imperative that the defined space should be outside of the treatment area and easily accessible to commanders and fellow service members who may want to pay respect to the deceased. Spaces to consider include morale welfare and a recreation tent. As indicated earlier the key to seamless management of behavioral issues during MASCAL events is advanced planning and rehearsal. The following section summarizes the behavioral health impact and potential actions that could help with managing the crisis.

Summary of Behavioral Health Considerations and Management of Impact during MASCAL

Given the examples that were previously discussed in Chapter 5, it is important to consider that such examples will introduce increased levels of stress to the NSMP as well as the respective casualty (i.e. service member) and anyone else who may directly or indirectly witness a traumatic event. With each stressful experience, even the most experienced NSMP is at an increased risk of becoming overwhelmed, as each event can have a cumulative effect. It is also important to note that an individual's stress level is subjective, based on their respective event experience of the event, their past history of traumatic exposure, whether or not they have a strong support system, and their effective coping mechanisms. As a result, something that may be considered a relatively minor event which would likely be easily overcome by one individual may have a much greater negative impact on another individual and become overwhelming. The same can be said for service members who experience the traumatic event – whether directly or indirectly.

In an attempt to assess the risk of an individual experiencing overwhelming stress levels, it is important to consider several factors that may increase the service member's risk level. These may include the respective individual's age, prior experience of highly stressful events – to include training experiences that simulate highly stressful events, or trauma, the existence of a support network, and the existence of effective coping mechanisms. While military medical NSMPs and medics may be well-versed in the effective treatment of medical concerns as a result of training they receive throughout their careers, it is important to note that non-specialty NSMPs and medics are not generally trained specifically to treat behavioral health concerns that may arise. As a result, exposure to a new, highly stressful behavioral health concern may easily become overwhelming to them in an austere environment with limited medical capabilities and/or resources. Data presented by Peterson, Baker and colleagues (2019)[6] indicates 60% or more of medical personnel reported at least a little impact when they had exposure to the following: women and children who were victims of war, wounded male patients, patients with severe burns, patients with severe burns, patients who lost a buddy, a patient with a traumatic head injury, a patient with a traumatic facial soft tissue injury, and patients who lost a leg. Although the sample in this study was limited, when large groups of medical personnel are exposed to these types of experiences, it may be particularly important to check in with them to confirm that they are coping effectively.

It is also important to consider that in the dynamic combat environment of today, technological advances have dramatically changed military operations for U.S. forces as well as for other countries. In turn, these technological advancements could significantly increase the casualty rates in any given MASCAL event. In an effort to remain current in our medical response, we must proactively plan for the detrimental effects of such advancements and assume for the worst-case MASCAL scenarios given current enemy force capabilities as well as our own medical capabilities in order to save as many lives as possible. Therefore, it is essential to gather current intelligence on enemy capabilities and plans and tie this into the medical response in advance of an actual event. In doing so, several contingency plans are recommended if case planned response becomes extremely limited or constrained altogether. This information must also routinely be communicated to command staff in order to prepare appropriately.

As a reminder, it is essential to communicate effectively throughout military operations—not only during the planning stages for a significant event (e.g., MASCAL, troop movement, etc.), but also during and after the actual event. In consideration of the various constraints that the austere environment alone will likely create, communication should be as accurate and timely as feasibly possible given the constraints. It is often difficult for individuals to recognize that they can be at an increased risk for behavioral health concerns or that they may be experiencing some of the more common warning signs associated with signs of being overwhelmed or stressed due to direct or indirect exposure to stressful events, their line of work, or just being in a new environment. This may become an even greater problem for those positions that are severely limited in an austere environment, to include NSMPs in a caregiver role, who may not readily acknowledge that they have a problem. Therefore, it is essential to consider this as a potential loss during planning for contingency operations in the event of an MCI, as additional loss or severe limitations may occur, including the loss of electricity, usual forms of communication, personnel, and/or equipment. Some of the more feasible contingency plans that have worked well in the past aimed to ensure all deploying service members are trained as combat lifesavers (CLS),

as they can assist an NSMP with basic medical lifesaving procedures—thereby, reducing the NSMPs medical workload and stress. Of special note for the CLS instruction, it is also highly recommended that the CLS trainer includes some of the more common behavioral health concerns that one might experience during a deployment, under conditions of high stress, exhaustion, etc.

A return to more traditional methods of communication should also be considered for the austere environment in particular, to include the use of daily leader/command briefs, planning visually through the use of butcher block paper, or verbal communication (as needed) instead of using technology like computers and telephone, which the current military structure relies heavily on to communicate. It is recommended that communication occurs often, with much of the stronger points being repetitive—much like MDMP for military decision-making in both tactical and garrison environments. It would be best to disseminate safety messages as well as medical and behavioral health messages in this manner to leaders for further dissemination, to include a reminder of some of the more common warning signs of becoming overwhelmed, exhausted, or mentally stressed. Another possible method for communicating and planning for future events where these messages can be relayed as reminders are through the use of After Action Reports (AARs). AARs should occur after a significant event and should include at least one representative from each section at a minimum, who will in-turn communicate information to their section members.

To sum up, combat in an austere environment can be stressful for service members making them vulnerable to anxiety, depression, and symptoms of burnout. Mass casualty events in such environments introduces additional stressors and increased exposure to potential behavioral distress such as moral injury, feelings of guilt, anger, and irritability among service members as well as NSMPs. Thus, management of the casualties as well as the behavioral impact of MCI on service members in resource constraint far-forward setting can be a challenge. Proactive interventional management, such as safety plans, training and rehearsals for triage and management in the event of MASCAL, support by peers, rest and self-care, early recognition of symptoms of behavioral distress among peers, clear communication and coordination with leadership, and leveraging of organic resources such as chaplain, along withAARs, can help with addressing potential psychological impact of MASCAL in austere settings and also provide lessons learnt for addressing issues in the future.

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Chapter 9

NSMP Stress and Burnout Management

Stress and Associated Conditions

Health care by its very nature is altruistic. It is a noble profession where selfless individuals commit their whole self to its main tenets of caring, healing, and helping others. A medical professional is more likely to experience burnout related to chronic work-related stressors because of this all-encompassing dedication.[1] Humanism and professionalism are two major motivating forces driving medical clinicians that often conflicts with the modern health care environment.[2] Health care workers can get lost in the overwhelming stress-related demand to work long shifts, complexity of patient care, demanding workloads, and challenging work environments which can take a toll on the person's whole-being—biological, psychological, and spiritual self.

Occupational stress for health care workers can result in compassion fatigue and/or burnout if stress and fatigue are unrecognized or ignored. It is important for health care workers to recognize not only the physical effects of stress but the psychological effects and its consequences. Common physical effects of stress experienced by health care workers include headache, upset stomach, rapid heart rate, and blood pressure changes.[3,4]

Psychological effects include irritability, job dissatisfaction, and depression, which may result in sleep problems or increased absenteeism.[3,4] Research consistently supports adverse health outcomes related to operational stress exposure such as depression, anxiety, substance use disorder, self-harm behaviors, suicide, and stress-related physical conditions such as heart disease and high blood pressure.[4-6]

Terms and Conditions Commonly Associated with Burnout in Health Care NSMPs

Moral distress can occur when one knows the ethical action to take but is not able to act upon it, resulting in a loss of moral integrity.[7-10] It commonly occurs in health care professionals when they must act in a way that contradicts their personal and professional beliefs and values.[11] Sources of moral distress include personal, interpersonal, professional, and environmental conflicts. Examples include working in situation where an NSMP feels they cannot deliver optimal care because of resource constraints or a lack of preparedness, disrespectful interactions with others, workplace violence, and situations where futilely or suffering is perceived.[12] Military NSMPs have additional stressors from deployment that may precipitate or exacerbate moral distress such as the physical impact of the environment, limits of personal decision-making, leadership impact, requirements to execute military operations, psychosocial expectations of military culture, disruptions of support systems, dynamics of professional relationships, and provisions of care in an operational environment.[13]

Moral distress has implications for the safe delivery of health care, recruitment, and retention of the health care NSMPs, and the operational readiness of our forces.[10,14,15] Military health care NSMPs have unique hardships that compound health care delivery and are at risk for psychological distress related to moral and ethical situations encountered within the often-unpredictable nature of military service.[10,15-17] Studies have demonstrated military health care NSMPs experience emotional exhaustion, anxiety, depression, alcohol misuse, and posttraumatic stress syndrome when exposed to battlefield health care encounters.[12-15,18,]

Moral injury occurs when a person experiences psychological consequences of betrayal by someone they regard as having legitimate authority over them in a high-stakes situation.[19,20] Moral injury is not unique to service members but is often used in describing the psychological injuries of military warfighters.[11,14,21] Military health care NSMPs are simultaneously warfighters and care NSMPs, which can lead to conflict and personal suffering. Bearing witness to, engaging in, or failing to act in situations which conflict with a military health care NSMP's values or beliefs may result in suffering leading to in an increased risk of PTSD, depression, risk of suicidality, and an overall decrease in mental and physical health well-being.[22-24]

Moral injury situations can leave a person with feelings of guilt, shame, anger, embarrassment, and suffering.[22,23] A morally injured person's worldview can change from a standpoint of safety, security, goodness, and trust of people to experiencing helplessness, guilt, shame, and fear as a result of a threat to his/her life or the life of someone else.[22,23]

Compassion fatigue is a natural consequence of working with traumatized clients or those who experience extremely stressful events and results from giving high levels of energy and compassion without experiencing the positive outcome of seeing patients improve.[11,25,26] It is caused by the prolonged or continuous exposure to these stressful events or by a single very intense event and is compounded by moral distress.[11,25,26] It consists of two components: frustration from the inability to act in accordance with one's beliefs and fear of reliving the stressful traumatic episode.[25] Compassion fatigue results in decreased job satisfaction and can lead to burnout and secondary traumatic stress. Symptoms include anger, apathy, cynicism, irritable mood, reduced empathy, decreased tolerance, feeling overwhelmed, reduced sense of accomplishment, difficulty concentrating on job duties, inability to pay attention to detail, poor sleep, flashbacks, exhaustion, isolation, and poor coping.[25]

Compassion satisfaction is a fulfillment an individual derives from helping others -- a result from feeling empathy. It results in positive and emotional consequences such as feeling strength from having helped, satisfaction with one's own situation and the work that was done, encouragement by work, and continued desire to assist others. Compassion satisfaction mitigates burnout and increases job satisfaction.[27,28]

Secondary trauma develops in health professionals who come into continuous and close contact with trauma survivors, while experiencing considerable emotional disruption themselves, and becoming indirect victims of trauma.[28,29] Secondary trauma includes behaviors and emotions experienced as a result of exposure to another's trauma such as irritability, inability to concentrate, anger, intrusive or recurrent disturbing thoughts, and sleep disturbances.[28,29]

Signs and Causes of Burnout in Medical NSMPs

Burnout is a syndrome characterized by emotional exhaustion, depersonalization (i.e. cynicism), and a low sense of contribution to the work or mission.[30] It is an occupational syndrome driven by the work environment. Burnout among health care NSMPs relates to their well-being, the quality of life of their patients, and caring effectiveness.[31,32,4]

Work-Related Causes

Burnout related to occupation can be grouped into subcategories such as work process in efficiencies, workload, lack of connectedness with unit, unit climate, and toxic leadership to name a few.[4,24,26,31,33,34]

Highlighted below are some of the characteristics of these stressors.

Work Process Inefficiencies

The following contribute burnout among service members:

- Repetitive and monotonous work.
- Long hours and lack of breaks or ability to disconnect from work.
- Administrative burden.
- Extremes in temperature or noise along with poorly designed technologies or lack of connectivity in remote and austere environments.4,26,31-34,

Excessive Workloads (Mental and Physical)

Across many industries, there is ample evidence that excessive workloads leads to increased worker stress and is associated with decreased job performance. In deployed settings, long work hours, rotating shifts, overnight call frequency, patient ratios, inadequate staffing,[26] frequency of surprising or unexpected events such as MASCAL, and high degree of unfinished tasks and missed care due to staffing restrictions and limited resources, impact the behavioral health of the NSMP evidenced by burnout.[35-37]

Additional Stressors

An inability to participate in decisions that affect the work environment or quality of leadership can also contribute to burnout among NSMPs. This can also occur in a unit climate where there is no recognition achievement, unfair management practices or unclear procedures for allocating rewards or promotion, and a lack of leadership qualities from an inadequate or low-quality supervisor.[32-34]

Finally, a frequent lack of ability or complete inability to resolve ethical dilemmas, especially during combat or during MASCAL events, has also been cited to impact the behavioral health of NSMP.[35-37] Causes related to the professional demands of either military and/or medical professionals that contribute to burnout include working with patients with extreme pain, life-threatening injury or wound, local/national medical needs, air evacuations, traumatic brain, spinal cord or neurologic injury, behavioral health needs, suicide ideation or attempts, death by suicide, mass casualty events, death, futile or catastrophic care, wounded or injured children, triaging medical cases, humanitarian missions, and infectious disease outbreaks.[35-37]

Personal Causes

In additional to occupational exposures and stress, several personal causes for burnout have been identified. Indicators include sustained physical or psychological effort without time for recovery coupled with feelings of isolation or lack of support from colleagues;[31-34,26,4] feeling underutilized and lacking confidence; not taking care of self, evidenced by skipping meals or breaks, lack of sleep, and having a strong internal drive to prioritize work over other important aspect of life; and an inability to disengage or disconnect from work or working excessive hours repeatedly.[31-34,26,4] Military nurses were found to experience more burnout than their civilian counterparts because of the additional professional duties and obligations of military status.[12-14]

Consequences of Burnout in Medical Personnel

Quality and safety are impacted when burnout is high[32,33] and can result in medical error, medical malpractice suits, health care associated infections, patient mortality ratios, lower perceived quality of interpersonal teamwork, decreased patient satisfaction, patient drop out, service member separation from duty, and loss of productivity—all of which impact the readiness of mission.[4,26,31-34] Burnout of military health care NSMPs can significantly and negatively affect force readiness. There is a great deal of pressure involved with being a primary or sole caregiver (e.g., due to medical personnel shortages in the austere environment, etc.). They are often highly valued, sought out for guidance, and making significant life-saving decisions – all of which can become overwhelming for someone who is often not well-versed in being the only caregiver available to treat the injured and dying.[4,31-34]

Managing Burnout

As discussed above, burnout is not a result of personal failure. It is due to a stressful environment that can force difficult decisions and cause moral distress to add up over time. However, there are some things that individuals can do personally and for each other that reduce the impact. Self and buddy care followed by a focus on organizational and systems-level change may be needed when burnout occurs.[4,31]

Self-Care

Self-care includes general activities that can reduce many types of personal distress.[4,33,34] These activities may include physical activity and exercise, social time with others, and pleasurable activities, like watching a favorite television show or playing a card game.[4,33,34] Also, a person may reach a threshold in which professional mental health intervention is needed and may seek services based on the resources available (see Chapter 1).

In high stress environments, conflict within a medical team may increase. The ability of an individual to manage conflict well is an aspect of positive self-care.[37,38] It is important to recognize the difference between conflict and abusive behavior. Components that would indicate behavior is abusive include

1. the behavior is physically threatening,
2. the behavior is causing or likely to cause harm or damage to people or property, and
3. the behavior is verbally abusive. Examples include racist, sexist, homophobic statements, or name-calling, etc. [37,38]

Recognizing the underlying need may help to de-escalate the situation quickly. Acceptance of the inevitability of conflict in most situations and learning how to best recognize and addressing it will likely produce more positive outcomes than taking it personally or unloading an already stressed colleague. The DELUDE Coping Model can be used to help improve your coping strategy when conflict arises: **D**on't take it personally, **E**ngage with the person, **L**isten, **U**nderstand the problem and **D**eal with it, and **E**scalate the concern if necessary. [37,38]

Buddy Care

When social support is high at work, burnout levels are lower. [39] Demonstrating high levels of compassion or care for others in the workplace is associated with positive outcomes both personally and in the workplace.[39] In the deployed work context, buddy care might include joking or using humor, engaging with one's buddies and asking them how they

are doing, writing encouraging notes for them to find, and talking about non-work-related topics, such as sharing stories about first and favorite experiences. [39]

As noted above, engaging positively as a buddy or co-worker might involve helping to manage conflict within one's team. Getting needs met means the listener must find ways to understand the full scope of the conflict. One suggested measure is the **LOWLINE Model for effective listening: Listen, Offer, Wait, Look, Incline, Nod, Express:**[40-43]

- **Active listening (L)** constitutes a very important first step in de-escalating behaviors like anger, but also include other methods of detecting emotions like non-verbal clues, tone, inflection, and volume.
- **Offer (O**) open-ended questions to communicate listening, such as, "What happened after that?" "Can you tell me what your experience was" "What other thoughts are you having right now?" Anything that causes the person to explain rather than argue usually helps to decrease the intensity of the encounter. [40-43]
- **Wait (W);** avoid the temptation to fill the silence when someone is talking.
- **Look (L)** at someone while they speak; eye contact is important but also can be too much. It's a personal judgement and usually gets better with experience in difficult conversations. Also, use your others body parts to convey listening, e.g. arms open and not crossed over body, smile, nod, sometimes a gentle touch on shoulder, arm, or upper back is appropriate—if you don't know what to do, then remain neutral in your expression.
- **Incline (I);** use an incline of the head to convey interest. A slightly inclined head often presents a non-threatening posture.
- **Nod (N)** an occasional and appropriate nod can indicate continued attention while the other person is talking.
- **Good listeners express (E)** a desire to understand empathy. Keep it brief and to the point (i.e. "I can see why you felt that way" or "It must be hard to be going through that"). Paraphrasing can be an effective way to convey empathy.

Organizational, System, and Process Change

Organizational and systems-level change is the most effective intervention for burnout. Every attempt to reduce redundancy and inefficiencies in the system is essential. With regard to an austere context, these organizational factors might include policy, patient flow, and leadership. Every team member might play a role in streamlining processes and reducing the amount of added administrative burden or decision-making to high stress situations. Maslach and Leiter (2005) describe six areas in which a person and system may be out of sync with each other:[44]

Table 9.1. Six Areas of Person/System Conflict: Maslach and Leiter (2005).

Area	Mismatch	Possible Remedy
Workload	Too much work &/or not enough resources	Reasonable, achievable, and safe
Control	Micromanagement, lack of influence, & accountability without power	Engaged & involved workforce
Reward	Not enough pay, acknowledgement, or satisfaction	Adequate compensation & recognition for a job well done
Community	Isolation, conflict, & disrespect	A sense of true teamwork & meaningful relationships
Fairness	Discrimination & favoritism	No discrimination or tolerance of favoritism
Values	Ethical conflicts and meaningless tasks	An ideal match of aligned passion & purpose

One frame for buffering against burnout is called distributed leadership which focuses on a culture of "empower and encourage" rather than "command and control."[45,46] This culture includes minimal rules to focus on a few high-level outcomes by giving control to others, ensuring they have competency and clarity of mission to safely assume the controls, providing regular feedback, and suggesting appropriate responses to those who are empowered to act. Cultivating a local environment addressing the six areas described in Table 9.1 falls back on best leadership practices.

- HHS toolkit: https://www.hhs.gov/surgeongeneral/priorities/health-worker-burnout/index.html
- Defense technical information center toolkit: https://apps.dtic.mil/sti/trecms/pdf/AD1186189.pdf
- VA toolkit: https://www.ptsd.va.gov/professional/treat/care/toolkits/provider/

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Chapter 10

Metrics and Outcome Data

During a 10-year surveillance period, 853,060 active-component service members were diagnosed with at least one disorder; of these individuals, 435,898 (51.1%) were diagnosed with behavioral health disorders in more than one diagnostic category. Overall, there were 1,672,809 incident diagnoses of behavioral health disorders in all diagnostic categories. Rates of incident diagnoses of at least one behavioral health disorder decreased by 6.2% over the period, from 981.2 cases per 10,000 person years in 2007 to 920.6 cases per 10,000 person years in 2016.

Of the active-duty service members who receive a behavioral health diagnosis, the vast majority of incident diagnoses are adjustment disorder (27.9%), depressive disorder (16.8%), anxiety disorder (14.9%), "other mental health disorder" (14.6%), alcohol-related disorder (9.9%), and posttraumatic stress disorder (PTSD) (8.3%).[1]

Mental health utilization is tracked through the Theater Medical Data Store (TMDS). TMDS includes individual inpatient and outpatient records for those treated in an operational environment and for patients who continue care at Level 4 facilities, such as Landstuhl Regional Medical Center. Behavioral health evacuation information is found in U.S. Air Force Transportation Command Regulating and Command & Control Evacuation System.[2]

Many of these conditions are assessed during the Periodic Health Assessment (PHA) and the mental health assessments (MHAs). MHAs are administered annually during the PHA, pre-deployment (within 120 days prior to deployment), every 180 days during deployment, post-deployment (30 days before and 30 days after return from deployment), and between 181 days and 18 months after return from deployment. Additional options for tracking behavioral health include the Behavioral Health Data Portal (BHDP). BHDP is a standardized assessment platform that administers various measures via a clinic computer kiosk before each behavioral health appointment in U.S. Army outpatient clinics. This system was initially implemented in 2012 and is now mandatory at all behavioral health treatment facilities, but is separate from the electronic medical record. Assessments administered by the BHDP include standardized measures of anxiety, depression, PTSD symptoms, alcohol use, marital distress, and suicidality. However feasibility and access to BHDP in austere environments might be a challenge.[3,4]

Conditions in Deployed Settings

Depressive Disorders

Estimates of the prevalence rate of depression after returning home from combat (3 to 12 months post-deployment) range from 9% to 31% (depending on the level of functional impairment reported).[5] A meta-analysis of 25 studies[6] estimated that the prevalence of recent major depression among U.S. military personnel was 12.0% among currently deployed, 13.1% among previously deployed, and 5.7% among never deployed. Factors associated with depression were being female, enlisted, young (ages 17 to 25), unmarried, and having less than a college education.

Metric and Outcome Recommendations

Recommend tracking diagnostic utilization of depressive disorders [International Classification of Disease, 10 (ICD-10) diagnoses of F32 (Major depressive disorder, single episode) and F33 (Major depressive disorder, recurrent)] in theater using TMDS.[7] In addition, responses from Patient Health Questionnaires, which are available in theater, (described in Chapter 2, see Appendix B for the full screener) surrounding a deployment during the MHAs and PHAs should be monitored. Depression is screened during the PHA and MHA in three stages. Stage 1 assessment includes the Patient Health Questionnaire (PHQ-2). The PHQ-2 is a valid and reliable two-item screening tool for depression in primary care settings. If the service member answers "more than half the days" or "nearly every day" on either question on the PHQ-2, the result is a positive screen. The deployer is then required to complete additional questions in Stage 2 on the Patient Health Questionnaire 8 (PHQ-8) detailing his/her depressive symptoms. If the initial screenings for depression are negative, the deployer will not answer additional depression questions in Stage 2, but will proceed directly to the Stage 3 (person-to-person) NSMP interview. Stage 3 of the assessment for depression consists of the person-to-person interview with the health care NSMP, involving direct interaction with the deployer to review and clarify answers provided in Stages 1 and 2.

Anxiety Disorders

Approximately 218,000 incidents of anxiety disorders were diagnosed among the active component of the U.S. Armed Forces -- a rate that steadily increased over the past 13 years. During the 13-year surveillance period, there were 217,409 incident diagnoses of anxiety disorders among active component service members.[8] The incidence rate of anxiety disorders among active-duty military was 14.9% during a 10-year surveillance period.[1]

Metric and Outcome Recommendations

Recommend tracking diagnostic utilization of anxiety disorders [ICD-10 diagnoses of F40 (phobic anxiety disorders), F41 (other anxiety disorders), and F42 (obsessive-compulsive disorder)] in theater using TMDS. When given, scores from the Generalized Anxiety Disorder Scale (GAD-7), described in Chapter 2 (and Appendix B), should also be monitored.

PTSD

Mental health conditions were common in military populations prior to the initiation of combat operations in Iraq (OIF) and Afghanistan (OEF). A study (Cameron, 2019)[9] examined trends between 1999 and 2008 in the incidence rate of physician-diagnosed PTSD in active-duty military personnel utilizing data from the Defense Medical Surveillance System (DMSS). During the study period, 52,771 incident cases of PTSD among active-duty US military personnel were documented in DMSS. The rate of PTSD was relatively stable prior to the initiation of combat operations in Iraq in March 2003; however, a substantial increase in the rate was observed in subsequent years. The average annual increase in the incidence rate of PTSD was 5.02% (95% CI: 1.85, 8.29%) between 1999 and 2002. Following the initiation of combat operations in Iraq the average annual increase in the rate of PTSD was 43.03% (95% CI: 40.55, 45.56%). Compared to the baseline period between 1999 and 2002, the incidence rate of PTSD in 2008 was nearly seven times higher (RR = 6.85, 95% CI: 6.49, 7.24). The observed increase in the incidence rate of PTSD following the initiation of OIF is likely due to the substantial increase in combat exposure and potentially the stressors associated with deployment experienced by active-duty military populations during this time period.[9]

Metric and Outcome Recommendations

Recommend tracking diagnostic utilization of PTSD (ICD-10 diagnoses of F43.1) in theater using TMDS. Responses from Posttraumatic Stress Disorder Checklist for DSM-5 and the Posttraumatic Stress Disorder Checklist – Civilian, given during the MHAs and PHAs should be annually monitored. Like depression, PTSD is assessed in three stages during the MHA and PHA. Stage 1 of the PTSD assessment involves the administration of the five item Primary Care PTSD Screen (PC-PTSD, included in Appendix B) questionnaire. This self-report tool is a valid and reliable screening measure for PTSD in a primary care setting. If the self-report responses for the initial questions for PTSD in Stage 1 are positive (two or more symptoms in the PC-PTSD scale are marked "yes"), they will trigger additional screening questions in Stage 2. Stage 2 consists of gathering more detailed information about the symptoms of PTSD through the administration of the PTSD Checklist-Civilian version (PCL-C). If the Stage 1 screening for PTSD is negative, the deployer will not answer the

additional PTSD questions in Stage 2, but will proceed directly to the Stage 3. During Stage 3, the health care NSMP conducts a person-to-person interview with the deployer to review and clarify the deployer's responses, addresses any specific behavioral health concerns raised by the deployer, provides reassurance and information, and/or makes a referral for further assessment or treatment (if needed).

Alcohol-Related Disorder

While alcohol misuse is dependent on access to alcohol, which is strictly controlled while on deployments, frequent heavy drinking, defined as consuming five or more drinks on one or more occasions per week, occurs among a substantial proportion of U.S. military personnel. Additionally, access to alcohol, although controlled in deployed environments, is still available through local nationals. Among service members with behavioral health diagnosis, the incidence rate of alcohol-related disorders among active-duty military was 9.9% during a 10-year surveillance period.[1] In 2005, a total of 43.2% of active-duty military personnel reported past-month binge drinking, resulting in 29.7 episodes per person per year. In all, 67.1% of binge episodes were reported by personnel aged 17-25 years (46.7%), and 25.1% of these episodes were reported by underage youth (aged 17-20 years). Heavy drinkers (19.8%) were responsible for 71.5% of the binge-drinking episodes and had the highest number of annual per-capita episodes of binge drinking.[10] More than 101,000 active-duty troops ended up in the hospital between 2009 and 2018 because of a problem related to excessive drinking. About half of them had potentially deadly alcohol poisoning — caused by drinking too much in a short period of time — 35% sought care for alcohol dependence disorders, 17% for alcohol-related injuries, and over 10% for alcohol-induced psychosis, according to the study in the Defense Health Agency's monthly publication. While the incidence rate of alcohol-related medical encounters declined 14% over the 10-year period, there was an increase in 2011 and 2012 — a period that corresponded with a surge in troop levels in Afghanistan. Once the surge ended, the rate of alcohol-related encounters declined.[11]

Metric and Outcome Recommendations

Recommend tracking the utilization of alcohol misuse (ICD-10 F10 series (alcohol-related disorders)) during deployment, with a particular focus on alcohol withdrawal symptoms (ICD-10 code F10.130). Responses from the Alcohol Use Disorders Identification Test-Consumption (AUDIT-C) given during the MHAs and PHAs assessment should be annually monitored. Alcohol use is assessed in Stage 1 of the MHA and PHA using the AUDIT-C, a three-item screening tool that is a valid and reliable scale for detecting heavy drinking and/or active alcohol use disorder in a primary care setting. Unlike PTSD and depression, there are no additional Stage 2 questions for alcohol use. A positive screen in Stage 1 goes directly to Stage 3. Like PTSD and depression, Stage 3 consists of the person-to-person interview with the health care NSMP involving direct interaction with the deployer to review and clarify answers provided in Stages 1 and 2, as well as provide brief intervention, alcohol education, and make a referral, if necessary.

Medical Evacuations Out of Theater

Behavioral health evacuations are common events as reviewed by the Armed Forces Health Surveillance Center (AFHSC) and other researchers.[8,12] According to Military Health System statistics, from 2015 to 2020, there were 700 to 1,000 behavioral medical evaluations each year for about 600 to 800 individuals (Table 10.1).

Table 10.1. Aeromedical Evacuations with a Behavioral Health Disorder Listed as the Primary Diagnosis.

Year	Behavioral Health Medical Evaluations	Individuals Evacuated
2015	911	628
2016	928	690
2017	896	649
2018	1002	769
2019	904	655
2020	753	610
Total	5,394	4,001

Rundell noted that behavioral medical evaluations accounted for 10.1% of all medical evacuations between 2001 and 2004.[13] The AFHSC published that 11.6% of all medical evacuations between 2003 and 2011 were behavioral health-related in nature. In their research work, Williams et al. discussed that nearly one-fifth (19.2%) of all medical evacuations between the years 2013-2015 (CENTCOM) were for behavioral health disorders.[1,8] Overall, behavioral health conditions accounted for more medical evacuations than any other injury or illness.[1] Females accounted for a higher proportion of medical evacuations for behavioral health disorders (25.5% of all medical evacuations) relative to males (18.2%). Williams et al. further noted that adjustment reaction (three-digit ICD-9 code: 309) was the most frequent diagnosis during the initial medial encounter following medical evacuations for behavioral health disorders.

Metric and Outcome Recommendations

Recommend tracking behavioral health evacuations from theater as a function of all disease non-battle injury (DNBI) casualties reporting by year and country or operation.

Suicide Deaths in Deployed Settings

Suicide surveillance was standardized across the services in 2008 using the Department of Defense Suicide Event Report (DoDSER) system. Initially, only suicide deaths were required for reporting. This expanded in 2010 to include both deaths by suicide and suicide attempts. The data summary below (see Table 10.2) presents the number and proportion of submitted forms reporting death by suicide or a suicide attempt, by calendar year, where the event occurred in a deployed environment. The data are specific to active-component service members.

Table 10.2. DoDSER Suicide and Suicide Attempts Forms Submitted: Numbers and Proportions by Year.

Year	Suicide		Suicide attempt	
2010	27	(9.5%)	58	(6.7%)
2011	24	(8.4%)	35	(3.7%)
2012	25	(5.9%)	32	(3.4%)
2013	12	(3.5%)	30	(2.6%)
2014	13	(4.6%)	30	(2.7%)
2015	3	(1.0%)	14	(1.2%)
2016	11	(3.7%)	45	(3.6%)
2017	6	(1.4%)	34	(2.3%)
2018	10	(2.1%)	21	(1.4%)
2019	9	(2.8%)	37	(2.3%)
2020	13	(2.6%)	30	(1.9%)
2021	4	(1.0%)	24	(1.7%)

Metric and Outcome Recommendations

Recommend continuing to track suicide data through the DoDSER. In addition, regularly monitor responses to Patient Health Questionnaire-9 (PHQ-9) and the Suicide Risk Evaluation.[15] The PHQ-9 is a self-administered 9-item depression measure in which patients respond “0” (not at all) to “3” (nearly every day) on each of the nine Diagnostic and Statistical Manual of Mental Disorders (4th ed.) (DSM-IV) criteria. The PHQ-9 has been evaluated as a diagnostic screen for a depressive disorder and as a measure of depression severity.[16,17] Results from the Columbia Screening assessment should also be monitored, when collected. All these assessment screeners are available in theater, described in Chapter 2 and Appendix B.

Combat and Operational Stress Reactions

Combat and operational stress reactions (COSRs) are defined as the physical, emotional, cognitive, or behavioral reactions, adverse consequences, or behavioral health injuries of service members who have been exposed to stressful or traumatic events in combat or military operations. They vary in severity and are sensitive to operational conditions such as combat intensity, duration, frequency of combat exposure, rules of engagement, leadership styles, quality of communications, unit morale, unit cohesion, and perceived importance of the mission. Doctrinally, COSRs do not represent behavioral health disorders (e.g., PTSD) or other medical conditions.[18]

Metric and Outcome Recommendations

DOD Instruction 6490.05 *Maintenance of Psychological Health in Military Operations*, 2020, was developed to standardize combat and operational stress control initiatives in the Military. Currently, there are no established outcome metrics common to all services.[19]

Outcome metrics of COSR programs, including use of embedded behavioral health providers, should be modelled on the metrics for the clinical conditions mentioned above as well as use of screeners described in Chapter 2.

Sleep Disruption and Deprivation

Incidence of sleep disturbances in military personnel and veterans who served in overseas contingency operations vary widely from roughly 30% to 93.5%.[5,20,12,21] Additionally, active military personnel have different rates of insomnia and obstructive sleep apnea when compared to their retired peers. Active-duty military personnel have a relatively lower rate of insomnia at 24.2%.[23,24] These conditions commonly persist upon returning from military combat operations. Insomnia can greatly decrease combat readiness and can contribute to vehicle accidents and other safety risks. Amongst those diagnosed with insomnia or other sleep disorders, roughly 63.6% also meet the criteria for obstructive sleep apnea once they have returned from combat.[22,24]

Metric and Outcome Recommendations

The primary tool used to track insomnia and other sleep disorders is the Epworth Sleepiness Scale (ESS; described in chapter 2 and also in Appendix B), which is a self-administered eight-item questionnaire which asks respondents to rate their chances of having dozed off while performing in eight different activities during the previous month on a scale of 0 to 3. It is recommended that the ESS be administered upon immediately returning from Overseas Contingency Operations. In addition, we recommend monitoring the number of deployed service members seeking care for sleep-related issues in theater.

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Appendix A: Clinical Interview Questions

Basic Demographics

Rationale: This information will give you context for the presenting issues. For example, some behavior issues might be relatively normal or expected for specific ages. You may already know the unit, military occupation code, and deployment-related information.

- How old are you?
- Are you married or do you have a partner?
- Do you have children or other dependents?
- What's your job? How long have you been in this position?
- How long have you been deployed?

Stress and Recent Trauma Exposure

Rationale: This information will give you a sense of their daily stress experience and to what extent recent events may contribute to their current state. For example, if they were recently in a fire fight, then some sleep disturbance or emotional outbursts may be normal.

- What's been on your plate recently?
- What kinds of stress have you been dealing with? [ask follow-up questions with considerations of financial, legal, and family stressors]
- Have you had any recent intense stressors where you felt helpless and out of control? [not necessary to get into detail; use question to get a sense of recent trauma exposure without delving into the event]

Substance Use

Rationale: This information will help you rule out whether their current behavior may be related to withdrawal or acute intoxication.

- Have you ever needed treatment for drug or alcohol use that you couldn't control?
- Have you ever had significantly more alcohol than you wanted?
- How much caffeine do you have on a daily basis?
- Have you ever used illegal drugs? Have you recently used any drugs?
- Have you ever had a history of an alcohol problem?

Violence or Suicide

Rationale: Past suicide or homicide related behavior are predictors of risk and future behavior. If the service member previously engaged in self- or other-directed violent behavior then they are significantly greater risk. Look towards Chapter 3 for suicide risk interventions.

- Have you ever had thoughts of suicide?
- If yes, have you thought of how you would do it?
- Have you ever acted on those thoughts? Have you ever attempted suicide?

- Have you ever had thoughts of harming or killing someone else?
- Have you ever acted on those thoughts?
- History of behavioral health issues

Rationale: This information will help you understand whether the presenting issue might be part of a history of behavioral health issues. For example, if the person previously had an adjustment disorder diagnosis, it may be unresolved or alternatively you may be able to help remind them of skills they've already learned. If they have a more severe behavioral health history, then that might lead you to consider medical evacuation more quickly.

- Have you ever seen behavioral health before? If yes, what were you seen for?
- Do you recall receiving any behavioral health diagnosis before?
- Have you ever been hospitalized for a behavioral health reason?

History of Neurological/Other Medical Issues

Rationale: This information will help you rule out whether cognitive symptoms or other behavior changes may be due to medical conditions rather than behavioral health or environmental issue.

- What other medical diagnoses have you had?
- Have you ever been diagnosed with a neurological issue? (e.g., seizures, migraines, other head injury)

APPENDIX B: SCREENERS

GAD-7 Anxiety

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days		Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2		3
2. Not being able to stop or control worrying	0	1	2		3
3. Worrying too much about different things	0	1	2		3
4. Trouble relaxing	0	1	2		3
5. Being so restless that it is hard to sit still	0	1	2		3
6. Becoming easily annoyed or irritable	0	1	2		3
7. Feeling afraid, as if something awful might happen	0	1	2		3

Column totals _____+ _____+ _____+ +_____

Total score _____

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

SCORING

Scores are calculated by assigning scores of 0, 1, 2, and 3 to the response categories, respectively, of "not at all," "several days," "more than half the days," and "nearly every day."

Scores are summed across all items. Scores can range from 0 to 21, and higher scores indicate higher levels of anxiety. The score ranges are:

- 0 – 4 = minimal anxiety
- 5 – 9 = mild anxiety
- 10 – 14 = moderate anxiety
- 15 – 21 = severe anxiety

Scores greater than or equal to 10 are categorized as having probable GAD.

PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "□" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

For office coding: Total Score _____= _____= _____+ _____+

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Patient Health Questionnaire- 9 (PHQ-9) Scoring

Scores are calculated by assigning scores of 0, 1, 2, and 3, to the response categories of "not at all," "several days," "more than half the days," and "nearly every day", respectively. Scores are summed across all items. Scores can range from 0 to 27, and higher scores indicate higher levels of depression. The score ranges are:

- 0 – 4 = minimal depression
- 5 – 9 = mild depression
- 10 – 14 = moderate depression
- 15 – 19 = moderately severe depression
- 20 – 27 = severe depression

Scores greater than or equal to 10 are categorized as having probable major depression.

PHQ 4

PHQ 4				
Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Little interest or pleasure in doing things	0	1	2	3
4. Feeling down, depressed, or hopeless	0	1	2	3

For office coding: Total Score _____= _____+ +_____ +_____

Couples Satisfaction Index (CSI-4)

Please indicate the degree of happiness, all things considered, of your relationship.

Extremely Unhappy	Fairly Unhappy	A Little Unhappy	Happy	Very Happy	Extremely Happy	Perfect
0	1	**2**	**3**	4	**5**	6

I have a warm and comfortable relationship with my partner

Not At All True	A Little True	Some-What True	Mostly True	Almost Completely True	Completely True
0	1	2	3	4	5

How rewarding is your relationship with your partner?

Not at all	A little	Some-what	Mostly	Almost Completely	Completely
0	1	2	3	4	5

In general, how satisfied are you with your relationship?

Not at all	A little	Some-what	Mostly	Almost Completely	Completely
0	1	2	3	4	5

SCORING

Scores are summed across all items. Scores can range from 0 to 21. Higher scores indicate higher levels of relationship satisfaction. Scores below 13.5 suggest notable relationship dissatisfaction.

Epworth Sleepiness Scale

How likely are you to nod off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you haven't done some of these things recently, try to work out how they would have affected you. It is important that you answer each question as best you can.

Use the following scale to choose the most appropriate number for each situation.

	Would never nod off 0	Slight chance of nodding off 1	Moderate chance of nodding off 2	High chance of nodding off 3
Sitting and reading				
Watching TV				
Sitting, inactive, in a public place (e.g., in a meeting, theater, or dinner event)				
As a passenger in a car for an hour or more without stopping for a break				
Lying down to rest when circumstances permit				
Sitting and talking to someone				
Sitting quietly after a meal without alcohol				
In a car, while stopped for a few minutes in traffic or at a light				

SCORING

Scores are summed across all items. Scores can range from 0 to 24, and higher scores indicate higher levels of daytime sleepiness. The score ranges are:

- 0 – 5 = lower normal daytime sleepiness
- 6 – 10 = higher normal daytime sleepiness
- 11 – 12 = mild excessive daytime sleepiness
- 13 – 15 = moderate excessive daytime sleepiness
- 16 – 24 = severe excessive daytime sleepiness

Scores of ranging from 11 – 24 represent increasing levels of excessive daytime sleepiness.

Primary Care PTSD Screen for DSM-5 (PC-PTSD-5)

Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. For example:

- a serious accident or fire
- a physical or sexual assault or abuse
- an earthquake or flood
- a war
- seeing someone be killed or seriously injured
- having a loved one die through homicide or suicide

Have you ever experienced this kind of event? YES NO

If no, screen total = 0. Please stop here. If yes, please answer the questions below with yes or no.

In the past month, have you…

1. Had nightmares about the event(s) or thought about event(s) when you did not want to? ____
2. Tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)? ____
3. Been constantly on guard, watchful, or easily startled?____
4. Felt numb or detached from people, activities, or your surroundings? ____
5. Felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused? _____

SCORING

Scores can range from 0 to 5. Scores are summed across all items, and higher scores indicate higher probability of PTSD. Scores greater than or equal to 3 may detect probable PTSD.

Columbia Suicide Severity Scale (C-SSRS)

	Past 1 month	
1. Have you wished you were dead or wished you could go to sleep and not wake up?		
2. Have you actually had any thoughts about killing yourself?		
If yes to 2, answer questions 3, 4, 5, and 6 If no to 2, go directly to question 6.		
3. Have you thought about how you might do this?		
4. Have you had any intention of acting on these thoughts of killing yourself, as opposed to you have the thoughts but you definitely would not act on them?	High risk	
5. Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?	High risk	
Always ask question 6	Lifetime	Past 3 months
6. Have you done anything, started to do anything, or prepared to do anything to end your life? Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, held a gun but changed our mind, cut yourself, tried to hang yourself, etc.		High risk

SCORING

The C-SSRS is made up of ten categories, all of which maintain binary responses (yes/no) to indicate a presence or absence of the behavior.

There are no specified clinical cutoffs for the C-SSRS due to the binary nature of the responses to items. When an item is endorsed, the clinician must pose follow-up inquiries to obtain additional information.

BASIS-24® (Behavior And Symptom Identification Scale)

Instructions to Staff: Please fill in the following information completely.

Client ID: __ __ __ __ __ __ __ __ __ __

HCO ID: __ __ __ __ __

Admission / Intake Date: __ __ /__ __/__ __

Time Point:

1. ☐ Admission/Intake
2. ☐ Mid-treatment
3. ☐ Discharge termination
4. ☐ Post-treatment follow-up

Level of Care:

1. ☐ Inpatient
2. ☐ Outpatient
3. ☐ Partial/day hospital
4. ☐ Residential

Program Type or Unit: __ __

Instructions to Respondents:

This survey asks about how you are feeling and doing in different areas of life. Please check the box to the left of your answer that best describes yourself during the ***PAST WEEK.*** Please answer every question. If you are unsure about how to answer, please give the best answer you can.

EXAMPLE: ***During the past week,*** **how much difficulty did you have sleeping?**

0. ☐ No difficulty
1. ☐ A little difficulty
2. ☑ Moderate difficulty
3. ☐ Quite a bit of difficulty
4. ☐ Extreme difficulty

During the PAST WEEK, how much difficulty did you have…

1. Managing your day-to-day life?

0. ☐ No difficulty
1. ☐ A little difficulty
2. ☐ Moderate difficulty
3. ☐ Quite a bit of difficulty
4. ☐ Extreme difficulty

2. Coping with problems in your life?

0. ☐ No difficulty
1. ☐ A little difficulty
2. ☐ Moderate difficulty
3. ☐ Quite a bit of difficulty
4. ☐ Extreme difficulty

3. Concentrating?

0. ☐ No difficulty
1. ☐ A little difficulty
2. ☐ Moderate difficulty
3. ☐ Quite a bit of difficulty
4. ☐ Extreme difficulty

During the PAST WEEK, how much of the time did you…

4. Get along with people in your family?

0. ☐ None of the time
1. ☐ A Little of the time
2. ☐ Half of the time
3. ☐ Most of the time
4. ☐ All of the time

5. Get along with people outside your family?

0. ☐ None of the time
1. ☐ A Little of the time
2. ☐ Half of the time
3. ☐ Most of the time
4. ☐ All of the time

6. Get along well in social situations?

0. ☐ None of the time
1. ☐ A Little of the time
2. ☐ Half of the time
3. ☐ Most of the time
4. ☐ All of the time

During the PAST WEEK, how much of the time did you…

7. Feel close to another person?

- 0 ☐ None of the time
- 1 ☐ A Little of the time
- 2 ☐ Half of the time
- 3 ☐ Most of the time
- 4 ☐ All of the time

8. Feel like you had someone to turn to if you needed help?

- 0 ☐ None of the time
- 1 ☐ A Little of the time
- 2 ☐ Half of the time
- 3 ☐ Most of the time
- 4 ☐ All of the time

9. Feel confident in yourself?

- 0 ☐ None of the time
- 1 ☐ A Little of the time
- 2 ☐ Half of the time
- 3 ☐ Most of the time
- 4 ☐ All of the time

During the PAST WEEK, how much of the time did you…

10. Feel sad or depressed?

- 0 ☐ None of the time
- 1 ☐ A Little of the time
- 2 ☐ Half of the time
- 3 ☐ Most of the time
- 4 ☐ All of the time

11. Think about ending your life?

- 0 ☐ None of the time
- 1 ☐ A Little of the time
- 2 ☐ Half of the time
- 3 ☐ Most of the time
- 4 ☐ All of the time

12. Feel nervous?

- 0 ☐ None of the time
- 1 ☐ A Little of the time
- 2 ☐ Half of the time
- 3 ☐ Most of the time
- 4 ☐ All of the time

***During the PAST WEEK*, how often did you…**

13. Have thoughts racing through your head?

- 0 ☐ Never
- 1 ☐ Rarely
- 2 ☐ Sometimes
- 3 ☐ Often
- 4 ☐ Always

14. Think you had special powers?

- 0 ☐ Never
- 1 ☐ Rarely
- 2 ☐ Sometimes
- 3 ☐ Often
- 4 ☐ Always

15. Hear voices or see things?

- 0 ☐ Never
- 1 ☐ Rarely
- 2 ☐ Sometimes
- 3 ☐ Often
- 4 ☐ Always

16. Think people were watching you?

- 0 ☐ Never
- 1 ☐ Rarely
- 2 ☐ Sometimes
- 3 ☐ Often
- 4 ☐ Always

17. Think people were against you?

- 0 ☐ Never
- 1 ☐ Rarely
- 2 ☐ Sometimes
- 3 ☐ Often
- 4 ☐ Always

***During the PAST WEEK*, how often did you…**

18. Have mood swings?

- 0 ☐ Never
- 1 ☐ Rarely
- 2 ☐ Sometimes
- 3 ☐ Often
- 4 ☐ Always

19. Feel short-tempered?

- 0 ☐ Never
- 1 ☐ Rarely
- 2 ☐ Sometimes
- 3 ☐ Often
- 4 ☐ Always

20. Think about hurting yourself?

- 0 ☐ Never
- 1 ☐ Rarely
- 2 ☐ Sometimes
- 3 ☐ Often
- 4 ☐ Always

During the *PAST WEEK*, how often…

21. Did you have an urge to drink alcohol or take street drugs?

- 0 ☐ Never
- 1 ☐ Rarely
- 2 ☐ Sometimes
- 3 ☐ Often
- 4 ☐ Always

22. Did anyone talk to you about your drinking or drug use?

- 0 ☐ Never
- 1 ☐ Rarely
- 2 ☐ Sometimes
- 3 ☐ Often
- 4 ☐ Always

23. Did you try to hide your drinking or drug use?

- 0 ☐ Never
- 1 ☐ Rarely
- 2 ☐ Sometimes
- 3 ☐ Often
- 4 ☐ Always

24. Did you have problems from your drinking or drug use?

- 0 ☐ Never
- 1 ☐ Rarely
- 2 ☐ Sometimes
- 3 ☐ Often
- 4 ☐ Always

ABOUT YOU

25. How old are you? ____

26. What is your sex?

- 1 ☐ Male
- 2 ☐ Female

27. Are you…

- 1 ☐ Hispanic or Latino
- 2 ☐ NOT Hispanic or Latino

28. What is your racial background?

- 1 ☐ American Indian or Alaskan native
- 2 ☐ Asian
- 3 ☐ Black or African-American
- 4 ☐ White/Caucasian
- 5 ☐ Native Hawaiian or other Pacific Islander
- 6 ☐ Multiracial or other (specify)

29. How much school have you completed?

- 1 ☐ 8th grade or less
- 2 ☐ Some high school
- 3 ☐ High school graduate/GED
- 4 ☐ Some college
- 5 ☐ 4-year college graduate or higher

30. Are you now…

- 1 ☐ Married
- 2 ☐ Separated
- 3 ☐ Divorced
- 4 ☐ Widowed
- 5 ☐ Never married

31. Outside of your treatment providers, what is your main source of social support?

- 1 ☐ wife, husband, or partner
- 2 ☐ Other family (parents, children, relatives)
- 3 ☐ Friends/roommates
- 4 ☐ Community/church
- 5 ☐ Other
- 6 ☐ No one

32. Where did you sleep in the past 30 days?

- 1 ☐ Apartment or house
- 2 ☐ Halfway house/group home/board and care home/residential center/supervised housing
- 3 ☐ School or dormitory
- 4 ☐ Hospital or detox center
- 5 ☐ Nursing home/assisted living
- 6 ☐ Shelter/street
- 7 ☐ Jail/prison
- 8 ☐ Other (fill in)_____

33. At any time in the past 30 days, did you work at a paying job?

- 1 ☐ No
- 2 ☐ Yes, 1 – 10 hours per week
- 3 ☐ Yes, 11 – 30 hours per week
- 4 ☐ Yes, more than 30 hours per week

34. At any time in the past 30 days, did you work at a volunteer job?

1☐ No
2☐ Yes, 1 – 10 hours per week
3☐ Yes, 11 – 30 hours per week
4☐ Yes, more than 30 hours per week

35. At any time in the past 30 days, were you a student in a high school, job training, or college degree program?

1☐ Yes
2☐ No

36. Do you now receive disability benefits; for example, SSI, SSDI, or other disability insurance (Check one or more)

1☐ No
2☐ Yes, I receive disability for medical reasons
3☐ Yes, I receive disability for psychiatric reasons
4☐ Yes, I receive disability for substance abuse

37. Today's Date: __ __ /__ __/__ __

THANK YOU VERY MUCH!

SCORING

Scores can be calculated as an overall score, or individual subscale scores. The questions are scored on a 5-point scale (from 0 to 4) and each subscale and overall mean scores also range from 0 to 4, with 0 being the lowest severity of symptoms and 4 being the highest severity of symptoms Higher scores indicate greater symptom/problem levels.

THE MOOD DISORDER QUESTIONNAIRE

Instructions: Please answer each question to the best of your ability.

	YES	NO
1. Has there ever been a period of time when you were not your usual self and...		
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	○	○
...you were so irritable that you shouted at people or started fights or arguments?	○	○
...you felt much more self-confident than usual?	○	○
...you got much less sleep than usual and found you didn't really miss it?	○	○
...you were much more talkative or spoke much faster than usual?	○	○
...thoughts raced through your head or you couldn't slow your mind down?	○	○
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	○	○
...you had much more energy than usual?	○	○
...you were much more active or did many more things than usual?	○	○
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	○	○
...you were much more interested in sex than usual?	○	○
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	○	○
...spending money got you or your family into trouble?	○	○
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	○	○
3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights? *Please circle one response only.* No Problem Minor Problem Moderate Problem Serious Problem		
4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	○	○
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	○	○

SCORING THE MOOD DISORDER QUESTIONNAIRE (MDQ)

The MDQ was developed by a team of psychiatrists, researchers and consumer advocates to address a critical need for timely and accurate diagnosis of bipolar disorder, which can be fatal if left untreated. The questionnaire takes about five minutes to complete, and can provide important insights into diagnosis and treatment. Clinical trials have indicated that the MDQ has a high rate of accuracy; it is able to identify seven out of ten people who have bipolar disorder and screen out nine out of ten people who do not.[1]

A recent National DMDA survey revealed that nearly 70% of people with bipolar disorder had received at least one misdiagnosis and many had waited more than 10 years from the onset of their symptoms before receiving a correct diagnosis. National DMDA hopes that the MDQ will shorten this delay and help more people to get the treatment they need, when they need it.

The MDQ screens for Bipolar Spectrum Disorder, (which includes Bipolar I, Bipolar II and Bipolar NOS).

If the patient answers:

1. **"Yes"** to seven or more of the 13 items in question number 1;

AND

2. **"Yes"** to question number 2;

AND

3. **"Moderate"** or **"Serious"** to question number 3;

you have a positive screen. All three of the criteria above should be met. A positive screen should be followed by a comprehensive medical evaluation for Bipolar Spectrum Disorder.

ACKNOWLEDGEMENT: This instrument was developed by a committee composed of the following individuals: Chairman, Robert M.A. Hirschfeld, MD – University of Texas Medical Branch; Joseph R. Calabrese, MD – Case Western Reserve School of Medicine; Laurie Flynn – National Alliance for the Mentally Ill; Paul E. Keck, Jr., MD – University of Cincinnati College of Medicine; Lydia Lewis – National Depressive and Manic-Depressive Association; Robert M. Post, MD – National Institute of Mental Health; Gary S. Sachs, MD – Harvard University School of Medicine; Robert L. Spitzer, MD – Columbia University; Janet Williams, DSW – Columbia University and John M. Zajecka, MD – Rush Presbyterian-St. Luke's Medical Center.

[1] Hirschfeld, Robert M.A., M.D., Janet B.W. Williams, D.S.W., Robert L. Spitzer, M.D., Joseph R. Calabrese, M.D., Laurie Flynn, Paul E. Keck, Jr., M.D., Lydia Lewis, Susan L. McElroy, M.D., Robert M. Post, M.D., Daniel J. Rapport, M.D., James M. Russell, M.D., Gary S. Sachs, M.D., John Zajecka, M.D., "Development and Validation of a Screening Instrument for Bipolar Spectrum Disorder: The Mood Disorder Questionnaire." *American Journal of Psychiatry* 157:11 (November 2000) 1873-1875.

Altman Self-Rating Mania Scale (ASRM)

Name _____ Date _____

Instructions:

1. There are 5 statements groups on this questionnaire: read each group of statements carefully.
2. Choose the one statement in each group that best describes the way you have been feeling for the past week.
3. Check the box next to the number/statement selected.
4. Please note: The word "occasionally" when used here means once or twice; "often" means several times or more and "frequently" means most of the time.

Question 1

- ☐ 0 I do not feel happier or more cheerful than usual.
- ☐ 1 I occasionally feel happier or more cheerful than usual.
- ☐ 2 I often feel happier or more cheerful than usual.
- ☐ 3 I feel happier or more cheerful than usual most of the time.
- ☐ 4 I feel happier or more cheerful than usual all of the time.

Question 2

- ☐ 0 I do not feel more self-confident than usual.
- ☐ 1 I occasionally feel more self-confident than usual.
- ☐ 2 I often feel more self-confident than usual.
- ☐ 3 I feel more self-confident than usual.
- ☐ 4 I feel extremely self-confident all of the time.

Question 3

- ☐ 0 I do not need less sleep than usual.
- ☐ 1 I occasionally need less sleep than usual.
- ☐ 2 I often need less sleep than usual.
- ☐ 3 I frequently need less sleep than usual.
- ☐ 4 I can go all day and night without any sleep and still not feel tired.

Question 4

- ☐ 0 I do not talk more than usual
- ☐ 1 I occasionally talk more than usual.
- ☐ 2 I often talk more than usual.
- ☐ 3 I frequently talk more than usual.
- ☐ 4 I talk constantly and cannot be interrupted

Question 5

- ☐ 0 I have not been more active (either socially, sexually, at work, home or school) than usual.
- ☐ 1 I have occasionally been more active than usual.
- ☐ 2 I have often been more active than usual
- ☐ 3 I have frequently been more active than usual.
- ☐ 4 I am constantly active or on the go all the time.

Permission for use granted by EG Altman, MD

Scoring

1. Sum items 1-5
   - A cutoff score of 6 or higher indicates a high probability of a manic or hypomanic condition (based on a sensitivity rating of 85.5% and a specificity rating of 87.3%).
   - A score of 6 or higher may indicate a need for treatment and/or further diagnostic workup to confirm a diagnosis of mania or hypomania.
   - A score of 5 or lower is less likely to be associated with significant symptoms of mania.

2. As a self-report measure of clinical efficacy, items 1-5 should be summed to give a total score, which then may be compared to subsequent total scores during and after treatment.

Psychometric Properties

Specificity of 85.5

Sensitivity of 87.3[1]

1. Altman EG, Hedeker D, Peterson JL, Davis JM. The Altman self-rating mania scale. Society of Biological Psychiatry 1997; 42:948-955.

Rapid Mood Screener (RMS)

Are you among the millions of people who have depressive symptoms? Answer the following questionnaire about your medical history and provide it to your doctor or nurse to assist in an important conversation about your mood.

Please select one response for each question. You can complete the **RMS** in less than 2 minutes.

Patient Name _____ Date _____

	YES	NO
1. Have there been at least 6 different periods of time (at least 2 weeks) when you felt deeply depressed?	☐	☐
2. Did you have problems with depression before the age of 18?	☐	☐
3. Have you ever had to stop or change your antidepressant because it made you highly irritable or hyper?	☐	☐
4. Have you ever had a period of at least 1 week during which you were more talkative than normal with thoughts racing in your head?	☐	☐
5. Have you ever had a period of at least 1 week during which you felt any of the following: unusually happy; unusually outgoing; or unusually energetic?	☐	☐
6. Have you ever had a period of at least 1 week during which you needed much less sleep than usual?	☐	☐

Rapid Mood Screener (RMS)

GUIDE FOR HEALTH CARE PROFESSIONALS

Approximately 70% of patients with bipolar I disorder (BP-I) are initially misdiagnosed, with a mean delay of 5 to 10 years between illness onset and diagnosis. Most commonly patients are misdiagnosed with major depressive disorder (MDD).[1,2]

The Rapid Mood Screener (RMS) was developed by a team of multidisciplinary experts (primary care clinician, psychiatry nurse practitioner, psychiatrists, pharmacist, behavioral therapists, psychometricians and health economists) to provide a pragmatic approach to address the need for timely and accurate evaluation of bipolar disorder. The screener was validated in a study of patients with BP-I and MDD.[3]

Clinical Utility

The RMS is a brief self-report screening instrument for BP-I that should take less than 2 minutes to complete. A positive screen should be followed by a comprehensive evaluation.

Scoring & validity*

"YES" responses to 4 or more of the 6 items is considered a positive screen providing high confidence for BP-I, with an estimated 88% sensitivity, 80% specificity, and 84% accuracy

Sensitivity = percentage of patients who have BP-I disorder that are correctly identified as positive

Specificity = percentage of patients who do not have BP-I and who are correctly identified as negative

Accuracy = percentage of patients correctly predicted as BP-I or not

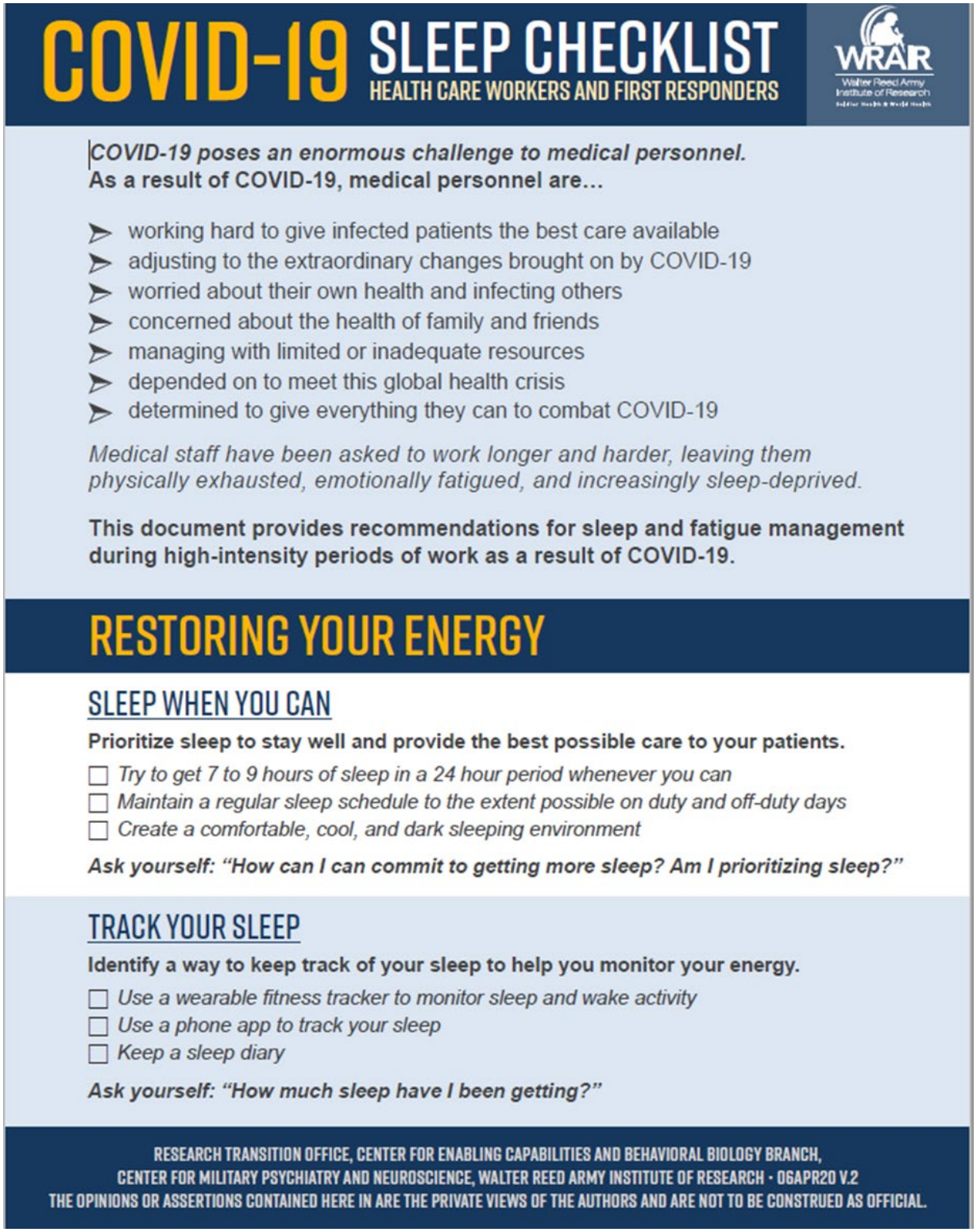
*"YES" to 3 or more of the 6 items also suggests a higher likelihood of BP-I than MDD with an estimated 97% sensitivity, 59% specificity, and 77% accuracy

1. Hirschfeld, RM et al. J Clin Psychiatry. 2003; 64(2):161-174.
2. Berk M, et al. J Affect Disord. 2007;103(1-3):181-186.
3. McIntyre RS, et al. Curr Med Res Opin. 2020 (in press).

Appendix C: Mental Status Exam

Domain	Content	NSMP Observations	Direct Questions
Appearance and Behavior	Hygiene, eye contact, interpersonal style, dress	Appearance: Do they look put together? Are they wearing the right uniform? Do they appear showered/clean relative to others in the same location? Behavior: candid, cooperative, defensive, engaging, guarded, hostile, open, relaxed, resistant, shy, withdrawn Eye contact: fleeting, good, none, inconsistent	N/A
Mood and affect	Affect: Observed emotional state. Mood: Self-reported emotional state.	Affect: Do they seem agitated? Do they appear flat? Are they tearful? What are their facial expressions?	Mood: How is your mood? Have you felt sad/discouraged lately? Have you felt energized/out of control lately?
Motor Activity	Facial expressions, movements, and posture	Are they pacing, wringing hands, unable to sit still? Are they moving and responding noticeably slow?	N/A
Orientation	Ability to recognize their place in time and space	Are they able to recognize where they are?	What year/month/day is it? Where are we? What is your name? When were you born?
Speech	Rate of speaking, volume, emotional tone, and word choice within norms according the person's background	Do they appear to speaking rapidly or slowly? Do they have any notable aspects to their manner of speech?	N/A
Thought processes	Goal-oriented organization of thoughts	Circum-referential: do they go through multiple related thoughts before arriving at the answer? Disorganized: Do they move from one topic to another incoherently? Tangential: Do they listen and discuss related thoughts but never answer the questions?	N/A

Appendix D: Sleep Checklist for Health Care Workers and First Responders, Tactical Naps



COVID-19 SLEEP CHECKLIST

HEALTH CARE WORKERS AND FIRST RESPONDERS

WRAIR
Walter Reed Army Institute of Research

COVID-19 poses an enormous challenge to medical personnel.
As a result of COVID-19, medical personnel are…

- working hard to give infected patients the best care available
- adjusting to the extraordinary changes brought on by COVID-19
- worried about their own health and infecting others
- concerned about the health of family and friends
- managing with limited or inadequate resources
- depended on to meet this global health crisis
- determined to give everything they can to combat COVID-19

Medical staff have been asked to work longer and harder, leaving them physically exhausted, emotionally fatigued, and increasingly sleep-deprived.

This document provides recommendations for sleep and fatigue management during high-intensity periods of work as a result of COVID-19.

RESTORING YOUR ENERGY

SLEEP WHEN YOU CAN

Prioritize sleep to stay well and provide the best possible care to your patients.

- ☐ *Try to get 7 to 9 hours of sleep in a 24 hour period whenever you can*
- ☐ *Maintain a regular sleep schedule to the extent possible on duty and off-duty days*
- ☐ *Create a comfortable, cool, and dark sleeping environment*

Ask yourself: "How can I can commit to getting more sleep? Am I prioritizing sleep?"

TRACK YOUR SLEEP

Identify a way to keep track of your sleep to help you monitor your energy.

- ☐ *Use a wearable fitness tracker to monitor sleep and wake activity*
- ☐ *Use a phone app to track your sleep*
- ☐ *Keep a sleep diary*

Ask yourself: "How much sleep have I been getting?"

RESEARCH TRANSITION OFFICE, CENTER FOR ENABLING CAPABILITIES AND BEHAVIORAL BIOLOGY BRANCH,
CENTER FOR MILITARY PSYCHIATRY AND NEUROSCIENCE, WALTER REED ARMY INSTITUTE OF RESEARCH · 06APR20 V.2

Appendix D: Sleep Checklist for Health Care Workers and First Responders, Tactical Naps

SLEEP IN THE DARK

Manage light to help you get better sleep and be more alert when you are awake.

- ☐ *Block light with eye masks and dark window shades to promote sleep*
- ☐ *Use light to prompt wakefulness: Open a window, turn on the lights, or use a light box*
- ☐ *Set your phone's blue-light settings to match your work/sleep schedule*

Ask yourself: "Am I using light to manage my sleep and optimize my alertness?"

TAKE A BREAK

Give your mind a break during waking hours to restore your energy.

- ☐ *Build in mental breaks: Walk outside, look at nature, or engage in a fun activity*
- ☐ *Find brief moments during the day to practice mindfulness and deep breathing*
- ☐ *Eat healthy foods and don't skip meals if you can avoid it*

Ask yourself: "Am I finding time to take care of myself and give myself a break?"

MONITOR CAFFEINE USE

Know when and how much caffeine to use to help you maintain your energy.

- ☐ *Limit caffeine intake to 400mg per day—about two medium (16oz) cups of coffee*
- ☐ *Try to avoid caffeine 6 hours prior to sleeping*
- ☐ *To reduce your caffeine use, decrease gradually. For coffee drinkers, mix caf & decaf*
- ☐ *Remember: Caffeine use is not a substitute for sleep!*

Ask yourself: "How much caffeine am I using? Am I using it wisely?"

TAKE NAPS

If you can't get a full night's sleep, then take naps when you can.

- ☐ *Take a 20-minute power nap to restore your energy*
- ☐ *Take a longer nap to catch up on sleep*
- ☐ *Shake off that groggy feeling after a nap with some caffeine to get back in gear*

Ask yourself: "When and where can I catch a quick nap?"

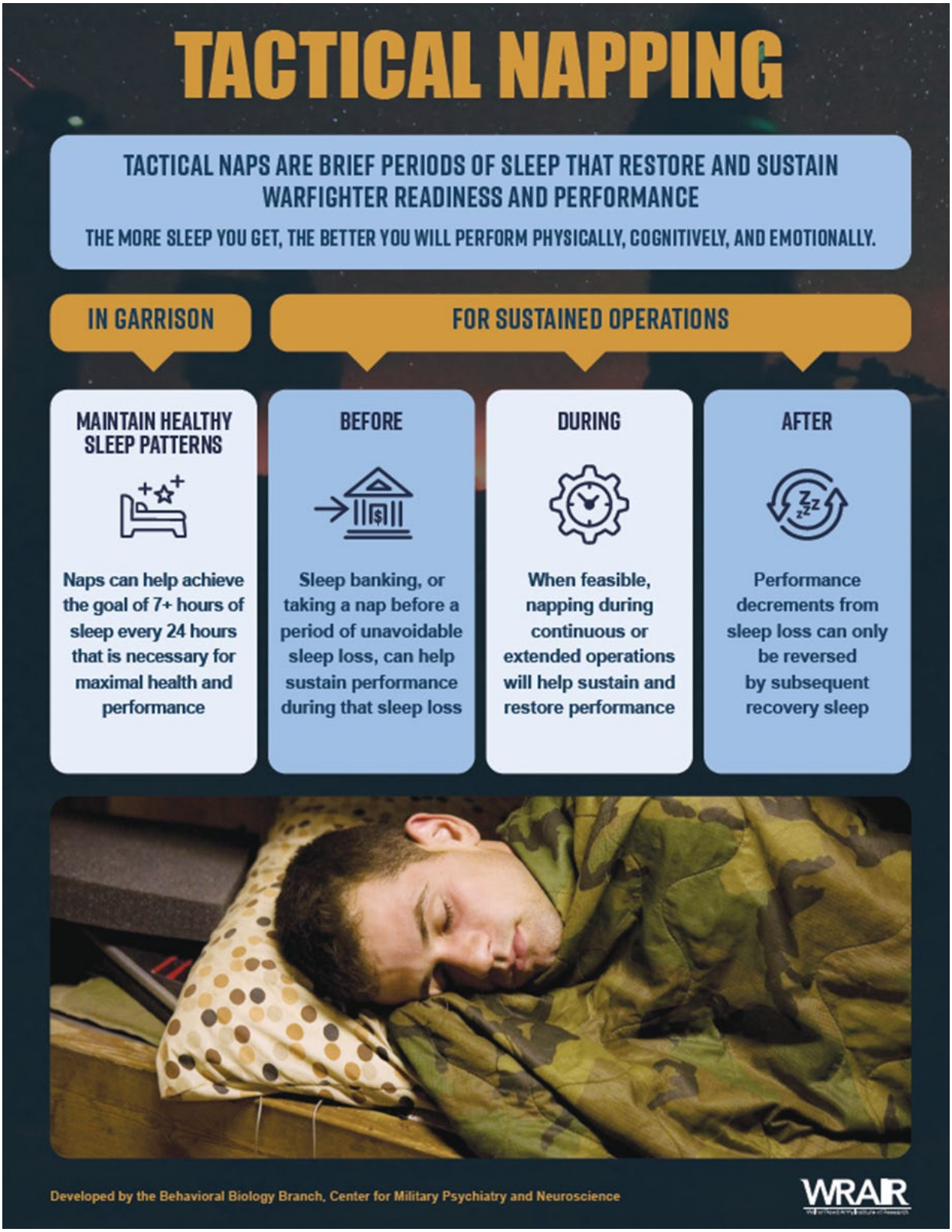
INVEST IN SLEEP

You can incur a sleep debt for a little while, but your body will need to catch up.

- ☐ *Sleep longer than you normally would on days off to try to catch up as much as possible*
- ☐ *Bank sleep ahead time to prepare yourself for long periods without sleep*

Ask yourself: "Am I in sleep debt? Am I investing in sleep?"

Selected references: Bonnet et al. (2005). The use of stimulants to modify performance during sleep loss: a review by the sleep deprivation and Stimulant Task Force of the American Academy of Sleep Medicine. Sleep, 28(9), 1163-1187. | Cocker et al. (2016). Compassion fatigue among healthcare, emergency and community service workers: A systematic review. International journal of environmental research and public health, 13(6), 618. | Martin-Gill et al. (2018). Effects of napping during shift work on sleepiness and performance in emergency medical services personnel and similar shift workers: a systematic review and meta-analysis. Prehospital emergency care, 22(sup1), 47-57. | Pigeon et al. (2003). Distinguishing between excessive daytime sleepiness and fatigue: toward improved detection and treatment. Journal of Psychosomatic Research, 54(1), 61-69.


TACTICAL NAPPING
TACTICAL NAPS ARE BRIEF PERIODS OF SLEEP THAT RESTORE AND SUSTAIN WARFIGHTER READINESS AND PERFORMANCE
THE MORE SLEEP YOU GET, THE BETTER YOU WILL PERFORM PHYSICALLY, COGNITIVELY, AND EMOTIONALLY.
IN GARRISON
FOR SUSTAINED OPERATIONS
MAINTAIN HEALTHY SLEEP PATTERNS
Naps can help achieve the goal of 7+ hours of sleep every 24 hours that is necessary for maximal health and performance
BEFORE
Sleep banking, or taking a nap before a period of unavoidable sleep loss, can help sustain performance during that sleep loss
DURING
When feasible, napping during continuous or extended operations will help sustain and restore performance
AFTER
Performance decrements from sleep loss can only be reversed by subsequent recovery sleep
Developed by the Behavioral Biology Branch, Center for Military Psychiatry and Neuroscience
WRAIR

TIPS FOR MAXIMIZING TACTICAL NAPPING IN THE OPERATIONAL ENVIRONMENT

CONSIDER THE SLEEPING ENVIRONMENT

- A disruptive sleeping environment can increase awakenings and prevent deep, restorative sleep.
- Try to nap in an environment that is dark, quiet, cool, with good air quality, and with a comfortable sleeping surface.
- DO NOT ATTEMPT TO NAP IN FRONT OF, BEHIND, OR UNDERNEATH TRUCKS OR VEHICLES.

TAKE A CAFFEINE NAP (CAFF NAP/NAPPUCCINO)

- Because the alerting effects of caffeine in coffee or energy drinks can take ~15-20 minutes to kick in, ingesting caffeine immediately before a short nap can result in awakening in about 20 minutes feeling refreshed and alert.
- During sustained or extended operations, if an opportunity for a short nap arises, caffeine naps may reduce post-awakening grogginess and disorientation ("sleep inertia").

AVOID THE NAP DANGER ZONE

DANGER

- Avoid napping too close to bedtime, as this may interfere with nighttime sleep.
- If naps are consistently impacting nighttime sleep, consider taking shorter, earlier, and/or fewer naps.

MINIMIZE SLEEP INERTIA (THAT GROGGY FEELING AFTER A NAP)

ZZZ

- Sleep inertia severely impacts alertness and performance.
- If possible, wait 10-20 minutes after awakening before engaging in critical cognitive tasks.
- If a 10-20 minute delay is not possible, caffeine chewing gum* can reduce sleep inertia in about 5 minutes (quicker than coffee or energy drinks).

*DID YOU KNOW?

Military Energy Gum, developed at WRAIR, comes as part of "extra rations" that can be ordered for your unit!

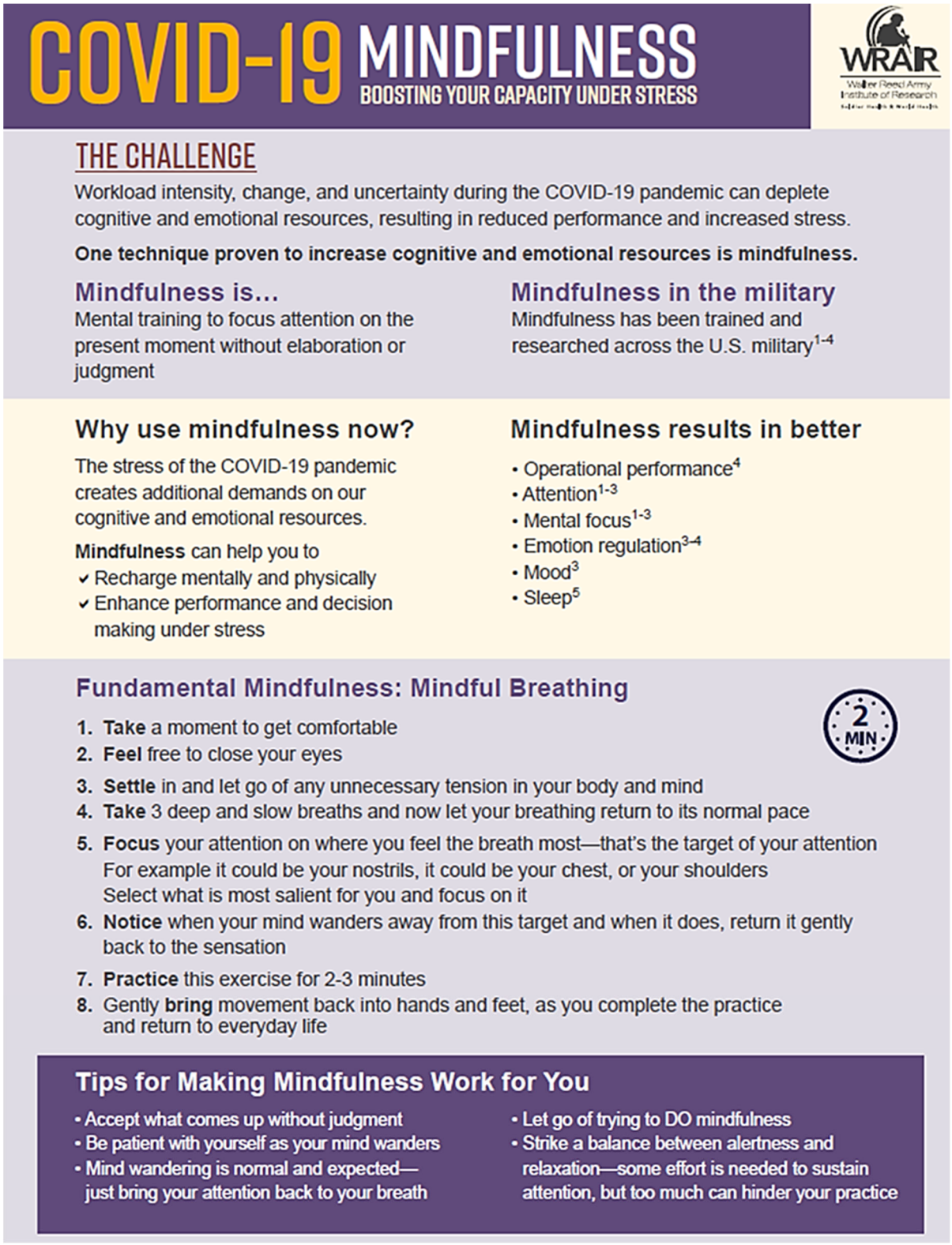
amazon-militaryenergygum.com

- Walter Reed Army Institute of Research is currently working on developing and testing strategies to maximize the effectiveness of napping in the operational environment.
- Comprehensive sleep and nap information is detailed in Army FM 7-22.
- Detailed information on the sleeping environment: *Mantua, J., et al. (2019), Military medicine, 184(7-8), e259-e266.*
- Validation of caffeine gum: *Kamimori, G. H., et al. (2002). International journal of pharmaceutics, 234(1-2), 159-167.*

Developed by the Behavioral Biology Branch, Center for Military Psychiatry and Neuroscience
For more sleep resources, check out our website: https://www.wrair.army.mil/node/348

WRAIR

Appendix E: Mindfulness – Boosting Capacity under Stress



COVID-19 MINDFULNESS
BOOSTING YOUR CAPACITY UNDER STRESS

WRAIR
Walter Reed Army Institute of Research

THE CHALLENGE

Workload intensity, change, and uncertainty during the COVID-19 pandemic can deplete cognitive and emotional resources, resulting in reduced performance and increased stress.

One technique proven to increase cognitive and emotional resources is mindfulness.

Mindfulness is...

Mental training to focus attention on the present moment without elaboration or judgment

Mindfulness in the military

Mindfulness has been trained and researched across the U.S. military[1-4]

Why use mindfulness now?

The stress of the COVID-19 pandemic creates additional demands on our cognitive and emotional resources.

Mindfulness can help you to

- ✔ Recharge mentally and physically
- ✔ Enhance performance and decision making under stress

Mindfulness results in better

- Operational performance[4]
- Attention[1-3]
- Mental focus[1-3]
- Emotion regulation[3-4]
- Mood[3]
- Sleep[5]

Fundamental Mindfulness: Mindful Breathing

2 MIN

1. **Take** a moment to get comfortable
2. **Feel** free to close your eyes
3. **Settle** in and let go of any unnecessary tension in your body and mind
4. **Take** 3 deep and slow breaths and now let your breathing return to its normal pace
5. **Focus** your attention on where you feel the breath most—that's the target of your attention
   For example it could be your nostrils, it could be your chest, or your shoulders
   Select what is most salient for you and focus on it
6. **Notice** when your mind wanders away from this target and when it does, return it gently back to the sensation
7. **Practice** this exercise for 2-3 minutes
8. Gently **bring** movement back into hands and feet, as you complete the practice and return to everyday life

Tips for Making Mindfulness Work for You

- Accept what comes up without judgment
- Be patient with yourself as your mind wanders
- Mind wandering is normal and expected—just bring your attention back to your breath
- Let go of trying to DO mindfulness
- Strike a balance between alertness and relaxation—some effort is needed to sustain attention, but too much can hinder your practice

Advanced Mindfulness: Open Monitoring

5 MIN

1. **Take** a moment to get comfortable, and feel free to close your eyes
2. **Settle** in by taking a few deep and slow breaths
3. On each exhale, **relax** more deeply, letting go of tension in the neck and shoulders
4. **Allow** your breathing to continue at its own natural pace
5. **Expand** awareness beyond your physical self to your surroundings
6. **Be aware** of sounds, smells, the touch of air on your skin, light through the eyelids
7. **Notice** when your mind wanders, then gently bring your attention back to awareness
8. **Feel** yourself to be unchanging and timeless—even as things come and go around you
9. **Practice** this exercise for 5-10 minutes
10. Gently **open** and **close** your eyes a few times as you complete the practice and return to everyday life

Additional Applications

Integrating Mindfulness into Every Day

- Take a couple of mindful breaths throughout the day to recharge mentally and physically
- Take a moment to monitor your inner and outer experience while walking from one place to another
- Accept what can't be controlled
- In response to difficult situations, pause and act with intention rather than react in the moment

Using Mindfulness to Connect

- Focus on sending positive thoughts to yourself and teammates to foster empathy and build cohesion
- Visualize a place in nature or another place that promotes well-being, calm, safety, and stability—feel free to imagine family, friends, or pets that support you in this safe place

Frequently Asked Questions

Q: What does mindfulness involve?
A: Mindfulness typically consists of exercises that build capacity to focus attention on inner and outer experience.

Q: Do I need to practice for hours every day?
A: Not necessarily. Benefits have been found with as little as 12 minutes a day and can be practiced a few days a week.

Q. Do I have to sit cross-legged in a lotus position?
A: No, you can practice mindfulness in any position you want, like walking, lying down, or sitting in a chair.

Q: When should I use mindfulness?
A: Mindfulness can be used when you want to manage stressful moments or restore attention and mental focus. It can also be used to build your capacity to operate under stress.

Try these apps to practice mindfulness

Available on Apple and Google Play

Mindfulness Coach
Learn mindfulness skills to manage stress

Breath2Relax
Practice diaphragmatic breathing to reduce tension

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Selected References:
[1]Jha et al. (2015). Minds "at attention": Mindfulness training curbs attentional lapses in military cohorts. PloS one, 10(2). [2]Zanesco et al. (2019). Mindfulness training as cognitive training in high-demand cohorts: An initial study in elite military service members. Progress in brain research, 244, 323-354. [3]Jha et al. (2010). Examining the protective effects of mindfulness training on working memory capacity and affective experience. Emotion, 10(1), 54. [4]Nassif et al. Mindfulness training and operational performance. Unpublished WRAIR Brief. [5]Hülsheger et al. (2015). A low-dose mindfulness intervention and recovery from work. Journal of occupational and organizational psychology, 88(3), 464-489.

APPENDIX F: ICOVER-MED: PEER-BASED MANAGEMENT OF ACUTE STRESS DISORDER IN MEDICAL TEAMS

COVID-19 iCOVER-Med

RAPID PEER-BASED MANAGEMENT OF ACUTE STRESS IN MEDICAL TEAMS

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WHAT IS iCOVER-Med?

iCOVER-Med is a rapid, peer-based response to help manage acute stress in team members and return the team back to a high level of functioning.

Health care workers providing treatment to patients during COVID-19 are serving under high-stress/high-stakes conditions. In this unprecedented context, health care workers on the front lines may encounter team members who are overwhelmed by stress.

When an individual becomes completely overwhelmed by stress, they may experience an Acute Stress Reaction. An Acute Stress Reaction can prevent a member of a medical team from functioning, which can impede the delivery of patient care and exacerbate team stress.

While an Acute Stress Reaction can resolve itself over time, teams that rely on one another to be effective in the moment need a way to immediately manage acute stress in others.

RECOGNIZE THE SIGNS OF ACUTE STRESS REACTION

Know the following possible signs of an Acute Stress Reaction:

- *Appearing "frozen" and detached from what is happening*
- *Showing extreme emotion (panic, fear, anger)*
- *Behaving erratically, such as dropping equipment or acting without regard to danger*

The common denominator is that the person stops functioning for a period of time

HOW YOU CAN HELP

Help your teammate return to functioning by using iCOVER-Med, a six-step protocol that can be completed in under 60 seconds. iCOVER-Med, based on a protocol developed by the Israel Defense Forces and adapted by the Walter Reed Army Institute of Research, has excellent user acceptability, is easy to learn, and is linked to better outcomes for military units.

identify *the team member who is having an Acute Stress Reaction*
Connect *to bring them to the present moment (eye contact, touch, hearing)*
Offer *commitment to reduce sense of isolation*
Verify *facts with simple questions to get the thinking brain back in gear*
Establish *order of events to reorient the individual*
Request *action to re-engage in purposeful action*

iCOVER-Med IN ACTION

STEPS	PURPOSE	ACTION	EXAMPLE
identify	See if team member needs help	Make sure there's not a physical reason for their presentation.	Team member is having trouble functioning—they may appear frozen, non-responsive, dissociated, or agitated.
Connect	Return to present moment	Make eye contact, talk, touch arm.	"Look at me. Can you hear me? I'm going to squeeze your arm, you squeeze mine back."
Offer commitment	Reduce sense of isolation	Remind them they are not on their own.	"I'm right here with you, I'm not going anywhere. You are not alone."
Verify facts	Get thinking brain back in gear	Ask 2-3 simple, fact-based questions.	"What hospital are we in?" "Who is the attending for this patient?" "What illness are we treating here?"
Establish order of events	Reorient the individual	Using simple statements, explain what happened, what is happening, and what will happen.	"We came on shift. We are putting on our PPE. We have to go take care of our patients."
Request action	Re-engage in purposeful action	Make a simple request to get them engaging in action.	"I need you to secure your face shield. Let's go!"

FAQs

What's going on when someone has an Acute Stress Reaction? Under extreme stress, the amygdala hijacks the brain and prevents the pre-frontal cortex—the thinking part of the brain—from functioning.

What tone of voice should I use when going through the iCOVER-Med steps? Be authoritative and clear. Don't be overly emotional and don't yell at them—the emotion part of their brain (the amygdala) is already overloaded.

What if I do the steps out of order or miss a step? Keep going and if it doesn't work, re-start the steps.

What if the person doesn't respond to me? Move them out of the way for safety and, depending on the situation, ask for additional help for the patient and the team member.

How often am I likely to see someone go through acute stress? About 40% of Soldiers report seeing a team member in combat experience an Acute Stress Reaction. Medical care isn't combat, but acute stress may be experienced under extreme conditions.

How is this relevant to COVID-19? Maximizing and preserving healthcare provider effectiveness is a crucial part of the fight against COVID-19. This adapted version is designed to support medical teams continue their dedicated response on the front lines of the pandemic.

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Selected references: Adler, A. B. et al. (2019). Rapid response to acute stress reaction: Pilot test of iCOVER training for military units. *Psychological Trauma: Theory, Research, Practice, and Policy*. Advance online publication. | Svetlitzky, V. et al. (2019). YaHaLOM: A rapid intervention for Acute Stress Reactions in high-risk occupations. *Military Behavioral Health*, 1-11. | Svetlitzky, V. et al. (2019). Rapid peer-based intervention for acute stress: Evaluation of YaHaLOM training in the military. *Psychological Services*. Advance online publication.

Appendix G: Non-specialty Medical Personnel Health Communication Form

Non-Specialty Medical Personnel Behavioral Health Communication Form

SECTION I – REASON FOR BEHAVIORAL HEALTH EVALUATION

Reason for MSE

_____

_____

Patient Information

Name _____ Rank/Grade _____ Status _____

Prefix _____ DOB _____ Sponsor DOD ID _____ MTF _____ Date _____

SECTION II – BEHAVIORAL HEALTH DISPOSITION DETERMINATION

□ Return to duty. Service member may benefit from temporary support and interventions, see recommendations from Sections IV and V, below.
□ Return to duty with short-term duty limitations. See recommendations from Sections IV and V, below.
□ Hold for further assessment/care. Service member under medical care, with command responsibilities as outlined below in recommendations from Sections IV and V.
□ Refer: Service member requires close medical/behavioral health observation and evaluation at a higher echelon of care, or possible evacuation out of theatre. Service member is on profile or limited duty status, expires on _____. Duty restrictions: _____
_____

SECTION III – PERTINENT FINDINGS ON MENTAL STATUS EVALUATION

Screenings performed: PTSD □ Depression □ Anxiety □ Sleep Problems □ Irritability/anger □

Cognitive performance: Not impaired □ Impaired □ Behavior: Normal □ Abnormal □

Perceptions: Not impaired □ Impaired □ Impulsivity: Normal □ Abnormal □

Risk of harm to self: Not elevated □ Low □ Intermediate □ High □

Risk of harm to others: Not elevated □ Low □ Intermediate □ High □

Positive screens/findings/elevated risks: _____
_____

Overall impressions/comments: _____
_____
_____

SECTION IV – FOLLOW-UP CARE RECOMMENDATIONS

□ No follow-up needed. □ Hold until _____ (date or TBD) and implement Section V Command recommendations indicated below.

□ Follow-up appointment scheduled with NSMP on _____.

□ Recommend appointment with chaplain, date TBD or scheduled for _____.

□ Recommend appointment with tele-behavioral health NSMP, date TBD or scheduled for _____.

□ Recommend medication evaluation for short-term stabilization, date TBD or scheduled for _____.

□ Comments: _____

_____

_____

SECTION V – RECOMMENDATIONS AND COMMENTS FOR COMMANDER

□ No safety precautions are indicated.

□ Recommend non-medical help-in-place or rest and replenish in/close to unit.

□ Ensure that service member attends all follow-up appointments with NSMP, chaplain, or tele-behavioral health provider.

□ Restrict access to or disarm all military weapons and ammunition, and secure medications.

□ Recommend appropriate unit watch and safety limitations.

□ Revisit planned mission rest times to ensure 8 hours of downtime for intended sleep.

□ Increase leader/supervisory support with intent of keeping service member engaged with unit members and other sources of support.

□ Ensure service member has an opportunity to meet directly with the Company Commander and/or First Sergeant in order to discuss any relevant concerns.

□ Ensure service member has contact with unit mentor regarding relationship or financial problems until the service member achieves the benchmarks set up by the mentor.

□ For sexual harassment or assault concerns in which the service member has chosen to complete an unrestricted report, ensure that service member has contact with SARC and the unit's victim advocate. Keep service member updated regarding status of legal case. Consider removal of perpetrator from AOR.

□ For legal issues, ensure adequate contact between the service member and support assets (Inspector General, Judge Advocate General, Trial Defense Service, chaplain).

□ For legal issues or occupational problems and adverse actions, ensure the service member receives written criteria, unit plan of support, and minimum of weekly feedback for how to meet requirements/standards until the service member achieves the requirements/standard identified.

□ Consider no contact order between service member and _____ to limit risk of harm to self/others.

□ If service member shows concerning changes in mood, behavior, or safety, then Command should remove service member's weapon and have service member escorted to NSMP for immediate evaluation, or after hours, to medic on duty.

□Comments/Other:_____

_____

_____

NSMP NAME AND SIGNATURE

Evaluating NSMP Name _____

Signature _____ Date _____

Consulting Tele-behavioral Health NSMP Name _____ Date Consulted _____

Appendix H: Unit Survey – Individual Questions (Unit IQ)

ANONYMOUS UNIT SURVEY– INDIVIDUAL QUESTIONS (UNIT-IQ) **Select Relevant Items or Sections to Administer. Unit Command Consultation, Date: _____**	
Demographic /Military Information *(Note to NSMP: Confidential information)*	
Service Branch: _____Rank: _____MOS: _____	
SECTION I – BEHAVIORAL HEALTH AND SLEEP INDICATORS	
Behavioral Health Indicators (Past Two Weeks) In the **past two weeks**, how frequently have you experienced the following?	**Service Member Rating**
1a) Bothered by disturbing memories, feeling distant from others, or avoiding certain activities as a result of an extremely stressful experience?	0 Not at all 1 Once or twice a week 2 3 or 4 times per week 3 5 or 6 times per week 4 Every day
2a) Little interest or pleasure in doing things; feeling down, depressed, or hopeless	0 Not at all 1 Once or twice a week 2 3 or 4 times per week 3 5 or 6 times per week 4 Every day
3a) Not being able to stop or control worrying; feeling nervous, anxious or on edge	0 Not at all 1 Once or twice a week 2 3 or 4 times per week 3 5 or 6 times per week 4 Every day
4a) Thoughts or acts indicating that you would be better off dead or of hurting self in some way	0 Not at all 1 Once or twice a week 2 3 or 4 times per week 3 5 or 6 times per week 4 Every day
5a) Getting angry at someone in the unit and yelling or shouting at them; threatening or getting into a fight with someone in your unit	0 Not at all 1 Once or twice a week 2 3 or 4 times per week 3 5 or 6 times per week 4 Every day

Functioning 6a) If you checked any of the above problems, how frequently have these problems made it difficult for you to perform your duty or get along with others?	0 Not at all 1 Once or twice a week 2 3 or 4 times per week 3 5 or 6 times per week 4 Every day
Sleep Issues (Past Two Weeks)	**Service Member Rating**
7a) On average, how many hours of sleep did you get per day?	0 8 hours or more 1 Between 6-8 hours 2 Between 4 and 6 hours 3 Between 2 and 4 hours 4 2 hours or less
8a) On average, how many hours of time were allowed for you/unit members to sleep per day?	0 8 hours or more 1 Between 6-8 hours 2 Between 4 and 6 hours 3 Between 2 and 4 hours 4 2 hours or less
Functioning 9a) How many days have sleep problems made it difficult for you to perform your duty or get along with others (e.g., daytime fatigue, ability to function at work, poor concentration, memory, mood, etc.)?	0 Not at all 1 Once or twice a week 2 3 or 4 times per week 3 5 or 6 times per week 4 Every day
Comments/examples/other issues: _____ _____ _____ _____	
NSMP Use Only: ***Section I Scoring.*** PTS (1a) = _____ Depression (2a) = _____ Anxiety (3a) = _____ Suicidal (4a) = _____ Irritability (5a) = _____ Sleep obtained (7a) _____ Sleep opportunity (8a) _____ **Total BH Indicators score (1a-5a sum) ÷ 5 = _____** **BH Indicators functional impact** (6a) = _____ **Sleep functional impact** (9a) = _____	
SECTION II - COMBAT AND OPERATIONAL STRESSORS	
Combat Stressors (Past Two Weeks)	**Service Member Rating**
1b) How frequently have you experienced significant combat-related events (e.g., killing, fighting, threat to self, death or injury of others)?	0 Not at all 1 Once or twice a week 2 3 or 4 times per week 3 5 or 6 times per week 4 Every day
2b) In the past two weeks, how many times did you feel overwhelmed, experience incredibly strong emotions, or have difficulty functioning during or after a combat-related event?	0 Not at all 1 Once 2 Twice 3 Three times

	4 Four or more times
3b) In the past two weeks, how many times did you encounter a service member in your unit who was so stressed that they were temporarily unable to function during or after a combat-related event?	0 Not at all 1 Once 2 Twice 3 Three times 4 Four or more times
Comments/examples/ issues (e.g., casualties, grief/loss, suicide, marital/family communication): _____ _____ _____ _____	
NSMP Use Only: ***Section II Scoring.*** Any item can be scored and interpreted individually. Combat stressors (1b-3b sum) _____ ÷ 3 = _____ **Combat functional impact** (4b) = _____ Operational stressors (5b-7b sum) _____ ÷ 3 = _____ **Operational functional impact** (8b) = _____	
SECTION III – UNIT CLIMATE AND LEADERSHIP CONCERNS	
Unit Morale/Cohesion (Past Two Weeks)	**Service Member Rating**
1c) How would you rate the overall level of unit irritability, aggression, and lack of safe environment (includes fights, conflict, bullying/hazing, attacks, sexual assault or harassment)?	0 Very Low 1 Moderately low 2 Neutral 3 Moderately high 4 Very high
2c) How would you rate the unit on frequency or severity of problem behaviors, such as risky behaviors, substance misuse, gambling, or other out of control behaviors?	0 Very Low 1 Moderately low 2 Neutral 3 Moderately high 4 Very high
3c) How would you rate the unit on moral and ethical behaviors?	0 Very high 1 Moderately high 2 Neutral 3 Moderately low 4 Very low
4c) How would you rate the unit on teamwork, motivation, and performance?	0 Very high 1 Moderately high 2 Neutral 3 Moderately low 4 Very low
5c) How would you rate your personal morale within your unit?	0 Very high 1 Moderately high 2 Neutral 3 Moderately low 4 Very low
Functioning 6c) Overall, to what degree have unit climate and morale issues made it difficult for you to perform your duty or get along with others?	0 Not at all 1 A little bit 2 Moderately 3 Quite a bit 4 Extremely

Unit Climate/Leadership (Past 2 Weeks) Thinking about your unit, rate how frequently leadership does the following:	**Service Member Rating for Sr. Enlisted Leadership**	**Service Member Rating for Officer Leadership**
7c) Harsh or critical interaction with service members (e.g., criticism of work; used insults, sarcasm, or gestures to humiliate service members; yelled at or were hostile to service members)	0 Not at all 1 Once or twice a week 2 3 or 4 times per week 3 5 or 6 times per week 4 Every day	5 Not at all 6 Once or twice a week 7 3 or 4 times per week 8 5 or 6 times per week 9 Every day
8c) Communication to unit was unclear or inconsistent; leadership didn't provide information or assistance when needed or intentionally interfered with work; showed favoritism to some service members; tried to look good to higher-ups by assigning extra missions or details to service members	0 Not at all 1 Once or twice a week 2 3 or 4 times per week 3 5 or 6 times per week 4 Every day	0 Not at all 1 Once or twice a week 2 3 or 4 times per week 3 5 or 6 times per week 4 Every day
9c) Tell service members when they have done a good job	0 Every day 1 5 or 6 times per week 2 3 or 4 times per week 3 Once or twice a week 4 Not at all	0 Every day 1 5 or 6 times per week 2 3 or 4 times per week 3 Once or twice a week 4 Not at all
10c) Show that they were concerned about the safety of service members	0 Every day 1 5 or 6 times per week 2 3 or 4 times per week 3 Once or twice a week 4 Not at all	0 Every day 1 5 or 6 times per week 2 3 or 4 times per week 3 Once or twice a week 4 Not at all
11c) Rate your overall level of satisfaction with your leadership	0 Very high 1 Moderately high 2 Neutral 3 Moderately low 4 Very low	0 Very high 1 Moderately high 2 Neutral 3 Moderately low 4 Very low
Functioning 12c) Overall, to what degree have any leadership issues made it difficult for you to perform your duty or get along with others?	0 Not at all 1 A little bit 2 Moderately 3 Quite a bit 4 Extremely	

Comments/examples/other issues:
_____
_____
_____
_____
_____

NSMP Use Only: ***Section III Scoring.*** Any item can be scored and interpreted individually.
Unit morale score (1c-5c sum) _____ ÷ 5 = _____
Officer climate score (OL 7c-11c sum) _____ ÷ 5 = _____
Sr. Enlisted climate score (SEL 7c-11c sum) _____ ÷ 5 = _____
Total morale/leadership score (1c-11c sum) _____ ÷ 15 = _____
Unit morale functional impact (6c) = _____ **Leadership climate functional impact** (12c) = _____

FOR NSMP USE ONLY: SCORE INTERPRETATION. **Average score (range 0 – 4):**
□ **0 – 0.9 = Little concern** □ **1.0 – 1.9 = Concern** □ **2.0 – 2.9 = Risk** □ **3.0 – 4.0 = High Risk**

Examples:	Not at all – Once/week Not at all – A little bit Very – Moderately Low*	1 – 3 times/week A little bit – Moderately Moderately Low – Neutral*	3-5 times/week Moderately – Quite a bit Neutral – Moderately High*	5 – 7 times/week Quite a bit – Extremely Moderately – Very High*

**Some "positive" response options were inversely scored in order to interpret all high scores as negative*