What is Mental Health?

An Overview for Service Members

“Mental health” clearly means different things in these common examples – which can cause a lot of confusion:

- I gotta’ hit the gym and take care of my **mental health**.
- I’m really struggling – I think I need to go see **mental health**.
- Our unit has embedded **mental health**.
- SrA Thomas is being kicked out because of **mental health**.

For this overview, “mental health” will be delineated into four specific terms:

- **Mental Health** (generic, non-clinical)
- **Clinical Mental Health / Mental Health Disorder**
- **Mental Health Care**
- **Clinical Mental Health Care**

Mental Health and **Clinical Mental Health** are different, but can be conceptualized as two intersecting states of being [Keyes & Lopez, 2002]:

- **Mental Health (MH)** is defined as the “state of mind characterized by emotional well-being, good behavioral adjustment, relative freedom from anxiety and disabling symptoms, and a capacity to establish constructive relationships and cope with the ordinary demands and stressors of life” [American Psychological Association, 2023].
- **Clinical Mental Health, Mental Illness,** or a **Mental Health Disorder**, is considered “any condition characterized by cognitive and emotional disturbances, abnormal behaviors, impaired functioning, or any combination of these” [American Psychological Association, 2023].

Based on these two definitions one might arrive at the conclusion that we are all human and some days are better than others. Sometimes we may exhibit optimal mental health and at other times we may struggle with managing the demands of daily life. While this simplification is appealing, it is not terribly helpful. How do we determine if someone’s struggles have crossed the threshold of being a “disorder” – of requiring clinical treatment – and potentially requiring a profile? Military MH clinicians spend many years honing the skill of making this differentiation, but to put it simply – it is all about horses and carts.

If someone is struggling to attain something they want to accomplish they might feel tired, anxious, or worried. They might even sleep less and avoid other aspects of their life. These are all in response to what they are striving to achieve. The horse is in front of the cart. While it might not be healthy, it is not a disorder. If, however, their anxiety gets in the way of their goals, it is no longer just a response to life but impairing it. This can be easier to understand using physical terms. Getting after it at the gym can cause muscle pain, exhaustion and fatigue– but it’s worth it because it’s the result of working hard. Conversely, if pain, exhaustion, or fatigue prevents someone from going to the gym it is a problem – it’s getting in the way of their goals. So – the key delineator between mental health and illness is evidence of clinically significant distress and/or occupational / social dysfunction [DSM-5-TR, 2022] – evidence that symptoms are getting in the way of someone’s goals.

Mental Health Care and **Clinical Mental Health Care** follow a similar spectrum, although Clinical Mental Health Care might utilize aspects of Mental Health Care to facilitate treatment.

- **Mental Health Care** is any effort an individual takes to maintain mental health or, put another way, to prevent mental illness. This can be anything from taking a walk before getting in their car at the end of the day, talking to a friend about the week’s struggles, meditating, journaling, or simply reflecting. It can also include engaging with non-clinical mental health assistance or engaging clinical mental health clinicians embedded in their unit to provide non-clinical counseling.
- **Clinical Mental Health Care** is delivered by MH clinicians - Psychiatrists, Psychologists, Licensed Clinical Social Workers, Psychiatric Nurse Practitioners, Psychiatric Nurses, and Mental Health Technicians (or “4Cs” in the DAF). There are several ways to get clinical mental health care. MH clinicians use carefully crafted psychotherapies designed for specific disorders. Sometimes you use medications to reduce symptoms – often to make it easier to engage in therapy. While clinicians will often use or recommend many examples of Mental Health Care listed previously, the keys to achieving remission (“curing” a MH disorder) are the clinical tools you are using. Some MH Disorders can go into remission with brief therapy or a short duration of psychiatric medication, while other less common conditions are persistent or may require life-long medication management or repeated hospitalizations. Understanding the requirements and limitations of clinical care is important – to include the DAF Standards associated with clinical mental health care.

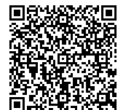
DAF STRESS CONTINUUM & RESOURCES

We've mentioned a few spectrums – let's visualize them here. The top half of the graphic details the progression of mental health symptoms as our stress levels increase. The bottom half lists appropriate resources and advocates that can best support Service Members when stress levels reach the indicated level. Moving to the right, the experiences shift from "mental health" to "clinical mental health." At the same time, the bottom shifts from generic MH care to clinical MH care. This graph is helpful because the transition from "mental health" to "clinical mental health" isn't always obvious. Similarly, the type of required care, non-clinical vs clinical, can overlap. The next chapter reviews how to "stay in the green" – how to stay mentally healthy.

READY	REACTING	INJURED	CRITICAL | CLINICAL
High quality sleep	Decreased sleep	Disturbed sleep	Insomnia
Future oriented	Unable to plan past today	Struggle to plan out today	Hopelessness
Able to handle uncertainty	Need to be in control	Fear of losing control	Feeling out of control
Sense of gratitude	Focused on recognition	Feeling unappreciated	Blaming self/others
Able to handle complexity	At capacity	Feeling overwhelmed	Feeling trapped
Clear sense of mission	Task focused	Getting through the day (surviving)	Avoiding work
Positive sense of self	Poor sense of self	Negative sense of self	Thoughts of suicide
Outward focused	Inward focused	Strained relationships	Broken relationships
RESOURCES:	**RESOURCES:**	**RESOURCES:**	**RESOURCES:**
Friends & Family	Friends & Family	Friends & Family	Primary Care
Command Team	Command Team	Command Team	Primary Care Behavioral Health
MilitaryOneSource	MilitaryOneSource	MilitaryOneSource	MH Clinic
Chaplain	Chaplain	Chaplain	If After Hours: Nearest ER | Call 988
Embedded Mental Health	Embedded Mental Health	Embedded Mental Health	Military Crisis Line (24/7) 1-800-273-8255 (Press 1) Text 838255
	Military & Family Life Counseling	Military & Family Life Counseling	www.veteranscrisisline.com
		Primary Care	
		Primary Care Behavioral Health	

Goal: Maintain Mental Health —— Goal: Return to Mental Health

WANT TO LEARN MORE?
SCAN HERE



Staying Mentally Healthy

An Overview for Service Members

Maintaining one's mental health (MH) is vital to sustaining a ready force. While struggle and even failure are normal parts of life, there are ways to prepare and respond to these tough times to minimize the impact.

PREVENTION

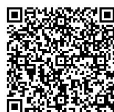
Just as we prepare for physical struggles by exercising and resting (recovery day is just as important as leg day), we must invest similarly in our mental wellness. Preventative measures are used to prepare ourselves for times of stress. These efforts provide structure and comfort in anticipation of our environment being chaotic. Engaging in what we are expected to do is a critical first step. Learning the basics of our job during training is what makes it easier to perform. Performing our best at peace time is what prepares us to excel in a contingency environment. Self-care before times of stress is also essential. Research has shown that poor sleep, poor nutrition, lack of exercise, and social isolation increase the risk of future mental health issues. Similarly, the time to develop a support network is before one is needed. These efforts do more than just prevent illness – these help us achieve wellness.

RESPONSE

When stressful events do occur, the time for preparation is over and we must decide how we will respond to them. If we have prepared successfully, we should be able to utilize the same self-care efforts that worked before the stressful event occurred. This is why people who routinely engage in prevention appear to have fewer stressful events – their prevention strategies are working. Prioritizing healthy coping strategies and relying on our support network is critical to succeeding in a stressful situation. Our support network can also help connect us to the additional resources and help we may need to cope, recalibrate, and return to a peak level of performance.

More tools to help stay mentally healthy can be found here:
https://www.resilience.af.mil/Tools-and-Guidance/

WANT TO LEARN MORE?
SCAN HERE



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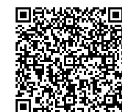
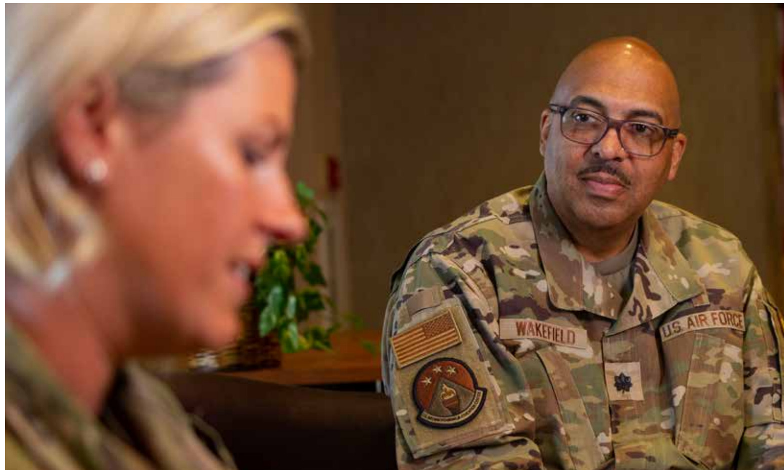


Seeking Non-Clinical Mental Health Assistance

An Overview for Service Members



There are numerous non-clinical mental health (MH) resources available for Service Members when they feel additional support is needed during challenging times. In addition to the resources listed below, fellow wingmen, supervisors, First Sergeants, and other unit leaders are often the most accessible supports for Service Members seeking assistance. A non-exhaustive list of non-clinical resources available to all Service Members are listed below.

- **Chaplain Team** – Offers general and spiritual non-clinical counseling services. No referral needed.
- **Military OneSource** – Non-medical counseling for a wide range of issues via telephone/video. No referral needed. Available 24/7 here: www.militaryonesource.com
- **Military and Family Life Counseling (MFLC)** – Non-medical counseling, as outlined above. Available on-base for in-person sessions. No referral needed.
- **Military & Family Readiness Center (M&FRC)** - Offers a wide range of military and family services and programs contributing to the well-being of the military community. M&FRC's overall goal is to ensure Service Members and families are informed, educated, and prepared for the unique demands of military life. No referral needed. You can find your local M&FRC here: https://installations.militaryonesource.mil/.
- **Primary Care Behavior Health (PCBH)** – Integrated mental health services within the primary care clinic. Their coordination allows the primary care team to work together to optimize a Service Member's overall health. PCBH can also provide clinical MH care to patients. Please see Chapter 6 for more details on Clinical MH care.

Still not sure which resource is best? Service Members can contact their DAF Mental Health Clinic for assistance. DAF Mental Health Clinicians are trained to first help determine what type of care is needed. It's not always easy to determine if clinical or non-clinical mental health assistance is required – let alone which type of non-clinical mental assistance would be best. This process is called "vectoring"– it's how DAF Mental Health clinics ensure Service Members receive the best care they need for their struggles.

Embedded Mental Health

An Overview for Service Members

Bringing Clinical Mental Health (MH) clinicians into units, close to warfighters and command teams, create unique opportunities to provide agile and responsive support to missions while also helping MH clinicians get a better understanding of the mission that Service Members are supporting. In the DAF, most embedded care occurs under the Integrated Operational Support (IOS) program. Despite being clinical MH clinicians, most of the time these embedded clinicians are delivering non-clinical MH care for Service Members with non-clinical MH concerns (see Chapter 1 for details). Embedded MH clinicians may engage in something called “limited scope counseling” for low acuity concerns that are not expected to impact readiness. When an embedded MH clinician detects elevated concerns, they will typically recommend the Service Member go to the MH clinic for vectoring to determine what level of care is needed (see Chapter 6 for details). In addition to providing non-clinical mental health support, embedded MH clinicians engage in command consultation, unit education & training, application of healthy behaviors, and monitor trends in unit mental health.

To reduce unanticipated or unnecessary readiness impacts, embedded MH clinicians can assist Service Members with non-clinical MH concerns through a service called “Limited Scope Counseling.”

WANT TO LEARN MORE?
SCAN HERE

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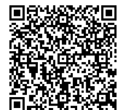


Being Evaluated for Clinical Mental Health Care

An Overview for Service Members

There are five basic ways that a Service Member might arrive at a Mental Health (MH) clinic. Going to a MH clinic doesn't necessarily mean someone has a clinical mental health disorder or needs clinical mental health care – so this chapter focuses solely on the logistics of getting to the clinic. The next chapter will review more about receiving clinical mental health care.

The five most common ways a Service Member might engage their MH clinic are:

1. Independently walk-in or call for an appointment
2. Referral from another clinician
3. Self-Initiated/Supervisor-Facilitated (via the Brandon Act)
4. Command Directed Evaluation due to concerns about member's mental health and its potential impact on the mission
5. As required for a clearance or special duty

INDEPENDENTLY WALK-IN OR CALL FOR AN APPOINTMENT OR REFERRAL FROM ANOTHER CLINICIAN

Service Members can typically walk into the MH clinic or call the MH clinic directly. Some MTFs require use of a central appointment line or engagement with Primary Care to obtain a referral. Sometimes other clinics like the Alcohol and Drug Abuse Prevention and Treatment (ADAPT) Program or the Family Advocacy Program (FAP) will refer members to the MH clinic for additional care. Regardless, upon initial contact with the MH clinic, individuals are briefly assessed to identify their presenting concerns. Mental Health clinics use a targeted approach to ensure Service Members are "vectored" to the most appropriate resource(s) based on their presenting concerns or issues. Thus, Service Members may be vectored to one of the non-clinical/non-medical resources listed in previous chapters if their condition is not clinical (i.e., not a disorder).

SELF-INITIATED/SUPERVISOR-FACILITATED (VIA THE 2020 BRANDON ACT)

Service Members may request supervisor support when seeking voluntary MH care. They start the referral process by talking to their Commander or Supervisor (E-6 or above), who will contact the MH clinic and facilitate scheduling a voluntary appointment for them. Once at the MH clinic, the process is basically the same as arriving independently, Service Members will be vectored into clinical or non-clinical MH Care. The two differences are (1) that the vectoring interview will include some extra questions ("triage") with an "eyes-on" from a licensed provider and (2) if their Commander/Supervisor calls the MH clinic to confirm their Service Member attended the appointment they helped them book, the MH clinic is required to confirm their attendance. Command notification is not otherwise required unless there is a safety, readiness, or duty concern (which is always true regardless of how a Service Member arrives at a MH clinic).

COMMAND DIRECTED EVALUATION DUE TO CONCERNS ABOUT MEMBER'S MENTAL HEALTH AND ITS POTENTIAL IMPACT ON THE MISSION

In accordance with DoDI 6490.04 and AFI 44-172, Service Members may be involuntarily referred to the MH clinic by their Commander, supervising officer, or civilian equivalent, due to a "MH concern" related to: (1) the safety of the Service Member or others; or (2) the Service Member's MH is adversely impacting mission readiness. The use of the phrase "MH concern" is intentional. Something is causing a Commander to be concerned – Command is not making a diagnosis. Instead, they are seeking expert help to determine if what they are concerned about represents a clinical MH disorder that warrants additional action. When the concern is related to safety, an "Emergency Command Directed Evaluation" (E-CDE) is executed promptly in an emergency setting. When the concern is limited to readiness only, a "Command Directed Evaluation" (CDE) is more appropriate and can be scheduled in the MH clinic as the next available intake. Neither of these types of evaluations automatically indicate that a Service Member has a mental health disorder – they are simply tools that enable Commanders to refer the member for appropriate evaluation by trained Mental Health experts. In these circumstances, a command directed mental health evaluation has the same status as any other military order. Additionally, although command directed evaluations are NOT voluntary, treatment is always voluntary.

AS REQUIRED FOR A CLEARANCE OR SPECIAL DUTY

Service Members may voluntarily request a psychological evaluation as part of a clearance for a variety of reasons: deployment, PCS, cross training, or an AFSC specific MH clearance outlined by the SPECAT Guide. In this case the Service Member will complete a one-time evaluation in the MH clinic to determine if they can participate.

WANT TO LEARN MORE?
SCAN HERE

VECTORING

Upon initial contact with the Mental Health (MH) clinic (phone call or walk-in), Service Members (who are NOT yet considered a patient) are first assessed, typically by a DAF MH technician, to understand the individual's presenting concern. The primary goal is to determine if the concern is clinical or non-clinical. If their concerns are non-clinical, the Service Member is "vectored" to the optimal non-clinical resource. For example, if someone is stressed about their finances, they will be vectored to finance. Talking about not getting paid is less effective at reducing stress than actually being paid.

Vectoring is a critical safety net for Service Members, the mission, and the MH clinic. It prevents normal struggles from being treated like disorders. Just like it would be inappropriate to call a bruised knee a fracture, it is not appropriate to call the normal struggles of life a "MH Disorder." It would be even more inappropriate to put screws in someone's knee and cast them if they were only bruised. The same is true in Mental Health – it would not be appropriate to start a medication or dive into therapy for troubles associated with daily life. This approach also protects the mission. In the past decade, 80% of the Service Members who presented to DAF MH clinics didn't have a MH Disorder [AFMED Data Analysis, 2023]. How can this be? A MH Disorder, requires evidence of "significant psychological distress and/or social/occupational dysfunction" [DSM-5-TR, 2023]. Most of the issues that bring Service Members to the MH clinic do not reach these levels of distress or dysfunction. They face real struggles – yes – but they don't have a MH Disorder. Over diagnosing them would not only be unethical; it would also result in a lot of unnecessary profiles. More importantly, it would undermine trust in the MH clinic and compromise mission readiness. Lastly, vectoring ensures the clinic has the space to support clinical MH patients. If a MH clinic is going to provide clinical MH care to the 20% of Service Members who present with a MH Disorder that requires the clinic to have time for their clinical patients.

Service Members do not need to worry about trying to figure out if something is clinical or not before going to the MH clinic. It can be very challenging to figure this out – the MH clinic is expertly trained to vector Service Members to the best resource. It's our job!

If a Service Member who does not have a clinical MH disorder insists on being seen by the MH clinic versus another non-clinical helping agency, they will not be turned away from the MH clinic, but this care will be limited to brief non-clinical MH care. Anything longer would require re-evaluation for a MH disorder.

INITIATING CLINICAL CARE

If Service Members have symptoms that might represent a mental health disorder, they will be vectored into the clinic for further evaluation (also called "triage") to help determine the most appropriate next steps and to confirm that they require clinical MH care. After this initial evaluation the next step is to schedule an intake.

During the intake, which can be the same day or up to a few weeks later, depending on severity and space in the clinic's schedule, a much more thorough evaluation will be completed. An intake requires reviewing the entire medical record and typically more than an hour of interviewing. Upon completion, the diagnosis, treatment goals, modality of treatment (e.g., group therapy, individual therapy, couple's therapy, family therapy, and/or medications), and expectations for length of treatment are typically discussed. Clinical MH treatment has a strong focus on achieving remission – which means no longer meeting criteria for having a clinical MH disorder. As such, treatment goals will typically include improving functionality at home & work, fitness & suitability for service, and rehabilitating duty-impairing symptoms.

Evidence-based treatment groups will be recommended for most patients. Group therapy is a scientifically supported stand-alone treatment to effectively address most symptoms and conditions. Group therapy promotes socialization, enhances communication, and allows participants to develop a sense of belonging. Whether patients are dealing with depression, anxiety, sleep issues, or any other mental health disorder, a group setting tends to contribute to improved sense of hope and offers the patients an opportunity to learn from others in attendance. Additionally, group sessions can help individuals learn about themselves as they hear and understand more about other people's struggles, which in turn helps them see things from a different perspective and therefore increases their self-awareness and self-acceptance.

Individual treatment is typically reserved for patients who, due to their MH disorder, are not ready for a group setting. Some patients may require individual therapy in addition to group therapy. This will be determined with each patient individually. The essential item to remember is that the primary goal of the MH clinic is to provide the best individualized care for each patient to help them get back to health. To accomplish this goal, MH clinicians will collaborate with patients to develop the best plan for their needs. Occasionally this requires individual therapy – but more often than not it requires processing fears, frustrations, and expectations regarding a patient's MH disorder and their treatment.

As such, active engagement in care is vital. MH clinicians know symptoms can make this challenging, but they will work with each patient to reduce their symptoms to get to the core of their struggles. Treatment is a collaborative effort between each patient and their clinician, sharing thoughts and opinions is critical. If something doesn't make sense, patients are empowered to ask questions.

SAFETY

In mental health, the term "safety" has a very specific meaning – threat to self or others, to include the military mission and national security. If a Service Member is having thoughts of "wanting to kill themselves" and indicates intent to act on these thoughts, the clinician is obligated to help. Most of the time suicide risk can be effectively managed in the outpatient clinical setting; this means developing a safety plan with the patient and their command. Occasionally, it involves inpatient hospitalization when acute risk is present. If a patient threatens serious bodily harm to another person, clinicians are required by law to initiate precautions to protect those involved, to include contacting law enforcement and notifying any identified potential victims. Action is also necessary if a patient presents with psychiatric symptoms that make it difficult to predict behavior (e.g., hearing or seeing things that are not really there, and/or acting in unintended ways). In this situation, clinicians would recommend hospitalization to keep everyone safe until the patient is stabilized. It is important to understand that the intention of these efforts is to keep the Service Member, other people, and the mission safe.

WHAT IF TREATMENT DOES NOT RESULT IN REMISSION?

A minority of patients will not be able to achieve remission within a year (12 months). These patients will need to be reviewed for retainability. Some will be retained; perhaps the diagnosis was complex and took months to determine, or care was delayed due to a medical illness, etc. Some will need to be medically retired or discharged (indicating that it is unlikely they will get better), but this is not the norm, this is the exception. For more on this topic see the next chapter on MH Standards.

[1]This is what "suicidal ideation" specifically means. It's not wanting to disappear or to die – it's the thought and desire to kill oneself.

This diagram provides an overview of all the steps described in this chapter.

RETURN TO DUTY

CASE CLOSURE

REMISSION

FIRST CONTACT
Phone/In Person with BH

INITIAL SCREENING (VECTORING) ENCOUNTER
More info needed?
Additional triage questions

NON-CLINICAL MH CARE

VECTORED TO:

CLINICAL MH CARE (MH CLINIC)

INTAKE

EVIDENCE-BASED GROUP

INDIVIDUAL THERAPY

NO RESPONSE TO TREATMENT

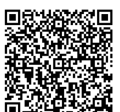
Unable to meet treatment goals for > 365 days
OR
Concern that situation will never be compatible with continued service

MEDICAL EVALUATION BOARD?

ADJUST TREATMENT PLAN

SEPARATION

WANT TO LEARN MORE? SCAN HERE



HOW DO STANDARDS APPLY TO MENTAL HEALTH DISORDERS?

If a patient's symptoms meet the criteria for a mental health (MH) disorder, they will typically be placed on a profile and provided treatment for their disorder with the goal of achieving remission so they can come off the profile. A profile is also required when a patient is psychiatrically hospitalized or attempts suicide.

A profile is a recommendation that clinicians make to a Commander to communicate potential risks and ways that Commanders can support Service Members. For example, if a Service Member is struggling to focus and forgets to correctly tighten a bolt on an airplane, people could be injured. That's risk. While Service Members are enrolled in treatment, profiles can also help protect against major disruptions in treatment caused by deployments or PCS activities. However, only Commanders can authorize the profile – so if a profile recommendation isn't made, it is challenging for them to protect their member and their mission.

Some mental health conditions can be severe enough to impact a patient's ability to do their job, even in a non-deployed setting. When conditions reach this level, a mobility profile is initiated to allow the Service Member to focus on their treatment and preserve mission capabilities. Duty profiles can include many duties – but some commonly impacted duties include arming, use of force, flight status, Personnel Reliability Program, and Top-Secret clearance. Many MH patients can deploy, treatment would not be impacted by a Permanent Change of Station, and they can do their job without difficulty. In these instances, the MH clinic will communicate to Commanders that the patient will require a Deployment Waiver (DW) to deploy. This is not a profile – it's just a pre-emptive notification of which Service Members will need a waiver to deploy. Specific details can be seen in the figure on page 36.

A common concern among Service Members is that seeking mental health care will have significant or permanent impact on their career. This is typically not the case, as most mental health disorders can be effectively treated or "cured" (i.e., go into "remission"). For example, 92% of patients living with PTSD go into remission after completing 12 sessions of evidence-based therapy [Galovski, 2012]. The MH clinic's mission is to help patients achieve remission as quickly as possible, so they can return to health, their profile can be removed, and they can fully return to work. In fact, if the profile is entered appropriately and in a timely manner, it is easier to demonstrate remission via the removal of the profile. It is much more difficult to prove that a patient is doing better and is ready to deploy, when their care has not been documented clearly.

HOW ARE PROFILES COMMUNICATED TO COMMANDERS?

The Airman and Guardian Availability Management (AGAM) system is a communication tool between medical providers, ill or injured Service members, and their supervisors or Commanders use to initiate and manage a profile. This system will send a notification to the command team indicating that one of their Service Members is on a profile, the anticipated length of the profile, and any specific mobility or duty limitations recommended by the clinician. A Service Member's diagnosis, treatment plan, and other detailed information is not visible to the patient's command team.

As a best practice, clinicians will often request permission from their patients to talk to their patient's Commander beyond what is accomplished through ASIMS. The goal is to gather more information about the patient's struggles, set expectations and answer questions the Commander might have regarding profiles, and to explain to the Commander how they can support their member. While it's only required that clinicians call Commanders for specific situations regarding risk [DoDI 6490.08], this additional optional communication is highly encouraged as it improves the clinician's ability to accurately understand their patient's struggles while also ensuring command can effectively support their Service Members.

WHAT IF TREATMENT DOES NOT RESULT IN REMISSION?

If a Service Member's MH disorder does not go into remission after a year of treatment, or if they experience a serious mental health event (e.g., suicide attempt, multiple hospitalizations) there is a possibility that the Service Member may not be able to stay in the military. This is NOT something a MH clinician determines. The clinician must first discuss the case with a local group of independent clinicians - the Airmen Medical Readiness Optimization (AMRO) Board. If the AMRO board determines a Service Member likely cannot remain in the military, based on their medical or Mental Health condition(s), their case is referred for another formal review to obtain a secondary objective opinion. This second opinion results in a recommendation to the Service Member's Commander. Possible recommendations include that the Service Member be (1) retained in DAF, (2) medically separated, or (3) administratively separated [Additional details are available on page 36]. When a Service Member is medically separated, a Military to Veteran's Affairs (M2VA) representative will contact the Service Member to ensure a smooth transition to the Veteran's Administration (VA) for continued mental health care.

		Can this member be retained? (Code 37)	Can this member fully do their job? (Code 31)	Can this member deploy/PCS? (DW possible?)	Further Guidance
Disorders / Situations that do not meet retention standards - retention is unlikely					
QIA	Schizophrenia Spectrum and Other Psychotic Disorders as defined in the current DSM.	U	U	N	Member will need to be placed on a Code 31 in AGAM by clinician. Clinician should begin narrative summary promptly and present case to the AMRO Board. AMRO Board will likely elevate to a Code 37. Retention is unlikely. Waiver to deploy is not possible. Note that the 6 months are not provided as a means for trialing these medications, but to provide time to stop unnecessary medications before a full iRILO is indicated.
QIB	Bipolar and Related Disorders, as defined in the current DSM.	U	U	N	
QIC	Mental disorder(s) requiring use of lithium, anticonvulsants, or antipsychotics beyond 6 months.	U	U	N	
Disorders / Situations that do not meet retention standards - retention is possible					
Q2A	DSM disorders causing or expected to cause duty/mobility restrictions (see Q3B-C Criteria) for greater than 12 months.	P	P	U	Member will need to be placed on a Code 31 in AGAM by clinician. Clinician should start narrative summary, and present case to the AMRO Board. If likely to improve expect a request for an iRLIO and continued Code 31. If unlikely to improve, expect a request for an MEB and elevation to a Code 37. If AMRO recommends a Code 37 and the disorder is a Neurodevelopmental or a Personality Disorder, a recommendation for Admin Sep is indicated rather than an MEB. Waiver to deploy is unlikely. If diagnosis substance related, ADAPT will engage command directly.
Q2B	DSM disorders resulting in more than one psychiatric hospitalization.	P	P	U	
Q2C	Requires care at least every 3 months from a specialty Mental Health provider for greater than 12 months.	P	P	U	
Q2D	Any suicide attempt/behavior in the past 12 months.	P	P	U*	In addition to the above, following any AD suicide attempt, the MTF SGH will convene an ad hoc AMRO Board (including at least one MH provider) to determine if an iRILO is needed. ARC members will always require a fitness for duty evaluation. ***Note:** This is "strictly disqualifying" for a DW to CENTCOM.
Disorders / Situations that meet retention standards but not deployment standards - waiver to deploy is possible					
Q3A	Any psychiatric hospitalization in the past 12 months.	Y	P	P*	Member will need to be placed on Code 31 in AGAM for 3 months by clinician. Clinician should review duty of deployment/PCS limitations with AMRO (informally). Clinician should reevaluate with AMRO every three months. At 12 months see guidance for Q2 criteria. ***Note:** PACAF requires 24 months prior to allowing PCS/Deployment.
Q3B	Concurrent use of 3 or more psychotropic medications.	Y	P	P	
Q3C	Currently meeting criteria for any DSM Disorder(s) (F-Prefix) not in remission as documented in last encounter.	Y	P	P	
Disorders / Situations that meet retention standards and deployment standards					
Q4A	Currently meeting criteria for any DSM Disorder(s) (F-Prefix) in remission for at least 3 months with treatment as documented in last encounter.	Y	Y	P*	***Note:** Waiver to deploy to CENTCOM is required if remission is accomplished via a Schedule II-IV medication (ex: Ritalin). This is because it is difficult to get these medications to theater.
Q4B	History of any DSM Disorder (F-Prefix) in remission for at lest 3 months without treatment as documented in last encounter.	Y	Y	Y	For patients on flight / special duty status, refer to flight med.
Q4C	Currently meeting criteria for any Z or T-Prefix DSM Diagnosis.	Y	Y	Y	For patients on flight / special duty status, refer to flight med.

Legend: **Y** YES · **P** POSSIBLE · **U** UNLIKELY · **N** NO

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