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MENTAL HEALTHCARE DURING DEPLOYMENT

Edition C, Version 1

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NORTH ATLANTIC TREATY ORGANIZATION

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NORTH ATLANTIC TREATY ORGANIZATION (NATO)

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NATO LETTER OF PROMULGATION

12 May 2026

1. The enclosed Allied Medical Publication AMedP-8.6, Edition C, Version 1, MENTAL HEALTHCARE DURING DEPLOYMENT, which has been approved by the nations in the MILITARY COMMITTEE MEDICAL STANDARDIZATION BOARD (MCMedSB), is promulgated herewith. The agreement of nations to use this publication is recorded in STANAG 2564.

2. AMedP-8.6, Edition C, Version 1, is effective upon receipt and supersedes AMedP-8.6, Edition B, Version 1, which shall be destroyed in accordance with the local procedure for the destruction of documents.

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4. This publication shall be handled in accordance with C-M(2002)60.

Thierry POULETTE
Major General, FRA (A)
Director, NATO Standardization Office

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RECORD OF RESERVATIONS

CHAPTER	RECORD OF RESERVATION BY NATIONS
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 Documents Database for the complete list of existing reservations.	

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RECORD OF SPECIFIC RESERVATIONS

[nation]	[detail of reservation]
DNK	Denmark is unable to commit to the implementation of AMedP-8.6 Annex C, specifically the minimum requirement medication list. The Danish healthcare system has a more restrictive approach to the use of psychiatric medication than what appears as examples on the list. The medication list is therefore not currently available at Role 1 and 2B. With the planned future implementation of a Mental Health Module for Role 2E, the list will be reviewed by experts and a Danish medication list will be implemented. Annex C will be used as a reference for this process, but deviations from the list may occur.
ESP	The possibility of addressing casualties outside the healthcare support system structure is not considered. 1.16 Outcome Monitoring: It will be the responsibility of the nation contributing to the deployment not the host nation.
GBR	Para 1.15.2. Only certain groups can self-refer directly to mental health professionals; however, all personnel can self-refer to primary health care who will make the referral to mental health professionals if required. Similarly, chain of command can refer personnel to primary health care, for referral to mental health professionals as required.
HRV	The Croatian Armed Forces accept the principles of this standardization document and the document will be implemented when the necessary organizational, material and financial requirements are met for its adoption. The reservation refers to the procedures related to the implementation of psychological crisis interventions, since formal support and assistance to members of the Croatian Armed Forces, including participants in peace support operations, after acute stressful situations and/or traumatic experiences, are provided primarily by military psychologists and allied professions, and the inclusion of professional staff for the clinical approach in the diagnostics, treatment and rehabilitation of personnel traumatized in the area of operations refers to cooperation with national civilian health institutions specialized in the subject. The procedures for psychological relief and psychological crisis interventions after stressful/traumatic events, as well as the conditions and method of their implementation, are elaborated in detail in the standard operating procedure in the Croatian Armed Forces.
ITA	ITA AIR: Future implementation is subject to reservations due to current limitations in the menthal health response capability in theaters of operation. At present, such capability is ensured only by high-readiness units that can be activated by Italian Joint Operations HQ(JMed). Furthermore, the current level of preparation and specialization of teams dedicated to advanced support is not yet sufficient to guarantee sustainable implementation.
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 Documents Database for the complete list of existing reservations.	

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CHAPTER 1 CORE GUIDANCE

1.1. AIM

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

The effective management of MH 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.

1.3. DEFINITIONS

1. The NATOTerm database has the following definitions relevant to Mental Healthcare during deployment:

a. Operational stress reaction (OSR): 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.[1] See Annex B.

b. Operational stress casualty (OSC): A person who suffers an adverse psychological reaction resulting from exposure to an operational stressor.[2]

1.4. OPERATIONAL STRESS CASUALTIES

These casualties may be managed outside of or within the structure of the medical support system, with an expectation of rapid return to duty.

1.5. INCIDENT RESPONSE TEAM (IRT)

A team held at high readiness to deploy in response to a crisis. [3] IRTs are an essential part of graduated incident response, since incident response requires immediate reaction, preparedness and ability to respond to such an event. IRTs are rapidly deployable assets representing this capability. The medical component of an IRT

[1] NATO*Term* 40758
[2] NATO*Term* 40757
[3] NATO*Term* 25648

should include trained, equipped and experienced specialist personnel to deal with the consequences of trauma or life-threatening illness.

1.6. MENTAL HEALTH PROFESSIONAL (MHP)

A clinician appropriately trained to perform diagnosis and treatment of medical, emotional and behavioral disorders[4] (includes Psychiatrist below). Note that additional personnel may help support the clinical MHPs, including mental health/behavioral health medics/technician, or professionals trained in non-clinical psychological fields, such as organizational or performance psychology. See Annexes A and B for psychological management strategies and Annex E for roles and responsibilities of MHPs.

1.7. MENTAL INCAPACITY

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.[5]

1.8. PSYCHIATRIST

A physician appropriately trained and licensed to perform diagnosis and treatment of mental, emotional and behavioral disorders.[6]

1.9. TELEHEALTH

The provision of all remote health services, including telemedicine, health education and preventive care, using information and communication technologies.[7]

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 MH 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

[4] NATO*Term* 25562
[5] NATO*Term* 39124
[6] NATO*Term* 25559
[7] NATO*Term* 17727

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. Differences between them are:

a. The emphasis is on **not** evacuating an operational stress case; however, robust evacuation chains are essential for some mental health disorders.

b. Although assessment and treatment by specialized MHPs may be required, far forward stress management should involve self-aid, buddy aid, command interventions and other non-medical means. See also STANAG 2565 AMedP-8.10 A Psychological Guide for Leaders Across the Deployment Cycle for more details on specific leader strategies to support psychological readiness.

c. Responsibility for operational stress management is a Chain of Command (CoC) responsibility, resting largely outside the medical area. The management of *stressors* is a CoC responsibility. Management of *stress reactions* is by a layered approach in accordance with Annex B.

1.11. CASUALTY AETIOLOGY

The nature and number of mental health casualties remains linked to the operational tempo, nature and the duration of deployment, home factors, physical health and occupational stressors, unit cohesion, and supportive military leaders. It is reasonable to assume that earlier management and effective risk communication will be effective in preventing dysfunction and maintaining operational effectiveness. Strong leadership and unit cohesion have been shown to protect against stress reactions and other mental health problems.

1.12. PRINCIPLES OF FORWARD DEPLOYED MENTAL HEALTH SUPPORT

1. The psychological welfare of troops is primarily a CoC responsibility. Mental health support begins with the leader who needs to:

- exercise good leadership, which engenders trust;
- show competence and be credible; and
- provide a caring attitude which encourages cohesion and strong morale.

2. 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. Please refer to the STANAG 2565 AMedP-8.10 A Psychological Guide for Leaders Across the Deployment Cycle for more details on specific leader strategies to support psychological readiness.

3. Ideally, no matter the context or location of service, military personnel should have access to mental health care and commanders should receive occupational mental health input to assist in force maintenance.

4. MHPs aim to establish relationships with primary care and command, so they can understand the needs of the command and the conditions they operate in. This connection enables them to flexibly assess, treat, support, and provide psychoeducation in their unit rather than taking unit members away from the operation to receive services. This approach has the added advantage of increasing unit and individual self-reliance and sustainability.

5. There should be a requirement for mental health professionals to make the transition to providing clinical service in operational environments when the need arises; care delivery should be a continuation of everyday peacetime practice with mental health professionals being an accepted asset throughout the armed forces and not a novelty during times of conflict.

6. Mental health care support consists of:

   a. Clinical Services – triage, assessment, diagnosis, early intervention, treatment, and rehabilitation.

   b. Education/Prevention – mental health promotion to all in the area of operations (AOO), specific briefs to groups such as individuals tasked with managing human remains and other groups considered to be exposed to high-impact stressors, and education of other medical personnel on detection and management of mental health problems.

   c. Advisory Support – Acting as a liaison with command on psychological threats, for example by visiting units around the AOO.

1.13. HEALTHCARE PROVISION

1. What MH care assets should be available for operations.

   a. Operations will be supported by a **Forward Mental Health Team** (FMHT) as close as possible to the units. Deployed MHPs deliver all levels of interventions in-theatre (Clinical, Education, and Liaison/Advisory services)) working within the principles of PIES. (PIES = ‘Proximity, Immediacy, Expectancy, Simplicity’), or a similar framework. MH support should be provided as close to units 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). With a goal as Force Sustainers, their Health Promotion and Command Liaison/Advisory roles are fundamental to Forward Mental Healthcare. Although FMHTs may be based with Role 2 or 3 medical treatment facilities (MTF), they need to support medics

and health professionals in Role 1 facilities through direct or virtual consultation. The classes of medication that should be available are annotated in Annex C.

b. The healthcare capability requirement of the FHMT is described at Annex E in the Operational Performance Statement that defines the roles and responsibilities of MHPs.

c. When applicable, designated **Aeromedical Evacuation Mental Health** teams, or flight medics trained in basic psychological first aid, should be available to support service members with serious mental health conditions needing aeromedical evacuation from the operational area. The aim of aeromedical evacuation is to move patients, for example those who have suicidal intent, by air in the safest possible way.

d. **Home Nation MH Support.** Delivering the retained task across the Home Force, outpatient MH support provides multidisciplinary MHP teams in support of primary care services and receiving MH casualties from theatre based MHP via chain of evacuation when required.

e. **Mental Health Incident Response Teams (MH IRT**). **MH** IRT go by many names and configurations in the different services (for example, Combat Operational Stress Detachment in the U.S. Army). They, reflect a surge capability, available for short notice deployment, able to initiate services, support established forward mental health treatment and decompression needs, liaise with command, and advise on in theatre threat assessment requirements. Used for crisis management, traumatic event management, and standby MHP personnel fully deployment ready.

1.14. 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 MHP assets will be provided by NATO nations in support of their troops.

1.15. CLINICAL TIMELINES

1. Urgent MH casualties optimally are to be seen by a MHP within 24 hours of referral by a primary care clinician or CoC. Urgency relates to the risk of deliberate self-harm, harm to others, or substantial deterioration of mental health. Options for self-referral should also be available.

2. Routine MH casualties are optimally seen within 7 days of referral by a primary care clinician. Options for referrals by CoC and self-referrals should also be available.

3. Tactical and strategic aeromedical evacuation times are stipulated in STANAG 3204 AAMedP-1.1 Aeromedical Evacuation.

4. It is recognized that these timelines may be impacted by the availability of ground, air, and sea evacuation and the operational environment.

1.16. OUTCOME MONITORING

1. Host nations will ensure the following outcome monitoring systems are in place for MH casualties:

a. Numbers and nature (diagnoses) of referrals.

b. Waiting time between referral and assessment.

c. Length of episode of care.

d. How many personnel return to duty, modified duty, or are repatriated.

e. Characterized outcomes by echelons of care and unit or operation.

ANNEX A PSYCHOLOGICAL MANAGEMENT OF POTENTIALLY TRAUMATIZING EVENTS, MENTAL HEALTH CONTINUUM, AND LEVELS OF MENTAL HEALTH SUPPORT

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 TRAUMATIC 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 mental health problems for some members. While the majority of those exposed to a traumatic event will not suffer long term effects or develop long-term psychological problems, a small but significant minority may have more difficulty in the form of short-term Operational Stress Reactions or may experience more 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.

A.3 DEFINITIONS

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

2. Potentially Traumatic Event (PTE) is defined as any serious or unexpected traumatic event that can evoke unusually strong emotional, cognitive, and physical 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 event or 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; unit members missing in action; torture; witnessing war crimes; mass casualty; intense combat; persistent drone warfare; delayed or prolonged medical evacuation; prolonged artillery bombardment; severe injury; and/or combat involving child soldiers.

3. Mental Health Continuum Model (shown at Figure A.1 below) 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 reactive distress (yellow), to more severe, persistent strain (orange), to clinical illnesses and disorders that may render the service member combat ineffective and require 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. Individuals may be at different levels across the six domains of functioning. Note that there are different versions of this continuum model that countries have used over the years, including a version in the STANAG 2565 AMedP-8.10 A Psychological Guide for Leaders Across the Deployment Cycle that includes a blue “optimize” zone. However, since the focus of this STANAG is on forward mental health care, rather than on leadership strategies to support optimal readiness, this version emphasizes the stages where medical support is most important.

Mental Health Continuum

	Ready	Reacting	Strained	Combat ineffective
Mood	Normal mood Stable Grounded Takes things in stride	Irritable/ impatient Nervous Sad Overwhelmed Touchy	Angry Anxiety Pervasive sadness Hopelessness	Out of control Strong anxiety Panic attacks Depressed or suicidal thoughts
State of mind	Performing well Capacity for enjoyment In mental control	Displaced sarcasm Little enjoyment Forgetful/distracted	Negative attitude Poor performance Poor concentration	Overt insubordination Unable to perform duties or concentrate
Sleep	Normal sleep pattern Little sleep difficulty	Restless sleep Bad dreams or nightmares	Restless/disturbed sleep Reccurent nightmares	Can’t fall or stay asleep Sleeping too much or too little
Physical	Good energy and physical activity levels	Tense muscles Headaches Low physical energy	Increased aches and pains Increased fatigue	Significant pains Constant fatigue
Social connection	Good social connections Trusting relationships	Reduced social connection	Avoidance Withdrawal	Active rejection of social connections
Behavior	Little use of alcohol and ot intoxicants	Increased substance use ar gambling Recklessness	Uncontrolled substance us and/or gambling	Self harm Addiction Suicidal behavior

Figure A.1: Mental Health Continuum: Signs and Symptoms

4. Mental Health Professional (MHP) (clinical) is a healthcare clinician appropriately trained to perform diagnosis and treatment of mental, emotional and behavioral disorders (i.e., psychiatrist, psychologist, clinical social worker, mental health nurse) authorized to provide mental health care.

5. Additional Members of the Team supporting mental health may include, for example, Chaplains, non-MHP social workers, behavioral health medics/technicians, and non-clinical professionals (e.g. research, organizational, performance psychologists).

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 PTEs vary and can range from no impact to falling in the red phase of the Mental Health Continuum Model in another. See figure 1 of this Annex. 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 may be delayed. In general, however, most individuals will recover using their own coping strategies without any professional intervention.

A.5 OVERVIEW OF PATIENT MANAGEMENT FRAMEWORK

1. The management of PTEs is a command responsibility. Primary care and specialized mental health care resources are available to support units in the management of PTEs. Leaders should consult with health professionals when responding to the PTEs to determine the type and level of support required.

2. The major components of the PTE framework are as follows: See also STANAG 2565 AMedP-8.10 A Psychological Guide for Leaders Across the Deployment Cycle for more details on specific leader strategies:

a. 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 use 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.

b. Post-incident support: The health and well-being of military members is a shared responsibility of the member, the Chain of Command (CoC), and medical services. Leaders are responsible for their personnel and have a

vital role to play in preventing and managing distress. As the severity of the stress increases, this may result in a more robust medical services involvement, but the CoC never abdicates responsibility of the member. Leaders always have a role and responsibility to maintain contact with and support their members throughout the continuum of care provided (Figure A.2). The individual also has responsibility for their actions across the continuum, and buddy aid has a role across the continuum as well.

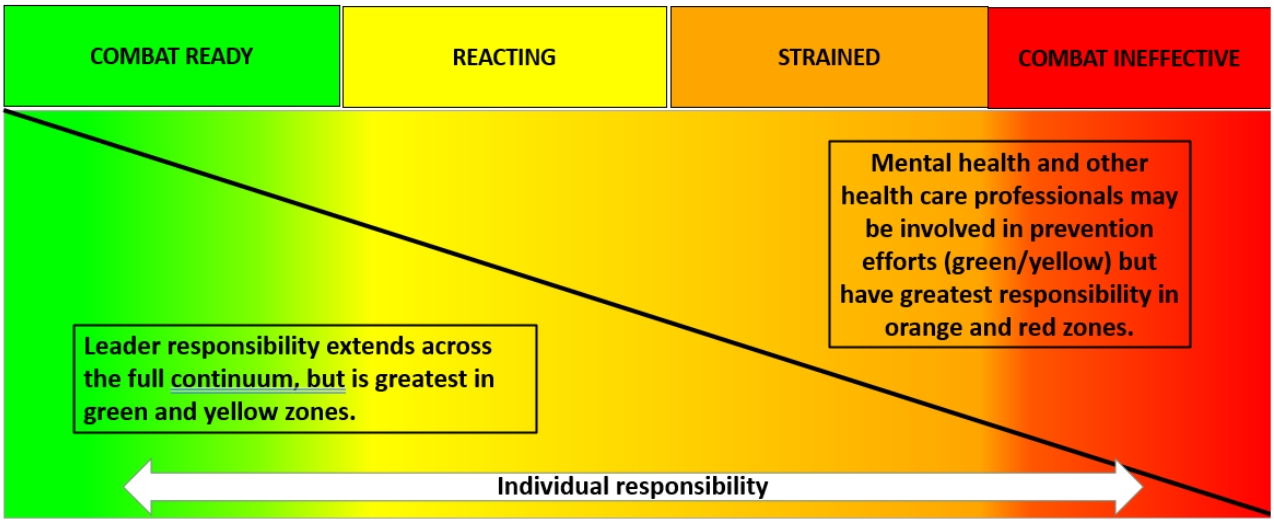


Figure A.2: Mental Health Continuum Model: Balance of Chain of Command and Mental Health Professional Services Responsibility

3. Post-incident support includes both formal and informal actions taken to assist those exposed to PTE. The level of support required through the mental health continuum will be dependent upon the nature of the PTE, reactions to it, and how potentially traumatizing the event is assessed to be. See figure A.2. As one moves from one level of severity to the next, the level of professional mental health support increases.

4. Figure A.3 shows levels of psychological/mental health support for individuals, applicable both to PTEs and other mental health conditions in general. 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, primary care and mental health professionals and Level 3 support involves assessment and treatment services by MHPs.

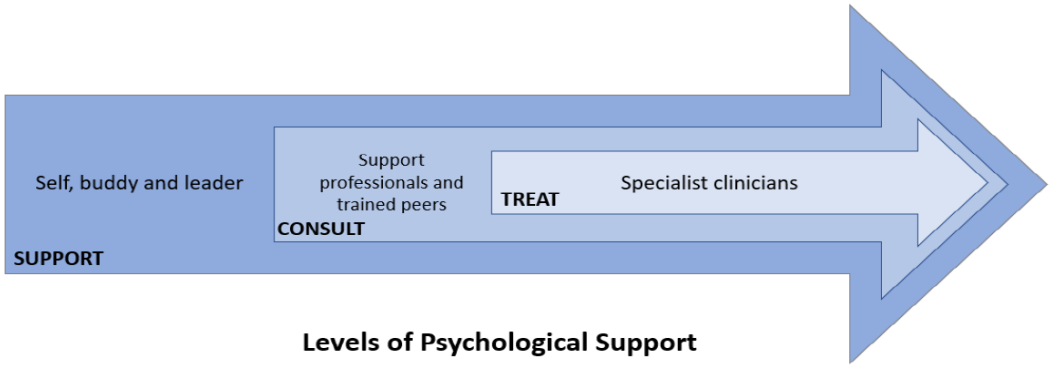


Figure A.3: Levels of Psychological Support

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

1. As the vast majority of PTE, as well as other psychological stressors occurring in the operational environment, 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 units, family and friends.

3. By acknowledging the event, leaders can foster a climate that supports the individuals involved. It may be helpful to bring the individuals together, to recognize their experiences, and allow them to talk about their feelings surrounding the incident and re-establishing a sense of connection and control. Leaders can emphasize the importance of and access to peer support, foster healthy individual self-care coping strategies, and provide information on available resources. This is often 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 Chaplains, MHPs, Primary Care Clinicians, 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 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, should be considered. Support at this level may include:

- psychoeducation 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;
- a brief screening/psychological triage to identify who is at highest risk or requires immediate referral to a MHP;
- provision of short-term one-on-one or group consultation. More information on this is in the STANAG 2565 AMedP-8.10 A Psychological Guide for Leaders Across the Deployment Cycle;
- referral of those individuals identified as requiring further assistance; and/or
- a standardized follow up screening post-incident.

A.8 LEVEL 3 SUPPORT - ASSESSMENT/TREATMENT BY MENTAL HEALTH PROFESSIONAL:

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

ANNEX B ACUTE STRESS REACTIONS/OPERATIONAL STRESS REACTIONS AND SUICIDE PREVENTION

B.1. AIM

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

B.2. ACUTE STRESS REACTION/OPERATIONAL STRESS REACTION[8]

1. An ASR is characterized by temporary psychological and physiological symptoms that can interfere with functioning and is often very transient (few minutes). These symptoms may span a broad range of physical, cognitive, and emotional symptoms. In a combat situation, for example, a soldier may be temporarily overwhelmed, confused, and disoriented by traumatic events such as blasts (perhaps compounded by exhaustion and/or sleep disruption), resulting in dissociation, panic, panic, freezing, agitation, or erratic behavior. Regardless of the specific symptoms, the common thread across these reactions is that the individual is unable to function for some brief period, potentially endangering themselves, the team, and the mission. ASRs are not psychological disorders, but normal responses to abnormal stressors, temporary periods of dysfunction resulting from extreme stress

2. A synonymous but broader term than ASR is the term OSR. OSR encompasses transient acute stress reactions, such as what is described above, but is the preferred terminology when symptoms due to operational stressors last for hours or a few days. All individuals can reach their mental, cognitive, or physical breaking point where their functioning becomes impaired due to cumulative or severe operational stressors, such as chronic sleep loss, physical exhaustion, injuries (including concussions), continuous operations, loss of team members, and exposure to other traumatic events. These reactions, which can involve a range of emotional, behavioral, cognitive, and physical symptoms, do not reflect a psychological disorder or diagnosis, but a normal response to extreme stress. OSRs include many types of symptoms, such as panic/anxiety, withdrawal, slowness of thought, difficulty prioritizing tasks, preoccupation with minor issues, cognitive problems, amotivation, exhaustion, agitation, confusion, and even temporary psychotic states.

3. Physical causes for an altered mental state may include lack of sleep, hyperthermia, hypothermia, atropine or physostigmine injections (taken in the belief that a chemical attack has occurred), physiological effects from a blast wave, inhalation of carbon monoxide, mild traumatic brain injury (concussion), infection,

[8] NATO*Term* 40758 ‘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.’

alcohol withdrawal, stimulant abuse, and other medical conditions. These exposures are more commonly found in operational situations.

4. Psychological causes include traumatic events, occupational and social stressors both within the theater and home-related, and other cumulative stressors which may lead to acute decompensation when the individual has reached the point where the stressors overwhelm their ability to cope (such as overwhelming combat stressors, work overload, family problems, victim of ongoing harassment or bullying). Psychological causes may be combined with physical causes.

5. In operational settings, team members can be taught to identify an ASR in others and promptly intervene to help the individual quickly return to functioning. Several NATO nations have developed and disseminated rapid intervention for peers to use. For example, the iCOVER technique is described in Box B1 (Reference: Adler AB, Gutierrez IA, McCauig Edge H, Nordstrand AE, Simms A, Willmund GD. Peer-based intervention for acute stress reaction: adaptations by five militaries. BMJ Mil Health 2024; 170:425–429).

Box B1: Essential Components of Peer-Based Management of OSR

(ASR) (iCOVER)

Identify acute stress reaction

Connect and get the individual's attention - to break through their sensory disconnection

Offer reassurance that the individual is not alone - to reduce their sense of psychological isolation

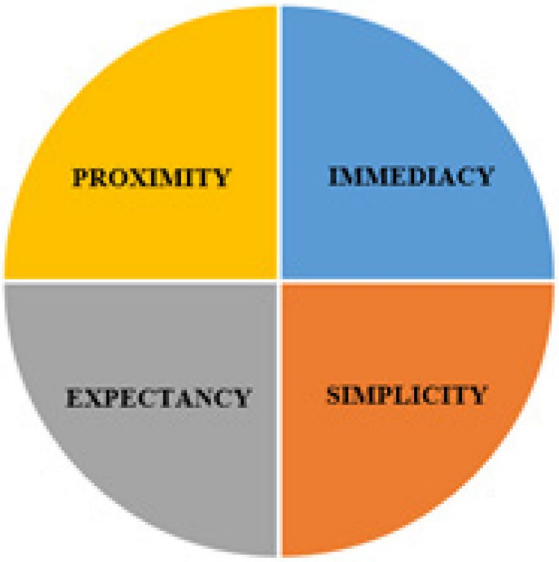
Verify simple facts - to kick-start the thinking brain

Establish what happened, is happening and will happen - to re-orient the individual

Request purposeful action - to counter feeling a lack of control

6. If OSR symptoms persist and do not respond to immediate buddy support, military personnel with OSR should receive an assessment by a military leader/medic/primary care clinician to check for physical causes and determine if a full mental health assessment/consultation by a Mental Health Professional (MHP) is required. After ruling out treatable physical causes, MHP assessment/consultation should be provided as close to the unit as practical if operational conditions allow.

7. Management intervention should initially utilize the model of forward mental health and the principles of proximity, immediacy, expectancy, and simplicity (PIES) (see Figure B1 below) or the 5Rs (see Box B2 below). PIES and 5Rs include simple restorative interventions such as hydration, food, and rest, provided as close to the unit as possible and with the expectation of rapid and full recovery (typically within 1-3 days). The patient should be kept in contact with their unit with the expectation that they will return to join their comrades within one to three days. Note that there are variations in PIES in different services. For example, BICEPS is currently part of U.S. military doctrine, which stands for Brevity, Immediacy, Expectancy, Proximity, and Simplicity, and is effectively the same thing as PIES.



Box B2: 5Rs

- **Reassurance**
- **Rest**
- **Replenish** body needs (sleep, food, water, hygiene)
- **Restore Confidence**
- **Return to Duty**

Figure B1: PIES

8. The limitations of the PIES/5Rs models should be recognized. If there are severe symptoms or symptoms that are non-responsive to simple measures, the appropriate medical personnel should be engaged.

9. The final decision as to whether the service member should be treated in the unit, close to the unit, or at some distance from the unit, lies with the unit commander, advised by medical support. It is important to create and support expectancy that the patient who suffered an episode of ASR should be able to return to duty within a short period. However, if the mental state of the patient is such that they cannot return to duty, then the diagnosis of ASR should be re-evaluated. The patient's level of functioning and safety, including the risk of harm to self or others, needs to be ascertained, as these factors may determine the treatment settings.

10. It is important to ensure that an appropriate medical evaluation is conducted as quickly as possible to ensure that medical conditions, such as a mild traumatic brain injury (mTBI), which might be associated with similar symptoms are addressed. Once it is determined that the symptoms are best explained by OSR, then the PIES and 5Rs principles apply.

11. Treatment of OSR should aim to rapidly restore the patient's functioning and avoid interventions that encourage illness behavior. Efforts should be made to encourage the acutely traumatized person to rely on their inherent strengths and existing support networks. Studies have shown that the further the treatment occurs from the unit, the higher the likelihood that the individual will not return promptly to full duties.

12. The unit should provide a supportive, non-judgmental environment for the patient upon their return.

13. Beyond OSR, it is important to acknowledge that military personnel may experience stress from various other domains and sources. These can include:

a. Environmental Stressors: Harsh weather conditions, difficult terrain, and limited access to resources.

b. Operational Stressors: High operational tempo, extended periods of high alert, and complex mission requirements.

c. Interpersonal Stressors: Conflicts with peers or superiors, issues within the Chain of Command, and concerns about unit cohesion.

d. Home Front Stressors: Worries about family members' well-being, financial concerns, and balancing military and family responsibilities.

e. Complexities of electronic communication, social media, cognitive and information warfare, and increasing need for signal discipline which

might reduce connectivity due to persistent surveillance of electronic communications.

f. *See the STANAG 2565 AMedP-8.10 A Psychological Guide for Leaders Across the Deployment Cycle for more on what leaders can do to support unit members with stress reactions.*

B.3. SUICIDE PREVENTION IN FORWARD OPERATIONAL SETTING

1. Suicide in the operational environment poses a significant challenge due to the lethality of the means generally available.

2. STO-TR-HFM-218 “Military Suicide Prevention Report (2018) and STO-TR-HFM-277 “Leadership Tools for Suicide Prevention” (2022) provide the most up to date recommendations of leader actions to prevent and respond to suicides and suicidal behavior. An extensive set of infographics to support education efforts are included with the HFM-277 report. The key conclusion for these reports is shown in Box B3.

Box B3: Key messages for military suicide prevention

a. Suicidal service members require immediate attention and must not be stigmatized.

b. Best practices in suicide prevention exist and their wide dissemination is imperative.

c. Leaders are strategically in an ideal position to ensure that suicidal service members receive timely assistance from mental health, substance use, chaplaincy, and/or family-focused programs.

3. In the operational environment some steps that can be taken to prevent suicide include the following:

a. Organization/Leadership

(1) Leadership at all levels needs to work to create a culture of trust, 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.

(2) Good educational mental health packages pre-deployment, in theatre and throughout the operational cycle that enable leaders to manage and recognize and respond to psychological distress, for

example the Ask-Care-Escort (ACE) training used in US and Canada.

(3) Establish 'Buddy' systems and trained Peer Support Network.

(4) 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).

(5) Certain individuals within military populations often act in a 'gate keeper's 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, peer supporters, military police and medics.

(6) 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.

(7) Ensure people are supported through stressors such as disciplinary action and relationship difficulties.

(8) Ensure that individuals are medically, mentally, and psychosocially fit at the time of deployment to undertake their operational duties.

(9) Ensure that all individuals are aware of what support services are available during the entire operational cycle.

(10) Ensure that individuals at risk of suicide are evaluated promptly.

(11) 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.

(12) The Chain of Command should have the capacity to restrict access to lethal means when required to safeguard a suicidal service person.

b. Mental Health Care

(1) Operations must be supported by a developed Forward Mental Health Team (FMHT) depending on the scale and nature of the operation.

(2) Timely access to evidence-based care must be the norm on operations and this must include both psychotherapeutic and psychopharmacological interventions.

(3) 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.

(4) Members of the FMHT should be visible and accessible across the theatre of operations.

(5) Facilities and processes should exist for the safe containment and onward evacuation of suicidal service persons.

c. Individual Factors

(1) Mental health and resiliency training.

(2) 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.

(3) Encourage a sense of personal responsibility for maintaining their mental health and seeking help if required.

(4) Encourage individuals to identify risk factors such as relationship difficulties and financial trouble early and seek help.

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ANNEX C OPERATIONAL CAPABILITY

C.1. AIM

To establish common procedures across NATO Nations for establishing mental health and psychiatric medication capability in forward operations.

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

Countries have differing policies with regards to the deployment of service members on psychoactive substances, as well as different formularies for service personnel who are deployed. The drug list presented provides a minimum requirement for the classes of medications needed in Role 1 to Role 3 medical facilities, as well as some medication examples within each class. While the medications may differ across countries, every effort should be made to ensure that there are one or more options available within each class. It is not a ‘best choice’ formulary, but is the minimum expected to be available in all nation’s medical facilities.

Drug class	Format
Benzodiazepine • *e.g. diazepam* • *e.g. lorazepam*	Oral/Injectable
First generation high potency antipsychotic • *e.g. h*aloperidol	Oral/Injectable
Second generation antipsychotic • *e.g. olanzapine* • *e.g. quetiapine*	Oral/Injectable
Antidepressants • *e.g. fluoxetine* • *e.g. sertraline* • *e.g. citalopram/escitalopram,* • *e.g. mirtazapine*	Oral
Anticholinergic • *e.g. benztropine* • *e.g. diphenhydramine*	Oral/Injectable
Hypnotic • *e.g. zolpidem* • *e.g. zopiclone/eszopiclone*	Oral

ANNEX D OPERATIONAL MENTAL FITNESS

D.1. AIM

The aim of these recommendations is to establish commonality in the factors to be considered in the assessment of psychiatric/mental fitness of personnel for deployment and across NATO. These recommendations are for before deployment AND when deciding whether someone should remain in theatre.

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. Note that mental fitness is synonymous with psychological fitness and mental/psychological readiness, and refers to the mental resilience, mental hardiness, and toughness to face the rigors and challenges of deployment, whether humanitarian, peacekeeping, combat, or the combination of all three. 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 Chain of Command (CoC), healthcare services, and service members. Any condition or treatment that negatively impacts on the mental health status of an individual must first be evaluated to determine the potential impact on the individual and to the mission.

3. The minimal standard for assessing mental health fitness to deploy should consider the following general factors:

a. The service person should be fit to deploy at short notice to any location worldwide and serve as directed by the CoC.

b. There must be an acceptable degree of certainty that they will be able to cope with heightened levels of stress frequently encountered on operations, whilst maintaining sufficient mental wellbeing to remain functional and effective.

c. They must be able to deploy away from their support network for prolonged periods, in a largely self-reliant capacity, without becoming an administrative burden or operational risk due to debilitating mental health symptoms.

d. They must be able to safely and effectively operate weapon systems on operations, particularly when required to discharge weapons in combat under pressure.

e. They must be able to deploy without additional special support requirements that cannot reasonably be provided by deployed healthcare and welfare provisions extant on that operation.

f. Relapses of symptoms must not carry a high risk of behaviors that may present significant problems in theater, for example serious self-harm, violence, unpredictable behavior or that leads to the loss of capacity or insight that may endanger others. This includes consideration of the speed of relapse and the responsiveness of the condition to treatment.

g. Oral psychotropic medications, if taken by individuals who are deploying, must have no special handling, storage, or other requirements, for example refrigeration, cold chain assurance, frequent blood testing or electrical power requirements. Medication should also be suitable for short term storage in ambient temperatures ranging from below freezing to extremes of temperatures in hot environments. Medication should not cause significant side effects that could be problematic on operations, for example sedation, reduced tolerance to extremes of temperature or likely to cause or worsen dehydration. The individual also needs to be able to continue to function effectively if they lose access to the medication.

h. The mental health disorder does not prevent the donning of personal protective equipment, including protective face masks, ballistic helmets, body armor, and chemical/biological protective garments.

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

D.3. OPERATIONAL FACTORS

1. The environment into which the service members are deployed.

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 be deployed.

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

8. The level of electronic/network connectivity available (including during mobilization, reception/staging, in the operational environment, and during combat operations.

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).

2. The experience and/or level of training for the duties to be undertaken.

3. The current welfare of the person and/or their close support (e.g. current relationship difficulties, financial difficulties or legal problems).

D.5. MENTAL HEALTH CONDITION FACTORS

1. How active/severe are the symptoms of their mental health problem. How stable are the symptoms and are there safety concerns?

2. To what extent does the condition affect concentration, sleep, judgement, impulsivity, attitudes, and motivation?

3. What their current treatment needs are. Is the individual on a medication that leaves them combat impaired (ineffective) or requires close monitoring?

4. How likely is the condition to relapse and/or recur?

5. What the anticipated speed of deterioration is if a relapse or recurrence occurs?

6. How responsive is the condition to treatment?

7. How insightful are the service members about their condition and its effect on themselves and the effect on the team around them/operational tasks?

8. Are resources available in theatre to continue treatment?

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ANNEX E MENTAL HEALTH PROFESSIONAL OPERATIONAL CAPABILITIES, 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 (MHPs) in clinical, administrative, command and consultant roles.

E.2. PRINCIPLES.

1. There are ethical considerations that define the role of MHPs on operations and all MHPs will operate under the core principle that they shall do no harm.

2. MHPs deployed in clinical role should not be involved in interrogation of prisoners.

E.3. DEFINITIONS.

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

JOB TITLE(S):	**NATO MENTAL HEALTH PROFESSIONAL** Specialties may include Psychiatrist, Psychologist, Mental Health Nurse, Clinical Social Worker, Occupational Therapist, and other specialties, as long as they are nationally authorized to provide mental health care. They may be supported by mental health medics/technicians and other non-clinical personnel.

E.4. CONDITIONS

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

E.5. EXPECTED TASKS

1. MHPs will be able to provide education/ prevention, advisory support, and clinical services.

a. Education/prevention tasks include the ability to provide educational seminars and briefings to support psychological readiness, for example education on sleep leadership, suicide prevention, self-care strategies, and other topics to unit members and leaders.

b. Advisory support includes the ability to assess operational mental health issues, brief the chain of command, and provide recommendations to support psychological readiness. This function also includes a liaison function, providing consultative support to medical, nursing and paramedical colleagues.

c. Clinical functions include:

(1) The ability to conduct a clinical evaluation of a patient with operational stress reaction (OSR) and other mental health problems and triage to the appropriate level of care.

(2) Provide clinical treatment (using evidence-based therapy, pharmacological, or social interventions) for service members with mental health conditions, to include managing patients with OSR and those who are suicidal, agitated, aggressive, violent, depressed, psychotic, or struggling with depression, anxiety, post-traumatic stress disorder, substance use disorder, or other mental disorders.

(3) Evaluates and monitors fitness for duty and ability to return to duty after or while under treatment.

(4) Coordinate referral and air-evacuation to a higher level of care if needed.

(5) Coordinates care with other medical personnel and chain of command as appropriate.

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