Healthcare Provider's Practice Guide for the Utilization of Behavioral Health Technicians (BHTs)

Information and Recommendations to Optimize Use of BHTs to Support Psychological Healthcare in the Department of Defense

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Introduction

Purpose

The purpose of the *Healthcare Provider's Practice Guide for the Utilization of Behavioral Health Technicians* is to provide information about military behavioral health technician (BHT) training, competencies, and utilization in the Military Health System (MHS). This practice guide will highlight common definitions across the Services and offer recommendations for the utilization and supervision of BHTs. The intent of the guide is to inform the clinical community of BHT capabilities in order to optimize BHT utilization to support psychological healthcare across the Department of Defense (DoD).

Background

In 2017, the Psychological Health Center of Excellence (PHCoE) conceptualized the development of a work group to address concerns unique to BHTs across the DoD, to include their utilization. With approval from the Defense Health Agency (DHA), the BHT Work Group (BHTWG) was established with the mission to "integrate knowledge, resources, and efforts to support BHTs across Services. The BHTWG will collaborate with BHT subject matter experts and licensed behavioral health providers in order to facilitate actionable recommendations across the Military Health System (MHS) (PHCoE Charter, 2017, p. 1)." The membership of the BHTWG is comprised of BHT leadership and behavioral health experts, and has representation from the U.S. Army, U.S. Navy, U.S. Air Force, and U.S. Marine Corps.

Through recurring group meetings and socializing observations from the field, the BHTWG identified a perceived gap in awareness of BHT capabilities, utilization, and supervisory relationships. As such, the BHTWG sought to develop this practice guide to help providers understand options for leveraging BHT support to utilize BHTs to their full scope of practice resulting in maximum impact.

BHTs support psychological healthcare through:

- Increased access to and efficiency of behavioral health services across the MHS
- Using their enlisted status to facilitate increased approachability not available to other behavioral health providers
- Provision of vital behavioral health services in the deployed setting
- Provision of integrated operational support as embedded BHTs

Rationale for Optimal use of BHTs in DoD

In recent years, demand for behavioral health services in all settings (deployed and garrison) has steadily increased (Quartana et al., 2014). Required behavioral health screenings and evaluations, such as those per policy or for assignment to positions of significant trust and authority, have similarly expanded (e.g. ALARACT 188/2014). Thus, there is an increasing demand for personnel to meet these behavioral healthcare needs. Optimal use of all behavioral health staff, to include BHTs, is key to meeting this demand.

BHTs Increase Access to and Efficiency of Behavioral Health Services across the MHS

BHTs have extensive training, and in many cases considerable experience, in both clinical and operational environments. Trained and supervised BHTs can directly impact patients' access to care and clinic efficiency as they serve to extend the amount and type of clinical services that can be offered. As clinical extenders, BHTs may allow for an increased number of patients to be seen and possibly contribute to a reduction in network referrals.

With appropriate training and supervision, BHTs can perform and support a wide range of clinical services including, but not limited to:

- Intake evaluations/biopsychosocial assessments
- Triage screenings
- Occupational evaluation screenings
- Group counseling (e.g., support groups)
- Individual counseling
- Psychometric testing administration (including neuropsychological and psychodiagnostic evaluations)
- Psychoeducational groups
- Psychoeducational presentations/briefings
- Outreach and prevention
- Treatment planning
- Case management/care coordination
- Crisis intervention
- Command consultation

Using BHTs to provide these services may allow licensed behavioral health providers additional time to focus on providing treatment to patients with complex psychopathology requiring highly skilled interventions and comprehensive consultation with command.

BHTs function under the supervision of a licensed behavioral health provider when performing clinical tasks. Therefore, patient suitability for BHT intervention is at the discretion of the supervising provider who is ultimately responsible for patient care. Factors a provider might consider when assigning a patient care task to a BHT could include patient diagnosis, symptom severity, and complexity of psychopathology, as well as training, skill level, and experience of the BHT. While there is no "ideal" patient for BHT assignment, basic BHT training typically prepares them for brief, solution-focused interventions for psychosocial concerns and stressors in both individual and group formats, including counseling and psychoeducational support.

BHTs frequently administer and score basic psychometric self-report measures in clinical settings. BHTs, with additional specialized training, can also serve in a psychometrist role, administering more complex tests and measures during neuropsychological and psychodiagnostic evaluations conducted by a supervising psychologist. This is but one example of BHTs as a clinical extender allowing more time for providers to perform more complex, provider-only tasks. Further discussion of BHTs as clinical extenders will be offered throughout this guide.

Embedded BHTs Provide Integrated Operational Support

The BHT career field provides important capabilities to unit commanders in support of improved mission outcomes. In operational units, BHTs employ primary and secondary prevention tactics to mitigate occupational and operational stressors, enhance resilience, prevent injury/illness, and facilitate access to the healthcare system when needed. Embedded BHTs advise commanders on the health of unit members, policies with impact on human performance, and other human factors to improve performance and lead to better mission outcomes (e.g., healthy lifestyle habits, responsible alcohol use, behavioral health cautions for energy and other supplements use, communication skills, stress management, sleep hygiene, job satisfaction and unit cohesion).

BHTs' Enlisted Status Facilitates Increased Approachability Not Available to Other Behavioral Health Providers

BHTs offer a unique perspective as enlisted personnel. They can often access patient populations directly through unit affiliations in ways that are not available to other behavioral health providers due to lack of opportunity or barriers associated with rank.

BHTs Provide Vital Behavioral Health Services in the Deployed Setting

BHTs serve as extenders of behavioral healthcare and are behavioral health force multipliers, particularly in the deployed setting. They are often deployed with small clinical sections responsible for providing behavioral health support to large formations of warfighters without the resources of traditional garrison settings. At times, they may even be forward deployed alone and work without direct on-site supervision from a licensed, privileged behavioral health provider. In such instances, provider consultation is typically available in some form (e.g., telephone, email). Remote supervision permits BHTs to operate as provider extenders in austere deployment environments where a provider may not always be readily available for patient care. This is in contrast to garrison settings, where direct supervision is available and required.

Barriers to Optimal use of BHTs

Absence of Policy to Specifically Define Manpower Utilization Requirements for Each Clinical Setting

Within a clinical setting, there may not be designated administrative support (e.g., medical administration, clerical, reception, etc.). In those cases, leadership may rely upon BHTs to perform these administrative functions in order fulfill the mission. Using BHTs for purely administrative functions represents inefficient resource allocation and risks degradation or loss of BHT resources. BHT clinical skills/readiness skills may deteriorate without use.

Varied Support (and Trust) From Providers

Some officers, non-commissioned officers (NCOs), and civilian providers do not understand, or are not comfortable with, the clinical skills and capabilities that a BHT can bring to the mission. Reluctance about BHT skills may also relate to a BHT typically lacking an advanced degree and formal credentialing. However, even when a BHT holds a certification commensurate with their role and duties, (e.g., Air Force Certified Alcohol and Drug Counselor (CADC), certified Navy Drug and Alcohol Counselor, certified Army Alcohol and Drug Counselor), and/or an advanced degree, provider trust and support is often variable.

Variations in Training and Proficiency Standards for BHTs

In general, standardized training plans for meeting BHT proficiency standards at the unit level are not widely available or enacted in all service branches. Some standardized training plans and information can be found within Headquarters, Department of the Army, *OTSG/MEDCOM Policy Memo 17-080*, *Military Occupational Specialty 68X*, *Behavioral Health Specialist Utilization* (2017), U.S. Department of the Air Force, *AFSC 4C0X1 Mental Health Service Specialty Career Field Education and Training Plan* (2018), and Department of the Navy, *BUMEDINST 1500.29C*, *Navy Medicine Command Training Program* (2018).

Limited Available Time Dedicated to Effective BHT Training and Supervision

Ideally, time for supervision is prioritized and occurs regularly; however, given the dynamic nature of military missions and the high demand for clinical services, it can be challenging to ensure supervision is consistently conducted. Similarly, qualified supervisors may be hesitant to assume supervisory responsibility for the work of BHTs given potential legal and ethical implications inherent in supervising unlicensed behavioral health personnel.

The Healthcare Provider's Practice Guide for the Utilization of Behavioral Health Technicians

This guide aims to address the aforementioned issues and offers providers a thorough understanding of the BHT functions, training, and supervision requirements for optimal use of BHTs in their clinical setting. It is organized into the following sections:

1. BHT Definition and Nomenclature
2. BHT Training
3. BHTs as Provider Extenders
4. BHTs in the Deployed Setting
5. Clinical Supervision
6. Summary and Recommendations

Section 1. BHT Definition and Nomenclature

BHTs are enlisted Service members, civil service, and contract employees that are trained to conduct a multitude of tasks to support the military behavioral health mission in both garrison and deployed operations across the world.

The Medical Education and Training Campus (METC), a tri-service educational training center for enlisted Service members, defines BHTs as "allied health professionals focused on communication techniques required to assess/evaluate military personnel and their family members in need of Behavioral Health care (METC, 2016, p. 4)." BHTs serve as healthcare extenders that support the delivery of safe and ethical direct patient care. METC's curriculum identifies BHT support areas as "communication techniques, human development, psychopathological disorders, psychological testing, consultation, interviewing, psychiatric behavioral interventions, counseling, and Combat and Operational Stress Control (COSC) (METC, 2016, p. 3)."

The table below depicts Service-specific definitions and classifications. Each Service uses a different name to identify a BHT. To promote common understanding, this practice guide will use "Behavioral Health Technician" (BHT) as a global term encompassing all three Service-specific names.

Service	Service-specific Name	Code/Designator	Definition
Army	Army Behavioral Health Specialist	Military Occupational Specialty (MOS) 68X10	Not specified (per OTSG/MEDCOM Policy Memo 17-080, Army PAM 611-21, and STP 8-68X14-SM-TG) From MEDCOM Reg 40-50, Appendix W – Behavioral Health Specialist (68X): "Facilitate BH activities in Garrison and Operational environments. Assist in conducting psycho-educational classes and groups, administering medication. Assisting in the treatment of clients with BH diagnoses or symptoms that include, but are not limited to substance use disorders, trauma and stressor related disorders and other BH disorders. Under the direct supervision of a Licensed Independent Provider/Privileged Healthcare Provider, conduct initial interviews, triage, risk assessments, client assessments, mental status examinations, psychological testing, develop and implement treatment plans, group facilitation, case management, collect and record psychosocial and physiological data, and other instruments that assess the client's potential or actual response to treatment and/or rehabilitation. Also support IAW Combat and Operational Stress Control Operations."
Navy	Behavioral Health Technician	Navy Enlisted Classification (NEC) L24A	"Provides behavioral and mental healthcare for service members and their families. Assists psychiatrists and psychologists by performing assessments, crisis triage and management, co-facilitation of therapy groups, short-term counseling, training and education classes and psychological testing. Provides intervention for persons affected by psychological trauma, mental illness and crisis. Completes observations and documentation in the care and treatment of patients in the inpatient and outpatient hospital settings and field environments. Has knowledge of operational stress control and mitigation methods and assessment of traumatic brain injury (Department of the Navy, 2018, p. 47)."
Air Force	Mental Health Technician	Air Force Specialty Code (AFSC) 4C0X1	"Supports mental health services in psychiatry, psychology, social work, family advocacy, substance abuse prevention, treatment and aftercare, integrated operational support, and other mental health programs. Manages mental health service resources and activities. Assists mental health professional staff with developing and implementing treatment plans. Performs specified mental health counseling. Reports and documents patient care." (U.S. Department of the Air Force, CFETP 4C0X1, 2018b, p. 12)

Section 2. BHT Training

Core Training

Following initial basic military training, enlisted personnel begin specialty career training at METC at Joint Base San Antonio in San Antonio, Texas. The goal of the BHT training program is to prepare tri-Service personnel to serve as entry-level BHTs in both clinical and operational settings, while working under the supervision of a behavioral health provider, trainer, and supervisor. Navy enlisted personnel must first complete hospital corpsman training on basic medical topics at Hospital Corpsman "A" school prior to BHT training at METC. At METC, the BHT training spans a range of mental health competencies. Instruction is provided by behavioral health officers and non-commissioned officers from each Service through classroom instruction, review of case studies, and group learning activities that allow students to integrate information and develop analytical skills. BHTs also participate in Directed Clinical Practicums (DCPs) at a variety of inpatient, outpatient, and emergency departments.

The BHT curriculum at METC includes 377 hours comprised of the following topics:

- Introduction to Behavioral Health and Human Growth and Development: 25.5 curriculum hours
- Psychopathology: 64 curriculum hours
- Psychiatric Interventions: 40 curriculum hours
- Interviewing Skills: 100 curriculum hours
- Counseling/Group Skills: 104 curriculum hours
- Psychological Testing: 20 curriculum hours
- Combat Operational Stress Control: 23.5 curriculum hours
- Performance-based training and testing: 200 hours (in addition to BHT curriculum hours)

Each Service also has Service-specific requirements for their BHTs to complete following initial training and in addition to curriculum training. In total for completion of Core Training, Army BHTs complete 676 hours (17 weeks); Air Force BHTs complete 554.5 hours (14 weeks); and Navy BHTs complete 598 hours (15 weeks) from the start of BHT training.

Service-Specific Training Requirements

Service	Training	Total Hours of Performance Tasks
Army	Joint Medical Training Field Training Exercise (FTX) Directed Clinical Practicums/Clinicals (DCPs)	15 hours* 97 hours 203 hours
Air Force	Joint Medical Training Expeditionary Medical Readiness Course Directed Clinical Practicums/Clinicals (DCPs)	15 hours* 82 hours 96.5 hours
Navy	Navy Specific Training Directed Clinical Practicums/Clinicals (DCPs)	18 hours 203 hours

Navy BHTs complete BLS during "A" school, hospital corpsman training
*Joint Medical training hours not included in total METC training hours

On-the-Job Training (OJT) Requirements

The Air Force has a formalized on-the-job (OJT) training program for its BHTs aimed to enhance skills and document training. The other Services also have OJT training which similarly guides BHT career progression.

Air Force BHTs (specialty code 4C0X1) are awarded the 1-level skill (4C011) upon arrival at METC. After completion of the training at METC, they are awarded the 3-skill level (4C031). They immediately begin 5-skill level upgrade training and enrollment in the 5-level Career Development Course (CDC) upon arrival to their first duty station. Upgrade to the 5-skill level requires:

- Completion of all 5-level core tasks identified in the 4C0X1 Career Field Education and Training Plan (CFETP)
- A minimum of 12 months of upgrade training (9 months for re-trainees)
- Completion of the CDC (4C051)
- Completion of all duty position training requirements
- Recommendation of supervisor that member meets all other requirements as outlined in AFI 36-2101, Classifying Military Personnel (Officer and Enlisted)

BHTs in the Air Force have an average of 18–24 months time-in-service before being awarded the 5-skill level. Assigned 3-/5-skill level BHTs also remain in Job Qualification Training (QT) and require continued experience, supervision, and mentorship to foster clinical proficiency, readiness training, and personal/professional growth for advancement. BHTs must perform patient counseling activities in the Alcohol and Drug Abuse Prevention and Treatment Program (ADAPT) or outpatient behavioral health clinics to meet the nationally accredited Certified Alcohol and Drug Counselor (CADC) certification requirements necessary to be awarded the 7-skill level.

Upon selection to Staff Sergeant (E-5), the 5-skill level BHT begins their 7-skill level upgrade training. The BHT is awarded their 7-skill level upon wearing the grade of Staff Sergeant (E-5) and:

- Completion of all 7-level core tasks identified in the Career Field Education and Training Plan (CFETP)
- A minimum of 12 months of upgrade training (6 months for re-trainees)
- Certified on all duty position training requirements
- Obtaining nationally accredited Alcohol and Drug Counselor certification (CADC)
- Recommendation of supervisor that member meets all other requirements as outlined in AFI 36-2101, Classifying Military Personnel (Officer and Enlisted)

Air Force BHTs have an average of six to seven years time-in-service before being awarded the 7-skill level. They continue to remain in QT throughout service.

Section 3. BHTs as Provider Extenders

Overview

With appropriate clinical supervision, BHTs can be utilized within their full scope of practice and serve as provider extenders. Specific BHT activities will vary depending on the Service component, installation mission, and clinic environment.

The Functions of BHTs

The primary functions of BHTs can be divided into four categories: (a) clinical care, (b) case management, (c) operational outreach, and (d) clinical administrative management duties.

Clinical Care

The clinical skill set of the BHTs can be effectively leveraged as provider extenders such that they function as a critical member of the treatment team. Clinical care includes settings across the spectrum of care including direct treatment of behavioral health and substance use disorders in outpatient, intensive outpatient, and inpatient settings. BHTs are provided specialty career training at METC and further OJT on all of the duties listed below.

1. Triage and Screening

   BHTs can screen patients for appropriateness, eligibility, level of care, and program admission using a variety of skills such as evaluating psychological, social, and physiological signs/symptoms, identifying co-existing conditions, determining urgency and severity, and eligibility for services. BHTs can assist in triaging walk-in patients. Triage services commonly involve brief same-day appointments focused on the presenting problem, a safety assessment, and dispositioning.

2. Intake Interviews and Biopsychosocial Assessments

   BHTs can conduct comprehensive intake interviews. Many clinics use BHTs to gather preliminary assessment data and then brief the provider on the findings, to include provisional diagnoses. Conversely, the BHT and provider can interview patients together, which allows for one person to complete the intake note while the other interviews the patient, facilitating patient engagement and clinical focus.

3. Counseling

   BHTs do not provide individual psychotherapy, but can perform individual counseling under the supervision of a privileged behavioral health provider. They are trained in exploring problems; assessing strengths, needs, abilities, and problems; establishing treatment plans; maintaining therapeutic relationships; examining attitudes and affective responses; encouraging healthy problem-solving; assisting in decision-making and disposition planning; and executing a treatment plan. BHTs are trained to deliver brief, solution-focused interventions, particularly for psychosocial concerns and stressors, consistent with evidence-based practice.

4. Safety Support

   BHTs are trained to recognize and respond to crisis situations. They can provide crisis intervention techniques and when necessary conduct safety planning with patients, which can increase touchpoints for the patient and offer the provider assistance with managing patient care and treatment. BHTs can provide brief one-to-one patient monitoring in high-risk situations until transport to a secure facility can be coordinated. They can also collect data for providers to use in completing risk assessments. In facilities where passive restraint techniques are used in inpatient settings, BHTs who have completed the requisite training can function as the team leader and restraint training monitor.

5. Group Interventions

   BHTs can support group therapy in many ways, including providing components of treatment as an extension or reinforcement to provider-led evidence-based therapy protocols. BHTs can actively lead psychoeducational and treatment groups that focus on stress, anger, assertiveness, sleep hygiene, tobacco cessation, coping with psychosocial issues, and basic Cognitive Behavioral Therapy (CBT) techniques. BHTs can facilitate aftercare or recovery groups and can also function as co-therapists for protocol-based treatment (i.e. manualized) groups such as Problem Solving Therapy (PST) and CBT. They can screen members for group inclusion, review expectations and parameters for group participation, encourage treatment engagement, and increase expectancy effects for treatment response. BHTs can assist with group therapy notes using established templates with subsequent provider review and completion of documentation. Tracking group attendance and member progress, as well as maintaining and disseminating group materials, are important tasks BHTs can also complete.

6. Reinforcing Clinical Objectives

   BHTs can actively monitor progress and compliance, reinforce treatment gains, and solidify specific clinical objectives through close collaboration between provider and BHT. BHTs can effectively monitor compliance with homework assignments. They can target patient motivation and treatment engagement through the use of motivational techniques. BHTs can accomplish motivation-enhancing tasks via short discussions with the patient before or after formal therapy sessions with providers. This motivation-enhancement may also occur during scheduled follow-up sessions, wherein the BHT conducts the majority of the encounter and the provider conducts a brief safety assessment of the patient afterward. This is often the case in substance abuse clinics. BHTs can also draft preliminary safety plans and review ongoing safety plans for accuracy and compliance. In the inpatient setting, BHTs can interact with patients to increase adherence to daily goals or to discuss and provide reinforcement for bibliotherapy, journaling, or other assignments to support treatment.

7. Psychometric Testing

   BHTs can administer and score psychometric testing, ranging from personality inventories to neuropsychological tests (with advanced training), depending on locally available training and supervision. Additionally, BHTs can conduct ongoing screening or administration of treatment-based outcome measures used to monitor treatment or symptom change over time.

8. Medical Tasks

   BHTs can assist with general medical tasks as dictated by the mission and specific Service, particularly those also trained as medics (e.g., Navy BHTs). These activities can include (a) taking vital signs, (b) collecting urine samples, (c) completing lab order paperwork, (d) dispensing medication, (e) drawing blood, (f) administering breathalyzer tests, and (g) collecting data regarding medication compliance.

9. Inpatient Support Activities

   On inpatient units, BHTs can assist patients and staff on any of the clinical care duties listed above with the addition of patient nutritional needs, hygiene and comfort measures, new patient orientation, and milieu management.

Case Management

BHTs can assist with active case management. Case management may decrease no-show and cancellation rates, ensure timely care during periods of heightened risk, facilitate appropriate treatment for patients with challenging conditions or needs, and enhance overall treatment response by reinforcing gains, identifying barriers to compliance, and improving treatment engagement.

1. Establish Accountability

   Make clear the responsibility of participants in a patient's care for a particular aspect of that care.

2. Communicate

   Share knowledge and information among participants in a patient's care team.

3. Facilitate Transitions

   Facilitate transitions between treatment levels/settings or between military healthcare system and post-military support agencies.

4. Assess Needs and Goals

   Determine the patient's needs for care and for coordination, including physical, emotional, and psychological health; functional status; current health and health history; self-management knowledge and behaviors; current treatment recommendations, including prescribed medications; and need for support services.

5. Create a Proactive Plan of Care

   Establish and maintain a plan of care, jointly created and managed by the patient/family and health care team, which outlines the patient's current and longstanding needs and goals for care and/or identifies coordination gaps. Ideally, the care plan anticipates routine needs and tracks current progress toward patient goals.

6. Monitor, Follow Up, and Respond to Change

   Jointly with the patient/family, assess progress toward care and coordination goals. Monitor for successes and failures in care and coordination. Refine the care plan as needed to accommodate new information or circumstances and to address any failures. Provide necessary follow-up care to patients.

7. Support Self-Management Goals

   Tailor education and support to align with patients' capacity for and preferences about involvement in their own care. Education and support include information, training, or coaching provided to patients to promote patient understanding of and ability to carry out self-care tasks, including support for navigating their care transitions, self-efficacy, and behavior change.

8. Link to Community Resources

   Provide information on the availability of and, if necessary, coordinate services with additional resources available in the community that may help support patients' health and wellness or meet their care goals.

9. Align Resources with Patient Needs

   Assess the needs of patients and allocate health care resources according to those needs.

10. Medication Management

    Reconcile discrepancies in medication use in order to avoid adverse drug events associated with transitions in care. This can involve review of the patient's complete medication regimen at the time of admission/transfer/discharge, including assessing use of over-the-counter medications and supplements; comparison across information sources and settings; or direct communication between patients and providers.

Operational Outreach

Another useful function of BHTs is outreach to military units. Unit members may feel more comfortable with BHTs than officers or healthcare providers.

1. Outreach to Operational Units

   BHTs can provide outreach via group educational briefings on various health and lifestyle topics, consultation with leadership, individual "walk-abouts," and other rapport-building efforts. BHTs can use skills, expertise, and insight into emotional, behavioral, and social functioning to assist with improving health and human performance in units. They also can provide consultation to unit leaders and unit members on topics relevant to adapting and responding to unique operational and/or combat related psychological health challenges. In order to facilitate familiarity, these activities should be performed in the unit setting where Service members work. As Service members become more comfortable with the BHT, they will be more inclined to disclose problems and more receptive to intervention efforts. In addition to providing preventative education and psychoeducational briefings, and brief interventions, BHTs can function as conduits to facilitate referrals from operational units to the Military Treatment Facility (MTF). That is, they can actively address barriers to care, provide motivational enhancement, introduce unit members to providers in the clinic, and consult with providers on referrals. BHTs most often act independently in these outreach functions as no direct clinical services are provided, utilizing their aligned supervising provider for support as needed.

2. Disaster or Traumatic Event Response

   BHTs can assist with disaster or traumatic event response, which may involve providing psychological first aid or other appropriate crisis interventions, consultation with the command, and other non-therapeutic outreach activities designed to mitigate the negative impact of exposure to trauma and increase adaptive behaviors. These activities can be integrated with general outreach efforts, and are most likely to be effective to the extent that the BHT is embedded in the day-to-day operations of the unit. As the BHT develops a trusting working alliance with unit members, their outreach efforts will likely be met with greater receptivity.

Clinical Administrative Duties

Clinical administrative duties should not be considered the primary role of a BHT. Administrative and clerical tasks typically fall within the scope of other specialties in clinical settings. BHTs can, if needed, serve in a secondary and temporary support role for an array of clinical administrative duties, such as arranging for behavioral health consultations and helping patients with completion of their forms and paperwork. They can assist with record management, to include entering information into records or databases, inspection of patient medical records, and managing medical reports from providers. BHTs can carry out other clinic tasks, such as copying provider's orders to forms and completion of psychiatric incident reports. Short-term use of BHTs in administrative roles should be limited to minimize mission degradation in the event that administrative staff is unavailable.

The Provider-BHT Paired Team Model

Optimal use of BHTs occurs when a provider-BHT paired team model is implemented. Ideally, a clinic should be structured such that each BHT is paired with a supervising provider. Each provider could work closely with the aligned BHTs, providing necessary training and supervision. The BHT can "shadow" the provider in a number of activities depending on the schedule, clinic demands, level of experience, and provider availability. This structure will help to build the trust necessary for a provider to feel confident in the skills of the technician. Without this trust a provider may be reluctant to delegate clinical tasks. Further, this team approach facilitates supervision and role-modeling. When an aligned BHT is side-by-side with the provider as they perform various clinical duties, learning will occur through observation and role-modeling, limiting the amount of additional time needed for an already busy provider to spend training the BHT. With the increase in trust and skill acquisition over time, a provider can more confidently delegate clinical tasks to the BHT. As a BHT gains clinical skills, provider templates may be modified for concurrent/staggered intakes or education/counseling sessions, which could lead to increased access to care for patients and RVU-generation for providers. It should be noted that not all BHTs will require this level of supervision and training. Rather, BHTs should continue to receive supervision and training consistent with improving upon their current skills.

Section 4. Promoting Readiness of the Force

Promoting Readiness

Given ongoing and often short-notice deployments for all military personnel, it is essential that BHTs maintain competence in the full range of required clinical skills (e.g., clinical behavioral health, combat operational stress control, outreach/prevention, medevac, etc.) that may be required. Seldom do these missions require the BHT to perform only clinical administrative duties. Only performing administrative duties, as is often the case in garrison, jeopardizes BHT readiness for more robust duties and may degrade BHT skills.

BHTs are often deployed with small clinical sections responsible for providing behavioral health support to large formations of warfighters, absent the resources of traditional garrison settings. At times, deployed BHTs are forward deployed alone and work without direct onsite supervision and oversight from a licensed privileged behavioral health provider, instead relying on email, phone, radio, secure video teleconferencing, or other communication for supervision. This off-site supervision is permitted in austere environments due to limited availability of behavioral health providers. A provider is otherwise required for direct supervision in garrison. Effective utilization, ongoing training, and clinical supervision are key methods for ensuring BHTs can effectively continue the mission of behavioral health, even in austere and forward locations if required. Utilizing BHTs to their full scope of practice while in-garrison promotes skill development, self-confidence, autonomy, job satisfaction, trustworthiness, and habits that ensure safe and effective patient care delivery in a deployed setting.

Section 5. BHTs in the Deployed Setting

Overview

This section describes the work of BHTs in the deployed environment. In many deployed settings, BHTs serve as provider extenders and as the first line of psychological support for warfighters due to mission requirements and manning limitations. The responsibilities of BHTs can vary depending on Service, installation mission, or operational environment.

ARMY BHTS IN THE DEPLOYED ENVIRONMENT

Army BHTs frequently deploy with a Brigade Combat Team or as a member of a Combat Operational Stress Control (COSC) detachment.

Army Brigade Combat Team (BCT)

Army Brigade Combat Teams (BCTs) consist of 3,000 to 5,000 Soldiers. For deployed missions, each BCT has a behavioral health section optimally consisting of two behavioral health officers, a licensed psychologist or licensed clinical social worker, and up to two BHTs. In comparison, the same brigade will be supported in garrison by the two active duty behavioral health providers, up to two BHTs, and a six to 12 person multi-disciplinary civilian and/or military embedded behavioral health team, including psychologists, licensed clinical social workers, a psychiatrist or psychiatric nurse practitioner, a nurse case manager, and support staff. (Note: The use of the term 'embedded behavioral health' varies across services. This description is specific to the Army.)

Combat Operational Stress Control (COSC)

COSC detachments provide behavioral health support to all units within a defined area of operations. A COSC detachment may include social workers, psychologists, psychiatrists, occupational therapists, psychiatric nurses, BHTs, an occupational

therapy specialist, a chaplain, and a chaplain's assistant. COSCs provide a range of BH support, including prevention services, psychoeducational classes, triage and assessment, psychotherapy, medication management, three to five day reconditioning programs designed to maintain Soldier functioning in theater, and stabilization prior to medical evacuation from theater.

AIR FORCE BHTS IN THE DEPLOYED ENVIRONMENT

Air Force BHTs have the opportunity to serve in several capacities in the deployed environment. They are expected to provide an array of support functions in multiple locations as described below.

Expeditionary Medical Services (EMEDS)

Some BHTs provide prevention and outreach services, outpatient behavioral health services in Outpatient Behavioral Health Clinics (OPBHC) or in other medical settings as dictated by the deployment, and combat stress support services while operating in a Combat Stress Facility (CSF). In these roles, the BHT will often conduct field assessments; complete abbreviated intakes, provide brief interventions, and provide treatment recommendations to support attending providers.

Air Force Theater Hospital (AFTH)

AFTHs provide dedicated in-theater and en route medical or psychiatric support to definitive care facilities in the continental United States (CONUS) and designated facilities outside the continental United States (OCONUS). Air Force BHTs may provide manpower support and serve as medical attendants both within theater and via medical evacuations. In this capacity, they often function as the sole personnel providing clinical care to address the psychological health support needs of the returning Service members.

Embedded Support to Joint/Sister Service Forward Operating Units

Air Force BHTs are periodically deployed in support of joint and sister services units. Duties under supervision include examination, diagnosis, treatment rehabilitation, and disposition of neuropsychiatric and combat stress cases. Also, diagnosis and treatment of psychiatric disturbances in the wounded, ill, and injured; COSC support and staff consultation to supported units; as well as training of unit leaders and medical personnel in identification and management of neuropsychiatric disorders, combat stress, and misconduct stress behaviors.

NAVY BHTS IN THE DEPLOYED ENVIRONMENT

Navy BHTs serve as paraprofessionals alongside embedded behavioral health providers (psychiatrists, psychologists, psychiatric nurse practitioners, and social workers) attached to various naval platforms, including surface ships and submarines. They also serve with Marines in Operational Stress Control and Readiness (OSCAR) teams and/or Combat Stress Teams. BHTs specialize in the prevention, identification, and treatment of behavioral health disorders. Some general duties are to perform patient intakes/counseling sessions, provide individual and/or group treatment in response to a psychological problem presented by the client(s), and monitor effects of psychotropic medications. BHTs are trained to appropriately respond to an agitated person, establish and maintain safety, while developing and maintaining a therapeutic relationship. BHTs with greater experience generally will be assigned to aircraft carriers and Fleet Surgical Teams where they will engage in an expanded range of practice activities and work one-on-one with the ship's behavioral health provider concerning behavioral health needs and assessments for the battle group while in a deployed setting. BHTs also assist with the care and treatment of patients with alcohol and drug use problems.

Embedded Support

Navy BHTs may be a part of an Embedded Mental Health team as an active duty behavioral health asset in a non-hospital setting, whose primary duties are to provide direct clinical care, command liaison/consultation, outreach, education and training, and psychological surveillance to an active duty unit.

For members assigned to Fleet Marine Force units, BHTs may perform duties in a tactical setting similar to an independent provider; liaison between Battalions, Regiment, and Division for Force Preservation; liaison for Medical Evaluation Boards for Navy and Marine Corps and may be part of an OSCAR Team for Marine units.

Special Psychiatric Rapid Intervention Team (SPRINT)

Navy BHTs may be assigned to a Special Psychiatric Rapid Intervention Team (SPRINT), a Navy contingency response team operating through brief, rapid deployments. They provide Psychological First Aid and emotional support immediately after a disaster with the goal of preventing long-term dysfunction or disability. These personnel may also provide educational and consultative services to local supporting agencies for long-term problem resolution. Teams are comprised of psychiatrists, psychologists, psychiatric nurses, psychiatric nurse practitioners, licensed clinical social workers, Navy Chaplains, Navy BHTs, and United States Public Health Service personnel.

Section 6. Clinical Supervision

Definition and Overview

"Supervision is an intervention provided by a senior member of a profession to a more junior member or members. ... This relationship is evaluative, extends over time, and has the simultaneous purposes of enhancing the professional functioning of the more junior person(s); monitoring the quality of professional services offered to the clients that she, he, or they see; and serving as a gatekeeper of those who are to enter the particular profession (Bernard & Goodyear, 2004, p. 8)."

Supervision is "a social influence process that occurs over time, in which the supervisor participates with supervisees to ensure quality of clinical care. Effective supervisors observe, mentor, coach, evaluate, inspire, and create an atmosphere that promotes self-motivation, learning, and professional development. They build teams, create cohesion, resolve conflict, and shape agency culture, while attending to ethical and diversity issues in all aspects of the process. Such supervision is key to both quality improvement and the successful implementation of consensus- and evidence-based practices (CSAT, 2007, p. 3)."

BHT Supervision Requirements

BHTs serving across the DoD are unlicensed and therefore require ongoing clinical supervision for patient care services. This clinical supervision is required for continuing skill progression. While credentialed licensed providers in DoD are required to provide clinical supervision for unlicensed behavioral health practitioners, the form and format of BHT supervision is variable across clinical settings. Some relevant policies and documents concerning training and supervision requirements for BHTs may include, Headquarters, Department of the Army, *OTSG/MEDCOM Policy Memo 17-080*, *Military Occupational Specialty 68X*, *Behavioral Health Specialist Utilization* (2017), U.S. Department of the Air Force, *AFSC 4C0X1 Mental Health Service Specialty Career Field Education and Training Plan* (2018), U.S. Department of the Navy, *BUMEDINST 1510.27 Hospital Corpsman Personnel Qualification Standards Program* (2017), and U.S. Department of the Air Force, *AFI 44-121, Alcohol and Drug Prevention and Treatment (ADAPT) Program* (2018).

Supervision promotes ongoing professional growth for BHTs, facilitates competent patient care that meets legal and ethical guidelines, and serves to protect patients, providers, and BHTs. Clinical supervision enhances the quality of patient care; improves efficiency of BHTs in direct and indirect services; increases workforce satisfaction, professionalization, and retention; and ensures that services provided to the public uphold legal mandates and ethical standards of the profession. Licensed behavioral health providers and senior BHTs work in tandem to deliver highly effective supervision to BHTs. Effective clinical supervision includes collaboration and rapport building, development of shared goals, personal/professional growth, open-mindedness, and mutual trust and respect (APA, 2014; NASW & ASWB, 2013).

It should be noted that clinical supervision from a provider should not be confused with the supervision and mentorship provided by more senior BHTs, also an important part in the professional growth of BHTs. While some clinical supervision will likely be involved, this senior BHT supervision and mentorship encompasses many more aspects of the BHT and Service member role.

"Eyes on Supervision" and Direct Observation

DoD Manual 6025.13, Medical Quality Assurance (MQA) and Clinical Quality Management in the Military Health System (MHS) defines supervision within the MHS as "the process of reviewing, observing, and accepting responsibility for assigned personnel (U.S. Department of Defense, 2013, p. 85)." It further specifies and defines three types of supervision, including indirect, direct, and verbal. In direct supervision "the supervisor is [directly] involved in the decision-making process," whereas indirect supervision is when the supervisor performs retrospective record reviews with a focus on "quality of care, quality of documentation, and the authorized scope of practice (p. 85)." Additionally, verbal supervision is when the "supervisor is contacted by phone or informal consultation before implementing or changing a regimen of care (p. 85)."

It is essential to incorporate direct supervision, sometimes referred to as "eyes on supervision," when working with BHTs as behavioral health provider extenders. One definition of "Eyes on supervision" can be found in U.S. Air Force regulations that define it as "Direct contact with the patient of sufficient length and interaction to validate the assessment and recommendation before the patient departs the appointment (U.S. Department of the Air Force, 2018a, p. 37)." Eyes on supervision consists of a behavioral health provider meeting with a patient assigned to a BHT for "a sufficient duration and assessment to determine the diagnosis, the appropriateness of the treatment plan or changes to the treatment plan, and to address crises to ensure safety (U.S. Department of the Air Force, 2018a, p. 37)." The privileged behavioral health provider performing the eyes on supervision must sign/co-sign the BHT's note in the patient record (U.S. Department of the Air Force, 2018a).

In accordance with Air Force Instruction 44-121 (2018) and similar guidelines, eyes on supervision of patients must be used in the following three instances: 1) Diagnosing, 2) Treatment Planning (or changing a Treatment Plan), 3) Crisis/Safety

situations. However, eyes on supervision should also be used in any instance where BHT supervisory needs and/or good clinical judgment dictate.

Clinical supervisors should also use direct observation methods to monitor BHT skills. Direct observation is one of the most effective ways of building skills, monitoring BHT performance, and ensuring quality care. The best way to determine a BHT's skills is to observe him/her perform clinical tasks and to receive input from the patients about their perceptions of the patient-BHT relationship.

Supervision Guidelines

While specific clinical supervision guidelines are not available for BHTs across all Services, the American Psychological Association (APA), the National Association of Social Workers (NASW), and the Substance Abuse and Mental Health Services Administration (SAMHSA) offer comprehensive guidelines regarding the qualifications necessary to provide high quality supervision and define the elements of effective supervision. Many of the central tenets overlap across these supervision guidelines:

- APA: Guidelines for Clinical Supervision in Health Service Psychology
- NASW: Best Practice Standards in Social Work Supervision
- SAMHSA: Clinical Supervision and Professional Development of the Substance Abuse Counselor

In general, high quality supervision, facilitated through a collaborative interpersonal process, should include:

- Regular observation of the full scope of a BHT's clinical work
- Evaluation of work quality
- Provision of feedback
- Facilitation of BHT self-assessment regarding his/her clinical work
- Acquisition of knowledge and skills by instruction, modeling, and mutual problem-solving

Clinical Supervisor Qualifications: Credentialed Providers

The APA, NASW, and SAMHSA offer specific guidelines on supervisor qualifications (links provided above). At a minimum, behavioral health providers supervising BHTs should possess current, unrestricted licensure to practice within their professional field. They should also be credentialed by the sponsoring healthcare institution to independently provide the clinical services which they supervise (e.g. those who supervise group therapy should be credentialed to provide that service themselves, etc.).

Per APA (2014), the following general guidelines are recommended for supervisors:

- Supervisors strive to be competent in the services provided to clients/patients by supervisees under their supervision and when supervising in areas in which they are less familiar they take reasonable steps to ensure the competence of their work and to protect others from harm.
- Supervisors seek to attain and maintain competence in the practice of supervision through formal education and training.
- Supervisors endeavor to coordinate with other professionals responsible for the supervisee's training to ensure communication and coordination of goals and expectations.
- Supervisors strive for diversity competence across populations and settings.
- Supervisors using technology in supervision (including distance supervision), or when supervising care that incorporates technology, strive to be competent regarding its use.

Senior Behavioral Health Technicians: Training, Supervision, and Mentorship Roles

Seasoned and experienced BHTs also perform clinical supervision of their subordinates in addition to important training and mentorship roles. A senior BHT providing quality clinical supervision would utilize the same clinical supervision guidelines discussed above in parallel to providers supervising BHTs. In contrast to clinical supervision from providers, the primary responsibility of training and mentoring a BHT falls to the senior BHT. Training strategies should incorporate shadowing of both providers and senior BHTs. Training should include exposure to patient assessment, individual counseling, group counseling, in-service trainings, and involvement in case management activities and meetings at a minimum.

Senior BHTs play a vital role in BHT development, mentorship and on-the-job training. Duties that experienced, senior BHTs may perform in your clinical setting include, but are not limited to:

- Creating a training plan and timeline for BHTs to ensure completion of required proficiency tasks, on-the-job training, and advancement training in a timely manner
- Modeling required clinical and administrative tasks (i.e. performing the task and having the junior BHT shadow and observe)
- Instructing and observing new BHTs to ensure compliance with standards and successful task accomplishment

- Providing debrief/feedback on successes and areas of improvement after observing BHT task performance
- Documenting BHT training progress, to include successful task completion and identifying any deficiencies
- Providing remedial training for BHTs that need additional support
- Approving BHTs to independently accomplish specified tasks after proficiency is demonstrated
- Facilitating group trainings for clinic staff, to include technicians and providers
- Modeling maintenance of clinical proficiency after initial training
- Modeling steps to career advancement
- Advocating to unit leadership for BHTs to be optimally utilized in clinical care

Some Service branches have more formally defined roles and responsibilities for senior BHTs in BHT training and career development. Therefore, you may find that some senior BHTs run the BHT training program, ensure that BHTs complete upgrade/advancement requirements in a defined timeframe, administer career development courseware and exams, and document all updates within Service-specific training records.

Documentation of BHT Supervision and Training

Location, form, and format of BHT training and supervision documentation varies by Service. Applicable information and forms for documentation may be found in Headquarters, Department of the Army, *OTSG/MEDCOM Policy Memo 17-080*, *Military Occupational Specialty 68X*, *Behavioral Health Specialist Utilization* (2017), Enclosures 1 and 2, and U.S. Department of the Air Force, *AFI 44-121 Alcohol and Drug Abuse Prevention and Treatment (ADAPT) Program* (2018), Attachment 2. Other standardized training/competency documentation forms such as Navy Personnel Qualification Standards (PQS), Joint Service Behavioral Health (JSBH) Enlisted Core Competencies Individual Tasks and Performance Measures, and JSBH Enlisted Clinical Hours Verification Logs may be utilized at some commands. It is recommended that providers consult with Senior BHTs/NCOs supervising BHTs in their clinical setting to obtain more information on appropriately documenting BHT training and supervision.

Section 7. Summary and Recommendations

Summary

BHTs have extensive training, and in many cases considerable experience, in both clinical and operational environments. They have a broad skill set to assist or conduct a range of clinical tasks, including but not limited to prevention, assessment, individual and group therapy, triage, case management, reconditioning, and traumatic events management. Optimizing BHT utilization within an organization requires an initial investment in learning about basic BHT competencies, building trust, and expanding training and supervision. However, the investment can lead to significant benefits, such as reduced provider workload, increased productivity, and increased access to care for DoD beneficiaries. Further, optimal use of BHTs in garrison will result in highly trained BHTs that can bring needed skills to the deployed environment to augment often limited behavioral health assets and better support deployed Service members.

Recommendations

1. Avoid using BHTs as primary administrative/clerical staff
2. Invest resources in training and supervising BHTs for clinical tasks appropriate to their training and experience and consistent with the needs of the mission
3. Focus BHT OJT on a core set of structured, evidence-based interventions that have wide application across various clinical settings
4. Consider using a structured BHT training and evaluation plan
5. Use care extender best practices (e.g., paired team model) to optimally incorporate BHTs into provider workflow and maximally utilize their skills
6. Provide opportunities for BHTs to practice and maintain clinical skills necessary for a range of clinical settings, particularly those applicable to deployed settings
7. Establish clear guidelines and expectations for the supervisory relationship with BHT(s) under your supervision, including clarity on what supervisory, mentoring, and training responsibilities are covered by senior BHT(s)
8. Utilize sound clinical supervision principles and practices

Appendix A. Acronyms and Definitions

Acronym	Definition
ADAPT	Alcohol and Drug Abuse Prevention and Treatment Program
AFMOA	Air Force Medical Operations Agency
AFMSA	Air Force Medical Support Agency
AFSC	Air Force Specialty Code
APA	American Psychological Association
ASWB	Association of Social Work Boards
BCT	Brigade Combat Team
BHCC	Behavioral Health Clinical Community
BHT	Behavioral Health Technician
BHTWG	Behavioral Health Technician Work Group
BN	Battalion
BSB	Brigade Support Battalion
CADC	Certified Alcohol and Drug Counselor
CBT	Cognitive Behavioral Therapy
CDC	Career Development Course
CDP	Center for Deployment Psychology
CFETP	Career Field Education and Training Plan
CONUS	Continental United States
COSC	Combat and Operational Stress Control
CSF	Combat Stress Facility
DCP	Directed Clinical Practicum
DoD	Department of Defense
DHA	Defense Health Agency
FMF	Fleet Marine Force
HM	Hospital Corpsman
HN	Hospitalman
JBSA	Joint Base San Antonio
JSBH	Joint Service Behavioral Health
LS	Logistics Specialist
MEDCOM	United States Army Medical Command
METC	Medical Education Training Campus
MHS	Military Health System
MTF	Military Treatment Facility
MOS	Military Occupational Specialty (USA and USMC)
NASW	National Association of Social Workers
NCR MD	National Capital Region Medical Directorate
NCO	Non-Commissioned Officer
NEC	Navy Enlisted Classifications
OCONUS	Outside the Continental United States
OJT	On-the-Job Training
OPBHC	Outpatient Behavioral Health Clinic
OSCAR	Operational Stress Control and Readiness (USMC)
PHCoE	Psychological Health Center of Excellence
PQS	Personnel Qualification Standards
PST	Problem Solving Therapy
RVU	Relative Value Unit
SAMHSA	Substance Abuse and Mental Health Services Administration
SPRINT	Special Psychiatric Rapid Intervention Team
USA	United States Army

Continued

Acronym	Definition
USAF	United States Air Force
USMC	United States Marine Corps
USN	United States Navy
USPHS	United States Public Health Service

Appendix B. Frequently Asked Questions (FAQs)

Frequently Asked Questions (FAQs)

What is "Eyes on Supervision"?

USAF regulations define "Eyes on supervision as "Direct contact with the patient of sufficient length and interaction to validate the assessment and recommendation before the patient departs the appointment (U.S. Department of the Air Force, 2018a, p. 37)." Eyes on supervision consists of the Mental Health Provider meeting with the patient for a sufficient duration and assessment to determine the diagnosis, the appropriateness of the treatment plan or changes to the treatment plan, and to address crises to ensure safety. The privileged Mental Health Provider performing the eyes on supervision must co-sign the note in the patient record (U.S. Department of the Air Force, 2018a).

In accordance with these and similar guidelines, eyes on supervision of patients must be used in the following three instances: 1) Diagnosing, 2) Treatment Planning (or changing a Treatment Plan), 3) Crisis/Safety situations. However, eyes on supervision should also be used in any instance where BHT supervisory needs and/or good clinical judgment dictate.

What is a Privileged Behavioral Health Provider?

According to Defense Health Agency (DHA), a Privileged Healthcare Provider is "A mental healthcare provider (MHP) or other healthcare provider whose credentials for practice have been verified and have been granted permission to practice within the scope and defined limits of their current licensure, relevant education and clinical training (DoDI 6490.04)." Other definitions may vary by Service branch and may be found in Service specific policies (e.g., U.S. Department of the Air Force, *AFI 44-121 Alcohol and Drug Abuse Prevention and Treatment (ADAPT) Program* (2018)).

What is a BHT qualified to do and how do I know when they are signed off as competent or still need supervision?

A BHT is qualified to support and/or perform a variety of clinical tasks under the supervision of a privileged behavioral health provider, Tasks include but are not limited to triage and screening, intakes, counseling and psychoeducation, group interventions, safety support, psychometric testing, and case management.

Optimal utilization of BHTs should include awareness and maintenance of BHT training and competencies. Location, availability, and format of BHT competency documentation varies by Service. Senior BHT's/NCOs supervising BHTs in your clinical setting should have information on which tasks BHTs have or have not yet accomplished proficiently. BHT competency completion may be documented on forms such as Navy Personnel Qualification Standards (PQS), Joint Service Behavioral Health (JSBH) Enlisted Core Competencies Individual Tasks and Performance Measures and JSBH Enlisted Clinical Hours Verification Log, or those found in Enclosures 1 and 2 of Headquarters, Department of the Army, *OTSG/MEDCOM Policy Memo 17-080*, *Military Occupational Specialty 68X*, *Behavioral Health Specialist Utilization* (2017), Headquarters, Department of the Army, *MEDCOM Regulation 40-50, Medical Services Career Management Field (CMF) 68 Clinical Baseline Competencies for Enlisted Medical Personnel Performing Direct Patient Care at the Military Treatment Facility*, Chapter 3 of Headquarters, Department of the Army, *STP 8-68X14-SM-TG*, *Soldier's Manual and Trainer's Guide*, *MOS 68X Behavioral Health Specialist,* (2017), Attachment 2 of U.S. Department of the Air Force, *AFI 44-121 Alcohol and Drug Abuse Prevention and Treatment (ADAPT) Program* (2018), pages 34–46 of U.S. Department of the Air Force, *AFSC 4C0X1 Mental Health Service Specialty Career Field Education and Training Plan* (2018), and *Navy Job Duty Tasks Analysis Manual-Behavioral Health Technicians* (2017). Some medical commands and units also maintain training files through other means (e.g., online training portals, or hard-copy training folders). Providers can direct questions, concerns, and/or updates on BHT competency completion to supervising Senior BHT's/NCOs.

Do BHTs have formal training in group and individual counseling?

Yes, BHTs do have formal training in group and individual counseling at Medical Education and Training Campus (METC) in San Antonio, Texas. BHTs complete 104 combined curriculum hours in group and individual counseling and also receive directed clinical practicum training hours in group and individual counseling.

Are there instances where a BHT may not have on-site supervision and how is the supervision requirement met?

There may be instances in deployed settings where BHTs function without on-site supervision from a provider. This accommodation permits BHTs to serve as provider extenders in such settings where a licensed behavioral health provider is not readily available on-site. Appropriate oversight is maintained to meet supervision requirements through email, radio, and/or telephone contact and consultation with a supervising provider. BHTs in garrison have on-site supervision from a credentialed behavioral health provider for clinical tasks in accordance with supervision requirements.

How do I document BHT training and supervision?

Location, form, and format of BHT training and supervision documentation varies by Service. Applicable information and forms for documentation may be found in Headquarters, Department of the Army, *OTSG/MEDCOM Policy Memo 17-080*, *Military Occupational Specialty 68X*, *Behavioral Health Specialist Utilization* (2017), Enclosures 1 and 2, U.S. Department of the Air Force, *AFI 44-121 Alcohol and Drug Abuse Prevention and Treatment (ADAPT) Program* (2018), Attachment 2, Navy PQS, JSBH Enlisted Core Competencies Individual Tasks and Performance Measures, JSBH Enlisted Clinical Hours Verification Log, and *Navy Job Duty Tasks Analysis Manual-Behavioral Health Technicians* (2017). Other standardized training/competency documentation forms may be utilized at some commands. It is recommended that providers consult with Senior BHTs/NCOs supervising BHTs in their clinical setting for more information on appropriately documenting BHT training and supervision.

How will I know how a BHT operating under my license is performing?

High quality supervision of BHTs involves a provider's direct observation of BHT clinical work. Providers supervising BHT work are required to review and sign/co-sign BHT clinical documentation. Supervision and documentation protocols in deployed and/or other operational settings may vary.

How do I integrate BHT provider extenders into my clinical workflow?

Using a paired-team model is a recommended way to integrate a BHT into a provider's clinical workflow, wherein each BHT is paired with a provider to shadow and work alongside. Two examples include a BHT completing an intake interview and briefing the provider on the findings, or a BHT and provider interviewing a patient together, allowing one to interview while the other completes the note. In situations where using a paired team model is not feasible, providers can still optimally utilize BHTs as provider extenders. Providers can advance this effort by focusing BHT tasks on a core set of structured, evidence-based interventions applicable across clinical settings.

What can I do to optimize use of BHTs even when they are tasked with some administrative and clerical work?

Use of BHTs as primary administrative and clerical task support is not recommended. When BHTs do have clerical and administrative duties, it can be helpful to establish a clinical task schedule for BHTs (e.g., psychoeducational group facilitation, intakes, psychometrics) to ensure continued clinical development and training. Additionally, monitoring a structured BHT training checklist (if available) can assist in focusing BHT work on clinical vs. other duties, ensuring that BHTs gain needed clinical experience. It is important to provide opportunities for BHTs to practice skills applicable to deployed settings to maintain readiness.

What is the Behavioral Health Technician Work Group?

The Behavioral Health Technician Work Group (BHTWG) was established in 2017 with the mission to "integrate knowledge, resources, and efforts to support BHTs across Services."

Where can I find more BHT resources?

In addition to the resources contained in this guide, a public website for BHT resources, in association with the BHTWG, is available through the BHT Community of Practice on Max.gov. To stay up-to-date on BHTWG activities and be notified of new resources, contact the work group at dha.ncr.j-9.mbx.phcoe-bhtwg@mail.mil.

Appendix C: METC — BHT Program Training

Core training for the BHT Program includes the following courses, units, and lessons:

Course Title	Unit
BHT 101 Introduction and Human Growth and Development	1. Duties and Responsibilities of the Behavioral Health Technician (BHT) 2. Ethics and Culture 3. Anatomy 4. Introduction to Neuroanatomy 5. Biophysical Development and Human Development Theories
BHT 102 Psychopathology	1. Psychopathology I 2. Psychopathology II 3. Substance Abuse and V Codes 4. Pharmacological Interventions and Practice Theories
BHT 103 Psychiatric Behavioral Interventions	1. Overview of In-Patient Procedures 2. Milieu Therapy 3. Managing Aggressive Behavior
BHT 104 Interviewing Skills	1. Elements of the Initial Interview 2. Managing Client Behavior (Verbal & Nonverbal) 3. Collateral 4. Mental Status Exam 5. Risk Assessment/Management 6. Case Presentations 7. Document the Initial Interview 8. Initial Interview
BHT 105 Counseling	1. Counseling Overview 2. Aspects of Counseling 3. Group Counseling (Group Dynamics/Processes) 4. Documenting a Counseling Session 5. Counseling Session 6. Group Counseling (Psychoeducational Groups)
BHT 106 Psychological Testing	1. Overview of Psychological Testing 2. Psychological Tests and Applications
BHT 107 Combat Operational Stress Control	1. Combat Operational Stress Control (COSC)
BHT 108 Basic Medical	1. Infection Control 2. Vital Signs 3. Basic Life Support
BHT 201A Army Behavioral Health Duties	1. BLS (cont.) 2. Army BHT duties 3. Seizure Management 4. Behavioral Healthcare Management 5. Medical Systems/Programs 6. Case Management 7. Psycho Educational Brief 8. Trauma Casualty Assessment 9. Soldier Skills
BHT 210A Directed Clinical Practicum	1. DCP Admin 2. Clinical Practice
BHT 211A FTX	1. BH Operations in a Tactical Environment
BHT 201N Navy Behavioral Health	1. Duties of the 8485 2. Psychotropic Medications for Mental Health Disorders
BHT 210N Directed Clinical Practicum	1. DCP Admin 2. Clinical Practice
BHT 201F Air Force Behavioral Health	1. USAF Medical Service 2. Administrative Management 3. Outpatient/Inpatient Services 4. Alcohol Drug Abuse Prevention and Treatment (ADAPT) 5. Air Force Family Advocacy Program 6. Automated Neuropsychological Assessment Metrics (ANAM)
BHT 210F Directed Clinical Practicum	1. DCP Admin 2. Clinical Practice

Appendix D: Distribution of BH Assets by Echelon of Care

The table below represents the distribution of BH assets in the echelons of care. Role one for all services begins with some form of self-aid or leadership intervention. BHTs rotate to these areas as needed to assess BH needs, provide command consultations, and engage in traumatic event management tasks.

Role	Army 68X	Air Force 4C0X1	Navy L24A	Marines (Navy L24A)
1	Self/Buddy Aid Battalion (BN) Aid Station	Self/Buddy Aid	Operational Stress Control (OSC)	Operational Stress Control and Readiness (OSCAR) BN Aid Station
2	Brigade Support Battalion (BSB)/Brigade Combat Team (BCT) Medical Company Area Support Medical Company (ASMC) Combat Operational Stress Control (COSC)	En Route Patient Staging System (ERPSS)	Fleet Surgical Teams Casualty Receiving and Treatment Ships (CRTS) Aircraft Carrier Battle Group	Combat and Operational Stress Control (COSC) Navy Medical BN
3	Combat Support Hospital Combat Operational Stress Control (COSC) — Restoration	Air Force theater hospital System (ERPSS)	Expeditionary Medical Facility Hospital Ships	Not Applicable
4	US and Medical Treatment Facilities, Veterans Hospitals, and Civilians			

Appendix E: Sample BHT On-the-Job Training Curriculum

Example of a Navy BHT and provider facilitated on-the-job training curriculum:

Date	Topic	Instructor(s)
09AUG18	OPNAVINST 5370.20	Logistics Specialist, Petty Officer First Class (LS1)
16AUG18	Health Care and Emergency Treatment	Hospital Corpsman, Petty Officer Second Class (HM2)
23AUG18	OPNAVINST 1720.4A	LS1
30AUG18	Risk Assessment and Crisis Intervention	Military Provider and Civilian Provider
06SEP18	BUMEDINST 6280.1C	HM2
13SEP18	Anatomy and Physiology	HM2
20SEP18	Front Desk Operations	Hospital Corpsman, Petty Officer Third Class (HM3) and Hospitalman (HN)
27SEP18	Mental Status Exam	Military Provider and Civilian Provider
04OCT18	Health Record Maintenance	HM3
11OCT18	Walk-ins	HM2 and HM3
18OCT18	Outpatient Groups	Military Provider and HM2
25OCT18	Diagnosis Part I	Military Provider and Civilian Provider
01NOV18	BUMEDINST 6300.19	HM2
08NOV18	Preventative Medicine Programs	HM2
15NOV18	Leadership 101	Hospital Corpsman, Petty Officer First Class (HM1) and HM2
29NOV18	Diagnosis Part II	Military Provider and Civilian Provider
06DEC18	Clinical Support Services (Laboratory) and Clinical Support Services (Pharmacy)	HM1
13DEC18	IOP/TBI Overview	HM2, HM3, and HN
31JAN19	Personality Disorders	Military Provider and Civilian Provider
28FEB19	Psychiatry and Medication Management	Military or Civilian Psychiatrist

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Appendix F: Examples of USAF BHT Competencies

USAF BHTs perform many general tasks and duties, including but not limited to performing outpatient and inpatient mental health patient care, ensuring staff provide safe, ethical, and reliable patient care, integrating quality communications, fostering partnerships, ensuring flexible and responsive resource processes, optimizing force management and development, and empowering continuous process improvement. The table below includes descriptions of some additional specific competencies, tasks, and roles of USAF BHTs. Clinical patient care tasks are conducted under guidance and supervision of a privileged provider.

BHT Task/Competencies	Description
Outreach, Prevention, Health and Force Fitness Promotion	• Utilizes skills, expertise, and insight into emotional, behavioral, and social functioning to assist with improving health and human performance. • Employs primary and secondary prevention tactics to mitigate occupational and operational stressors, enhance resilience, prevent injury/illness and facilitate access to the healthcare system when needed. • Provides mental health and substance abuse outreach, prevention, and education.
Combat and Operational Stress Control (COSC) and Disaster Mental Health	• Performs COSC activities. • Prevents and manages battle related stress before, during, and after deployments. • Supervises and assists with care of individuals experiencing acute and post-traumatic stress reactions. • Consults with unit leaders and unit members on topics relevant to adapting and responding to the unique operational and combat related challenges of their unit. • Provides psychological first aid to individuals and groups who may have had direct exposure to an all-hazard incident. • Performs Disaster Mental Health activities.
Screening, Triage, and Assessment	• Screens patients for program admission, which includes triage and evaluating psychological, physiological, and social signs/symptoms. • Completes mental status examinations. • Obtains and records vital signs. • Conducts clinical interviews for biopsychosocial, mental health, and substance abuse histories. • Administers standardized psychological testing. • Utilizes assessment tools and procedures to assist in identifying mental health and nursing diagnoses as well as patients' strengths, weakness, problems and needs. • Contacts military and community agencies for collateral information.
Intake and Orientation	• Performs intakes, including gathering demographics and completing required admission forms. • Provides program orientation procedures to new patients. • Briefs patients on safety and evacuation procedures.
Case Management, Care Coordination, and Consultation	• Coordinates and participates in treatment team meetings. • Communicates high interest enrollment/disenrollment and duty limitations. • Provides safety recommendations to commanders and primary care providers. • Coordinates mental health services for patients in transition. • Identifies patient needs that can't be met by the counselor or program and refers patient to appropriate support system. • Assists in, or arranges patient referral to public, private, and military community agencies. • Coordinates with appropriate agencies regarding specified care, treatment, prevention, rehabilitation, and administrative functions. • Coordinates with appropriate agencies regarding specific care, treatment, prevention, rehabilitation, and administrative functions. • Consults with other professionals and subject matter experts to assure comprehensive quality care for the patient.
Crisis Intervention and Acute Care	• Recognizes patients in acute emotional and physical distress and provides crisis intervention techniques and precautionary measures. • Performs aeromedical evacuation procedures when needed. • Assists patients with nutritional needs, hygiene, and comfort measures.
Training	• Establishes, maintains, and evaluates specific mental health, family advocacy, and substance abuse training programs. • Conducts in-service and readiness trainings. • Schedules recurring training for subordinates.

Continued

BHT Task/Competencies	Description
Clinical Counseling and Treatment Planning	• Performs patient counseling to assist individuals, families, and groups in achieving treatment goals through exploration of problems. • Establishes and executes the treatment plan. • Maintains therapeutic relationships. • Examines attitudes and affective responses. • Provides alternative solutions. • Assists in decision-making/disposition planning.
Supervision, Management, and Mentoring	• Performs clinical supervision of subordinates in relation to their skill level. • Manages enlisted resources. • Plans and supervises BHT mental health service activities. • Conducts task evaluations of subordinates. • Reviews procedures and requirements within behavioral health specialty services to preclude duplication and to free personnel for more direct service work with patients. • Evaluates and effectively manages BHT mental health service activities. • Conducts unit self-assessments. • Establishes priorities based on knowledge of interchangeable skills among assigned enlisted personnel. • Defines requirements and utilizes emerging knowledge, research, and technology.
Administrative and Documentation	• Supervises and performs administrative duties. • Collects and updates administrative and statistical data. • Monitors preparation, maintenance, and disposition of mental health, family advocacy, and substance abuse electronic and paper copy treatment records. • Receives patients and schedules appointment. • Charts the assessment results, treatment plans, reports, progress notes, discharge summaries and other patient care documentation. • Compiles and prepares medical and administrative reports.

Appendix G: Principles of Clinical Supervision

The eight principles of clinical supervision below can be applied to the provision of high quality supervision for military BHTs.

Principles of Clinical Supervision include:

1. Clinical supervision integrates the program mission, goals, and treatment philosophy with clinical theory and evidence-based practices. Clinical supervision ensures (1) quality patient care, and (2) continued professional development in a systematic and planned manner.
2. Clinical supervision enhances staff retention and morale and improves workforce retention. Staff turnover and workforce development are major concerns in the behavioral health field, including in the DoD.
3. Every BHT, regardless of skill level and experience, needs and has a right to clinical supervision. Supervision needs to be tailored to the knowledge, skills, and experience of each provider and BHT. All staff need supervision, but the frequency and intensity of the oversight and training will depend on the skill level and competence of the individual.
4. The supervisory relationship is the medium through which ethical practice is developed and reinforced. The supervisor needs to model sound ethical and legal practice in the supervisory relationship. Supervision provides the means to translate ethical concepts into practice. Through supervision, BHTs can develop a process of ethical decision-making for application as they encounter new situations.
5. Clinical supervision is a skill that has to be developed. Strong clinicians tend to be promoted into supervisory positions with the assumption that they have the requisite skills to provide professional clinical supervision. However, clinical supervisors need a different role orientation toward both program and client/patient goals and a knowledge base to complement a new set of skills. Programs should strive to increase their capacity to develop good clinical supervisors.
6. Clinical supervision requires balancing administrative, clinical, and supervision tasks. Sometimes these roles are complementary and sometimes they conflict. Balancing these roles effectively is a key to success.
7. Supervisors have the responsibility as gatekeepers for the profession. Supervisors are responsible for maintaining professional standards, recognizing and addressing impairment, and safeguarding the welfare of patients. More than anyone else in an agency, supervisors can observe BHT behavior and respond promptly to potential problems. Supervisors also fulfill a gatekeeper role in performance evaluation and in providing formal recommendations to unit leadership, credentialing offices, and certification boards.
8. Clinical supervisors should use direct observation methods. Direct observation is one of the most effective ways of building skills, monitoring BHT performance, and ensuring quality care. The best way to determine a BHT's skills is to observe him/her and to receive input from the patients about their perceptions of the patient-BHT relationship.

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