

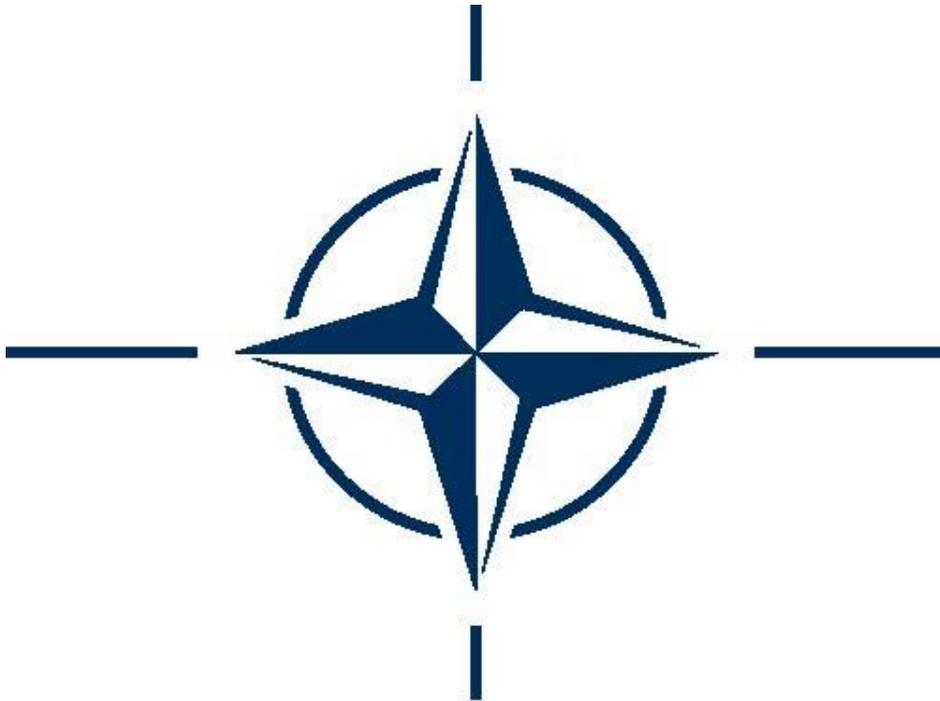
**NATO STANDARD**

**AMedP-8.6**

**FORWARD MENTAL HEALTHCARE**

**Edition B Version 1**

**OCTOBER 2019**



**NORTH ATLANTIC TREATY ORGANIZATION**

**ALLIED MEDICAL PUBLICATION**

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**NORTH ATLANTIC TREATY ORGANIZATION (NATO)**  
**NATO STANDARDIZATION OFFICE (NSO)**  
**NATO LETTER OF PROMULGATION**

31 October 2019

1. The enclosed Allied Medical Publication AMedP-8.6, Edition B, Version 1, FORWARD MENTAL HEALTHCARE, which has been approved by the nations in the Military Committee Medical Standardization Board, is promulgated herewith. The agreement of nations to use this publication is recorded in STANAG 2564.
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Brigadier General, HUNAF  
Director, NATO Standardization Office

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## RECORD OF SPECIFIC RESERVATIONS

[nation]	[detail of reservation]
DEU	<p>AMedP-8.6 Forward Mental Healthcare is largely consistent with the standardized procedures of the Bundeswehr and therefore compatible with DEU provisions / regulations.</p> <p>However, the DEU Mental Health Model makes a strict distinction between the preclinical and the clinical stage. The full psychotherapeutic competence is available at the clinical stage, only.</p> <p>It must therefore be kept in mind that also in multinational military operations the DEU Mental Health Model is designed as a two-level one:</p> <p>Level I:</p> <p>Embedded military psychologists at brigade level and above without clinical (diagnostic and therapeutic) competence, trained for psychological crisis intervention.</p> <p>Level II:</p> <p>Within the evacuation chain, clinical care is provided at competent medical treatment facilities with a specialist (psychiatric) component.</p> <p>DEU therefore preserves the right to apply the above-mentioned national provisions / regulations. According to DEU provisions / regulations, the full spectrum of forward mental health care will always be provided at different levels, combining psychiatrists and psychologists whose competencies are not identical.</p>
ESP	<p>The determination of the mental health leave, the need for evacuation from the area of operations, and the prescription of medication are subject to national regulation, being the responsibility of medical personnel.</p> <p>The evaluation of mental fitness prior to deployment is subject to national regulation according to the medical chart of exclusions, not being deployable staff with psychopathology that affects their performance and safety.</p> <p>Item 1.17 is not ratified. Since the aforementioned tasks are the responsibility of the contributing nation, not of the host nation.</p> <p>The Mental health Incident Response Team and Aeromedical Evacuation Mental health Team will be the established generic ones, adapting them to each case and situation.</p>

<p>NLD</p>	<p>The Royal Netherlands Navy is not able to support all maritime operations with a Forward Mental Health Team compared to the home nations military mental health provision, there will be a role 1 MTF that will provide the level 1 intervention.</p> <p>In a maritime environment it is difficult to meet the timelines as stated in 1.16, due the nature of the maritime environment.</p> <p>The Netherlands Armed Forces do not use the second generation antipsychotic and SSRI medications as mentioned in Annex C-3. The future availability of first generation high potency antipsychotic (oral) en Anticholinergic is subject to study.</p> <p>The Royal Netherlands Navy will not have all the drug classes available aboard all vessels.</p>
<p>SVN</p>	<p>Slovenian Armed Forces cannot provide all conditions which are required by AMed P-8.6. With our current mental health professionals we can successfully implement the provisions of the STANAG 2564 (2) in the nondeployed environment. The problem occurs in the context of increasing needs and on deployment. In those cases Slovenian Armed Forces cannot provide all relevant treatment (especially on third level of interventions) in the area of mental health without the support of another NATO member state.</p>
<p>Note: The reservations listed on this page include only those that were recorded at time of promulgation and may not be complete. Refer to the NATO Standardization Document Database for the complete list of existing reservations.</p>	

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<b>CHAPTER 1 INTRODUCTION</b>
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**1.1. AIM**

1. The aim of this Allied Medical Publication (AMedP) is to standardize for the NATO forces the general principles governing Mental Health (MH) support to the forward area of the theatre of operations and aid nations' interoperability.

**1.2. GENERAL**

1. The effective management of mental health problems is a force multiplier, and specialist mental health capability should be included in operational medical support. While the medical management of specific disorders follows national guidelines and is not covered by this publication, the principles of prevention, management and treatment of operational stress differ significantly from other medical and surgical interventions and warrant inclusion in this publication<sup>1</sup>.

**1.3. DEFINITIONS**

1. The NATO Search Term database on the NSO website has the following definitions relevant to Forward Mental Healthcare:

- a. Battle fatigue (see battle stress reaction).
- b. Battle shock reaction (see battle stress reaction).
- c. Battle stress case (BSC) (see operational stress case).
  - i. Note: Battle stress cases are classified as battle casualties. The majority of these casualties do not become patients because they can be managed outside of the medical support system and rapidly returned to duty.
- d. Battle stress reaction (see operational stress reaction).
- e. Combat stress reaction (see operational stress reaction).
- f. Operational stress reaction (OSR).

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<sup>1</sup> HFM081

- i. A disorder of psychological function which is a normal response to an abnormal situation experienced during operations, and which may cause a temporary inability to perform duties. See Annex B.
- g. Obsolete Synonym: shell shock.
- h. Synonyms: combat stress, battle fatigue, battle shock reaction, combat stress reaction, battle stress reaction and post-traumatic stress.

#### **1.4. OPERATIONAL STRESS CASE**

- 1. Individual experiencing operational stress reaction.

#### **1.5. INCIDENT RESPONSE TEAM (IRT)**

- 1. A team held at high readiness in order to deploy in response to a medical crisis. Incident Response Teams are an essential part of Graduated Incident Response, since Incident Response requires immediate reaction, preparedness and ability to respond to such an event. Incident Response Teams are rapidly deployable assets representing this capability. The medical component of an IRT should include trained, equipped and experienced specialist personnel to deal with the consequences of trauma or life-threatening illness.

#### **1.6. TTF 2012-0208 MENTAL HEALTH PROFESSIONAL (MHP)**

- 1. A healthcare clinician appropriately trained to perform diagnosis and treatment of mental, emotional and behavioral disorders (includes Psychiatrist below).

#### **1.7. MENTAL INCAPACITY**

- 1. A condition resulting from temporary or permanent mental instability as a result of injury, disease, an incapacitating agent, psychological trauma or other mental condition that leads to an impairment of function.

#### **1.8. TTF 2012-0207 PSYCHIATRIST**

- 1. A physician appropriately trained and licensed to perform diagnosis and treatment of mental, emotional and behavioral disorders.

## 1.9. TTF 2011-1646 TELEPSYCHIATRY

1. Psychiatric medical care provided at a distance by means of Information and Communication Technologies (ICT).

## 1.10. STATEMENT OF DETAILS

1. Control of operations is to be in accordance with local directives and the organization of the force concerned.
2. Nations planning to operate together formulate a specific MH care plan guided by this AMedP and its Annexes.
3. Military Mental Health services provide Clinical, Educational and Advisory Mental Health support to Command.
4. The effective management of mental health problems is a force multiplier, and specialist mental health capability should be included in operational medical support. While the medical management of specific disorders follows national guidelines and is not covered by this publication, the principles of prevention, management and treatment of operational stress differ significantly from other medical and surgical interventions and warrant inclusion<sup>2</sup>. Differences between them are:
  - a. The emphasis is on **not** evacuating a battle stress case (BSC); however, robust evacuation chains are essential for some mental health disorders.
  - b. Although assessment & treatment by specialized Mental Health Professionals (MHP) may be required, far forward stress management should involve buddy aid, command interventions and other non-medical means.
  - c. Responsibility for operational stress management is a Chain of Command (CoC) responsibility, resting largely outside the medical area<sup>3</sup>. The management of *stressors* is a CoC responsibility. Management of *stress reactions* is by a layered approach in accordance with Table 1 and Annex B – Acute Stress Reactions.

## 1.11. CASUALTY AETIOLOGY

1. The nature and number of psychiatric casualties remains linked to the operational tempo, nature and the duration of deployment, home factors, physical health and occupational stressors. Recent operations, which have usually been of a

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<sup>2</sup> RTO TR HFM081 'Stress and Psychological Support in Modern Military Operations' April 2008.

<sup>3</sup> STANAG 2565 'A Psychological Guide for Leaders Across the Deployment Cycle'.

relatively fixed duration, have led to the majority of casualties presenting after return from operations; the numbers of frank intra-conflict MH casualties have been low. Post conflict syndromes remain poorly understood and difficult to treat. However, it is reasonable to assume that earlier management and effective risk communication may be effective in prevention of disability and maintains operational effectiveness.

## **1.12. PRINCIPLES OF MENTAL HEALTH SUPPORT ON OPERATIONS**

1. The psychological welfare of troops is primarily a chain of command responsibility. Mental health support begins with the executive who need to:
  - a. exercise good leadership, which engenders trust.
  - b. show competence and be credible.
  - c. provide a caring attitude, which encourages cohesion and good morale.

All these command factors are protective of mental health. Realistic collective and individual training promoting confidence in skills and equipment is another protective factor. There should be a persisting, unobtrusive command interest in the psychological welfare of personnel promoting both resilience and the acceptability of asking for help.

2. No matter where military personnel serve the ideal is that they should receive the same level of mental health care and commanders should expect the same level of occupational mental health input to assist in force maintenance.
3. Mental healthcare assets aim to establish relationships with primary care and command and understand the needs of the command and the conditions they operate in and be able to flexibly assess, treat, support and educate people in situ rather than taking them away from the operation. This has the added advantage of increasing unit self-reliance and sustainability.
4. There should be minimal requirement for mental healthcare professionals to make a transition in service when operations arise; care delivery should be a continuation of everyday peacetime practice with mental healthcare personnel being an accepted asset throughout the armed forces and not a novelty during times of conflict.
5. Mental health care support consists of:
  - a. Clinical Services – assessment, triage, engagement, treatment and rehabilitation.

- b. Educational Services – mental health promotion to all in area of operations (AOO), specific briefs to groups such as body handlers and any other group considered to be exposed to particular stressors and education of other medical personnel on detection and management of mental health problems.
- c. Advisory Support – liaison with command on psychological threat, for example, by visiting units around the AOO.

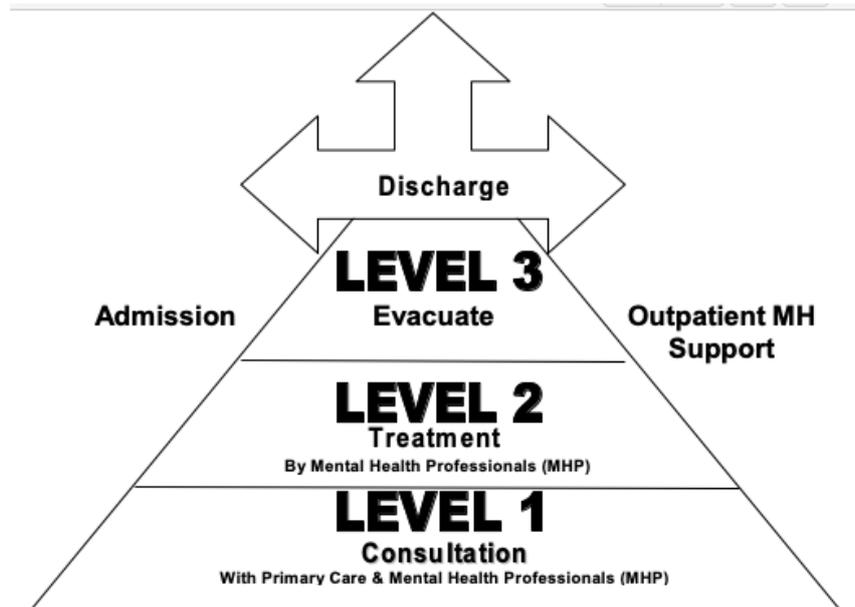


Figure1: Levels of Intervention <sup>4</sup>

### 1.13. FORCE HEALTH PROTECTION PRINCIPLES

1. The 4 principles of Med FP<sup>5</sup> are closely aligned to forward mental healthcare:
  - a. **Measured Assessment of the Threat.** The Mental Health Estimate is through an objective in-theatre evaluation process in conjunction with J2 & J4 Medical Estimate actions. The Med FP Cell should commission an

<sup>4</sup> Taken from Psychological Guide for Leaders, STANAG 2565. Page G2 Box 6.4. 'Trained Peers' such as GBR Trauma Risk Incident Management (TRIM) practitioner. Reference: How to Trim away at Post Traumatic Reactions: Traumatic Risk Management – Now and in the Future. Greenberg N., Cawkhill P. and Sharpley J. Journal of Royal Naval Medical Service. 2005. Vol 91. 26-31.

<sup>5</sup> MH Briefing such as US Army BATTLEMIND. Reference: Battlemind Debriefing and Battlemind Training as Early Interventions With Soldiers Returning From Iraq. Adler A., Bliese P., McGurk D., Hoge C. and Castro C. Sport, Exercise and Performance Psychology. 2011. August Vol 1 Supplement 1. 66-83.

estimate at initial deployment and annually in support of operations. The Estimate for mental health support<sup>6</sup> will depend on the following factors:

- i. Numbers deploying.
- ii. Likely level of pathology (% of population at risk (PAR) that will present).
- iii. Hardship of deployment (likelihood of physical casualties, environment, extent of hostilities and psychological factors, asymmetry of threat, CBRN threat – actual and perceived, rules of engagement, length of tour, child soldiers etc.).
- iv. Ability to move around (less mobility of mental health resources = a requirement for more in theatre, as MH care should be proximal / immediate).
- v. Any formal assessment of psychological threat and other Allied assets.
- vi. The number of MHP required will be in accordance with national guidelines but should be at least comparable to what is available in home areas.

Resulting data assists in planning in-theatre psychological support and informing the review to the theatre Commander's education and decompression policies, and managing media issues.

- b. **Risk Assessment / Mental Healthcare Provision.** Forward MH assets provide Risk Assessment of MH injury to Command through objective estimation process and routine clinical activity. The assessment of mental fitness for deployment is a matter for national policy; nevertheless the factors that should be considered in assessing mental fitness are described in Annex D.
- c. **Health Risk Management.** Robust, through career/deployment cycle, Health Promotion in the Management of Stress is embedded in policy<sup>7</sup>. Responsibility lies with Unit Commanders to implement policy. MHP may be used as Subject Matter Experts to advise and deliver MH briefings, at the request of Command, as part of Mental Health Promotion for all personnel.
- d. **Audit and Surveillance.** NATO and national governance/quality management processes operate across MH. In theatre assessment may involve teams of mental health experts who visit clinicians, leadership, and troops in theatre. Such teams interview deployed service members and may administer standardized questionnaires to assess morale, leadership, and levels of psychiatric symptoms<sup>8</sup>. In theatre threat monitoring provides

<sup>6</sup> STANAG 2228 Ed2 covering AJP4.10 (Allied Joint Medical Support Doctrine).

<sup>7</sup> STANAG 2565 Ed1 'A Psychological Guide for Leaders Across the Deployment Cycle'.

<sup>8</sup> Examples include the US Mental Health Advisory Team (MHAT) process, as developed by the Walter Reed Army Institute of Research. Since 2003 teams of mental health research experts visited deployed service members (usually each year) throughout Iraq and Afghanistan completing formal reports of morale, leadership issues, soldier concerns, and levels of psychiatric symptoms.

executive Mental Health surveillance, with disease monitoring systems such as EPINATO or MEDICS providing routine psychological morbidity data.

#### 1.14. HEALTHCARE PROVISION

1. What Mental Health care assets should be available for operations.
  - a. All operations will be supported by a **Forward Mental Health Team (FMHT)** comparable to the home nation's military mental health provision. Deployed Mental Health Professionals<sup>9</sup> deliver all levels of interventions in-theatre (see Figure 1) working within the principles of PIES<sup>10</sup>. With a remit as Force Sustainers, their Health Promotion and Command Liaison/Advisory roles are fundamental to Forward Mental Healthcare. Based with Role 2 or 3 medical facilities, with a peripatetic role visiting forward areas. Medication that should be available to the Forward Mental Health Team is laid out in Annex C.
  - b. The healthcare capability requirement of the Forward Mental Health Team is described at Annex E in the Operational Performance Statement that defines the roles and responsibilities of mental health professionals.
  - c. Designated **Aeromedical Evacuation Mental Health** teams will be available to repatriate mental health casualties from the operational area. The aim of AE is to move patients by air in the safest possible way. This is achieved by using trained Aeromedical staff familiar with in-flight care and the possible hazards of air travel<sup>11</sup>. Specially trained MHP, conversant with International Aviation rules & regulations, provide a robust evacuation service for those in need of "long-term" geographical respite.
  - d. **Home Nation MH Support.** Delivering the retained task across the Home Force, outpatient MH support provides multidisciplinary MHP teams in support of Role 1 primary care services and receiving MH casualties from theatre based MHP via Aeromedical Evacuation. Outpatient MH manages the interface with home nations Role 4 inpatient services and operational zones.
  - e. **Mental Health Incident Response Teams (MH IRT)**<sup>12</sup>. A surge capability, available for short notice deployment, able to initiate services, support

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These teams and their published reports were used to evaluate and adjust in-theatre mental health practices. Reports on OIF MHATs can be found at: <http://www.armymedicine.army.mil/reports/mhat/mhat.html>.

<sup>9</sup> Mental Health Professionals are defined in the Operational Performance Statement at Annex E and at Chapter 1.3.

<sup>10</sup> PIES = 'Proximity, Immediacy, Expectancy, Simplicity'. MH support provided as close to casualty unit as possible (Proximity), as soon as possible (Immediacy), with the Expectation that they will return to their unit fully 'fit to fight' with the minimum intervention possible (Simplicity).

<sup>11</sup> STANAG 2087 Ed6 Medical Employment of Air Transport in the Forward Area.

<sup>12</sup> Formally known as PST or Psychiatric Support Teams.

established FMHT and decompression needs, liaise with command and advise on in theatre threat assessment requirements. Used for crisis management, with standby MHP personnel fully deployment ready.

### **1.15. STANDARDS OF CARE**

1. The quality of Mental Healthcare will be monitored following national governance guidelines. Governance covers systems of clinical safety, clinical and cost effectiveness, systems of accountability and clinical leadership, patient focus, accessibility and responsiveness of care, care environment and amenities, public and occupational health.
2. Scalable deployable mental health professional assets will be provided by NATO nations in support of their troops.

### **1.16. CLINICAL TIMELINES**

1. Urgent mental health casualties are to be seen by a mental health professional within 24hrs of referral by a primary care physician. Urgency relates to risk of deliberate self-harm, harm to others or deterioration of mental health.
2. Routine mental health casualties are to be seen within 7 days of referral by a primary care physician.
3. Aeromedical evacuation timelines are laid down in STANAG 2546/AJMedP-2 (Allied Joint Doctrine for Medical Evacuation).

### **1.17. OUTCOME MONITORING**

1. Host nations will ensure the following outcome monitoring systems are in place for mental health casualties:
  - a. Numbers and nature (diagnoses) of referrals.
  - b. Waiting time between referral and assessment.
  - c. Length of episode of care (assessment to discharge).
  - d. How many personnel return to duty/modified duty or are repatriated.

<b>ANNEX A      PSYCHOLOGICAL MANAGEMENT OF POTENTIALLY TRAUMATIZING EVENTS</b>
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### **A.1. AIM**

To establish common procedures by NATO Nations to enable frontline healthcare personnel to support command for psychological management of potentially traumatizing events.

### **A.2. PSYCHOLOGICAL MANAGEMENT OF POTENTIALLY TRAUMATIZING EVENTS**

1. Military personnel by the very nature of their duties are often placed in potentially traumatic environments. Frequent exposure to potentially traumatizing events (PTEs) in the course of duties may increase the risk of psychological injuries for some members. While the majority of those exposed to a traumatic event will deal with them without suffering long term effects or developing any long term psychological injuries, a small but significant minority may have more difficulty and may experience lasting effects. Therefore, proactive approaches to the management of PTEs are necessary. Military units can mitigate the risk by preparing for PTEs and responding to the needs of those who may become affected.

2. Protocols to manage the effects of PTEs should consider the full spectrum of operations including training, pre-deployment, deployment and post-deployment<sup>13</sup>.

### **A.3. DEFINITIONS**

The following terms and definitions are used for the purpose of this document.

1. Potentially Traumatic Event (PTE) is defined as any unexpected event that can evoke unusually strong emotional reactions and have the potential to interfere with the individual's ability to function appropriately. These events usually involve personnel having experienced, witnessed, or being confronted with a single acute event or a prolonged one or a series of events occurring over time that involve actual or threatened death or serious injury, or threat to the physical integrity of self or others. Examples of PTEs include death in training; suicide; combat death of unit members; witnessing war crimes; mass casualty; intense combat; severe injury and/or combat involving child soldiers.

2. Mental Health Continuum Model is a four coloured model that promotes the viewing of mental health along a continuum. The model goes from healthy, adaptive coping (green), through mild and reversible distress or functional impairment (yellow),

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<sup>13</sup> Psychological Guide for Leaders across the deployment cycle (STANAG 2565).

to more severe, persistent injury or impairment (orange), to clinical illnesses and disorders requiring more concentrated medical care (red). Health, be it physical or mental, is a dynamic changing state that can deteriorate or improve given the right set of circumstances, therefore movement in both directions along the continuum is possible and indicative that there is always the possibility for a return to full health and functioning.

3. Ad Hoc Incident Review (AIR) is a leadership tool to structure a supportive intervention with a group or an individual following exposure to PTE. All leadership levels may be taught this skill (Corporals and above).

4. Mental Health Professional (MHP) includes the following; psychiatrist, psychologist, social worker and mental health nurse authorized to provide mental health care<sup>14</sup>.

4. Welfare Professionals includes for example Chaplains or non MHP Social Workers.

#### **A.4. MANAGEMENT OF PTE**

1. The management of PTEs is intended to mitigate the impact of the PTEs through the promotion of natural recovery, the identification of those requiring assistance, encouraging help seeking and the referral of those requiring mental health care.

2. Reactions to potentially traumatic events vary and can range from no reaction all the way up to the red phase of the Mental Health Continuum Model. See figure 1. It is anticipated that most troops will experience some “reaction” (yellow phase of the Mental Health Continuum Model) after exposure to a PTE. Sometimes these reactions occur immediately following the event whereas for others the reactions maybe delayed. In general, however, most individuals will recover using their own coping strategies without any professional intervention.

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<sup>14</sup> As per NATO CONOPS Mental Health Professional.

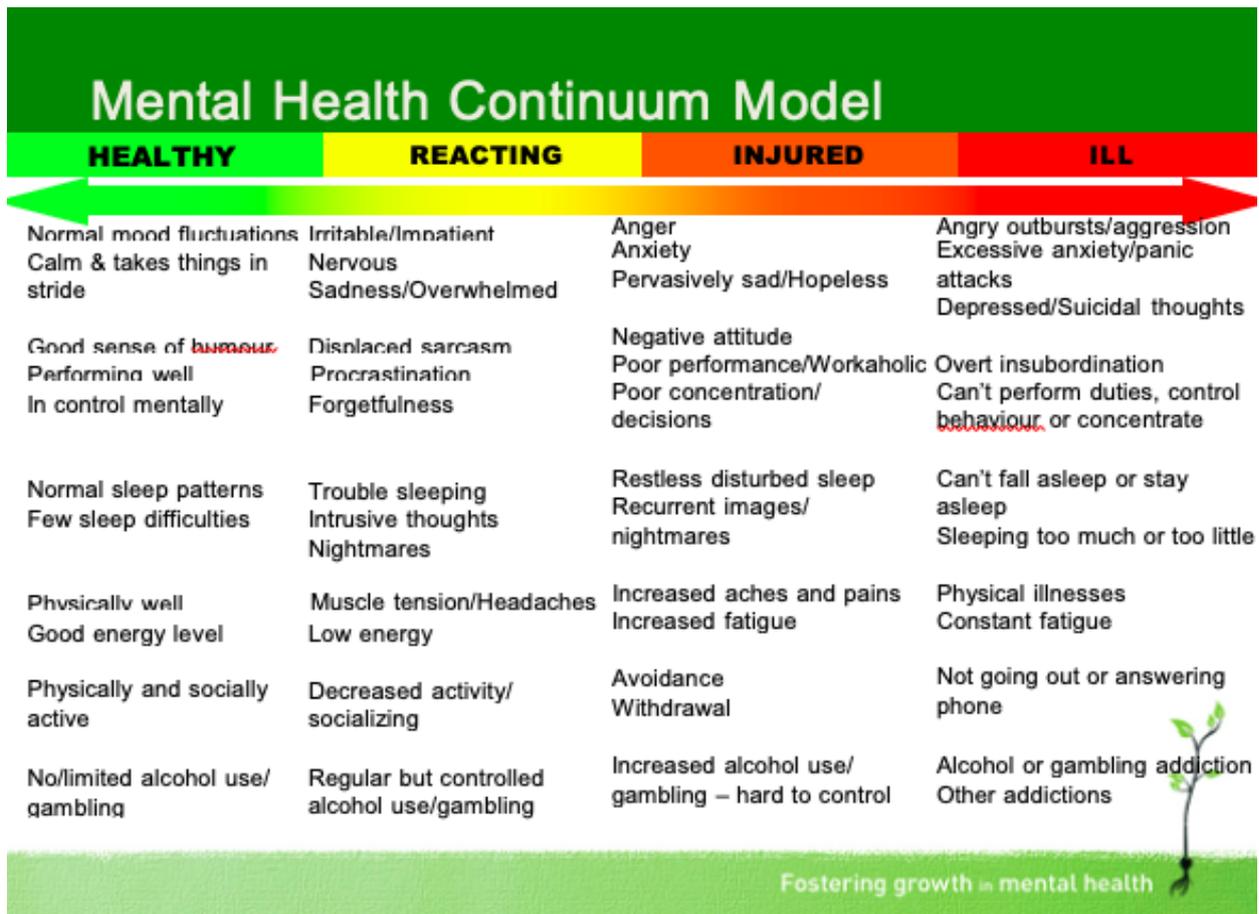


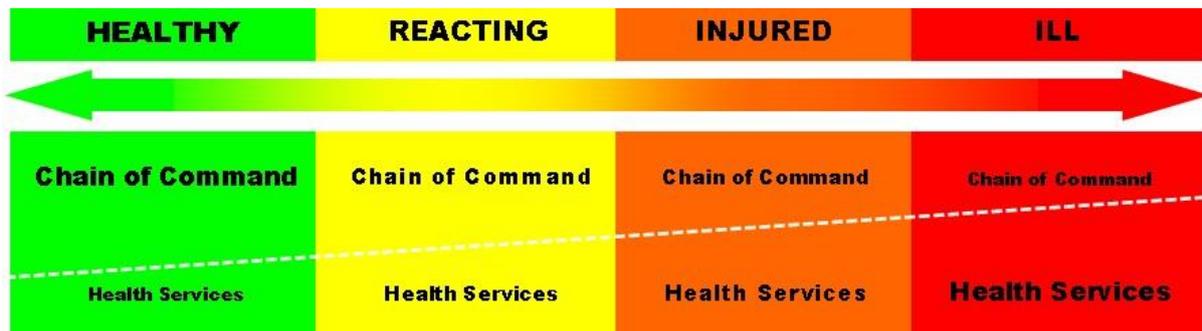
Figure 1: Signs and Symptoms

#### A.5. OVERVIEW OF PATIENT MANAGEMENT FRAMEWORK

1. The management of PTEs is a command responsibility. Specialist mental health care resources are available to support units in the management of PTEs. Leaders should consult with health authorities when responding the PTEs to determine the type and level of support required.
2. The major components of the PTE framework are:
3. Pre-incident education: Pre-incident education is a preventive approach initiated prior to exposure to a potentially traumatic event. The goal of this education is to enhance the resiliency of the service member / unit to mitigate the consequences of exposure to a PTE. Topics include stress identification and management; potentially traumatic events and their impact on self and others; substance misuse education and suicide awareness. This education should be ongoing and imbedded

in the leadership and career curriculum, part of health promotion programs and pre deployment training.

4. Post-incident support: The health and well-being of military members is a shared responsibility of the member, the Chain of Command and medical services. Leaders are responsible for their personnel and have a vital role to play in preventing and managing distress<sup>15</sup>. As the severity of the stress increases, this may result in a more robust medical services involvement, but the Chain of Command never abdicates responsibility of the member. Leaders always have a role and responsibility to maintain contact and support their members throughout the continuum of care provided. See figure 2.



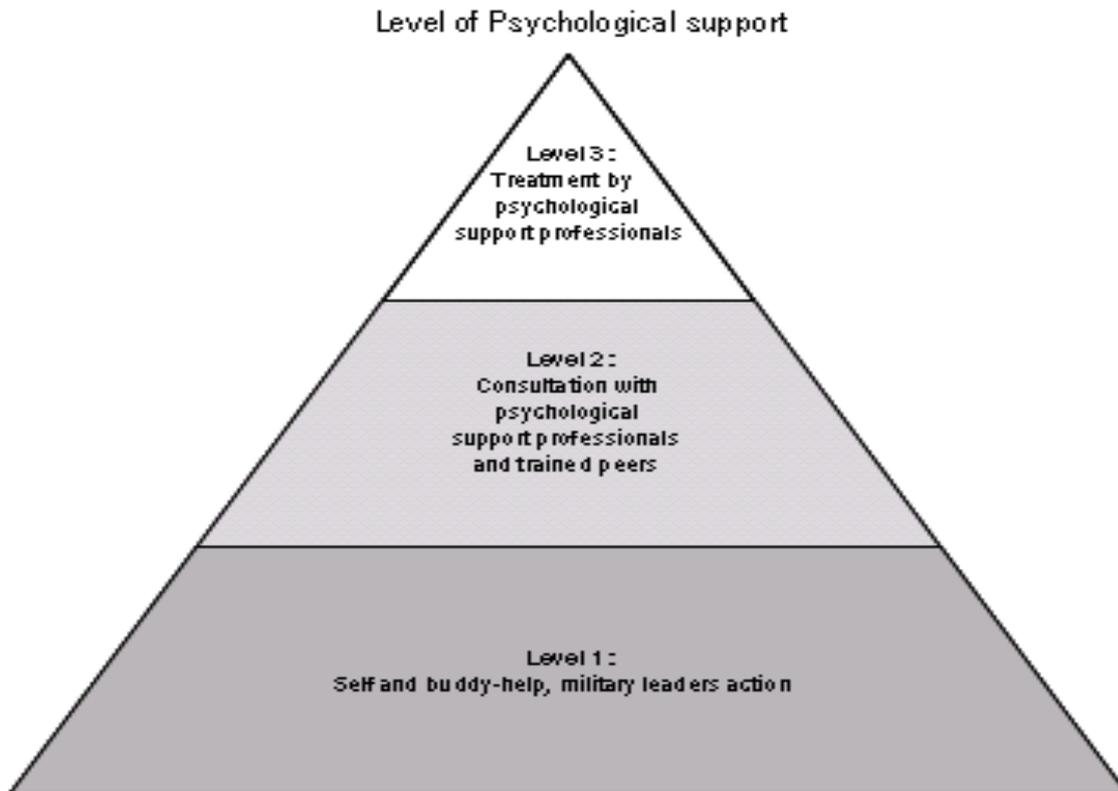
**Figure 2: Mental Health Continuum Model**

5. Post-incident support includes both formal and informal actions taken to assist those exposed to a PTE. The level of support required will be dependent upon the nature of the PTE, reactions to it and how potentially traumatizing the event is assessed to be.

6. A three tier level of support model based on the needs of those affected by exposure to a PTE and their response over time is described in the final report of the Task Group RTO-TR-HFM-018. See figure 3. As one moves from one level to next, the level of support required increases whereas the number of individuals requiring support decreases.

7. Level 1 support is the first line of support and includes leadership actions, self-help and “buddy” support. This level normally occurs immediately following a PTE and represents the most frequently called upon level of support. Level 2 support consists of a combination of peers and mental health professionals and Level 3 support involves assessment and treatment services by mental health professionals.

<sup>15</sup> STANAG 2565 Psychological Guide for Leaders.



**Figure 3: Level of Psychological Support**

**A.6. LEVEL 1 SUPPORT – LEADERS’ ACTIONS, SELF AND BUDDIES:**

1. As the vast majority of PTE will be managed at the unit level, the actions of leaders are critical in establishing a climate that reassures those involved, legitimizes the stressors/emotional reactions and conveys the expectation of recovery and resumption of duty.
2. The initial hours following a PTE can be difficult and those exposed may need to be reminded to care for themselves and to attend to their basic needs including focusing on personal safety, sustenance, hydration, acute medical problems, sleep and restoration of communication with unit, family and friends.
3. By acknowledging the event, leaders can foster a climate that supports the individuals involved. It is important to bring the individuals together, to recognize their experiences, and allow them to react to re-establishing a sense of control. Through the use of such tools as the Ad Hoc Incident Review (AIR) leaders can emphasize the importance of and access to peer support, foster healthy individual coping strategies and provide information on the available resources. Often this is all that is required for most instances of PTEs.

4. A higher level of support may be required when leaders identify personnel who are experiencing an extreme reaction or personnel who are unable to function despite the actions taken (orange/red phases of the Mental Health Continuum Model). At such times leaders should consult with their medical authority to discuss the potentially traumatic event and possible other courses of action.

#### **A.7. LEVEL 2 SUPPORT - MEDICAL AND TRAINED PEERS:**

1. This level of support may be provided by a combination of mental health professionals and or specifically trained peers who are available to assist Commanding Officers at their request in the management of PTEs. Support at this level is designed to assess and provide early intervention. This level of support will take place as soon as possible after a request has been received and be tailored to the particular PTE, the operational needs and requirements of the affected unit or individual.

2. In consultation with the Commanding Officer an assessment with a focus on what happened; who was involved; the context of the incident; the reaction of those involved and the need for and the degree of support required will be conducted. Support at this level:

- a. may include psycho-education emphasizing normalizing the common reactions to trauma, improving coping skills, enhancing self-care, facilitating recognition of significant problems and increasing knowledge of and access to resources;
- b. may include a brief screening/psychological triage to identify who are at highest risk or require immediate referral to Level 3;
- c. may include provision of short term one on one or group consultation<sup>16</sup>;
- d. may include referral of those individuals identified as requiring further assistance;
- e. may include a standardized follow up screening three months post incident.

#### **A.8. LEVEL 3 SUPPORT - ASSESSMENT/TREATMENT:**

Support at this level involves specialized mental health personnel providing assessment and treatment for those individuals who continue to experience difficulty.

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<sup>16</sup> The routine use of single session psychological debriefing (PD) and specifically the use of critical incident stress debriefing in response to PTEs has come under critical review. There is insufficient evidence for or against conducting these types of briefings. Routine use of psychological debriefings is not recommended.

**A.9. FAMILY SUPPORT:**

Potential traumatic events may impact on the families of those members involved. In many incidents they are the first line of support to the member and often are the ones who must deal with the impact of the event on the member. It is important to ensure that support is available to family members post PTE.

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<b>ANNEX B      ACUTE STRESS REACTION AND SUICIDE PREVENTION</b>
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### **B.1. AIM**

To establish common procedures by NATO Nations for frontline healthcare personnel in understanding and managing Acute Stress Reactions (ASR) and the prevention of suicide.

### **B.2. ACUTE STRESS REACTION**

1. An acute stress reaction (ASR) is a transient disorder of significant severity which develops in an individual without any other apparent mental disorder in response to exceptional physical and/or mental stress and which usually subsides within hours or days<sup>17</sup>. It can incapacitate the individual and it can lead to operational disruption if it affects someone in a leadership role or in a responsible position. When ASR occurs on operations, it is known as Operational Stress Reaction (OSR)<sup>18</sup>.

2. Physical causes for an altered mental state may be lack of sleep, hyperthermia, hypothermia, Atropine or Physostigmine injections (taken in the mistaken belief that a chemical attack has occurred), air embolism from a blast wave, inhalation of carbon monoxide, concussion, infection, alcohol withdrawal and stimulant abuse. These are risk factors found more commonly in operational situations.

3. Psychological causes include traumatic events, occupational and social stressors both within theatre and home-related, and may reflect sudden decompensation when under chronic stressors (such as work overload, family problems, harassment) to which the person was thought to be reasonably adapted.

4. Military personnel with ASR should receive an assessment by a military leader/medic to see if full mental health assessment/consultation by a mental health professional (MHP) is required. MHP assessment/consultation is provided if operational conditions allow and as close to the unit as is practical.

5. Management intervention should be undertaken utilizing the model of forward mental health and the principles of proximity, immediacy and expectancy (PIE).

6. The limitations of the PIE model should be recognized in some severe cases and that is the point when MHP should be engaged.

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<sup>17</sup> F43.0 - ICD 10.

<sup>18</sup> This definition includes the previous terms 'battleshock' and 'shellshock' but excludes post-traumatic stress disorder (PTSD).

7. The final decision as to whether the patient should be treated in the unit, close to the unit or at some distance from the unit lies with the unit commander, advised by his medical support.
8. There is an expectancy that the patient who suffered an episode of ASR should be able to return to duty within a short period of time. If the mental state of the patient is such that they are unable to return to duty, then the diagnosis of ASR should be re-evaluated.
9. The patient's level of functioning and safety, including his or her risk of harm to self or others needs to be ascertained. These factors may determine the treatment settings.
10. It is recommended that clarity is obtained as expeditiously as is possible to differentiate between ASR and mild traumatic brain injury (mTBI) as the prognosis and deployability between these two conditions differ.
11. Mental health treatments initiated should be based on a firm evidence base and should also aim to meet an individual's physiological needs such as sleep, fluids and food. Lack of these basic physiological requirements can aggravate the ASR.
12. The patient should be kept in contact with their unit in the expectation that they will be returning to join their comrades within a few hours or in one to two days.
13. The patient should be kept in uniform and he/she is required to maintain military standards and discipline in their behavior. The patient with ASR is to be kept separate from the seriously ill and injured personnel.
14. Treatment should be aimed at restoring the patient's self-esteem and the interventions should not encourage military personnel to adopt illness behavior. Every effort should be made to encourage the acutely traumatized person to rely on their inherent strengths and their existing support networks.
15. The unit should provide a supportive, non-judgmental environment for the patient upon returning to his/her unit.

### **B.3. SUICIDE PREVENTION**

1. Suicide in the operational environment poses a significant challenge due to the lethality of the means generally available.
2. It can be readily seen how these factors can arise in an operational environment, particularly in a leadership vacuum and where morale and Unit cohesion is low.

3. The 2009 International Suicide Prevention Panel convened by the Canadian Armed Forces modified the Mann et al model<sup>19</sup> to better reflect military populations<sup>20</sup>. This gives guidance on how the suicide pathway can be targeted, in order to prevent this outcome (Figure 1).

4. In the operational environment there are steps that can be taken to prevent suicide in keeping with this model:

a. Organization/Leadership

- i. Leadership should create an open culture free of stigma towards mental health conditions through positive messaging about the importance of mental health to operations and the acceptability of help-seeking. Modelling is an important technique for leaders.
- ii. Good educational mental health packages pre-deployment, in theatre and throughout the operational cycle that enable leaders to manage and recognize psychological distress.
- iii. Establish 'Buddy' systems of informal support from peers.
- iv. Organizations as much as possible should attempt to shape operations to minimize operational stress (e.g. tour length, time between deployments and levels of training to prepare for operations and facilitate communication with support networks).
- v. Certain individuals within military populations often act in a 'gate keeper' role on operations and are more likely to encounter distressed individuals. Therefore, they should have levels of training to facilitate access to care. Examples of gate keepers include chaplains, military police and medics.
- vi. In operational planning specific attention must be given to anticipated and unique operational stressors for each operation and mitigation should be planned, along with suitable training to prepare service persons and to support them during these operations.
- vii. Ensure people are supported through stressors such as disciplinary action and relationship difficulties.
- viii. Ensure that individuals are medically and psychologically fit at the time of deployment to undertake their operational duties.
- ix. Ensure that all individuals are aware of what support services are available during the entire operational cycle.
- x. Both healthcare and command structures need to be aware of the risk of suicide contagion and the important role that inappropriate communication can play e.g. rationalizing, romanticizing or glorifying the event.

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<sup>19</sup> Mann JJ, Apter A, Bertolote J, Beautrais A, Currier D and Haas A et al. Suicide prevention strategies: a systematic review. JAMA 2005 October 26;294(16):2064-74.

<sup>20</sup> Zamorski, M. Canadian Forces Expert panel on Suicide Prevention Report. 2009. Canadian Forces Health Services Group.

- xi. The chain of command should have the capacity to restrict the access to lethal means when required to safeguard a suicidal service person.
- b. Mental Health Care
- i. Operations must be supported by a developed forward mental health team (FMHT) depending on the scale and nature of the operation.
  - ii. Timely access to evidence based care must be the norm on operations and this must include both psychotherapeutic and psychopharmacological interventions.
  - iii. Ideally all health professionals on operations should have basic training in the recognition and management of mental health problems, particularly in the recognition of mental health emergencies like suicidality.
  - iv. Members of the FMHT should be visible across the theatre of operations.
  - v. Facilities and processes should exist for the safe containment and onward evacuation of suicidal service persons.
- c. Individual Factors
- i. Mental health and resiliency training.
  - ii. Service persons on operations should ensure that they maintain a healthy lifestyle that promotes resilience and includes physical fitness, avoidance of psychoactive substances and having enough sleep.
  - iii. Encourage a sense of personal responsibility for maintaining their mental health and seeking help if required.
  - iv. Encourage individuals to identify risk factors such as relationship difficulties and financial trouble early and seek help.

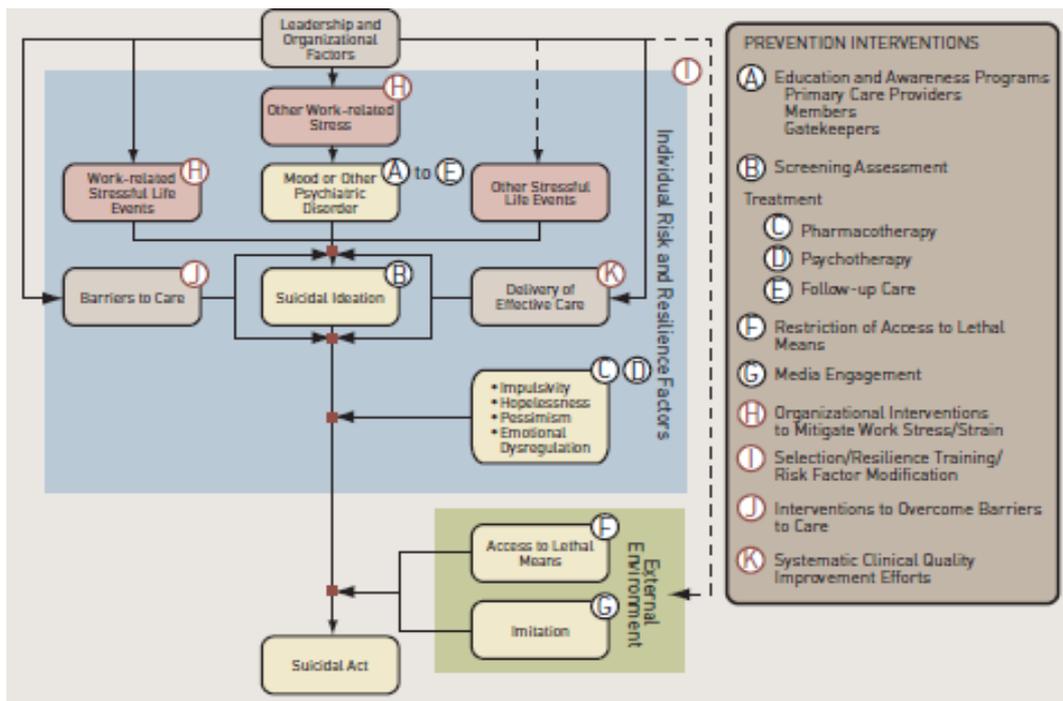


Figure 1: The Mann et al model of suicide prevention (Modified for the purposes of this NATO document)

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**ANNEX C OPERATIONAL CAPABILITY**

**C.1. AIM**

To establish common procedures by NATO Nations of Mental Health capability to operations and Psychiatric medications available across NATO nations.

**C.2. OPERATIONAL CAPABILITY**

1. Military Mental Health services provide Clinical, Educational and Advisory Mental Health support to Command.
2. The effective management of mental health problems is a force multiplier, and specialist mental health capability should be included in operational medical support.
3. National guidelines on delivery of therapy will be respected. Several Nations have legislation limiting therapy delivery to specific professional groups.

**C-3 MEDICATION USE ON OPERATIONS**

Differing countries have differing policies with regards to the deployment of service members on psychoactive substances. The drug list presented below is seen as a minimum requirement list of medication for Role 1 to Role 3 medical facilities. It is not a 'best choice' formulary, but is the minimum expected to be available in all nation's medical facilities.

<b>Drug class</b>	<b>Format</b>
Benzodiazepine • <i>E.g Diazepam</i>	Oral
Benzodiazepine • <i>E.g. Diazepam, Lorazepam</i>	Injectable
First generation high potency antipsychotic	Injectable
First generation high potency antipsychotic	Oral
Second generation antipsychotic • <i>E.g Olanzapine</i>	Oral
SSRI • <i>E.g Fluoxetine</i> • <i>E.g Citalopram</i>	Oral
Anticholinergic • <i>E.g Benztropine</i>	Oral
Hypnotic • <i>E.g Temazepam</i> • <i>E.g Zopiclone</i>	Oral

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<b>ANNEX D MENTAL FITNESS FOR OPERATIONS</b>
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### **D.1. AIM**

The aim of these recommendations is to establish commonality in the factors to be considered in the assessment of fitness of personnel with psychiatric / mental health disorders for deployment and across NATO.

### **D.2. MENTAL FITNESS FOR OPERATIONS**

1. Serving in the armed forces requires the physical and mental fitness necessary to plan and execute military operations. Any health condition that limits the physical or psychological ability of a service member to plan, train or execute the mission represents a risk to the success of that individual, the unit and the mission.

2. Mental or psychological fitness of the personnel is a shared responsibility of the CoC; healthcare services and the soldiers themselves. Any condition or treatment that negatively impacts the mental health status of an individual must first of all be evaluated to determine the potential impact to the individual and to the mission.

3. The assessment of mental fitness prior to deployment should consider the following factors:

### **D.3. OPERATIONAL FACTORS**

1. The environment into which the service member is deploying.

2. The likelihood of psychologically traumatic events, including combat, exposure to life threatening events, or psychologically demanding decisions.

3. The level of physical hardship likely to be encountered including temperature, humidity, noise, nutrition and hydration stressors.

4. The level of sleep disturbance likely to be encountered.

5. The level of social support that will be available, such as peer cohesion and welfare support.

6. The level of medical support that will be available. Considerations include the level of training of those deployed and whether specialist mental health services will deploy.

7. The length of deployment including the time away from the home nation and the level of communication with the home nation.

#### **D.4. PERSONAL FACTORS**

1. The duties to be performed (likelihood of exposure to traumatic events, burden of hours / time on task, likelihood of new / novel tasking, level of responsibility – i.e. leadership role or degree to which the service member is critical to operation – i.e. are they the only person with that specialist knowledge).
3. The experience and / or level of training for the duties to be undertaken.
4. The current welfare of the person and / or their close supports (e.g. current relationship difficulties, financial difficulties or legal problems)

#### **D.5. CONDITION FACTORS**

1. How active / present are the symptoms of their mental health problem.
2. How much the condition affects concentration, sleep, judgement, impulsivity, attitudes, morale & motivation.
3. What their current treatment needs are.
4. How likely the condition is to relapse.
5. What the speed of deterioration is if relapse does occur.
6. How responsive the condition is to treatment.
7. How insightful the service member is about their condition and its effect on themselves and the effect on the team around them / operational tasks.

<b>ANNEX E MENTAL HEALTH PROFESSIONAL OPERATIONAL CAPABILITIES</b>
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## **OPERATIONAL PERFORMANCE STATEMENT**

### **DEFINITION OF MENTAL HEALTH PROFESSIONALS ROLES AND RESPONSIBILITY**

#### **E.1. AIM.**

This Annex aims to define the roles and responsibilities of mental health professionals (MHP) in therapeutic, administrative, command and consultant roles.

#### **E.2. PRINCIPLES.**

1. There are ethical considerations that define the role of MHP on operations and all MHP will operate under the core principle that they shall do no harm<sup>21</sup>.
2. MHP deployed in clinical role should not be involved in interrogation of prisoners<sup>22</sup>.

#### **E.3. DEFINITIONS.**

1. The roles and responsibilities of MHP are defined in the operational performance statement for Mental Health Professionals.

<b>JOB TITLE(S):</b>	<b>NATO MENTAL HEALTH PROFESSIONAL</b> (Psychiatrist, Clinical Psychologist, Mental Health Nurse, Mental Health Social Worker, Occupational Therapist, Mental Health Technician)
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#### **E.4. CONDITIONS**

Unless otherwise stated, the terms and conditions of the individual nations, together with the following conditions apply throughout the document:

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<sup>21</sup> Hippocratic Oath. 500BC.

<sup>22</sup> FRA experience in Battle of Algiers; USA experience in Abu Ghraib.

**E.5. PHYSICAL ENVIRONMENT**

1. As an individual or part of a team.
2. Worldwide.
3. In all operational environments.
4. Possibly at sea or CBRN environment.
5. At any operational location.
6. With or without access to references.

<b>Task/ Sub Task Number</b>	<b>Performance</b>	<b>Standard</b>
(a)	(b)	(c)
1.0	Provision of operational Mental Health (MH) advice to the Chain of Command (CoC)	a Assess operational MH issues b Brief CoC
1.1	Provision of Liaison Service to medical, nursing and paramedical colleagues.	a Assess operational MH issues b Brief Medical chain
2.0	Provision of operational MH briefings to military forces.	a Understand scope of available briefing materials b Brief military forces as required
3.0	Manage MH problems in military forces.	a Assess referred patients
3.1	Manage violent mentally disturbed patient.	b Formulate problem
3.2	Manage substance related problems.	c General principles of managing mentally disturbed patients in accordance with PIE principles
3.3	Manage suicidal patient.	
3.4	Manage depressed patient.	
3.5	Manage acute psychotic patient.	
3.6	Manage acute stress reaction and PTSD.	d To include evidence based pharmacological, psychological, social methods

3.7	Manage any other mental health problems.	e Decide management/treatment plan
4.0	Contribute to Aero-medical Evacuation (AE) Procedures.	a Assess need for AE of patients b Produce required documentation c Provide treatment to patient to ensure fitness for AE.

**E.6 SOCIAL/POLITICAL CONDITIONS**

1. At Role 2 and Role 3.
2. At any operational location.
3. Appropriate language skills, or access to an interpreter.
4. Using operational mental health drug/equipment module.

**E.7. ORDERS**

1. NATO References and STANAGS.
2. National Doctrine, standards and subordinate publications.
3. In accordance with Formation Standing Operating Procedures and References.

**AMedP-8.6(B)(1)**