CENTCOM COMPREHENSIVE BEHAVIORAL HEALTH PROTOCOL

Original Release/Approval:	Note: CCOP-1.0 requires an annual review
Reviewed:	**Approved for Adult Use Only** (18 and up)
Supersedes:	Version: CCOP-: Version 1.0 with Appendices
☐ Minor Changes (or)	■ New Document That Requires Thorough Reading
☐ Significant Changes	OPR: CCSG

1. PURPOSE. The purpose of this document is to standardize behavioral health (BH) practices in CENTCOM to increase clarity, efficiency, quality, and safety.

2. APPLICABILITY. This CENTCOM Comprehensive Clinical Operating Protocol (CCOP) applies to all USCENTCOM Service Components, Combined and other Joint Task Forces (CJTFs), and all U.S. military forces operating under Title 10 within the Area of Operation (AOR) assigned or allocated to Commander, USCENTCOM by approved Global Force Management (GFM) processes (e.g., Command Plan) and DoD civilian medical employees deploying with U.S. Forces consistent with DoD and Service specific guidance. Specific applicability is to medical and allied health care professionals (Skill Type 1 through 4), assigned/attached, allocated to perform duties, and providing care at the Role 1, 2, and 3 medical facilities that involve direct or indirect patient care.

3. REFERENCES

a. FM 4-02.51 Combat and Operational Stress Control Field Manual 2006
b. Air Force Instruction 44-153, Disaster Mental Health Response & Combat and Operational Stress Control 13 April 2020
c. Joint Health Services, Joint Publication 4-02 dated 29 August 2023
d. DoDI 6490.08- Command Notification Requirements to Dispel Stigmas in Providing Mental Health Care To Service Members 6 September 2023
e. DoDI 6000.14- DoD Patient Bill of Rights and Responsibilities in the Military Health System (MHS) 3 April 2020
f. Title 10, USC, section 1074m (Mental Health Assessments for Members of the Armed Forces) IT-MHA- Central Command Regulation 40-2 (CCR 40-2, Section 2.9 g)
g. DoDI 6490.03 Deployment Health 19 June 2019
h. DoD Directive-type Memorandum 23-005- “Self-Initiated Referral Process for Mental Health Evaluations of Service Members”
i. DoDI 6490.04; Mental Health Evaluations of Members of the Armed Forces 22 April 2020
j. Air Force Instruction 44-172, Mental Health 23 April 2020
k. DoDI 6490.05 Maintenance of Psychological Health in Military Operations 29 May 2020
l. US TRANSCOM Handbook 41-1, 3 MAY 2016, Global Patient Movement Operations
m. CENTCOM PAD CCOP 05: Patient Administration and Patient Movement Protocol in a Deployed Setting
n. CENTCOM MOD-17; US CENTCOM Theater Medical Clearance Information or current version.
o. ATP 4-02.5 Casualty Care

p. ATP 4-02.10 Theater Hospitalization
q. Reference ATP 4-02.8 Force Health Protection
r. CENTCOM Policy 40-1
s. CENTCOM BH Consultant Site Assistance Visit Checklist
t. VA/DoD Clinical Practice Guidelines: https://www.healthquality.va.gov/
u. AMEDD Virtual library: https://register.openathens.net/amedd.army.mil/register
v. Suicide Prevention Resources: https://www.health.mil/Military-Health-Topics/Mental-Health/Mental-Health-Topics/Suicide-Prevention
w. Psychological Health Resource Center: https://www.health.mil/Military-Health-Topics/Centers-of-Excellence/Psychological-Health-Center-of-Excellence/Psychological-Health-Resource-Center
x. MILPER Number: 07-206; DD FORM 93 Update: Non-Medical Attendant Issued 03AUG07.

4. RESPONSIBILITIES
   a. USCENTCOM Command Surgeon (CCSG) establishes and maintains the USCENTCOM Comprehensive Behavioral Health Strategy consistent with DoD directives, instructions, recommended best practices, and other applicable policy documents.
   b. CENTCOM BH Theater Consultant is responsible for coaching, consultation, education, training, and review of records, policies, and procedures to promote adherence to CCOP and CCSG Strategy. The BH CENTCOM Consultant engages with deployed BH assets through Staff Assistance Visits (SAV) and documents these visits with a standard checklist. Site Assessment Visits will be completed quarterly. The BH CENTCOM Consultant will liaise with the CENTCOM pharmacist to ensure adequate supply of medication and appropriate prescribing practices.
   c. All BH providers are responsible for knowledge of and compliance with the Comprehensive BH Strategy and its implementation.
   d. Any communication of information will be done in accordance to references in paragraph 3.

5. ELIGIBILITY (CARE)
   a. Provision of care within USCENTCOM AOR will be determined by interpretation of the current USCENTCOM Medical Rules of Eligibility (MEDROE) and within the purview of CENTCOM entry criteria.
   b. Emergency Care is synonymous to Acute Care and Routine Care synonymous to Chronic Care

6. OVERVIEW OF IN-THEATER BH SERVICES. In-theater BH services broadly fall into two categories: prevention (to include primary and secondary prevention) and treatment. Prevention services are typically provided by technicians and are discussed further below. The goals of prevention services are to both prevent mortality and excess morbidity associated with BH conditions, to include Combat and Operational Stress Reactions (COSRs). Behavioral Health Officers (BHOs), to include psychiatrists, psychologists, Advance Practice Providers such as psychiatric nurse practitioners or physician assistants, social workers, and in Combat Operational Stress Control units, occupational therapists) offer treatment interventions pending the results of a BH assessment. Assessments can be done at the level of the individual or the unit. In the latter case, the resulting intervention could be increasing prevention services, or in more extreme cases, the implementation of a formal Reconstitution program. Individual assessments can be emergent or routine, and can be initiated by the SM, a referral (e.g. from

another medical provider, medical technician, or chaplain), or directed by command. Pending the findings of the assessment, the goal of BH intervention is to restore SMs to functionality or to evacuate them from theater. Treatment runs the spectrum from outpatient to inpatient and should be provided at the least restrictive level that will produce the desired result.

7. FRAMEWORK FOR PROVISION OF CARE

a. TIER 1: PREVENTION- (Reference ATP 4-02.8 Force Health Protection). The goal of Tier 1 is to prevent COSR and to identify and refer persons identified for appropriate care. Tier 1 can be accomplished using embedded and non-embedded BH services. Tier 1 services are typically primary or secondary prevention and are not documented in the medical record. Common Tier 1 services are Mobile Prevention Teams, Support for Unit-led Master Resiliency Training, Unit Needs Assessments, and Suicide Awareness and Prevention. Tier 1 interventions are often led by Mental Health Specialists and Occupational Therapy Technicians with Officer supervision. In-Theater Mental Health Assessments (IT-MHAs) are performed by qualified providers and should be conducted in-person in accordance with Title 10 Section 1074. IT-MHAs should be documented in the electronic medical record. Providers should have a list of local referral sources and resources for the SMs for whom they do the IT-MHAs. After traumatic incidents, BH assets with training in Traumatic Event Management should approach Unit Leadership to coordinate COSC interventions as soon as possible. All interventions should be consistent with COSC principles IAW DoDI 6490.05 Maintenance of Psychological Health in Military Operations.

b. TIER 2- OUTPATIENT SERVICES. The goal of Tier 2 is to provide tertiary prevention and clinical care. This resource level is supported by Outpatient clinics in Role 1, 2 and 3 facilities, COSC, and other BH settings. Tier 2 services are typically provided directly by BHOs. Clinics should offer walk-in and scheduled appointments for intakes and follow-up care. An on-call schedule will be established to provide round-the-clock consultation-liaison services whenever Emergency Room facilities are not available. A process should be in place for use of Primary Care and Other Providers for pharmacotherapeutic treatment whenever Psychiatric Prescriber or tele-behavioral health technology is not available. Clinics and medical treatment facilities should have a process for either providing or accessing tele-behavioral health services. Service Members accessing tele-behavioral health services should meet in a confidential location with a point of contact in the area in case of emergency. If possible, the Behavioral Health Data Portal (BHDP) should be used. If not, providers should use appropriate screeners for assessment and measurement of the progress of their interventions. Providers should have processes to ensure smooth transitions of care.

c. TIER 3- ENHANCED AND INTENSIVE OUTPATIENT SERVICES (IOP). The goal of Tier 3 is to provide specialized intervention services including psychotherapy and pharmacotherapy for patients who display impairment in functioning. Tier 3 programs should have a point of contact to coordinate referrals and provide referral sources with a written schedule and description of the program. These services should have clear inclusion and exclusion criteria in writing. A comprehensive intake and treatment plan should be developed on the first day of the program. This plan should be communicated with the SM in writing. The initial intake assessment should include standard screening measures including the BHDP whenever possible. Documentation of an exit assessment to determine next level care and communication of this plan with the SM and next level provider. The exit assessment should use standard screening instruments, including the BHDP whenever possible. Enhanced outpatient and intensive outpatient programs for

the purposes of Restoration or Reconditioning have a typical duration of 1-7 days. A BHO should evaluate the SMs at the beginning and end of the enhanced or intensive treatment program. Follow-up care should be established within at least 7 days of discharge from the program, whenever possible.

d. TIER 4- - INPATIENT SERVICES. The goal of Tier 4 is to provide the highest level of care to SMs, who require a structured environment of care due to the severity of the presenting problem(s). Tier 4 services provide an initial comprehensive psychiatric and psychosocial assessment with a BHO. Use of a non-medical attendant is required unless the inpatient services is specifically a designated psychiatric unit. SOPs should be in place for responding to aggression, elopement, self-harm, ensuring informed consent and confidentiality, providing off unit programming, and managing contraband, visitors, and ligature risk. Upon discharge, there should be documentation of communication with next-level providers. Consider an MOU for flow of information for evacuations out of theater. Follow-up care should be established within 24 hours of discharge or as soon as feasible.

8. CRISIS MANAGEMENT. The goal of Crisis Management is to provide immediate assistance to any SM in need of BH services. Emergent evaluations can be referred by Commanders or other BH or non-BH providers. If a patient is determined to be at risk of harm to self or others or found to be incapacitated, an escort or non-medical attendant shall be provided, and weapons, including multi-tools, will be removed. The SM will be referred to the appropriate level of care.

9. EVACUATION. BH providers may recommend evacuation from CENTCOM for SMs who have medical needs that cannot be met in theater and/or whose condition places burden on accomplishment of the overall mission. BH providers may work with Commanders on three types of evacuation: Individual Early Release (IER), outpatient medical, or inpatient medical. IER is pursued for SMs who do not require medical follow-up after release from theater. BH providers should know the process for all three types of evacuation.

10. DOCUMENTATION AND QUALITY ASSURANCE. Before meeting with SMs, BHOs and technicians should be clear about what is and is not documented in the health record. Primary and secondary prevention services (Tier 1) are not documented in the medical record. As per 7.a., In-Theater Mental Health Assessments are an exception, and must be documented in the Electronic Medical Record. Tertiary prevention services and clinical interventions (Tiers 2-4) should be documented in the medical record within 72 hours. An exception is when the medical record is down or unavailable because of austere conditions. In that case, BHOs should enter their notes at the earliest possible time. Using DSM5-TR V- and Z-codes is encouraged until a SM clearly meets criteria for a formal disorder. Clinicians should avoid Joint Commission DO NOT USE abbreviations. Standardized intake and follow up forms should be used. If feasible, the BHDP should be used to collect patient-centered metrics. If not, clinicians should use appropriate screeners. Outcome metrics should be standardized across CENTCOM to track quality, safety, and access to care.

11. CREDENTIALING AND PRIVILEGING. Credentialing and privileging should be in accordance with current service component standards in CENTCOM Policy 40-1. When applicable, licensure and/or board certification must be maintained per service component requirements according to the role and skill type of the personnel.

12. STANDARD OF CARE. Care shall be provided based on appropriate standards published by the American Psychiatric Association, American Psychological Association, VA/DoD Practice Guidelines, and National Association of Social Workers Code of Ethics.

13. MEDICATION AND FORMULARY. The Theater Behavioral Health Consultant works with the CENTCOM Pharmacist to ensure adequate formulary and to promote evidence-based prescribing practices including minimizing polypharmacy. Current USCENTCOM MOD waiver criteria will be followed while prescribing medications. On-site pharmacy services should be used for SMs who are prescribed new medications to facilitate and ensure correct titration of medications. Express Scripts should be used for dispensing medications for up to 90-days for SMs on stable medications. In emergent and austere conditions, Express Scripts may be mailed to in-country US Embassy for currier delivery, only with prior arrangement with the embassy to ensure this resource is available. Whenever possible, prescriptions should be ordered through the electronic health record to maximize safety.

14. TELEBEHAVIORAL HEALTH. The CENTCOM AO is large and spread over multiple countries. In-person provision of BH services is preferred and is the best practice whenever possible, notwithstanding METT-TC (Mission, Enemy, Terrain & Weather, Troops, Time Available and Civil) considerations. However, at times Behavioral Health Assets (BHA) are not onsite when a need for BH services arises. As such, audiovisual or audio-only technology can be used as a force multiplier to allow BH services to be delivered to an originating site from a distant site. BH services delivered thusly are considered Tele-Behavioral Health (TBH) services. Certain Tier 1 (e.g. IT-MHAs) and all Tier 2 services can be delivered using TBH. TBH services must comply with the provisions of this document and with the Standard Operating Procedure Tele-Behavioral Health for US Central Command (CENTCOM). IAW this SOP, TBH must be delivered using an approved and HIPAA-compliant solution:

a. Primary: Bi-directional approved audiovisual solution e.g. Global Teleconsultation Platform (GTP)
b. Alternate: Audio only using DSN to DSN
c. Contingency: Audio only using government-issued mobile phone to government-issued mobile phone
d. Emergency: In true clinical emergencies, DO NOT DELAY teleconsultation due to an unsecure connection unless operational requirements dictate otherwise. Use the most secure solution possible given METT-TC considerations. Note that HIPAA exceptions only apply to true emergency situations and do not extend to routine clinical situations where HIPAA compliant solutions are merely inconvenient or simply haven't been obtained.

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LARRY J. McCORD
COL, MC
Command Surgeon

CENTCOM BH CONSULTANT STAFF ASSISTANCE VISIT CHECKLIST		DATE OF VISIT	
FUNCTIONAL AREA/SUBORDINATE AREA: FORSCOM	RATING	CHECKLIST EFF DATE: TBD	PAGE **1 OF 2**
INSPECTION OFFICE/AGENCY CENTCOM	SITE		

REQUIREMENTS	YES	NO	NA
ACCESS TO CARE			
Is the ratio of SMs to BHOs in the area ≤ 700:1?			
Is the ratio of SMs to BH techs in the area ≤ 700:1?			
Is the average time from 1st contact to 1st appointment fewer than 48 hours?			
Can the BH site accommodate walk-ins?			
If the BHO is not on-site full-time or is not a prescriber: Is there space and equipment suitable for telehealth services?			
STAKEHOLDER COMMUNICATION			
Are BH hours/informational materials visible at the dining facility?			
Are BH materials visible at Chapel or Religious Affairs?			
Are BH materials visible where SMs receive routine medical care?			
Can a randomly selected medical provider say how to refer to BH?			
Can a randomly selected chaplain or chaplain's assistant say how to refer to BH services?			
Can a randomly selected commander say what BH resources are available and how to access them?			
Can a randomly senior NCO advisor to a commander say what BH resources are available and how to access them?			
If the BHO is not on-site full-time: Can a randomly selected medical provider say how to access urgent BH support?			
If the BHO is not on-site full-time: Can a randomly selected chaplain or chaplain's assistant say how to access urgent BH support?			
QUALITY CONTROL			
Does the site have reliable (≥90% of the time) access to internet connectivity?			
Does the BH team have access to the Electronic Medical Record?			
Does the BH team have access to other databases of importance (e.g. Joint Longitudinal Viewer, systems for entering/ tracking duty-limiting physical and BH conditions, and if applicable, systems for tracking required periodic surveillance/prevention based mental health assessments)?			

Does the site have computers and/or government-issued mobile phones that are given priority use for Tele-Behavioral Health services? If “yes” to above, do these devices have TBH software solutions loaded and do on-site users have accounts (e.g. for GTP)? Does the site have sufficient designated space for BH assets to provide services in a HIPAA compliant manner? *If the BHO is not a prescriber:* Is there an identified process for providing prescribing services via telehealth? Do all BH prescribers have a DD Form 577 on file with CENTCOM pharmacist? *If the BHO is on-site full-time*: Can the BHO support additional forces (as evidenced by spending <70% of duty hours in direct provision of services, or if there is no technician on-site, also providing prevention services)? *If the BH tech is on-site full-time*: Can the BH tech(s) support additional forces (as evidenced by spending <70% of duty hours in direct provision of prevention services or other clinical duties as assigned)? Does the BHO have a process for the 3 types of evacuation (inpatient, outpatient, IER)? Are materials for accessing EO, sexual harassment/assault, and legal resources posted and/or available at the BH site? <u>COMMENTS FOR ANY ITEM MARKED “NO”</u>			
<u>Rater Rank, Last name, First name, Service, Job Title, DSN:</u>			

Appendix B: STANDARD OPERATING PROCEDURE TELE-BEHAVIORAL HEALTH FOR US CENTRAL COMMAND (CENTCOM)

1. **PURPOSE:** To describe the provision of Tele-Behavioral Health (TBH) service throughout the CENTCOM Area of Operations (AO.)
2. **REFERENCES:**
    a. Department of Defense 602S.13-R (Clinical Quality Assurance in the Military Health System), 11 June 2004
    b. Title 42, United States Code (The Public Health and Welfare)
    c. NDAA 2017: Section 718 Requirement
    d. Section 1094(d) Title 10, United States Code (10 USC)
    e. DoD Instruction (DoDI) 6025.13 “Medical Quality Assurance and Clinical Quality Management in the Military Health System.” July 26, 2023, paragraph 4.4a.(7)
    f. Joint Trauma System Clinical Practice Guideline (JTS CPG) “Telemedicine in the Deployed Setting.” 19 September 2023.
    g. Operational Virtual Health Platform Quick Sheet (SEP 2024) Ver. 2.0
    h. Health Insurance Portability and Accountability Act (HIPAA) of 1996, Title II, Subtitle F-Administrative Simplification, Public Law 104-91
    i. CENTCOM Comprehensive Behavioral Health Strategy. Behavioral Health Comprehensive Clinical Operating Protocol (BH CCOP) **XX XXX** 2025
3. **SCOPE:** All personnel providing, receiving, supporting, or enabling TBH within the CENTCOM AO.
4. **DEFINITIONS:**
    a. Tele-Behavioral Health (TBH): Behavioral Health services delivered using audiovisual or audio-only technology.
    b. Originating Site: The location of the Service Member receiving TBH services.
    c. Distant Site: The location of the Behavioral Health Asset providing TBH services
    d. Behavioral Health Asset: Any uniformed or duly credentialed civilian serving in the following job functions:
        i. Psychiatrist (Air Force 44PX, Army 60W, Navy 16X0 or 16X1)
        ii. Psychologist (Air Force 42PX, Army 73B, Navy 1841 or 1842)
        iii. Social Worker (Air Force 42 SX, Army 73A, Navy 1870)
        iv. Psychiatric Advanced Practice Provider (Air Force 46YXP, Army 66R, Navy 1973)
        v. Enlisted Behavioral Health Technician (Air Force 4COX1, Army 68X, Navy L124A)
    e. Behavioral Health services: any Tier 1 or higher services as described in CENTCOM BH CCOP
5. **POLICY:** TBH services are delivered in accordance with published DoD standards of care, comport with federal law, and meet quality standards across a dynamic and heterogenous battle space.
6. **BACKGROUND:** Behavioral Health services are required from both routine administrative (e.g. the In-Theater Mental Health Assessment) and clinical perspectives. The CENTCOM AO is large and spread over multiple countries. In-person provision of BH services is preferred and is the best practice whenever possible, notwithstanding METT-TC (Mission, Enemy, Terrain & Weather, Troops, Time Available and Civil) considerations. However, at times Behavioral Health Assets (BHA) are not onsite when a need for BH services arises. As such, audiovisual or audio-only technology can be used as a force multiplier to allow BH services to be delivered to an originating site from a distant site.
7. **PROCEDURE:**
    a. A Behavioral Health Asset is alerted of the need for TBH services. In clinical practice, this can occur from a wide variety of sources including but not limited to: a medical provider, medic or chaplain identifying a Service Member in need, a Service Member directly reaching out to a BHA, a BHA reaches out to another BHA, or a commander requesting an evaluation.
    b. The BHA at the distant site coordinates with requesting personnel at the originating site to arrange for a TBH encounter. The distant site’s local policies or SOPs will determine how this is arranged.
        i. BH services from BHAs must remain within the scope-of-practice for their job function
        ii. For routine situations, nothing in this policy precludes the use of triage and scheduling practices used in the routine course of business at the distant site

iii. TBH encounters can be a one-time assessment, a follow-up encounter from a face-to-face or TBH encounter, or a series of recurring follow-up visits until the Service Member can be seen face-to-face.
iv. In emergency situations (e.g. clinical situations involving suicidality, homicidality, psychosis, mania, acute change in mental status)
    1. The needs of the Service Member at the originating site should be addressed immediately.
    2. Prior to outreach to BHAs, personnel at the originating site should assign a 1:1 non-medical attendant at or above the SM's rank to be at arm's reach at all time, and should remove any weapons, knives, multitools, and medication from the SM's person until such time as advised differently by a Behavioral Health Officer.
v. In an emergency, if a BHA cannot be reached or respond in a timely fashion, the ADVISOR line should be used: Call: 833-ADVSRLN (833-238-7756)/ DSN: 312-429-9089

c. The originating and distant sites will identify a mutually interoperable technology to use for the TBH service. The Operational Virtual Health Platform Quick Sheet (SEP 2024) Ver. 2.0 should be used to guide this selection based on what resources both sites have.
d. TBH must be delivered using an approved and HIPAA-compliant solution.
    i. Primary: Bi-directional approved audiovisual solution e.g. Global Teleconsultation Platform (GTP)
    ii. Alternate: Audio only using DSN to DSN
    iii. Contingency: Audio only using government-issued mobile phone to government-issued mobile phone
    iv. Emergency: In true clinical emergencies, DO NOT DELAY teleconsultation due to an unsecure connection unless operational requirements dictate otherwise. Use the most secure solution possible given METT-TC considerations. Note that HIPAA exceptions only apply to true emergency situations and do not extend to routine clinical situations where HIPAA compliant solutions are merely inconvenient or simply haven't been obtained.
e. When the session is terminated the distant site's Electronic Medical Record should be used to document the encounter as per the BH CCOP. The documentation should note that the encounter was TBH and what means of TBH was used.

8. **ADDITIONAL:** The following guidance should be followed, METT-TC considerations dependent.
    a. For first-time assessments, emergency TBH encounters, and whenever else as directed by BHA, the originating site should have a designated individual to speak with the BHA at the distant site at the start and the conclusion of the encounter.
        i. This is in case urgent action needs to be taken for SM safety (e.g. placement of a 1:1 non-medical attendant, removal of knives, multitools, medication etc) needs to be undertaken
        ii. This individual will also serve as the point-of-contact in the event the BHA cannot reach the SM receiving BH services.
    b. Distant sites should have:
        i. Designated computers (preferably) and/or government issued mobile phones (as contingencies) for TBH encounters.
            1. Such computer and phones should have TBH software solutions installed that are listed in The Operational Virtual Health Platform Quick Sheet (SEP 2024) Ver. 2.0
            2. This does not preclude those devices being used for other purposes, but TBH will take priority over other uses when the need arises.
        ii. Pre-identified private space for TBH encounters. SMs receiving TBH services should be given the benefit of the same degree of privacy as they would receive during a face-to-face encounter given clinical acuity. In emergencies, the timely provision of services

takes precedence over other concerns. Further, in emergencies a high degree of privacy can cause an unacceptable trade off with SM safety (e.g. in the event the SM needs constant monitoring at all times, such as in the event of suicidal ideation/attempt, homicidality, or gross disturbance in behavior.)

c. It is incumbent on both originating and distant sites to anticipate the need, and prepare, for TBH services. If resources as described above in 7.c. and 8.b.(i) are not available, it is incumbent on the command at the site to procure and arrange such materiel so as to comply with this policy.
d. IAW the CENTCOM BH CCOP, the CENTCOM (FWD) Behavioral Health Consultant will periodically assess the TBH readiness of distant and originating sites in Site Assistance Visits using the appropriate SAV checklist.