

GUIDELINE FOR FORWARD
MANAGEMENT OF ACUTE
MENTAL HEALTH
CONDITIONS BY
NON-SPECIALTY
MEDICAL PERSONNEL

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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 mental 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 mental 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 mental 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 mental 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 mental health support (discussed in Chapter 1). At Role 1, facilities (such as battalion aid stations) typically received direct support from mental health technicians and rotational support from mental health officers. Role 2 facilities provided direct support through uniformed mental 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 mental 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 mental health support that have been relied upon in previous wars. Contested airspace and advanced air defense likely will delay medical evacuation of low-priority mental 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 mental 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 mental 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 MENTAL 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, mental 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 mental health interventions are useful in a deployed environment.^{3,4}

Ongoing research and training are underway to prevent, identify, and initiate early treatment for mental health casualties at the frontlines of conflict. Challenges in tracking mental 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 mental health conditions
- Training of organic resources and leadership in recognition and management of emergent mental health conditions
- Guidance on strategies and resources to mitigate psychological impact and operational stressors in austere environments.
- Objective real time mental 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 mental health resources for Role 1 in forward locations necessitates battlefield circulation of mental 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 mental 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

MENTAL HEALTH ASSETS TYPICALLY AVAILABLE IN THE DEPLOYED ENVIRONMENT

The focus of this chapter is to provide a brief background on the need for mental health assets during deployment as well as an overview of available mental 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 Mental 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 mental health providers to employ a “battlefield rotation” in order to provide care nearest to the point of injury as well as to help mitigate mental 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 mental health services.¹²

Control and management of combat and operational stress necessitates the utilization of embedded and forward deployed mental 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 mental 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 mental 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 mental 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 mental 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 mental 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 mental health assets is to make mental health care available at the point of need in order to conserve the fighting strength of the military.

Each service’s mental 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 mental 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 HSS 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 mental hospital team, and a combat stress control restoration center. Thus, service members can leverage tri-service assets. Table 1.1 provides a snapshot of mental health assets and capabilities across services in forward environment.

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

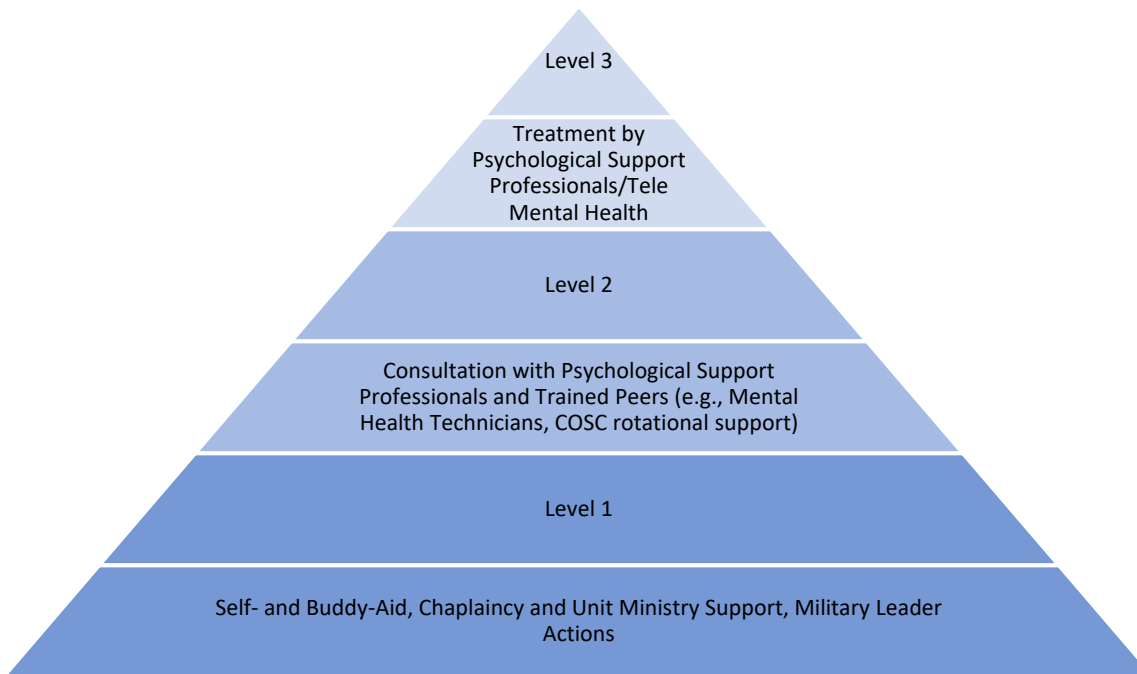
Role/ Capability	Service Branch	Mental Health Assets	Team Composition
Role 1 Immediate and short-term care Primary care management of routine mental health concerns	Army	Self-Aid/Buddy Aid, Combat Medic, Religious Support teams	Depends on unit mission and size. Training and number of members trained 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 mental 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 mental 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 mental health nurse practitioner or mental health registered
	Navy/ Marine Corps	Operational Stress Control and Readiness Team, OSCAR Combat Stress Platoon (CSP)	

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	Air Force	The Combat and Operational Stress Control (COSC) detachment or clinics	nurse) and an enlisted mental 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, mental health nurse practitioner, mental health registered nurse and tele mental 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 mental health professionals (e.g., mental 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 mental 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). Mental 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. Mental 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 mental 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 mental 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 mental 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 settings¹⁵. 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 mental 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 YaHaLOM²¹ and the U.S. forces adaptation, iCOVER²², 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 mental health and resiliency training, assisting with iCOVER, and coordinating with external mental health services, etc.

MEDICS AND ROLE 1 MEDICAL PROVIDERS

Access to specialty mental health providers or technicians at Role 1 facilities will be greatly diminished with decreased battlefield circulation. Furthermore, while tele-mental 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 mental health providers. Currently, medics receive limited training in mental health, therefore enhanced training for Role 1 providers must emphasize the most common and most serious differential diagnoses of mental 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 mental 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.

MENTAL HEALTH OPTIONS

Mental 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 mental health assets provide training to their units on protective factors related to mental 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 mental health casualties when possible, and help bridge people into care if they become a mental 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 mental 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 mental health support can be obtained through battlefield circulation from (BHOs based at Role 2 facilities.

MENTAL HEALTH TECHNICIANS

Mental health technicians (Military Occupational Specialty 68Xs in the Army, L24A in the Navy and 4COX1 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 asset²⁶ 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 mental health. However, a recent report demonstrated inconsistent utilization and underutilization of enlisted mental 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 mental health specialist. Most chaplains are trained in basic counseling and are usually familiar with common mental health conditions from having worked closely with mental 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.

MENTAL HEALTH OFFICERS

As indicated earlier, individual and unit mental health promotion will be more readily facilitated through organic unit assets such as self-aid, buddy aid, medics, and embedded mental health technicians. However, in instances where additional support might be needed, rotational support from Role 2 could be leveraged. In these situations, the mental

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 mental 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 mental 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 mental health care in theater since Operation Enduring Freedom.^{29,30} These COSC clinics exclusively focus on specialty mental 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 mental health teams travel to other FOBs from their “home base” as part of battlefield circulation.³¹ COSC clinics utilize traveling teams of mental 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 mental health sections assigned to the brigade support medical company of the brigade support battalion. If required, these resources can receive direct support from the mental 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 mental 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 mental 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 mental health needs and trends at the individual as well as unit level. The mental health technicians thus serve a unique role and are a critical asset²⁵ 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 mental 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 mental 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 Mental Health Officer MHOs (social worker and/or psychologist) and two to four 68Xs (mental 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

Mental health care at this level will be provided through the combined efforts of mental health assets embedded within the unit, as well as mental health assets assigned to forward medical units. It is not expected that an operational unit's organic mental 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 mental 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 mental 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 mental 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 mental 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 mental 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 mental 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 mental health surveillance, serving as command liaison, providing preventive mental health and resiliency training, and coordinating with external mental 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 mental health services in forward-deployed operational environments where services would otherwise be unavailable.

ROLE 3

The mission of deployment mental 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 mental 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 mental 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, mental health nurse practitioner, and mental health registered nurse if needed. An example from the Navy is described below.

NAVY ROLE 3

This level of care in Navy mental 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 mental 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-MENTAL HEALTH

Tele-mental health is an emerging consultative capability that extends the reach of mental health providers and adds fluidity, continuity, and expanded capability to the previously established roles. With the use of telehealth, a mental 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

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a conflict. Telehealth is utilized as a force multiplier and allows for access to care in locations/during times when embedded mental health/mental 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 mental 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-mental 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) system³⁶ 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 phase³⁷ 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 mental 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 mental health assets to fully support the service member under the area of responsibility, tele-mental health options need to be considered. The options include virtual deployment of mental 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-mental 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.

MEDICAL HEALTH OFFICER 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/>

MENTAL 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

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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 mental 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 MENTAL HEALTH CARE

Exposure to operational stress during deployment increases the risk of developing a range of mental health conditions, including PTSD, major depression, and substance misuse.¹⁻³ While the extant literature has focused primarily on the diagnosis and treatment of mental 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 mental health diagnoses in particular may be at increased risk for developing acute symptoms requiring mental health care in a deployed setting. Frontline mental 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 mental 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 mental 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 mental health conditions without available specialty services. Whereas mental health providers ideally intervene for needed services, the reality of far-forward care is that they are often 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

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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 mental 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. Mental 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 mental 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 mental health measures that offer important information about overall mental 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 mental 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

- **Open 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?"
- **Affirming:** "No wonder you feel overwhelmed. That is a lot to manage at home from so far away."
- **Reflective 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."
- **Summarizing:** "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 mental 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-5) is 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 mental 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 mental 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.

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- **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 mental health issues: SPC Miller says that he has not engaged in mental health before and doesn't think he has mental 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 mental health condition and often can trigger an apparent mental 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 mental 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 mental 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 mental 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 mental 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 mental 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 mental 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 mental health resources and self /buddy interventions are described in Chapter 1 as well as in the chapters 3 and 4, addressing mental 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 mental 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 mental 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 mental 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 mental 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 mental health diagnosis. To make matters more challenging, far-forward deployments often lack the mental health resources necessary to provide traditional outpatient therapies. In order to effectively and efficiently assess and treat mental health issues of service members with or without a history of mental 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 mental 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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