The increased incidence of mild-to-moderate traumatic brain injury (concussion) in military personnel throughout Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) generated heightened concern over the past several years regarding the use of mental status and acute concussion evaluations in the military health system (MHS). That heightened concern remains in place and is instrumentally important in enhancing the role of psychologists supporting the MHS. The relevance of gathering early information on neuropsychological function for follow up assessment after potential head injury is growing stronger in current military operations. The proactive role taken by military leadership to enhance the capacity for gathering early information on neuropsychological function after potential head injury offers Service-members greater access to psychology support capabilities.

Servicemember assessment following apparent, or suspected, head injury is now more systematic than ever before. The summarized guideline on “Primary Care Management of Concussion (mTBI) in a Deployed Setting” is an example. Additionally, simple checklists that allow rapid assessment for monitoring and referral are currently available and clearly outlined in emerging Department of Defense (DoD) policy. The HEADS evaluation, for instance, is a rapid review of symptoms associated with head injury: Headaches (Yes/No); Ear ringing (Yes/No); Amnesia or altered consciousness (Yes/No); Double vision or dizziness (Yes/No); and something feels wrong or is not right (Yes/No). In conjunction with normal unit reporting following a potential head injury that might warrant medical evaluation, a “Yes” response to any of the listed symptoms in the HEADS evaluation is an indication for medical referral and psychology consultation.

With concussion suspected, initial medical evaluation includes application of the MACE (Military Acute Concussion Evaluation). Outcomes on the MACE may then affect decisions within clinical practice guidelines. An effective mnemonic for documentation is CNS: Cognitive score (on the MACE); Neurologic exam (normal or abnormal); and Symptoms (none or at least one). The use of neurobehavioral assessments is not limited to any one tool.

In fact, DoD DTM 09-033 (Directive-Type Memorandum 09-033) indicates that there is no one neuropsychological assessment tool that is recommended over any other. Later this year DTM 09-033 is scheduled to convert to a DoDI (Department of Defense Instruction). The key determinate in the use of a neuropsychological assessment tool is that it evaluate at minimum the following five domains affected by concussion: (1) Attention; (2) Memory; (3) Processing speed; (4) Executive functioning; and (5) Social pragmatics. The ImPACT (Immediate Post Concussion Assessment and Cognitive Testing), the ANAM (Automated Neuropsychological Assessment Metrics), and the RBANS (Repeatable Battery for the Assessment of Neuropsychological Status) are three neuropsychological assessment tools that have been used in contemporary operating environments to evaluate the five domains affected by concussion.

Psychology support capabilities are expanding such that the role of psychologists in the MHS working in direct conjunction with other healthcare providers is becoming more of an established norm. The expanding role of psychologists is both multi-disciplinary and multi-functional. Clinical, operational, and organizational psychology consults are critically important in supporting military leaders, supervisors, and healthcare providers as they weigh decisions regarding assessment, treatment, and follow-up services offered to Servicemembers involved in incidents leading to suspected, or confirmed, concussion.