

**FM 4-02.51 (FM 8-51)**

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**COMBAT AND OPERATIONAL  
STRESS CONTROL**

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**JULY 2006**

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**Headquarters, Department of the Army**

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# COMBAT AND OPERATIONAL STRESS CONTROL

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## Preface

This publication outlines the functions and operations of each combat and operational stress control (COSC) element within an area of operations (AO). This field manual (FM) establishes Army doctrine and provides guidance for conducting COSC support for combat, stability, and reconstruction operations from brigade to theater level. The information provided in this publication will assist commanders and their staffs to operate efficiently at all levels of command and throughout the operational continuum. It may be used by medical planners to supplement FM 4-02, FM 8-42 (4-02.42), and FM 8-55 (4-02.55). Users of this publication should be familiar with Army Regulation (AR) 40-216 and with FM 4-02, FM 4-02.6, FM 4-02.10, FM 4-02.21, FM 4-02.24, FM 6-22.5, FM 8-10-6, FM 8-10-14, and FM 22-51.

This manual is in consonance with FM 7-15, Army Universal Task List (AUTL) and support the following Army tactical task (ART) provided below. Commanders should use the AUTL as a cross-reference for tactical tasks. The AUTL provides a standard doctrinal foundation and catalogue of the Army's tactical collective tasks.

### **AUTL ART**

ART 6.5.1	Provide Combat Casualty Care
ART 6.5.1.5	Provide Mental Health/Neuropsychiatric Treatment
ART 6.5.4	Provide Casualty Prevention
ART 6.5.4.5	Provide Combat Operational Stress Control Prevention

The staffing and organization structure presented in this publication reflects those established in the base tables of organization and equipment (base TOE) and are current as of the publication print date. Such staffing is subject to change to comply with manpower requirements criteria outlined in AR 71-32. Those requirements criteria are also subject to change if the modification table of organization and equipment (MTOE) is significantly altered.

Users of this publication are encouraged to submit comments and recommendations to improve the publication. Comments should include the page, paragraph, and line(s) of the text where the change is recommended. The proponent of this publication is the United States (US) Army Medical Department Center and School (USAMEDDC&S). Comments and recommendations should be forwarded in a letter format directly to the **Commander, USAMEDDC&S, ATTN: MCCS-FCD-L, 1400 East Grayson Street, Fort Sam Houston, Texas 78234-5052**, or at e-mail address: [Medicaldoctrine@amedd.army.mil](mailto:Medicaldoctrine@amedd.army.mil).

This FM applies to the Active Army, the Army National Guard (ARNG)/Army National Guard of the United States (ARNGUS), and the United States Army Reserve (USAR) unless otherwise stated.

Unless this publication states otherwise, masculine nouns and pronouns do not refer exclusively to men.

Use of trade or brand names in this publication is for illustrative purposes only and does not imply endorsement by the Department of Defense (DOD). The Army Medical Department (AMEDD) is in a transitional phase with terminology. This manual uses the most current terminology; however, other FM 4-02-series and FM 8-series may use the older terminology. Changes in terminology are a result of adopting the terminology currently used in the joint and/or North Atlantic Treaty Organization (NATO) and American, British, Canadian, and Australian (ABCA) Armies publication arenas. Therefore, the following terms are synonymous and the current terms are listed first, to include—

- Force health protection (FHP), health service support (HSS), and combat health support (CHS).
- Medical logistics (MEDLOG), health service logistics (HSL), and combat health logistics (CHL).
- Levels of care, echelons of care, and roles of care.

- Combat and operational stress control (COSC) and combat stress control (CSC).
- Behavioral health (BH) and mental health (MH).

Additionally, please note that the term “battle fatigue (BF)” that is used in AR 40-216 is being replaced with the term “combat stress reaction (CSR).” This change is due to DOD Directive (DODD) 6490.5, which specified that all Military Services use the term CSR for the purpose of joint interoperability. A DOD (Health Affairs) working group with the Services later added the term “operational stress reaction (OSR)” to further characterize stress reactions experienced by Soldiers. The only difference between a CSR and an OSR is that it takes place in a combat environment. To reduce confusion from this change in terminology, this manual will use combat and operational stress reaction (COSR) as opposed to “BF”. The COSR (battle fatigue) “casualties” are Soldiers experiencing a stress reaction in combat or operational environment.



## Introduction

In our own Soldiers and in the enemy combatants, control of stress is often the decisive difference between victory and defeat across the operational continuum. Battles and wars are won more by controlling the will to fight than by killing all of the enemy combatants. Uncontrolled combat stress causes erratic or harmful behaviors, impair mission performance, and may result in disaster and defeat of COSC preventive measures. The COSC preventive measures are aimed at minimizing maladaptive stress reactions while promoting adaptive stress reactions, such as loyalty, selflessness, and acts of bravery.

This manual provides doctrinal guidance for controlling excessive stress in combat and other operational environments. It identifies command and leadership responsibilities for COSC. It identifies COSC consultation, training, and education assistance available for units. This manual provides definitive guidance to BH personnel and CSC units for their COSC mission and for management of COSR and other behavioral disordered patients (BDPs). It identifies the requirements for COSC consultation, planning, coordination, rehearsal, and implementation of the COSC plan contained in the FHP annex of the operation order (OPORD).

Many stressors in a combat situation are due to deliberate enemy actions aimed at killing, wounding, or demoralizing our Soldiers and our allies. Other stressors are due to the operational environment. Some of these stressors can be avoided or counteracted by wise command actions. Still other stressors are due to our own calculated or miscalculated choice, accepted in order to exert greater stress on the enemy. Sound leadership works to keep stressors within tolerable limits and prepares the troops mentally and physically to endure them. Some of the most potent stressors can be due to personal organizational problems in the unit or on the home front. These, too, must be identified and, when possible, corrected or controlled. Unit needs assessments (UNAs) can help BH providers identify specific stressor in a unit and develop interventions to help unit personnel cope.

This manual identifies MH sections and medical units, CSC, that provides COSC support to units. It identifies the requirements for COSC assistance, as a unit transitions through the different phases of a deployment. Chaplains, commander, leader and COSC Soldier mentors provide assistance with after-action review (AAR) and traumatic events management (TEM).

# Chapter 1

## Combat and Operational Stress Control

### SECTION I — INTERVENTION AND CONTROL FOR THE COMBAT AND OPERATIONAL STRESS THREAT

#### STRESS CONTROL

1-1. Combat stress includes all the physiological and emotional stresses encountered as a direct result of the dangers and mission demands of combat, see AR 40-216. Combat and operational stress control in the Army may be defined as programs developed and actions taken by military leadership to prevent, identify, and manage adverse COSRs in units. This program optimizes mission performance; conserves the fighting strength; and prevents or minimizes adverse effects of COSR on Soldiers and their physical, psychological, intellectual, and social health. Its goal is to return Soldiers to duty expeditiously. According to DODD 6490.2, COSC activities include routine screening of individuals when recruited; continued surveillance throughout military service, especially before, during, and after deployment; continual assessment and consultation with medical and other personnel from garrison to the battlefield.

1-2. Combat and operational stress control is the commander's responsibility at all levels. The commander is assisted with his responsibility for COSC by his staff, unit leaders, unit chaplain (Appendix A), and organic medical personnel. The commander may also receive assistance from organic COSC personnel at brigade and above, and from corps and above medical company/detachment CSC BH personnel. The key concern to combat commanders is to maximize the return-to-duty (RTD) rate of Soldiers who are temporarily impaired or incapacitated with stress-related conditions or diagnosed behavioral disorders.

1-3. The purpose of COSC is to promote Soldier and unit readiness by—

- Enhancing adaptive stress reactions.
- Preventing maladaptive stress reactions.
- Assisting Soldiers with controlling COSRs.
- Assisting Soldiers with behavioral disorders.

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*Note.* The word control is used with combat and operational stress, rather than the word management, to emphasize the active steps that leaders, supporting BH personnel, and individual Soldiers must take to keep stress within an acceptable range.

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#### COMBAT AND OPERATIONAL STRESS THREAT

1-4. Many stressors in a combat situation are due to deliberate enemy actions aimed at killing, wounding, or demoralizing our Soldiers and our allies. Other stressors are due to the natural environment, such as intense heat or cold, humidity, or poor air quality. Still others are due to leaders' own calculated or miscalculated choices (for example, decisions about unit strength, maneuver, the time of the attack, and plans for medical and logistical support). Sound leadership works to keep operational stressors within tolerable limits and prepares troops mentally and physically to endure them. In some cases however, excessive stress can affect both leaders' and Soldiers' decision-making and judgment, resulting in missed opportunities, or worse, in high casualties and/or failure to complete the mission. Finally, some of the most potent stressors are interpersonal in nature and can be due to conflict in the unit or on the home front. Extreme reactions to such stressors may involve harm to self (as in the hypothetical case of a Soldier that becomes suicidal on discovering that his wife wants a divorce) or to others (as in the case of a Soldier that

impulsively fires a weapon at his noncommissioned officer (NCO) out of rage over perceived unfairness). These stressors must be identified and when possible, corrected or controlled. For more information on the control of combat/operational stressors and for details about specific leader actions to control stress, see FM 22-51. Also see FM 4-02 and FM 4-02.17 for additional information on the general and medical threat.

## **EFFECT OF STRESS**

1-5. Focused stress is vital to survival and mission accomplishment. However, stress that is too intense, or prolonged, results in COSR that impairs their ability to function effectively. Some stressors contribute to misconduct that requires disciplinary action and may take the Soldier from duty for legal action and incarceration. In a broader context stress may cause battle and nonbattle injuries through inattention, clumsiness, and reckless behavior. These resultant injuries can include equipment losses and friendly fire incidents. Stress may increase disease rates by disrupting hygiene and protective measures, and impairing the body's immune defenses. Stress may progress to BH disorders, or suicidal behaviors and/or homicidal behaviors. Excessive stress in combat contributes to lapses in operational and tactical judgment and to missed opportunities that could increase the numbers of Soldiers injured over time.

## **MODEL FOR COMBAT AND OPERATIONAL STRESS CONTROL INTERVENTIONS**

1-6. Combat and operational stress control assessments are performed during all phases of combat operations, stability and reconstruction operations, and support operations so the term COSC may refer to any of these different types of Army operations. The COSC assessments are performed at unit and individual level. They consider the range of variables according to a model, which recognizes that biological, psychological, and social factors influence each other. The COSC assessment reviews the interaction systematically to a depth appropriate to the need. The assessment identifies which variables can be modified to improve coping or outcome. Based on these assessments COSC personnel recommend courses of action (COA) to the commander. They identify and initiate COSC interventions to improve unit effectiveness and Soldier efficiency and well-being.

1-7. Provided in Figure 1-1 is a conceptual model of stress, its mitigating and aggravating factors and potential outcomes on Soldiers and families. This model can be helpful when designing COSC interventions to improve short-term and long-term outcomes.

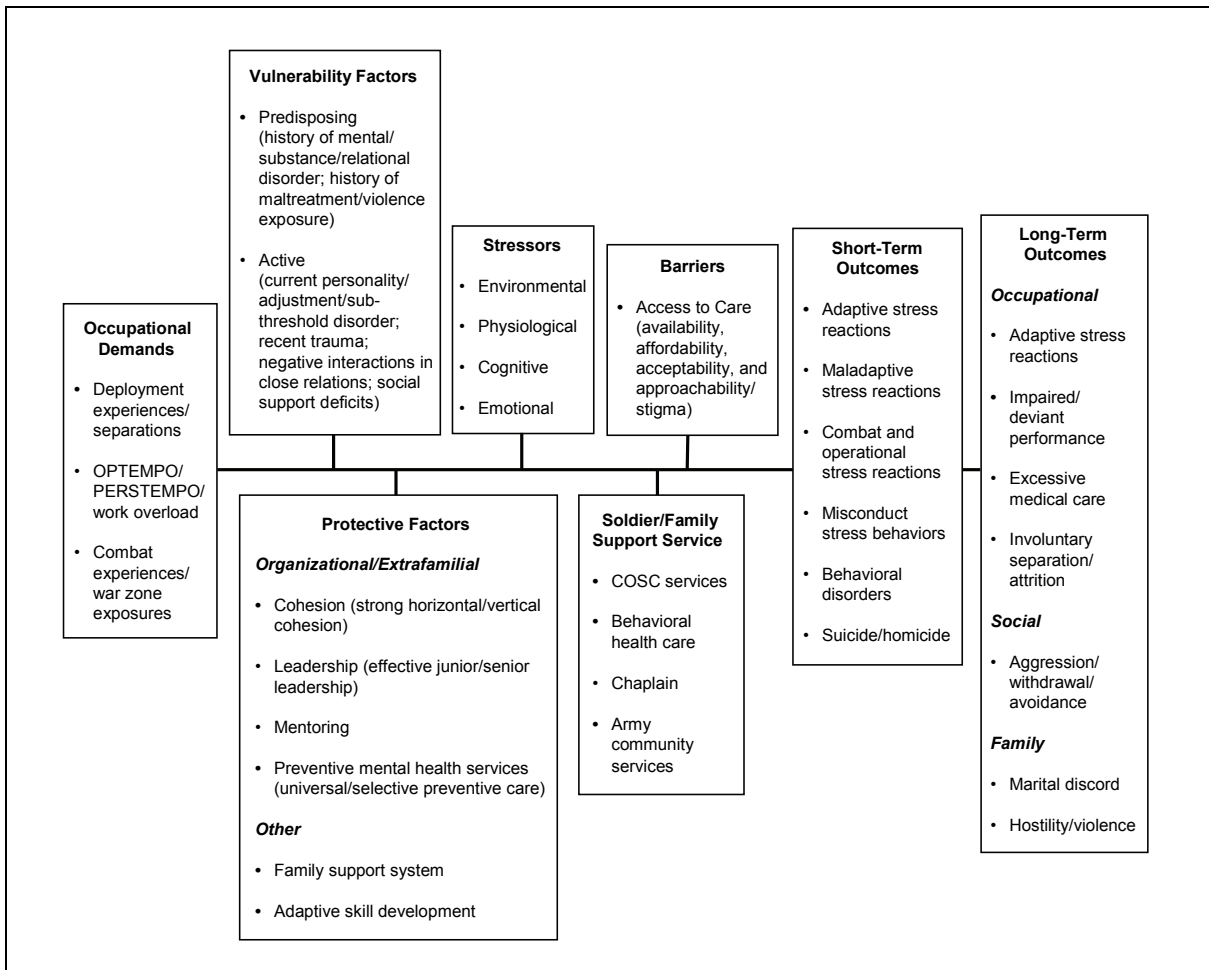


Figure 1-1. Model of stress and its potential Soldier and family outcomes

## MENTAL AND PHYSICAL STRESSORS

1-8. A rough distinction between a mental and physical stressor can be made—

- A mental stressor is one in which the brain receives information about a given threat or demand, but this information results in only indirect physical impact on the body. Instead, its primary effect is to place demands on and evoke reactions from the perceptual, cognitive and/or emotional systems of the brain (such as information overload, perceived lack of control, or grief-producing losses).
- A physical stressor has a direct, potentially harmful effect on the body. These stressors may be external environmental conditions (such as temperature) or the internal physiologic demands required by or placed upon the human body (such as the need for hydration, or an immune response to a viral infection).

## TYPES OF MENTAL AND PHYSICAL STRESSORS

1-9. Figure 1-2 provides examples for the two types of physical stressors (environmental and physiological) and the two types of mental stressors (cognitive and emotional). Also, as recognized in the COSC intervention model (Figure 1-1) physical stressors cause mental stressors when they result in discomfort, distraction, and threat of harm, as well as when they directly impair brain functions. Mental stressors can lead to adaptive or maladaptive stress behaviors that decrease or increase the exposure to physical stressors.

PHYSICAL STRESSORS	MENTAL STRESSORS
<p><b>ENVIRONMENTAL</b></p> <p>Heat, cold, wetness, dust  Vibration, noise, blast  Noxious odors (fumes, poisons, chemicals)  Directed-energy weapons/devices  Ionizing radiation  Infectious agents  Physical work  Poor visibility (bright lights, darkness, haze)  Difficult or arduous terrain  High altitude</p> <p><b>PHYSIOLOGICAL</b></p> <p>Sleep deprivation  Dehydration  Malnutrition  Poor hygiene  Muscular and aerobic fatigue  Overuse or underuse of muscles  Impaired immune system  Illness or injury  Sexual frustration  Substance use (smoking, caffeine, alcohol)  Obesity  Poor physical condition</p>	<p><b>COGNITIVE</b></p> <p>Information (too much or too little)  Sensory overload or deprivation  Ambiguity, uncertainty, unpredictability  Time pressure or waiting  Difficult decision (rules of engagement)  Organizational dynamics and changes  Hard choices versus no choice  Recognition of impaired functioning  Working beyond skill level  Previous failures</p> <p><b>EMOTIONAL</b></p> <p>Being new in unit, isolated, lonely  Fear and anxiety-producing threats  (of death, injury, failure, or loss)  Grief-producing losses (bereavement)  Resentment, anger, and rage-producing  frustration and guilt  Inactivity producing boredom  Conflicting/divided motives and loyalties  Spiritual confrontation or temptation  causing loss of faith  Interpersonal conflict (unit, buddy)  Home-front worries, homesickness  Loss of privacy  Victimization/harassment  Exposure to combat/dead bodies  Having to kill</p>

**Figure 1-2. Examples of combat and operational stressors**

## STRESS BEHAVIORS IN COMBAT AND OTHER OPERATIONS

1-10. Combat and operational stress behavior is the generic term that is used for the full spectrum of combat and operational stress behaviors. It covers the range of reactions, from adaptive to maladaptive. Figure 1-3 provides a listing of typical adaptive and maladaptive stress reactions.

### ADAPTIVE STRESS REACTIONS

1-11. Stressors, when combined with effective leadership and good peer relationships may lead to adaptive stress reactions which enhance individual and unit performance. Examples of adaptive stress reactions include—

- The strong personal trust, loyalty, and cohesiveness (called horizontal bonding), which develops among peers in a small military unit.
- Personal trust, loyalty, and cohesiveness that develops between leaders and subordinates (called vertical bonding).
- Esprit de corps is also defined as a feeling of identification and membership in the larger, enduring unit with its history and ideas. This may include the unit (such as battalion, brigade

combat team [BCT], regiment, or division) the branch (such as infantry, artillery, or military police [MP]) and beyond the branch to the US Army level.

- Unit cohesion is the binding force that keeps Soldiers together and performing the mission in spite of danger and death. Cohesion is a result of Soldiers knowing and trusting their peers and leaders and understanding their dependency on one another. It is achieved through personal bonding and a strong sense of responsibility toward the unit and its members. The ultimate adaptive stress reactions are acts of extreme courage and almost unbelievable strength. They may even involve deliberate self-sacrifice.

## **MALADAPTIVE STRESS REACTIONS**

1-12. Combat and operational stress reaction and misconduct stress behaviors comprise the maladaptive stress reactions.

## **COMBAT AND OPERATIONAL STRESS REACTION**

1-13. The Army uses the DOD-approved term/acronym COSR in official medical reports. This term can be applied to any stress reaction in the military unit environment. Many reactions look like symptoms of mental illness (such as panic, extreme anxiety, depression, hallucinations), but they are only transient reactions to the traumatic stress of combat and the cumulative stresses of military operations. Some individuals may have behavioral disorders that existed prior to deployment or disorders that were first present during deployment, and need BH intervention beyond the interventions for COSR.

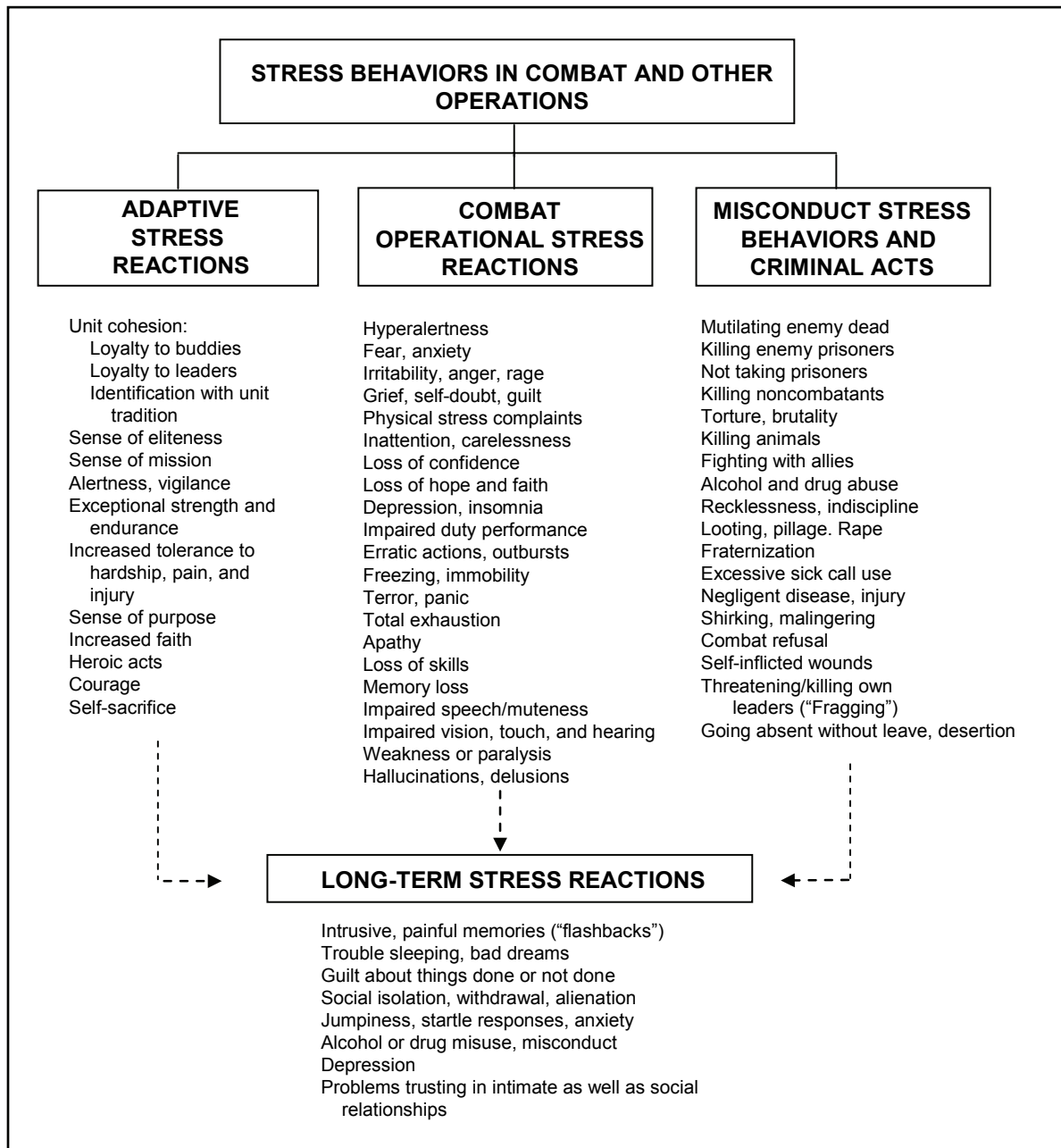
## **MISCONDUCT STRESS BEHAVIORS**

1-14. Examples of misconduct stress behaviors are listed in Figure 1-3. These range from minor breaches of unit orders or regulations to serious violations of the Uniform Code of Military Justice (UCMJ) and the Law of Land Warfare. Misconduct stress behaviors are most likely to occur in poorly trained undisciplined Soldiers, however good and heroic, under extreme combat stress may also engage in misconduct. Generally, misconduct stress behaviors—

- Range from minor breaches of unit orders or regulations to serious violations of the UCMJ and the Law of Land Warfare.
- May also become a major problem for highly cohesive and proud units. Such units may come to consider themselves entitled to special privileges and, as a result, some members may relieve tension unlawfully when they stand-down from their military operations. They may lapse into illegal revenge when a unit member is lost in combat. Stress control measures and sound leadership can prevent such misconduct stress behaviors, but once serious misconduct has occurred, Soldiers must be punished to prevent further erosion of discipline. Combat stress, even with heroic combat performance, cannot justify criminal misconduct.

## **OVERLAPPING STRESS BEHAVIORS**

1-15. The distinctions among adaptive stress reactions, misconduct stress behaviors, and COSRs are not always clear. Indeed, the three categories of combat and operational stress behaviors may overlap. Soldiers with COSR may show misconduct stress behaviors and vice versa. Soldiers with adaptive stress reactions may also suffer from COSR. Finally, excellent combat Soldiers that have exhibited bravery and acts of heroism may also commit misconduct stress behaviors.



**Figure 1-3. Stress behaviors in combat and other operations**

1-16. It is common for stress reactions to persist or arise long after exposure to distressing events. When there is impairment in social and/or occupational functioning, a clinical assessment is warranted. Combat and operational stress control is important to sustain Army strength over the long-term and reduce the cost to society, the DOD, the Soldiers, and families.

## SECTION II — PRINCIPLES AND FUNCTIONAL AREAS FOR COMBAT AND OPERATIONAL STRESS CONTROL

### COMBAT AND OPERATIONAL STRESS CONTROL INTERVENTIONS

1-17. Soldier and unit readiness is best achieved through an active, prevention-focused orientation that is embodied in the principles. These principles apply to all COSC interventions or activities throughout the theater and are followed by medical personnel in all BH/COSC elements. Their application may differ based on a particular level of care and other factors pertaining to the mission, enemy, terrain and weather, troops and support available, time available, and civil considerations (METT-TC).

1-18. Preventive interventions seek to reduce the occurrence or severity of COSR and behavioral disorders, thereby sustaining Soldier and unit readiness. These interventions are tailored to the needs of the population. There are four categories of preventive interventions that include—

- Universal. Interventions targeted to the general population or an assigned AO.
- Selective. Interventions targeted to a unit or Soldier whose risk is higher than average.
- Indicated. Interventions targeted to Soldiers with COSR or indications of a potential behavioral disorder, and to units that show signs their mission effectiveness is being affected by combat and operational stressors.
- Treatment. Interventions targeted to treat and follow-up Soldiers with behavioral disorders to prevent their loss from duty.

1-19. Identify life- or function-threatening medical, surgical, or psychiatric condition as soon as possible and provide those patients emergency treatment.

### COMMUNICATIONS

1-20. To maximize prevention, COSC personnel must maintain a high degree of involvement with Soldiers and leaders of supported units. Regular visits to the battalion/squadron level are essential to maintain appropriate accessibility. The COSC personnel must always be attuned to Soldiers around them and not rely on Soldiers to come to them. This means that when time permits, COSC personnel need to start conversations with as many supported Soldiers as possible.

1-21. Communication is the delivery system of COSC services and therefore is essential. Use all available means to communicate/coordinate with supported units, subordinate teams, and higher headquarters to ensure delivery of effective and timely COSC and BH services.

### COMBAT AND OPERATIONAL STRESS CONTROL MANAGEMENT PRINCIPLES

1-22. The COSC management principles of brevity, immediacy, contact, expectancy, proximity, and simplicity (BICEPS). These principles apply to all COSC interventions or activities throughout the theater, and are followed by COSC personnel in all BH/COSC elements. These principles may be applied differently based on a particular level of care and other factors pertaining to METT-TC.

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*Note.* The BICEPS principles are discussed in-depth in FM 6-22.5. This is a multiservice publication with the US Marine Corps (USMC). Due to differences in organizational structure the USMC defines the “C” in BICEPS to mean *centrality*, while the US Army defines it to mean *contact*, which will be used for the remainder of this manual.

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## **BREVITY, IMMEDIACY, CONTACT, EXPECTANCY, PROXIMITY, AND SIMPLICITY**

1-23. Using BICEPS is extremely important in the management of Soldiers with COSR and/or behavioral disorders.

### **Brevity**

1-24. Initial rest and replenishment at COSC facilities located close to the Soldier's unit should last no more than 1 to 3 days (USMC and Navy is 3 to 4 days). Those requiring further treatment are moved to the next level of care. Since many require no further treatment, military commanders expect their Soldiers to RTD rapidly.

### **Immediacy**

1-25. It is essential that COSC measures be initiated as soon as possible when operations permit. Intervention is provided as soon as symptoms appear.

### **Contact**

1-26. The Soldier must be encouraged to continue to think of himself as a warfighter, rather than a *patient* or a *sick person*. The chain of command remains directly involved in the Soldier's recovery and RTD. The COSC team coordinates with the unit's leaders to learn whether the overstressed individual was a good performer prior to the COSR. Whenever possible, representatives of the unit or messages from the unit tell the Soldier that he is needed and wanted back. The COSC team coordinates with the unit leaders, through unit medical personnel or chaplains, any special advice on how to assure quick reintegration when the Soldier returns to his unit.

### **Expectancy**

1-27. The individual is explicitly told that he is reacting normally to extreme stress and is expected to recover and return to full duty in a few hours or days. A military leader is extremely effective in this area of treatment. Of all the things said to a Soldier suffering from COSR the words of his small-unit leader have the greatest impact due to the positive bonding process that occurs. A simple statement from the small-unit leader to the Soldier that he is reacting normally to COSR and is expected back soon have positive impact. Small-unit leaders should tell Soldiers that their comrades need and expect them to return. When they do return, the unit treats them as every other Soldier and expects them to perform well.

### **Proximity**

1-28. Soldiers requiring observation or care beyond the unit level are evacuated to facilities in close proximity to, but separate from the medical or surgical patients at the battalion aid station (BAS) or medical company nearest the Soldiers' unit. It is best to send Soldiers who cannot continue their mission and require more extensive intervention to a facility other than a hospital, unless no other alternative is possible. Combat and operational stress reactions are often more effectively managed in areas close to the Soldier's parent unit. On the noncontiguous battlefield characterized by rapid, frequent maneuver and continuous operations, COSC personnel must be innovative and flexible in designing interventions which maximize and maintain the Soldier's connection to his parent unit. See FM 6-22.5 for additional definition of proximity.

### **Simplicity**

1-29. Indicates the need to use brief and straightforward methods to restore physical well-being and self-confidence.

1-30. The actions used for COSR control (commonly referred to as the 5 R's) involve the following actions:

- Reassurance of normality.
- Rest (respice from combat or break from the work).

- Replenish bodily needs (such as thermal comfort, water, food, hygiene, and sleep).
  - Restore confidence with purposeful activities and contact with his unit.
  - Return to duty and reunite Soldier with his unit.
- 

*Note.* Historically the Army had used the terms proximity, immediacy, expectancy and simplicity (PIES) but began using BICEPS when it became the approved joint terminology.

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## **NONPATIENT STATUS**

1-31. To prevent Soldiers with COSR from adopting the *patient* role, these guidelines should be followed:

- Keep the Soldier in uniform and hold him responsible for maintaining Soldier standards.
- Keep the Soldier separate from seriously ill or injured patients.
- Avoid giving him medications unless essential to manage sleep.
- Do not evacuate or hospitalize the Soldier unless absolutely necessary.
- Do not diagnose the Soldier prematurely.
- Transport the Soldier via general-purpose vehicles, not ambulances.

## **COMBAT AND OPERATIONAL STRESS CONTROL FUNCTIONAL AREAS**

1-32. Combat and operational stress control interventions and activities are organized into nine functional areas. These functional areas cover the full spectrum of BH care from preventive through clinical intervention. They are defined below and are discussed further in subsequent chapters of this manual.

### **UNIT NEEDS ASSESSMENT**

1-33. Unit needs assessment is the systematic and frequent assessment of supported units to determine the priority and types of BH interventions required. See Chapter 4.

### **CONSULTATION AND EDUCATION**

1-34. Consultation involves the liaison with and preventive advice to commanders, staff of supported units, and Soldiers. Education involves training in concepts and skills for increasing Soldier resilience to stress. See Chapter 5.

### **TRAUMATIC EVENTS MANAGEMENT**

1-35. Traumatic events management blends other COSC functional areas to create a flexible set of interventions specifically focused on stress management for units and Soldiers following potentially traumatizing events (PTE). Like other functional areas, COSC providers must tailor TEM to the needs of the unit and the Soldier. See Chapter 6.

### **RECONSTITUTION SUPPORT**

1-36. Reconstitution is extraordinary action that commanders plan and implement to restore units to a desired level of combat effectiveness commensurate with mission requirements and available resources. It transcends normal day-to-day force sustainment actions. However, it uses existing systems and units to do so. No resources exist solely to perform reconstitution. In COSC reconstitution support, COSC personnel are responsible for providing unit Soldier restoration and conducting the COSC functions. This support is provided to units following traumatic events and during reconstitution, redeployment, and transition among levels of operational tempo (OPTEMPO). See Chapter 7.

### **COMBAT AND OPERATIONAL STRESS CONTROL TRIAGE**

1-37. Combat and operational stress control triage is the process of sorting Soldiers with COSR and/or BH disorders based upon where they can best be managed. See Chapter 8.

### **COMBAT AND OPERATIONAL STRESS CONTROL STABILIZATION**

1-38. This function provides initial management of Soldiers with severe COSR or behavioral disorders. Their safety is ensured and they are evaluated for RTD potential or prepared for further treatment or evacuation. See Chapter 9.

### **SOLDIER RESTORATION**

1-39. Soldier restoration involves the one- to three-day management of Soldiers with COSR or behavioral disorders normally near a medical treatment facility (MTF) in close proximity to his unit. This approach uses the 5 R's discussed above. See Chapter 10.

### **BEHAVIORAL HEALTH TREATMENT**

1-40. Patients with identified behavioral disorders receive ongoing evaluation, treatment and follow-up to sustain them. This functional area implies a therapist-patient relationship, clinical documentation, and adherence to clinical standards of care. See Chapter 11.

### **SOLDIER RECONDITIONING**

1-41. Reconditioning is an intensive program of work therapy, military activities, physical training and psychotherapy. Reconditioning programs are conducted up to seven days (or more) in the corps area. Additional reconditioning may be provided in the theater outside the combat zone (CZ). See Chapter 12.

### **PRIORITY OF FUNCTIONAL AREAS**

1-42. The medical company/detachment, CSC commanders, MH section leaders, senior medical commanders, and command surgeons must set priorities, coordinate their actions, and allocate resources to accomplish missions based upon the total situation/METT-TC. Needs assessments and available resources guide COSC interventions. At the unit level, the unit needs assessment helps determine which functional areas (such as consultation and education; and critical event and transition management) take priority to achieve success with the COSC mission. At the Soldier level, COSC triage helps determine which functional areas (such as consultation and education, stabilization, Soldier restoration, behavioral health treatment, and reconditioning) take priority to achieve COSC mission goals.

## Chapter 2

# Behavioral Health and Combat and Operational Stress Control Elements in the Theater

### SECTION I — MENTAL HEALTH SECTIONS

#### ASSIGNMENTS

2-1. Mental health sections are located in medical companies assigned to brigades, divisions, corps, and theater-level medical units.

#### ARMY OF EXCELLENCE

2-2. In the Army of Excellence (AOE) divisions, the division MH section (DMHS) is organic to the main support medical company (MSMC). In the armored cavalry regiments (ACRs) and separate brigades, a MH section is assigned to the forward support medical company (FSMC) of the forward support battalion (FSB) or a medical troop. In the corps and echelons above corps (EAC), the MH sections are located in the headquarters and headquarters detachment (HHD), area support medical battalion (ASMB) and in the area support medical companies (ASMCs). In those AOE divisions that are undergoing transformation, the MH sections are assigned to each of the brigade support medical companies (BSMCs) of the brigade support battalion (BSB) and in the ASMCs from the corps ASMB.

#### MODULAR FORCE

2-3. In the modular BCTs, Stryker BCTs (SBCTs) and the heavy BCTs (HBCTs) MH sections are assigned to the BSMC of the BSB. At echelons above brigade (EAB) and at the division, corps, or theater levels, the MH sections are assigned to the multifunctional medical battalion (MMB).

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*Note.* Under the modular design, the MMB will replace the ASMB, the medical logistics battalion, and the medical evacuation battalion.

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#### ORGANIZATIONS

2-4. The AOE divisions have only one MH section that is assigned to the MSMC of the main support battalion (MSB), which is located in the division support area (DSA). See Table 2-1 for a listing of personnel assigned to the division MH section. These personnel are deployed to the supported brigade as two-man teams comprised of one officer and one MH specialist.

**Table 2-1. Division mental health staff**

Division Psychiatrist (MAJ, Area of Concentration [AOC] 60W00, Medical Corps [MC])
Social Work Officer (CPT, AOC 73A67, Medical Service [MS] Corps)
Clinical Psychologist (CPT, AOC 73B67, MS)
Mental Health NCO (E7, E6, and E5, Military Occupational Specialty [MOS] 68X40/30/20)
Mental Health Specialist (Four)—(Two E4 and Two E3, MOS 68X10)

## FUNCTIONS AND RESPONSIBILITIES OF ALL MENTAL HEALTH SECTIONS

2-5. All MH sections regardless of their organizational assignment are tasked with providing COSC for their supported units. In all of these units, COSC is accomplished through vigorous prevention, consultation, training, educational, and Soldier restoration programs. These programs are designed to provide BH expertise to unit leaders and Soldiers where they serve and sustain their mission focus and effectiveness under heavy and prolonged stress. The MH sections identify Soldiers with COSRs who need to be provided rest/Soldier restoration within or near their unit area for rapid RTD. These programs are designed to maximize the RTD rate of Soldiers who are either temporary impaired, have a diagnosed behavioral disorder, or have stress-related conditions. Also the prevention of posttraumatic stress disorders (PTSDs) is an important objective for brigades and EAB. The behavioral health officer (either a clinical psychologist or social work officer) and MH specialist are especially concerned with assisting and training of—

- Small-unit leaders.
- Unit ministry teams (UMTs) and staff chaplains.
- Battalion medical platoons.
- Patient-holding squad and treatment squad personnel of the medical company.

### RESPONSIBILITIES

2-6. The MH section has a primary responsibility for assisting commanders with COSC by implementing the brigade combat mental fitness program. Also the MH section serves as a consultant to the commander, staff, and others involved with providing prevention and intervention services to unit Soldiers and their families. The MH section has staff responsibilities for assisting the brigade surgeon with establishing brigade policy and guidance for the prevention, diagnosis, treatment, management, and RTD of stress-related casualties. This is accomplished under the guidance and in close coordination with maneuver battalions and FSMC/BSMC physicians.

### FUNCTIONS

2-7. The COSC functional areas were identified in Chapter 1. The functions of all MH sections are to support the nine functional areas except Soldier reconditioning.

### UTILIZATION IN GARRISON

2-8. In garrison, BH personnel assigned to the division, brigade, or corps/EAC units continue to perform the same staff and outreach functions with supported units as they do in a field environment. An increase in the BH treatment functions may be possible as a result of consolidating BH care providers. The BH providers make available their consultation skills and clinical expertise to the Soldiers of supported units and their family readiness groups. Clinical care of family members and of Soldiers that require longer-term care beyond crisis intervention, brief treatment, and medication follow-up is the responsibility of the medical department activity (MEDDAC)/medical center (MEDCEN). The MH section personnel should focus their clinical work primarily on Soldiers with problems amenable to brief treatment.

2-9. Clinical services may be provided as part of a consolidated BH activity (as is usually established by a DMHS) or by augmenting an existing MEDDAC/MEDCEN BH staff.

2-10. The MH sections should strive to reduce referrals for BH treatment by working closely with unit leaders and chaplains to control organizational stress and rapidly identify and intervene with those Soldiers having BH disorders.

2-11. When the medical company or battalion deploys on training exercises, assigned BH personnel deploy with them to provide COSC training and support. In addition, they train to improve their own technical and tactical skills.

*Note.* In accordance with AR 40-216, clinical responsibilities in garrison must not interfere with participation in field and deployment exercises and maintenance of combat readiness.

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## **MEDICAL DETACHMENT, COMBAT STRESS CONTROL**

### **MISSION**

2-12. The mission of the medical detachment, CSC (TOE 08463A000) is to provide COSC interventions and stress prevention activities to supported units in its AO. The staff augments division and brigade MH sections; provides direct support (DS) to combat brigades without organic BH officers; and provides area support in its AO. The medical detachment, CSC reconstitutes other brigade and division COSC assets. The medical detachment, CSC provides COSC interventions and activities to indigenous populations as directed in stability and reconstruction operations, humanitarian assistance, disaster relief, peace support operations, and detention facility operations. The medical detachment, CSC provides COSC interventions and activities to units in support of their readiness preparation and throughout their deployment cycle.

### **ASSIGNMENT**

2-13. The Medical Reengineering Initiative (MRI) medical detachment, CSC (TOE 08463A000) is assigned to a corps medical brigade (MEDBDE) (TOE 08422A100), or other medical command and control (C2) element. Its teams may be further attached to a medical company, CSC (TOE 08467L000), an ASMB (TOE 08456A000), a BSMC/MSMC, or a combat support hospital (CSH). See Appendix B for the proposed future medical detachment, COSC.

### **EMPLOYMENT AND CAPABILITIES**

2-14. The detachment headquarters is usually located in the DSA. Its teams disperse throughout the division's AO, and may extend support to corps if no CSC medical company is available. At TOE Level 1, the MRI medical detachment, CSC provides—

- A preventive section capable of dividing into four preventive teams. Each team provides mobile COSC interventions and activities.
- A fitness section capable of dividing into two fitness teams. Each fitness team provides mobile COSC interventions and activities. Each team is equipped to hold 40 Soldiers at the same time. With additional logistical support, each team can accommodate additional Soldiers under surge conditions.

### **STAFF RESPONSIBILITIES**

2-15. The medical detachment, CSC assists the C2 headquarters (of the unit to which it is assigned or attached) regarding planning and coordination of COSC support, stress threat, mental and physical stressors, stress behaviors, principles of COSC, and implementation of COSC functional areas.

### **DEPENDENCY**

2-16. This unit is dependent on—

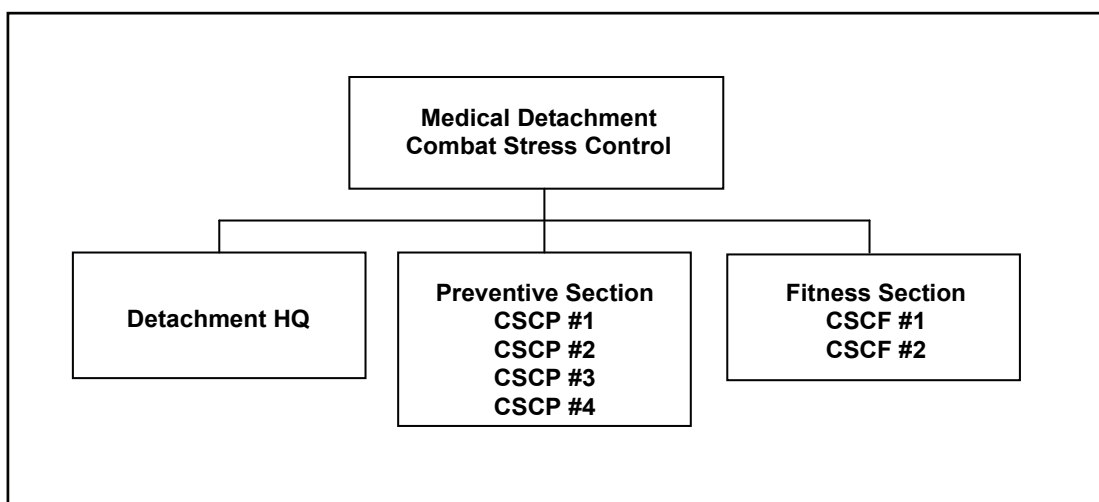
- Appropriate elements of the corps for FHP, religious support, legal, finance, field feeding, personnel and administrative services support; laundry and clothing exchange; mortuary affairs support; and security of enemy prisoners of war (EPW), detainee, and US prisoner patients.
- The medical headquarters to which it is assigned/attached for FHP; medical administration, logistics, including MEDLOG; medical regulating of patients; evacuation; coordination for RTD; and unit level equipment and communications-electronics (CE) maintenance.

## MOBILITY AND SECURITY

2-17. This unit is 100-percent mobile. It requires 100 percent of its organic personnel and equipment be transported in a single lift, using its organic vehicles. Upon relocation, Soldiers being held will require additional transportation. This unit is responsible for perimeter defense of its immediate operational area. However, it is dependent on appropriate elements of the corps for additional security, to include security of convoy operations. Personnel of the detachment are provided weapons for their personal defense and for the defense of their patients and/or held Soldiers.

## ORGANIZATION

2-18. This 43-person MRI medical detachment (Figure 2-1) is organized into a headquarters section; a preventive section composed of four CSC preventive (CSCP) teams; and a fitness section consisting of two CSC fitness (CSCF) teams.



**Figure 2-1. Medical Reengineering Initiative medical detachment, combat stress control (TOE 08463A000)**

## DETACHMENT HEADQUARTERS

2-19. The medical detachment, CSC headquarters provides C2 for the detachment. The headquarters element is responsible for planning, coordinating, and implementing COSC support for supported units. Personnel of the headquarters element provide maintenance, supply and service, and personnel administrative support. See Table 2-2 for a list of personnel assigned to the detachment headquarters.

**Table 2-2. Detachment headquarters assigned personnel**

Detachment Commander (LTC, AOC 60W00, MC)
Field Medical Assistant (1LT, AOC 70B67, MS)
Detachment Sergeant (E7, MOS 68X40)
Supply Sergeant (E5, MOS 92Y20)
Human Resource Specialist (E4, MOS 42A10)
Wheeled Vehicle Mechanic (E4, MOS 63B10)
Cook (E3, MOS 92G10)
<b>Note.</b> Detachment officers and NCOs from the preventive section and the fitness section may be assigned additional duties, which enhance the overall effectiveness of the headquarters section.

**Preventive Section**

2-20. The medical detachment, CSC has a 16-person preventive section. See Table 2-3 for listing of personnel assigned to the preventive section. The section can be divided into four separate CSCP teams. Three CSCP teams are normally allocated to supported maneuver brigades (one team per brigade). The fourth CSCP team may provide direct support to a SBCT, an aviation brigade, other brigade-sized units, or to corps units operating in a division’s AO. Preventive section personnel may be task-organized with personnel of the fitness section into teams for specific missions. The section (and team) leader position may be held by any of the officers assigned to the section. The section’s COSC interventions and activities are—

- Unit needs assessment; consultation and education; TEM; COSC triage; stabilization (emergency); and BH treatment.
- Assisting with Soldier restoration and reconditioning at the CSC detachment program. Overseeing a one- to three-day COSC Soldier restoration program in a brigade, division, or ASMC holding section or in another area suitable for Soldiers experiencing COSR and/or other stress-related disorders.

**Table 2-3. Preventive section assigned personnel**

Social Work Officer (Four)—(Two MAJ and Two CPT, AOC 73A67, MS)
Clinical Psychologist (Four)—(Two MAJ and Two CPT, AOC 73B67, MS)
Mental Health NCO (Four)—(E5, MOS 68X20)
Mental Health Specialist (Four)—(E4, MOS 68X10)

**Fitness Section**

2-21. The medical detachment, CSC has a 20-person fitness section. Personnel assigned to the fitness section are identified in Table 2-4.

**Table 2-4. Fitness section assigned personnel**

Psychiatrist (Two)—(LTC and MAJ, AOC 60W00, MC)
Occupational Therapist (Two)—(MAJ and CPT, AOC 65A00, Army Medical Specialty Corps [SP])
Psychiatric/BH Nurse (Two)—(MAJ and CPT, AOC 66C00, Army Nurse Corps [AN])
Occupational Therapy NCO (Four)—(Two E6 and Two E5, MOS 68W30/20N3)
Mental Health NCO (Four)—(Two E6 and Two E5, MOS 68X30/20)
Mental Health Specialist (Six)—(Four E4 and Two E3, MOS 68X10)

2-22. The fitness section is task-organized to provide COSC interventions and activities. Fitness section personnel may be task-organized with personnel of the preventive section into teams for specific missions. This section can divide into two CSCF teams. Each fitness team can deploy a four-person mobile team using the team’s high-mobility multipurpose wheeled vehicle (HMMWV). One CSCF team usually collocates with a supported divisional medical company to provide mobile COSC support within a DSA and conduct Soldier restoration programs, as required. The second CSCF team augments area support to corps units in the division AO and in forward areas of the corps. The CSCF team provides staff and equipment for operating a Soldier restoration or reconditioning center. This section’s COSC interventions and activities are—

- Unit needs assessment; consultation and education; TEM; COSC triage; stabilization; and BH treatment.
- Conducting Soldier restoration and reconditioning programs.
- Staffing and operating a psychiatric ward for supported CSH when this capability is required (refer to FM 8-10-14).



## MEDICAL COMPANY, COMBAT STRESS CONTROL

2-23. The MRI medical company, CSC is employed in the corps and EAC. The basis of allocation is one medical company, CSC per corps or theater. The medical company, CSC is task-organized, METT-TC-dependent for stability and reconstructions operations. Medical company, CSC (TOE 08467A000) replaces medical company, CSC (TOE 08467L000). A medical company, CSC provides comprehensive preventive and treatment services to a corps and EAC during war. It provides this support to all services on an area support basis. The medical company, CSC provides DS to combat and combat support (CS) brigades, as needed. It reinforces or reconstitutes other CSC assets in the corps or divisions if required. The medical company, CSC provides COSC/BH services to indigenous populations as directed in stability and reconstruction operations, humanitarian assistance, disaster relief, and peace support operations. The comprehensive support provided by the CSC medical company entails all of the nine COSC functional mission areas. The COSC functional mission areas are identified in Chapter 1 and discussed in subsequent chapters of this publication.

### CAPABILITIES

- 2-24. At TOE Level 1, the CSC medical company provides—
- Advice, planning, and coordination for COSC to commanders.
  - Reconstitution (COSC) support for units up to division size.
  - Preventive and fitness teams (four to ten personnel) for consultation, treatment services, and reconstitution support for up to battalion-sized organizations.
  - Soldier restoration or reconditioning programs for up to 50 Soldiers per fitness team on an area basis.
  - Deployment of COSC elements to forward areas for support of contingency operations.

### ASSIGNMENT

2-25. The medical company, CSC (TOE 08467A000) is assigned to a Medical Command (US Army) (MEDCOM). Elements of this TOE may be further attached to a corps MEDBDE or to either a MMB or an ASMB.

### ORGANIZATION

2-26. The medical company, CSC is organized into a headquarters section, a preventive section, and a fitness section. The company is dependent on appropriate elements of the MEDCOM or MEDBDE for administrative and MEDLOG support, medical regulating, COSR casualty delivery, and medical evacuation. The company is dependent on appropriate elements of the corps or EAC for finance, legal, personnel and administrative services, food service, supply and field services, supplemental transportation, and local security support services. When CSC medical company elements or teams are deployed to division areas, they are dependent on the division medical companies (such as MSMC or FSMC/BSMC) for patient accounting, transportation, food service, and field service support.

### Employment

2-27. The medical company, CSC is employed in all intensities of conflict when a corps with two or more divisions is deployed. Task-organized COSC elements are deployed for division-sized combat operations, stability and reconstruction operations, and other contingency operations which are METT-TC-dependent. Together, the preventive and fitness sections provide all five BH disciplines. These resources are flexibly task-organized in a variety of combinations to meet the fluid COSC threat at different phases in the operations. Personnel may be quickly cross-attached from one section to another to accommodate the shifting workload and to provide reconstitution support packages. The preventive and fitness sections both organize into teams. The COSC preventive or fitness teams deployed forward of the corps boundaries in support of tactical operations come under the control of the FHP operations element in the supported units. These teams will also come under the operational control of the division or brigade CSC teams. One or

more of the medical company, CSC's eight preventive teams may locate at the BSMC when deployed in DS of SBCT, HBCT, and separate brigades or ACRs.

### **Fitness Teams**

2-28. One or more of the four (ten-person) fitness teams may reinforce ASMCs which are deployed to locations throughout the corps and EAC. These teams provide a basis for COSC prevention and intervention. The teams may conduct Soldier restoration programs at the ASMCs, as required. These teams may also be deployed forward to provide temporary augmentation/reinforcement, as required.

2-29. Based on workload, one or more of the four fitness teams, plus one or more preventive teams locate with a theater hospital where they conduct Level IV COSC reconditioning programs, as required. A hospital located in the corps rear or out of the CZ is the best location to conduct the theater COSC reconditioning program. When deployed with a hospital, these teams provide mobile consultation in the vicinity of the hospital. These teams are also prepared to restrict reconditioning programs and deploy forward in support of higher priority missions on very short notice. These teams can also augment hospital BH ward services by staffing a temporary BH ward.

2-30. The medical company, CSC is divisible into four functionally emulative increments for split-based operations and stability and reconstruction operations as assigned. Nonstandard task elements for specific missions can be organized using any combination of the preventive section and fitness section personnel to meet specific BH needs. For stability and reconstruction operations, the minimum is an officer/NCO team to supplement a brigade COSC team or a preventive module/team of two officers, one NCO, and one enlisted. These modules may be augmented with personnel from the fitness section to add additional specialty expertise.

### **Headquarters Section**

2-31. The headquarters section provides C2 and unit-level administrative and maintenance support to its subordinate sections when they are collocated with the company. The headquarters section may also provide assistance to detached elements by making site visits if the elements are within a feasible distance for ground transportation. The CSC medical company elements normally deploy with limited maintenance capability. When these COSC elements deploy, they are dependent on the supported units for patient accounting, transportation, food service, and field services. The personnel assigned to the headquarters section are identified in Table 2-5. See Appendix C for information on the AOE L-Series TOE medical company and medical detachment, CSC.

**Table 2-5. Medical company, combat stress control, headquarters section personnel**

Commander (LTC, AOC 60W00, MC)
Chaplain (CPT, AOC 56A00, Chaplain [CH])
Field Medical Assistant (CPT, AOC 70B67, MS)
First Sergeant (E8, MOS 68W50)
Mental Health NCO (E7, MOS 68X40)
Chemical Operations Specialist (E5, MOS 54B20)
Patient Administrative NCO (E5, MOS 68G20)
Supply Sergeant (E5, MOS 92Y20)
Power Generator Equipment Repairer (E4, MOS 52D10)
Wheeled Vehicle Mechanic (E4, MOS 63B10)
Administrative Specialist (E4, MOS 71L10)
Patient Administrative Specialist (Two)—(E4 and E3, MOS 68G10)
Armorer (E4, MOS 92Y10)
Cook (E3, MOS 92G10)
<b>Note.</b> Personnel from the headquarters section are deployed with teams or task-organized COSC element, as required.

## SECTION II — OPERATIONAL STRESS ASSESSMENT TEAM IN A THEATER

### MISSION OF OPERATIONAL STRESS ASSESSMENT TEAMS

2-32. The operational stress assessment team (OSAT) is task-organized when needed from personnel in the research institutes of United States Army Medical Research and Materiel Command (USAMRMC). The mission of this team is to deploy with BH research expertise, equipment and supplies to provide scientifically valid needs assessment of multiple units in the theater and macro analysis of COSC stressors, stress, and Soldier needs. The source is predominantly the Walter Reed Army Institute of Research, augmented when needed with research psychologists and enlisted technicians from the US Army Aeromedical Research Laboratory, the US Army Medical Research Institute of Chemical Defense, and the US Army Research Institute of Environmental Medicine. The OSATs are USAMRMC teams that are assembled entirely from personnel in table of distribution and allowances (TDA) units and are dependent on TOE units when they deploy to a theater.

### ASSIGNMENT AND CAPABILITIES

2-33. The OSAT normally is used for augmenting the senior medical command in the theater. The OSAT has the capabilities to—

- Plan, coordinate, and conduct questionnaire and interview surveys.
- Establish a database and analyze scientific-quality data from their own surveys and from standardized unit assessments conducted by unit MH section and CSC units for their local supported units.
- Provide rapid reports of findings to the command that include recommendations for policy and for COSC actions and interventions.
- Design and validate survey instruments, including ones to address new and emerging stressors and issues in the theater.
- Use USAMRMC capability to archive and analyze data for comparison with other conflicts.
- Educate and mentor COSC and other personnel in survey methodology and provide them, as well as the theater commander, the wider perspective to use in their local UNA.

- Interface with the theater surveillance capabilities of preventive medicine (PVNTMED) and occupational and environmental medicine to address the BH aspects of chemical, biological, radiological and nuclear (CBRN) exposures and threats.

### **DEPENDENCY**

2-34. The OSAT depends on the medical headquarters or the units with which it is working for administrative support. The OSAT depends on the theater (line) command for implementation of the approved surveys.

### **MOBILITY AND SECURITY**

2-35. The OSAT depends on the medical and theater command and the units with which they work for transportation. The OSAT personnel are issued personal weapons and protective equipment, but depend on the units they are with for protection.

### **COMMUNICATIONS**

2-36. The OSAT depends on the medical and theater command and the units with which they work for communications. With approval of theater command, they may be allowed USAMRMC-issued phones for satellite communication for mission-essential purposes.

### **ORGANIZATION**

2-37. The typical OSAT has three officers and two enlisted Soldiers. The officer positions are listed as research psychologists (AOC 71H), but may be filled by clinically qualified BH officers with research training and experience. The enlisted are usually MH specialists (MOS 68X) with research training and experience. Staffing may also include personnel with information management specialties. The equipment is the required personal equipment of the team members, plus data collection and automated data processing equipment appropriate to the mission.

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## Chapter 3

# Combat and Operational Stress Control Support Operations

### SECTION I — COMBAT AND OPERATIONAL STRESS CONTROL PROFESSIONAL DISCIPLINES AND PROFESSIONAL CONSULTANTS

#### PROFESSIONAL DISCIPLINES

3-1. There are five BH professional disciplines and two enlisted specialties that serve in support of the COSC mission. The professional disciplines and enlisted specialties were identified in Chapter 2. The professional disciplines include social work, clinical psychology, psychiatry, occupational therapy (OT), and psychiatric/BH nursing; the enlisted specialties are in BH and OT. While much of the COSC knowledge base and most of the skills are shared by all the BH personnel, each discipline brings its own perspective from its professional training, skills that can only partially be familiarized to the others, and in some cases unique credentials to conduct specific assessments and treatments. The special perspectives and skill sets of the officer and enlisted members of the COSC team are summarized in the following subparagraphs.

#### OFFICER AREAS OF CONCENTRATION

##### Social Work Officer

3-2. The social work officer (AOC 73A67) evaluates the psychosocial systems affecting the Soldier, his family, and the unit; identifies and coordinates with military and civilian support agencies (including the Army Substance Abuse Program and the Family Advocacy Program [FAP]); assesses BH disorders; provides a range of counseling and psychotherapies. Installation MTFs are responsible for BH services that are beyond the scope of COSC functional areas such as long-term clinical care, inpatient services, and alcohol treatment programs. This officer provides proactive consultation, conducts individual and group counseling, supervises Soldier restoration/reconditioning, and coordinates RTD of recovered cases. He also provides staff advice and coordinates Army and civilian social services support.

3-3. When deployed as a member of a COSC preventive team or task-organized COSC element, the social work officer's duties include—

- Evaluating psychosocial (unit and family) functioning of Soldiers with COSR and misconduct stress behavior.
- Coordinating and ensuring the return of recovered COSR and neuropsychiatric (NP) Soldiers to duty and their reintegration into their original or new unit.
- Identifying and resolving organizational and social environmental factors which interfere with combat readiness.
- Coordinating support for Soldiers and their families through Army and civilian community support agencies, when possible.
- Apprising unit leaders, primary care physicians, and other health care providers of available social service resources.
- Providing consultation to supported unit commanders and to other BH/COSC personnel regarding problem cases.
- Counseling and providing therapy for Soldiers with psychological problems.
- Conducting and supervising unit needs assessment and TEM.

3-4. The doctoral level social work officer, as outlined in DODD 6490.1, may conduct clinical evaluations for imminent risk or dangerousness.

**Clinical Psychologist**

3-5. A clinical psychologist (AOC 73B67) diagnoses BH disorders and a range of psychotherapies including cognitive/mental approaches, assessment for safety evaluations, and psychometric assessment.

**Psychiatrist**

3-6. The psychiatrist (AOC 60W00) is a physician that is credentialed to diagnose and treat BDPs. He also conducts mental assessments, makes differential diagnosis, provides a range of psychotherapies and safety evaluations, and prescribes medication.

**Psychiatric/Behavioral Health Nurse**

3-7. This AN officer (AOC 66C007T) provides specialized nursing services for emotionally distressed individuals and promotes COSC within the MTF and the adjacent military community. He performs liaison and consultative functions to ensure continuity of patient care. The additional skill identifier of 7T indicates that advanced skills and competencies are required for this position and that the individual may act as a consultant in clinical nursing practices.

**Occupational Therapist**

3-8. The occupational therapist (AOC 65A00), plans, implements, and supervises preventive and restorative OT services to enhance the occupational performance of Soldiers. This officer evaluates Soldier's performance across the spectrum of occupational areas (such as activities of daily living, work, education, leisure, and social participation). Analyze jobs and job tasks for underlying performance requisites. Identify and evaluate mental and physical stressors and stress reactions and teach prevention, adaptive coping and psychosocial skills. Apply therapeutic media in both, individual and group settings to include environmental adaptation, the therapeutic use of self, consultation, education, and occupation (purposeful activity). Match Soldiers to therapeutic and/or vocational activities based on therapeutic need and functional ability.

**ENLISTED MEDICAL OCCUPATIONAL SPECIALTIES****MENTAL HEALTH SPECIALIST**

3-9. The MH specialist (MOS 68X30/20) provides the perspective of the enlisted Soldier, takes the initial history and conducts mental status evaluations for supervising officer, and administers psychological tests. The MH specialist also performs counseling and may have advanced specialty training (such as drug and alcohol counseling with higher ranked individuals).

**OCCUPATIONAL THERAPY SPECIALIST**

3-10. The OT specialist (MOS 68W30/20N3) provides the perspective of the enlisted Soldier, assists the supervising OT officer in evaluating a Soldier's occupational performance; conducts initial occupational performance history interviews and mental status evaluations; observes clients to gather data as part of task performance skill assessments; and implements OT interventions under the supervision of an OT officer.

**CONSULTANTS**

3-11. There are two levels of COSC consultants—the theater-level consultant and the subordinate commander consultant. The theater-level COSC consultant is normally the senior COSC officer designated by the theater surgeon and approved by the theater commander. The subordinate command COSC consultants are MH officers that function as the point of contact (POC) for one or more commanders.

These consultants oversee, coordinate, and conduct COSC interventions and activities for their respective commanders. They accomplish the following tasks appropriate to their level of operation:

- Direct and report AO-wide COSC needs assessments.
- Coordinate AO-wide implementation of COSC functional areas.
- Ensure COSC standards are established and consistently applied.
- Ensure compatibility between COSC standards and hospital BH standards (theater/AO COSC consultant).
- Define COSC operational requirements.
- Recommend the AO COSC evacuation policy (theater/AO COSC consultant).
- Prepare the COSC portion of the FHP estimate and operations plan.
- Review all command medical policies affecting COSC interventions and activities.
- Evaluate the quality of COSC interventions and activities rendered in the AO.
- Make regular AO COSC consultant site visits to COSC sections and units.
- Coordinate with other COSC consultants in adjoining AOs and in the primary medical support elements to ensure unity of effort.
- Oversee AO COSC training.
- Coordinate joint and combined COSC interventions and activities as necessary.
- Plan for future COSC operations.
- Consult with the command surgeon on all COSC matters.

## SECTION II — DEPLOYMENT AND EMPLOYMENT OF MENTAL HEALTH SECTIONS

### MENTAL HEALTH SECTIONS

3-12. The MH section assignments, staff, functions and responsibilities were discussed in Chapter 2. The information provided in this section pertains to deployment and employment and how these sections prepare for COSC support for their units in garrison, combat operations, and stability and reconstruction operations predeployment. The involvement of MH section with support units during field and other training exercises is important. It permits BH personnel to gain a familiarity with type of units supported, how they conduct operations, their mission, and the likely stressors associated with a particular type of unit. It also allows them to interact and become familiar with unit personnel and to gain some level of trust through their interactions. Combat and operational stress control personnel should be active participants in all training exercises. Unit predeployment training must be planned when the unit is alerted for its deployment but scheduled after cross-leveling and filling of all positions is completed. Training of BH personnel will include—

- Ensuring their active participation in the normal training cycle of the BCT/ACR to which assigned.
- Training the BH officers and specialists in all COSC functional areas that support their unit.
- Working with the supported units on a frequent basis so BH personnel may gain a familiarity with the unit's personnel, capabilities, and possible stressors associated with its mission.
- Providing predeployment train-up to include refresher and operation-specific training before deployment.

### PLANNING

3-13. Since planning is normally performed at battalion level, MH sections are involved in developing a COSC estimate to support the unit plan. The COSC estimate of the situation is derived from mission analysis, to include considerations for COSR, BH disorders, substance abuse, misconduct behaviors, suicide, major stressors, troop populations to be supported, and COSC augmentation requirements or assets available.



## COORDINATING

3-14. The BH personnel may be involved in coordinating COSC support with supporting and supported units, as appropriate. Brigade BH personnel must be known and trusted by the leaders of the units they support. Brigade BH personnel coordinate with other BH officer and enlisted personnel pertaining to the professional disciplines associated with conducting the COSC mission. They also coordinate with other key medical and nonmedical personnel (such as health care providers, surgeons, chaplains, UMTs that assist or may be involved with the COSC mission).

## DEPLOYMENT OF MENTAL HEALTH SECTIONS

### Early Deployment

3-15. The MH section should be deployed early into staging areas with the lead elements of the medical company and supported units.

### Command and Control

3-16. The MH section falls under the C2 of the FSMC/BSMC and may receive mission guidance from the brigade surgeon through the FSMC/BSMC commander. Tasking for COSC operational support flows through the BSMC/FSMC headquarters. When BH personnel from the medical detachment/company, CSC are attached, the MH section ensures the timely flow of operations and situation awareness information to that element.

## EMPLOYMENT OF THE MENTAL HEALTH SECTIONS

3-17. Employment of the MH section is based on the type of operations being conducted. The MH section normally operates from the FSMC/BSMC located in the brigade support area (BSA). When MH personnel are deployed forward, they are dependent on supported units for rations and logistical support.

## MENTAL HEALTH FUNCTIONAL AREA CONSIDERATIONS

3-18. When determining COSC support for BCT units, the BH team should review each of the BH functional areas and determine which BH functions need to be implemented for each supported unit. Also, in developing the COSC plan, the BH team should consider—

- Conducting a UNA for each supported battalion and separate company supported.
- Establishing a consultation and education/training program for supported units to include—
  - Traumatic event and transition management.
  - The need for COSC triage, stabilization, and BH treatment should be addressed as they arise.
  - Soldier restoration, which can only be accomplished within and by the BSMC holding section or with augmentation by or referral to CSC unit personnel.
  - Reconditioning services that will need to be referred to nearest location where available.

## SECTION III — SUPPORT OPERATIONS CONDUCTED BY THE MEDICAL UNIT, COMBAT STRESS CONTROL

## PREDEPLOYMENT ACTIVITIES FOR ALL MEDICAL UNITS, COMBAT STRESS CONTROL

3-19. The predeployment activities identified in Section II for MH sections also apply for the units in Section III that include the ASMB or MMB and medical companies and detachments, CSC. These units must also keep themselves focused on applying the nine functional areas during the predeployment phase.

*Note.* The MMB is the C2 organization which will replace the ASMB, the medical logistics battalion, and the evacuation battalion.

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### **MEDICAL DETACHMENT, COMBAT STRESS CONTROL DEPLOYMENT**

3-20. The medical detachment, CSC is deployed to provide COSC support whenever a division or two BCTs/regiments are deployed. It is assigned to a medical brigade or other medical headquarters for C2. Elements of the detachment may be further attached to FSMCs/BSMCs for operational control and logistical support while in support of the BCT.

### **MEDICAL COMPANY, COMBAT STRESS CONTROL DEPLOYMENT**

3-21. The primary mission of this unit is to provide COSC support throughout a corps AO. It is assigned to either a MEDCOM/MEDBDE and may support from two or up to five divisions. They assign teams to any operational area based on troop populations without BH support. They move teams rapidly to areas of surge workload or mass casualties.

### **MEDICAL FORCE 2000 VERSES THE MEDICAL REENGINEERING INITIATIVE DETACHMENTS**

3-22. The Medical Force 2000 (MF2K) and MRI CSC detachments conduct COSC support operations very similarly. However, in the MRI detachment, psychiatry assets are assigned to the fitness section and psychology assets are assigned forward to the prevention section as compared to the MF2K detachment, the manning strategy for psychology and psychiatry is reversed. The psychologists are assigned to the fitness section and psychiatrists are assigned to the prevention teams.

### **Medical Detachment, Combat Stress Control Support to a Division and Brigade Combat Teams During Combat Operations**

3-23. When in support of an AOE division, a medical detachment, CSC is usually attached to the MSMC/BSMC and for a transformation division the medical detachment, CSC is attached to the MMB or MEDBDE. It can be attached to other battalion-sized units for support. It is under the operational control of the support battalion and MSMC/FSMC/BSMC and closely coordinates its augmentation support with the division surgeon and division psychiatrist. Habitual long-term relationships of medical detachments, CSC with specific divisions should be established so that COSC support is integrated as a normal function of the FHP mission. However, as an echelon above division (EAD) asset, the detachment (or its modular teams) may be task-organized and deployed to support other units or missions other than divisional units, as workloads require. The medical detachment, CSC depends on the units to which it is attached for administrative and logistics support. It may be reinforced and/or receive personnel replacements from a medical company, CSC or from another medical detachment, CSC.

#### ***Preventive Section Operations***

3-24. Upon arrival to a theater, the detachment is initially attached to a higher medical headquarters for C2 and its three CSCP teams of four-person each are usually further attached. One CSCP is attached to each divisional MSMC prior to commencement of combat operations. This will allow the teams to linkup with and augment division COSC assets in support of the brigades.

- The deployment of each CSCP provides additional COSC personnel that increase COSC augmentation capabilities at the FSMC. A CSCP may routinely visit the BASs to provide consultation. The CSCP may deploy, as needed, to provide reconstitution support to units undergoing hasty or deliberate reorganization.
- In some operations, some or all of the CSCP personnel may either be attached to an ASMC or are deployed in support of a maneuver brigade or reconstitution site. It is important for all CSCP personnel to understand that they are responsible for all functional areas, and will conduct them as dictated by the mission.

### *Fitness Section Operations*

3-25. The CSCF may locate with any Level II or above MTF in the AO. This section has tents and is equipped to operate a Soldier restoration center and can supervise Soldier restoration activities to include consultation, rest, relaxation, and treatment as necessary for speedy RTD within three days. The CSCF also provides triage and stabilization at the MSMC and consultation to other division units located in the DSA and division rear areas. All CSCF members are responsible for providing support for all COSC functional areas as dictated by the mission.

3-26. The CSCF staff may move within the AO to temporarily reinforce or reconstitute a CSCP at the brigade level, or to escort COSR casualties to the Soldier restoration center. The CSCF personnel give reconstitution support to attrited units, especially when the units return to the DSA. The CSCF supplements the division psychiatrist; brigade COSC teams, CSCPs, and chaplains and leaders in after-action debriefings. The CSCF helps integrate recovered Soldiers and new replacements into units during reorganization activities. When either the BSA or DSA is tactically too unstable to allow Soldier restoration operations, the CSCF may locate with an ASMC or a CSH and attempt to continue their support to the division from that location.

## **COMBAT STRESS CONTROL DETACHMENT IN CONTINGENCY OPERATIONS**

3-27. For contingency operations, a task-organized CSC element from the CSC medical detachment may be deployed. A CSCP supporting a maneuver brigade may operate out of a central base of operations. The team may deploy forward to the BSA (base camps or fire bases), in response to—

- Anticipated battle.
- After-action debriefing requirements.
- Alcohol/drug problems in a unit.
- Incidents of misconduct stress behaviors.
- High incidence of COSRs.
- Unit rotation in or out of theater.

3-28. Several CSCF and CSCP from two or more CSC medical detachments may be consolidated under the command of the senior medical detachment, CSC commander to staff a central reconditioning program for the AO. This may also function as an alcohol/drug detoxification rehabilitation program. This may be referred to as a COSC center and will also provide consultation and treatment support to MP confinement facilities where misconduct stress behaviors may have led to incarceration. This could also include support for EPW and detainee confinement facilities.

## **STABILITY AND RECONSTRUCTION OPERATIONS**

3-29. In stability and reconstruction operations, if the force deployed is smaller than a division, a medical detachment, CSC would not be required to provide COSC support. In such cases, the medical company, CSC or the medical detachment, CSC may be tasked with providing either a COSC team or a task-organized COSC element. The COSC team or the task-organized COSC element is attached to the supporting medical headquarters or to an MTF and conducts its mobile consultation mission.

## **MEDICAL UNITS, COMBAT STRESS CONTROL INTERFACE AND COORDINATION REQUIREMENTS**

3-30. The medical units CSC must interface with its higher headquarters element and with the unit to which it is attached. The higher headquarters may be a MEDCOM, MEDBDE, or an ASMB/MMB.

- Interface between the CSC units and their higher headquarters. The medical unit CSC interfaces with its higher headquarters pertaining to its assigned mission. It provides estimates and has input to the operation plan (OPLAN). The unit receives its OPORD from the higher

headquarters. Interface between the unit and higher headquarters staff elements will include the following subject areas—

- The COSC operations.
  - Assignment or attachment of the medical detachment, CSC elements.
  - Daily personnel and equipment status reports.
  - Class VIII (medical supply) status and resupply requirements.
  - Casualty feeder reports.
  - Operation orders.
  - Personnel replacement for the detachment.
  - Medical intelligence information.
  - Behavioral health/COSC consultation tasking and results.
  - Maintenance requirements and requests.
  - Replacement and reconstitution operations.
  - Civil-military operations.
  - Communications (signal operation instructions [SOI], access to message centers and nets, and transmission of COSC messages through medical, land, and other channels).
  - Mass casualty plan.
  - Road movement clearances.
  - Tactical updates.
  - Contingency operations.
  - Return-to-duty and non-RTD procedures.
  - Medical evacuation procedures (air and ground ambulances).
  - Changes in locations of supported unit.
- Interface and coordination with unit to which attached. The headquarters of the unit to which a medical detachment, CSC is under operational control (OPCON) or attached is responsible for providing the administrative and logistical support requirements of the detachment. These requirements are normally identified in the attachment order. The higher headquarters will be identified in the attachment order and the medical detachment, CSC will be coordinated with this headquarters prior to deployment. The medical detachment, CSC must coordinate with the headquarters staff according to the tactical standing operating procedures (TSOP) of the unit of attachment. The staff shares information with the detachment commander or his representative pertaining to the threat, tactical situation, patient/COSR casualty status, and changes in FHP requirements. Coordination activities and subject area information exchange should include—
    - Command and control procedures.
    - Status of FSMCs/BSMCs and CSCPs.
    - Communications and SOI.
    - Operational support requirements.
    - Civil-military operations.
    - Soldier restoration operations.
    - Reinforcement and personnel replacement.
    - Road movement and clearances.
    - Casualty reporting and accountability.
    - Patient-holding procedures.
    - Force protection.
    - Convoy operations.
    - Geneva Conventions.
    - Detainees/EPW.
    - Improvised explosive devices (IEDs).
    - Religious and cultural considerations.

## **RECONDITIONING CENTERS**

3-31. The medical company, CSC task-organizes CSC elements to staff separate small reconditioning centers in locations that are relatively secure. However, under some circumstances, the company may consolidate teams to establish a large reconditioning center, which supports two or three divisions. Reconditioning facilities normally locate near a CSH. See Chapter 12 for definitive information on reconditioning center operations.

## Chapter 4

# Unit Needs Assessment

### SECTION I — PRINCIPLES AND TENETS OF UNIT NEEDS ASSESSMENT

#### GENERAL PRINCIPLES

4-1. The UNA is a systematic process for identifying the COSC needs of units. The UNA allows COSC personnel to identify priorities for interventions and activities and for allocating resources. The UNA is not a clinical screening to identify individuals who have or are at risk for BH disorders problems, but rather evaluates the needs of the Soldier population and leads to more effective preventive COSC activities and early interventions. The UNA allows COSC personnel to—

- Identify and describe specific areas of COSC need.
- Discover factors contributing to the needs.
- Provide an assessment of the BH training needs of Soldiers, leaders, UMT, and medical personnel within the unit.
- Develop plans to meet or improve the COSC needs of Soldiers and units through prevention and early intervention activities.

#### SCOPE

4-2. Unit needs assessments can be conducted at various command levels from small to large units. The COSC personnel at each level should conduct UNAs for their supported units. Larger-unit UNAs can include the composite findings and recommendations of one or more UNAs completed at subordinate levels. For example, a brigade UNA may include the results of several subordinate battalion UNAs (consolidated for confidentiality). Generally, UNAs are not conducted below the company level, though exceptional circumstances may dictate a platoon or lower UNA.

#### TENETS

4-3. Tenets of UNAs—

- Gain commander approval and support prior to conducting the UNA.
- Protect anonymity and ensure confidentiality of Soldiers and commanders. This includes the protection of unit identification from higher headquarters.
- Provide the commander with an unbiased assessment.
- Consider the social, political, and organizational factors of the environment.
- Ensure that information sources represent the entire unit.
- Select an assessment method that is consistent with the operational situation.
- Limit overgeneralizing the findings from one unit to another or from one time or situation to another.
- Recognize that UNAs provide population-level assessments of COSC needs, not clinical screening tools to identify individuals who may benefit from COSC interventions.
- Distinguish between what respondents report they need and what interventions are required.
- Ensure the UNA is planned and coordinated at a level commensurate with the complexity of the assessment and/or situation before starting.

## SECTION II — FOCUS AND METHODS OF DETERMINING UNIT NEEDS ASSESSMENT

### AREAS OF FOCUS FOR A UNIT NEEDS ASSESSMENT

4-4. A UNA involves the systematic assessment of numerous areas of Soldier and unit functioning. A typical UNA includes, but is not limited to, the following areas:

- Major stressors impacting the unit.
- Level of unit cohesion.
- Well-being of unit Soldiers.
- Soldier concern about home-front issues.
- Soldier knowledge and skill for controlling combat and operational stress.
- Soldier ideas for addressing COSC needs.
- Soldier knowledge of accessing COSC resources.
- Barriers and stigma that prevent Soldiers from accessing COSC services.
- Training needs of Soldiers, leaders, UMT, and medical personnel on topics of COSC importance (such as buddy aid, suicide awareness, or suicide prevention). See FM 6-22.5, FM 22-51, and US Army Training and Doctrine Command (TRADOC) Pamphlet 600-22 (available at: <http://www.tradoc.army.mil/tpubs/pamndx.htm>) for additional information on suicide awareness and prevention.

### METHODS OF UNIT NEEDS ASSESSMENTS

4-5. The UNA takes advantage of all available information. Various methods can be used to assess general unit needs and to identify issues that differ among subgroups (for example, gender, rank, or race/ethnicity). The use of multiple assessment methods is recommended. These methods may include—

- Interviewing Soldiers to hear their perceptions and concerns. Information gathered during the casual conversation, although informal, may afford valuable anecdotal information (as well as developing trust and familiarity).
- Reviewing policy documents (standing operating procedures [SOPs]).
- Interviewing key unit personnel (chain of command, chaplain, and medical personnel).
- Conducting structured group interviews (focus groups or unit survey interviews).
- Administering standardized surveys and questionnaires (paper/pencil or web-based).
- Monitoring trend indicators (such as high rates of BH referrals, sick call, or misconduct, Soldier suicide, sexual assault, fratricide or disciplinary actions).
- Using multiple methods for gathering information when possible to ensure different viewpoints are considered.

### Planning Considerations for Unit Needs Assessment

4-6. The UNA varies in complexity and formality depending on the purpose of the assessment and the needs of the supported unit commander. Many factors determine the complexity and formality of a UNA, which in turn influence its feasibility.

### Complexity

4-7. Complexity equates to the requirements and cost to complete a UNA. Complexity is influenced by factors such as—

- The size and number of units to be assessed.
- Geographic dispersion of the units and time constraints.

**Formality**

4-8. Formality equates to the degree that scientific principles and methods are employed in the conduct of the UNA. An example of a UNA with low formality is one where the assessing team uses nonstructured group and individual interviews and perhaps brief questionnaires they have developed. The information is obtained from key individuals and a convenience sample of troops. That may be sufficient to quickly identify problems and make recommendations to resolve them. A UNA with high formality is one that uses professionally validated questionnaires and structured focus group interviews according to standard protocols. The data is collected from a scientifically selected sample of the larger population. The data is analyzed by standard analysis programs, so that statistically selected samples of valid comparisons can be made with other similarly sampled units in other geographical locations and across time. The OSAT expertise and assistance may be necessary for some UNA instruments and methods. In general, increasing formality increases the complexity of the UNA. The UNA requires a higher level of formality as the need for objective data and scientific precision increases (such as when results from multiple units are to be merged or compared with other UNAs).

**Feasibility**

4-9. Feasibility is the ability to accomplish a UNA with available resources. In developing a particular UNA, trade-offs are made to achieve an acceptable level of data quality (formality) for an affordable cost (complexity).

**UNIT NEEDS ASSESSMENT PROCESS**

4-10. All UNAs are conducted following a three phase plan.

**PREASSESSMENT**

4-11. Preassessment is an initial phase to obtain command support, determine target issues, and select appropriate methods to use.

**ASSESSMENT**

4-12. Assessment is the phase for gathering, integrating, and analyzing information to identify the COSC needs of the unit.

**POSTASSESSMENT**

4-13. The principal task of the postassessment phase is to determine the COAs to present to the commander which address the identified COSC needs. These findings are then linked to a plan of action.

**WHEN TO CONDUCT UNIT NEEDS ASSESSMENTS**

4-14. Unit needs assessments may be conducted at various times throughout the deployment cycle. A UNA may be conducted—

- Prior to initiation of COSC interventions and activities while COSC personnel and units establish their support relationships.
- To assess the effectiveness of COSC interventions and activities that are in the process of being conducted or that have been completed.
- At the request of supported commanders.
- To monitor trend indicators (see Paragraph 4-5).
- After serious traumatic events and significant unit transitions.
- To collect unit information for COSC planning.

4-15. Unit needs assessments should be conducted during all types of deployments, including stability and reconstruction operations, and combat operations.



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## Chapter 5

# Consultation and Education

### SECTION I — PRINCIPLES AND TENETS OF CONSULTATION AND EDUCATION

#### GENERAL PRINCIPLES

5-1. Combat and operational stress control consultation is defined as the transmission of information through an interactive relationship between the consultant and consultees. Education is used here in a broader sense in that it is the transmission of information by any means. Examples of consultation include providing COSC advice, coaching, training, and planning assistance. During this process, the consultant learns about the consultees and their needs, and tailors the interactions accordingly. Examples of education include distributing flyers, video and radio broadcasts, and news articles. The consultation and education functional area supports the other COSC functional areas.

#### CONSULTANTS

5-2. The term BH consultant is used in the general sense to describe any person performing COSC consultation or education. In addition to those theater or subordinate commander COSC consultants identified in Chapter 3, all BH/COSC personnel may serve as consultants at their level. Familiarization training with other BH disciplines enriches the ability to serve as a consultant.

#### CONSULTEES

5-3. Depending on the units in the area of support, broad types or categories of personnel may be consultees. These personnel are involved in recognition and control of stress as a result of their position or duty assignments. Consultation and education consultees may include—

- The command or unit surgeon and his staff.
- Staff chaplain and UMT.
- The senior commander and the senior NCO of a battalion, brigade, division, or corps.
- Staff officers and NCOs, including adjutant and personnel (S1/G1), intelligence (S2/G2), operations (S3/G3), civil-military affairs (G9), and the Judge Advocate General (JAG).
- Medical personnel such as PVNTMED teams that have missions that often complement the COSC mission.
- Company grade leaders, especially company commanders, executive officers, first sergeants (1SGs) platoon leaders, platoon sergeants, company NCOs, and Soldiers that are trained to be peer mentors.

#### SOLDIER-PEER MENTORS

5-4. Soldiers selected by their commanders may be trained to provide COSC help-in-place assistance for COSC information to peers. They may also serve as a POC between fellow Soldiers and the COSC and UMT teams. Selected Soldier-peer mentors with additional training could assist commanders with conducting COSC training in mission risk assessments.

## TENETS FOR CONSULTATION AND EDUCATION

5-5. Consultation and education are ongoing processes that are performed across the deployment cycle and the continuum of operations. They may be provided in response to a specific request by command or recommendation of COSC personnel. Consultation and education may be provided during routine scheduled meetings such as a commander's weekly update or a leader professional development class.

5-6. Effective consultation is accomplished by the consultant's active outreach. Consultation is best conducted through recurring face-to-face contact, preferably at the consultee's location. Telephone and radio may be used to setup initial meetings and provide follow-up consultation. Consultation may be conducted one-on-one or in small groups where interaction is feasible. When necessary and feasible, audio or video teleconference may suffice. Active outreach supports the functional areas particularly COSC triage and traumatic event and transition management.

5-7. Successful consultation depends on the consultant's credibility, and the trust and familiarity established with consultees. In addition to sound professional knowledge base and clinical skills, the consultant must have military bearing and knowledge of the military (including the units, missions, vocabulary, acronyms, and skills involved). Rapport is enhanced by the demonstration of the consultant's genuine interest in the consultee and the unit. There are some situations when consultation and education are more effectively provided by the COSC officers, the NCOs, or the junior enlisted personnel.

## SECTION II — CONSULTATION, EDUCATION, AND PLANNING

### CONSULTATION PROCESS

5-8. The following six steps outline the process for most consultations:

- Initiate the process by introducing yourself and your capabilities to key leadership and get approval to continue.
- Assess the needs of consultees and formulate ways to address them.
- Present COA to consultee and define goals and feasibility of alternative actions.
- Implement approved COA.
- Evaluate outcomes or progress.
- Plan follow-up actions.

5-9. Consultation and education encompasses a broad range of topics, extending from prevention to treatment. The process of consultation and education assists the consultee with anticipation, identification, and control of stressors (environmental, physiological, cognitive, and emotional) and stress reactions (adaptive and maladaptive stress reactions). The following list of COSC functions, resources and their availability provides examples of consultation and education topics:

- Operation risk factors.
- Individual risk factors.
- Stress moderators.
- Unit cohesion, esprit de corps, and morale.
- Critical event management.
- Barriers to care and overcoming stigma.
- Operations planning.
- Integration of new personnel to unit.
- Trust in equipment and supporting units.
- Tough realistic training.
- Home-front stressors.
- Indicators of unit stress level.
- Combat and operational stress behaviors.
- Combat and operational stress reactions.

- Misconduct stress behaviors.
- Mental disorders.
- Suicidal and homicidal behaviors.
- Command referral processes.
- Scapegoating behaviors.
- Rumor control.
- Physical needs (such as sleep, nutrition, and hygiene).
- Social/emotional needs (such as morale, welfare, recreation push package).
- Communication with home.
- Reintegration of Soldiers into unit.
- Alcohol and substance abuse.
- Procedures for COSC triage.
- Care provider stress (such as compassion fatigue, vicarious trauma, moral dilemma).
- Long-term consequences of COSR and mental disorders.
- Medical evacuation policy and procedures.
- Leadership.
- Fear management.
- Rest and relaxation (R&R) considerations.

5-10. Additional details about some of these topics may be found in FM 22-51.

5-11. From theater staff level down to the MH sections, BH personnel are involved in the consultation and planning process for COSC support. Their support may be either through providing situational updates, developing staff estimates, or being directly involved and assisting with the development of the FHP plan. Planning starts with mission analysis. The mission analysis is the first step of the military decision making in abbreviated planning for a time-constrained situation, see FM 5-0. A part of mission analysis is based on the commander's intent and guidance. A medical battalion headquarters staff may receive addition instructions from the MEDBDE headquarters staff. During the planning process, command surgeons and medical planners (S3/G3) may seek information from the BH/COSC consultant or task medical company/detachment, CSC for COSC estimates.

## MISSION ANALYSIS

5-12. The COSC planning is an essential part of every medical estimate and operations plan. Ensure that the command surgeon involves the COSC consultant in all medical planning. Mission analysis includes—

- Assessing COSC capabilities (organic and attached assets with current status and location).
- Gathering information from the commander's guidance regarding the upcoming operations. (See the S2 for intelligence, the S3 for scheme of maneuver and forces involved; the S1 for casualty estimates, personnel status issues, and units supported, and the logistics staff officer [S4/G4] for logistical considerations). Surgeons provide disease and nonbattle injuries (DNBI) estimates and status of medical units. Unit needs assessments, organic medical personnel, and UMT can provide additional information.
- Developing the COSC estimate based on the gathered information. The COSC estimate helps medical planners to anticipate demands on medical and COSC resources and to prepare accordingly. See FM 3-0, FM 5-0, and FM 8-55 for methods to develop the COSC estimate.
- Assessing limitations (specify reasons that BH assets are not available).
- Identifying specified, implied and essential COSC task in the FHP annex of the OPORD.
- Providing COSC COA.
- Presenting estimate and COA to command surgeon. Define goals and feasibility.
- Implementing approved COA. Consult with implementing COSC personnel about estimate and operational details.

- Evaluating outcomes or progress.
- Providing estimate and COA for fragmentary order (FRAGOs) and planning follow-up actions.

### REHEARSAL

5-13. To achieve optimal synchronization, the FHP plan is rehearsed as an integral part of the combined arms plan at the combined arms rehearsal. Medical leaders provide input to the over all plan and develop the concept for the FHP plan. During the decision-making/orders process, they identify critical events and synchronize the FHP plans. In addition to medical locations on the CSS overlay, these plans indicate the triggers for FHP events. At the rehearsals, leaders practice their synchronized plans that include FHP.

5-14. The CSS/FHP annex of the OPORD that includes map overlays is the conclusion of the medical planning efforts; the rehearsal is the culmination of the preparation phase for an operation. The medical platoon leader has the responsibility for rehearsing FHP operations. Rehearsals are done to achieve a common understanding and a picture of how the plan will be implemented. The following leads to a successful rehearsal—

- All plans must be completed prior to the rehearsal.
- The FHP portion of the battalion rehearsals should focus on the events that are critical to mission accomplishment. A successful rehearsal ensures explicit understanding by subordinate medical personnel of their individual missions; how their missions relate to each other; and how each mission relates to the commander's plan. It is important for all medical units to understand the complete FHP concept.
- Rehearsing key FHP actions allows participants to become familiar with the operation and to visualize the “triggers” which identify the circumstances and timing for friendly actions. This visual impression helps them understand both their environment and their relationship to other units during the operation. The repetition of critical medical tasks during the rehearsal helps leaders remember the sequence of key actions within the operation and when they are executed.
- The OPORD is issued through effective troop leading procedures.

## SECTION III — TRANSITION MANAGEMENT AND SUPPORT IN THE DEPLOYMENT CYCLE

### SUPPORTING TRANSITION AND PHASES OF A DEPLOYMENT

5-15. Transition and phases of a deployment cycle may have different and sometimes unique stressors. These stressors may be subjects for consultation and education. Needs assessment may be necessary to redistribute COSC assets and change the means for delivering COSC activities and interventions.

5-16. The COSC personnel conduct transition (change of command) workshops, especially after relief of commanders. These workshops are normally requested by the incoming commander. The purpose of these workshops is to—

- Facilitate staff discussion of what the staff sees as the unit and staff's strong points and the areas needing more work.
- Provide the new commander the opportunity to discuss his leadership style and his expectations and set priorities for the staff.

5-17. The change of OPTEMP may include—

- Going from deployment to combat (offensive or defensive operations).
- Conducting battle handover in place by turning the battle over to another unit.
- Going from high intensity combat to stability and reconstruction operations.

### PREDEPLOYMENT SUPPORT

5-18. Medical support in predeployment is mainly the responsibility of MEDDAC personnel or of a US Army Reserve (USAR) mobilization site augmentation unit (which has no BH personnel assigned).

Division and brigade COSC BH personnel are involved with their unit's Soldiers who are being treated for mental disorders, and with general COSC prevention of the unit members and families. The CSC units that are not deploying may be tasked to support predeployment COSC activities and interventions. Combat and operational stress control screening of individuals during predeployment may include—

- Secondary BH screening for Soldiers who are referred by primary care providers that flagged positive on DD Form 2795 (Pre-Deployment Health Assessment).
- Health screening of medical and BH records.
- Fitness for duty evaluations according to AR 40-501.
- Evaluations and recommendations to leadership about Soldiers who are fit for duty overall, but should not be deployed at this phase of the operation for BH reasons.

5-19. Other predeployment functions may be provided on request. These functions may include—

- Briefings, consultation and education on deployment cycle stressors and how to cope, and on specific stressors that Soldiers may encounter in the AO.
- Unit assessments at request of commanders.

### **MID-TOUR REST AND RECUPERATION OR EMERGENCY LEAVE**

5-20. Leaders must be aware and alert for Soldiers who exhibit a need for COSC screening prior to mid-tour R&R. Other Soldiers may only require some education briefings and handout cards on handling their transition from a hostile CZ to R&R environments. In some cases, prior to emergency leave, some screening for domestic violence risk may also be necessary in any potential high-risk Soldier. This COSC screening is done for ensuring the safety of the Soldier and of others. One protocol has unit commanders referring those Soldiers that have requested leave for the purpose of addressing marital, legal, or other highly charged difficulties at home, to the BH officer. The BH officer explores the situation and the Soldier's reactions to it and checks for history with the rear detachment of the MH section, MEDDAC/MEDCEN and FAP. If the BH officer finds the Soldier to be at high risk, the commander can deny leave. Another option is to escort the Soldier to home base. At home base, he is kept by his unit's rear detachment until a meeting is held under safe conditions with the Soldier, BH, FAP personnel, his family, and the others involved in the difficulty. At this meeting the situation is defused or resolved before the Soldier is permitted to leave the rear detachment area.

### **REDEPLOYMENT**

5-21. For Soldiers, redeployment is the process of getting orders to redeploy, embarking towards the demobilization site, or deploying to another out-of-the-theater mission. Screening of these individual Soldiers may be a requirement and have established criteria that should be used to ensure appropriate screening is conducted. The theater or specific units may require that all primary care providers who perform screening interview, postdeployment health assessment have a designated BH consultant. Available COSC/BH personnel provide secondary one-on-one BH screening for Soldiers who are referred by primary care providers because they flagged positive on DD Form 2795. Some Soldiers may require brief treatment or referral may be required as a result of the screening.

### **END-OF-TOUR STRESS MANAGEMENT**

5-22. End-of-tour stress management is essential to reduce mental problems with Soldiers returning to their home station and/or families. This also promotes Soldiers seeking help early when problems occur. Mental health/COSC personnel consult with command on activities during redeployment and for postdeployment. Issues may include—

- Common mental disorders and potential misconduct may result when Soldiers are relieved of the stress and the focus of dangerous missions and are looking towards and preparing to go home.
- Memorial services for those Soldiers who died during the deployment.
- Recognition of outstanding performance and the equitable awarding of decorations.
- Closure ceremonies.
- Homecoming-reunion education briefing and training.

5-23. The end-of-tour debriefings (EOTDs) are like leader-led after-action debriefings, except that the time period covered extends from predeployment through to this point in redeployment. The EOTD should be conducted while the unit is still in the theater or at some place where transportation home pauses for one or more days. For each phase of the operation, the participants review what were the significant events and the problems or stressor that bothered the group (including critical events, if any). Equally important the group recalls what went well, how problems and stressors were overcome (at least by some members), and what positive memories and feelings they had and will take home.

## **FACILITATORS**

5-24. The COSC or UMT facilitators should be invited to advise the leader and sit in if there are likely to be many negative memories and feelings that have disrupted or threaten unit cohesion. Advise leaders and troops on the importance of sustaining unit identity and contact with teammates beyond postdeployment and in the future.

## **POSTDEPLOYMENT**

5-25. Postdeployment covers that period of time from embarking from theater, through scheduled postdeployment activities, and return to work after block leave. As with predeployment, medical support in postdeployment is mainly the responsibility of installation MTF, often augmented by a USAR mobilization site augmentation unit. Division and brigade COSC/BH personnel and CSC units that are themselves demobilizing as their units are deactivating will have limited involvement with the BH and COSC needs of fellow Soldiers. These personnel continue to provide, as needed, consultation to the command and to key personnel of the unit that they were assigned/attached. They consult with the installation MTF about BH and coordinate COSC needs that should be met. The CSC units that were not deployed may be tasked to support postdeployment COSC activities and interventions. The COSC personnel who are not demobilizing provide reintegration education. Screening of individuals postdeployment will continue and secondary screening will continue in postdeployment and be recorded on a DD Form 2796 (Post-Deployment Health Assessment). Each primary screener should have a designated BH consultant from the MEDCEN/MEDDAC. Secondary screening and treatment of referrals are provided by the installation MTF. Recent research with a returning division indicated that a secondary postdeployment screening from 90 and 120 days after returning from the theater may be necessary. This seems to be the time when persisting or delayed symptoms, problems, and perhaps impairment show need for intervention. All Soldiers should be advised about follow-up BH support resources. Soldiers that are leaving active service should also be informed about deployment-related entitlements and benefits.

## **READINESS PHASE OF THE DEPLOYMENT CYCLE**

5-26. Division/brigade MH sections and medical units, CSC, of Active Army and Reserve Component (RC) must use their training opportunities to the fullest. During these training exercises, they should provide COSC consultation, education, and training to supported units the same as they would in an actual deployment. Mental health personnel will perform many of their critical mission functions and should not just simulate them. The management of real COSR occurs in field and garrison/home-station settings. Triage and emergency stabilization may be required. Restoration may be appropriate in some field exercises. Even reconditioning can sometimes be provided as a multiday "course" at Active Army posts where CSC units are stationed. Further, TEM and transition management are also potential major roles for organic MH sections and medical units, CSC in peacetime. The RC as well as Active Army medical units, CSC have been used extensively to respond to traumatic events and to assist units that are in the premobilization, mobilization, or postdeployment phases of their deployment cycles.

## Chapter 6

# Traumatic Event Management

## OVERVIEW OF TRAUMATIC EVENT MANAGEMENT

### TAILORING TRAUMATIC EVENT MANAGEMENT

6-1. Traumatic event management blends other COSC functional areas to create a flexible set of interventions specifically focused on stress management for units and Soldiers following potentially traumatizing event (PTE). Like other functional areas, COSC providers must tailor COSC and TEM support to the needs of the unit and Soldier.

6-2. An event is considered *potentially traumatic* when it causes individuals or groups to experience intense feelings of terror, horror, helplessness, and/or hopelessness. Guilt, anger, sadness, and dislocation of *world view* or faith are potential emotional/cognitive responses to PTEs. Studies of Soldiers in Operation Iraqi Freedom (OIF) and Operations Enduring Freedom (OEF) have shown a correlation between exposure to combat experiences and BH disorders, most particularly acute stress disorder and PTSD. The following events should be monitored as PTEs for Soldiers and units:

- Heavy or continuous combat operations.
- Death of unit members due to enemy or friendly fire.
- Accidents.
- Serious injury.
- Suicide/homicide.
- Environmental devastation/human suffering.
- Significant home-front issues.
- Operations resulting in the death of civilians or combatants.

### Scope of Traumatic Events Management

6-3. In this chapter, TEM is discussed as it applies to military units and personnel to support readiness. Traumatic events management can be adapted to nonmilitary groups or individuals brought together by a PTE. Traumatic events debriefing should be conceptualized as an ongoing process and not an acute intervention. For military units and personnel, TEM is active in all phases of the deployment cycle and across the continuum of military operations.

### Traumatic Events Management Functional Mission Area

6-4. Successful TEM relies on a solid foundation of other COSC functional area activities such as UNA that may require the COSC provider to—

- Establish a credible working relationship with supported unit leadership.
- Understand the unit's needs via previously conducted UNAs.

6-5. In the absence of preexisting relationships and UNA, COSC providers should secure command support and recommend a UNA as the first step in TEM. Subsequent UNAs will clarify unit responses to other TEM interventions and to ongoing unit needs.

### Unit Needs Assessments

6-6. When conducting a UNA after a PTE the COSC providers need to take under consideration the following—

- Ensure a timely arrival that does not disrupt unit operations but facilitates the UNA.



- They should not interrupt or intrude on the people who are attending to the acute crisis when arriving at the unit, unless asked. Presence without intruding will gain trust information and POC.
- Understanding that the UNA may be limited by the urgency of the unit's return to action, the difficulty of data collection, and having limited resources. Sufficient knowledge must be gained to tailor the interventions to the unit before initiating them. It is better to defer the intervention to the next opportunity if the unit must return to action immediately after replenishment and/or before necessary data is collected.
- Know that the UNA is a unit-level assessment and does not substitute for individual-level screenings or COSC triage. See Chapter 4 for a detailed discussion of UNA.

### Consultation and Education

6-7. The COSC provider should conduct unit leader consultation and education activities prior to a PTE. Consultation and education topics should include—

- The impact of PTE on unit and Soldier readiness.
- Common PTEs for units and Soldiers.
- An overview of TEM.
- Components of TEM.
- Normal responses to PTEs.
- Triggers to refer Soldiers for BH evaluation.
- Development of SOPs for responding to PTEs when they occur.

6-8. Preemptive consultation and education prepare unit leaders to institute TEM interventions following a PTE. The 5 R's are a good model to build on. In acute TEM interventions, leaders should consider interventions that target—

- Safety, security, and survival.
- Food, hydration, clothing, and shelter.
- Sleep.
- Medication (replace medications destroyed or lost).
- Orientation of unit/Soldiers to developing situation.
- Restoration of communication with unit, dependents, friends, and community.
- Location should be at a secure site that provides protection from ongoing threats, toxins, and harm.

6-9. Consultation and education to Soldiers should emphasize normalizing the common reactions to trauma, improving their coping skills, enhancing self-care, facilitating recognition of significant problems, and increasing knowledge of and access to COSC services. Post-PTE UNAs guide further consultation and education efforts. Combat and operational stress control providers should be aware that leaders may not have experienced the PTE in person, but have experienced the PTE through their Soldiers and may require support.

6-10. For an in-depth discussion of consultation and education, refer to Chapter 5.

### Combat and Operational Stress Control Triage

6-11. The COSC provider should be prepared to provide COSC triage in the aftermath of the PTE. Consultation and education is important to ensure appropriate and timely referrals for triage. The COSC provider can offer the following guidelines in referral of Soldiers for COSC triage:

- Persistent or worsening traumatic stress reactions (such as dissociation, panic, autonomic arousal, and cognitive impairment).
- Significant functional impairments (such as role/work relationships).
- Dangerousness (suicidal or violent ideation, plan, and/or intent).

- Severe psychiatric comorbidity (such as psychotic spectrum disorder, substance use disorder, or abuse).
- Maladaptive coping strategies (such as pattern of impulsivity or social withdrawal under stress).
- New or evolving psychosocial stressors.
- Poor social support.
- Failure to respond to acute supportive interventions.
- Exacerbation of preexisting psychiatric conditions.
- Soldier request for assessment.

### Stabilization

6-12. The COSC provider should be prepared to provide or coordinate stabilization services following the PTE. Pre-PTE coordination with medical unit personnel promotes safe management.

### Soldier Restoration

6-13. The measures below are applicable to Soldiers with COSR following a PTE. The COSC provider should be familiar with the 5 R's and with BICEPS. In keeping with restorative efforts, the COSC provider focuses on the following measures through leadership consultation, Soldier education, and/or direct management:

- Minimizing exposure of Soldiers with COSR to further PTE.
- Reducing physiological arousal.
- Mobilizing support for those who are most distressed.
- Providing information and fostering communication and education.
- Using effective risk communication techniques.
- Proving assurance/reassurance.
- Mitigating fear and anxiety.
- Encouraging sleep hygiene.
- Reestablishing routines.
- Promoting exercise and nutrition.
- Encouraging self-paced emotional ventilation.
- Discouraging use of alcohol/substances.

### Behavioral Health Treatment

6-14. Given the correlation between PTE and development of traumatic stress disorders the COSC provider must be familiar with the best current practices for evaluation and treatment. The Veterans Health Administration (VHA)/DOD Clinical Practice Guidelines website (<http://www.oqp.med.va.gov/cpg/cpg.htm>) offers clinicians evidence-based assessment and treatment algorithms for acute stress disorder, PTSD, and many other BH disorders.

6-15. In recent years, the use of early interventions in response to PTE has come under critical review. The focus of much of this debate is on the use of psychological debriefing (PD) and more specifically, the critical incident stress debriefings provided to individuals or groups exposed to PTEs. Current research suggests that PD/critical incident stress debriefings can be harmful to participants, while failing to reduce traumatic stress reactions or to prevent the progression to PTSD. As PD/critical incident stress debriefings undergo definitive study, COSC providers should adhere to current evidence-based best practices.

6-16. In accordance with the VHA/DOD Clinical Practice Guidelines (<http://www.oqp.med.va.gov/cpg/cpg.htm>) for PTSD, COSC providers should—

- Consider alternative methods to PDs for individuals affected by PTEs.
- Avoid PD as a means to reduce acute posttraumatic distress (acute stress reaction or acute stress disorder) or to slow progression to PTSD.

- Understand there is insufficient evidence to recommend for or against conducting structured group debriefings.
- Be aware that compulsory repetition of traumatic experiences in a group may be counter-productive.
- Consider group debriefings with preexisting groups (such as teams, units, emergency medical treatment [EMT] teams, coworkers, family members) may assist with group cohesion, morale, and other important variables that have not been demonstrated empirically.
- Emphasize that group participation must be voluntary.

## **LEADER-LED AFTER-ACTION DEBRIEFING**

6-17. A leader-led after-action debriefing is led by a platoon, squad, or team leader and is not normally conducted above platoon level. The leader-led after-action debriefing should be conducted after all missions especially when the maneuvers did not go according to plan. A leader-led after-action debriefing may even be sufficient for PTEs involving injury or death. For the leader to conduct a PD, his personnel should have received previous PDs; and normally provide peer support and validation for showing and talking about their emotional reactions during and after the debriefing. The best time to conduct this debriefing is as soon as is feasible after the team/squad/platoon has returned to a relatively safe place and members have replenished bodily needs and are no longer in a high state of arousal. Usually a well-conducted leader-led after-action debriefing is the best option to manage PTEs during a mission. The exception to this type of debriefing is when the event evoked reactions that seriously threaten unit cohesion and/or have a high likelihood of arousing disruptive behavior and emotions. In these situations the leader should ask himself the following—

- Should I conduct the debriefing?
- Should a trained facilitator be present?
- Should a request for COSC TEM be submitted for his team/squad/platoon?

## **CONDUCTING A LEADER-LED AFTER-ACTION DEBRIEFING**

6-18. These debriefings require the leader to extend the lessons-learned orientation of the standard AAR. He uses the event reconstruction approach or has the individuals present their own roles and perceptions of the event, whichever best fits the situation and time available. See Training Circular (TC) 25-20 for definitive information on AARs. When individuals express or show emotions, the leader and the teammates recognize and normalize them; they agree to talk about them later and support the distressed Soldier through personal interactions. The group then returns to determining the facts. Lessons-learned discussion is deferred until all the facts are laid out. See FM 22-51 for additional information. The leader may provide education about controlling likely reactions or referral information at the end, depending on his knowledge and experience.

6-19. When a PTE is likely to create individual or collective guilt, distrust, or anger, the unit leader should be encouraged to request COSC assistance. Either a COSC or a UMT person trained in TEM sits in with the leader-led debriefing as a familiar and trusted friend of the unit. The COSC or UMT facilitator helps the unit/team leader rehearse and mentors the leaders on the debriefing process. During the PD, the facilitator can ask questions of the group to clarify the facts and steer the process away from divisive anger, blaming, and scapegoating toward a positive, cohesion-restoring outcome. This method is halfway between a simple leader-led after-action debriefing and a PD and is referred to as a *facilitated leader-led after-action debriefing*. The leader conducting the debriefing must be attentive to identify individuals needing COSC follow-up.

6-20. Leaders in positions above platoon level also have a role in leader-led after-action debriefing. Company commanders and 1SGs may conduct leader-led after-action debriefing with their subordinate leaders. Battalion commanders and higher may conduct leader-led after-action debriefings with their staff after distressing actions and may include subordinate leaders when time allows bringing them together.

## COOL DOWN MEETINGS

6-21. A cool down meeting is referred to as an immediate, short meeting when a team or larger unit/group returns from the battlefield or other missions. These cool down meetings are held after heavy/intense battles with the enemy or a shift in the mission has occurred which is highly arousing and/or distressing. This is especially important after critical events. The cool down meeting is an informal event and occurs before the participants fully replenish their bodily needs and precedes any other activities including more COSC interventions, or return to the mission.

6-22. Personnel who coordinate and wait for the return of the unit that has been in a heavy intense battle, include leaders or supporting officers or NCOs from the command, UMT, and COSC providers. (In domestic support operations the same personnel identified above or other trained personnel from governmental or nongovernmental organizations such as the Red Cross may be waiting on the return of the unit after a PTE. These personnel may be present at the cool down meeting.)

### COMPONENTS OF A COOL DOWN MEETING

6-23. Components of a cool down meeting may include—

- Assembling all of the unit personnel at a safe and relatively comfortable location for a brief period of time (about 15 minutes).
- Receiving or sharing nonstimulating beverages and convenient food (*comfort* foods if available).
- Providing personnel the opportunity to talk among themselves.
- Giving recognition and praise for the difficult mission they have completed.
- Providing information to unit personnel on where and how they will rest and replenish.
- Previewing the immediate agenda for the unit on what will happen after the cool down meeting including plans for further debriefing and/or other available stress control or morale/welfare intervention.
- Providing announcements pertaining to further preparations and expected time of return to the mission.

6-24. The COSC personnel may have a role in cool down meetings. In consultation and education, COSC consultants emphasize the value of cool down meetings and the simplicity of the components, which are easily neglected in crisis situations. When feasible, they unobtrusively attend the cool down meeting, showing “presence” while learning of the event, getting familiar with the key people, and observing anyone showing signs of distress and being available to them. If requested, they may give a very brief introduction and review of normal stress reactions that unit personnel may have in the next few hours.

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## Chapter 7

# Combat and Operational Stress Control Support for Units Undergoing Reconstitution

## UNIT RECONSTITUTION SUPPORT

7-1. Unit reconstitution support is defined in FM 100-9 as extraordinary actions that commanders plan and implement to restore units to a desired level of combat effectiveness commensurate with mission requirements and available resources. Besides normal support actions, reconstitution may include—

- Removing the unit from combat.
- Assisting the unit with external assets.
- Reestablishing the chain of command.
- Training the unit for future operations.
- Reestablishing unit cohesion.

7-2. When tasked as part of a reconstitution task force, COSC personnel are responsible for providing units with Soldier restoration, performing the COSC functions of the UNA, and providing consultation and education, as required. They provide triage, stabilization, Soldier restorations, and short time-constrained COSC treatment, when needed. Reconstitution is a time-constrained process, but Soldier restoration may be provided at the reconstitution site if several days are available. The focus of consultation and education efforts include—

- Rebuilding unit cohesion.
- Integrating new Soldiers or groups of Soldiers into the unit.
- Facilitating assumptions of command by replaced leaders.
- Facilitating the building of Soldiers' confidence in their leaders and themselves.
- Mentoring unit leaders in leader-led after-action debriefing process.
- Advising on COSC aspects of bereavement memorial services and communication with the family support group and unit families. The COSC personnel also facilitate leader-led after-action debriefings and lead or serve as observers in TEM interventions.

## RECONSTITUTION PROCESS

7-3. Reconstitution of units transcends normal day-to-day force sustainment actions. Reconstitution is a total process. Its major elements are reorganization, assessment, and regeneration, in that order. All COSC personnel should be thoroughly familiar with FM 100-9.

### Reorganization

7-4. Unit reorganization primarily involves a shifting of internal resources and is accomplished as either immediate or deliberate reorganization. The commander of the attrited unit decides to reorganize when required and may consider the following—

- Immediate reorganization is the quick and usually temporary restoring of degraded units to minimum levels of effectiveness. Normally, the commander implements immediate reorganization at his combat location or as close to that site as possible to meet near-term needs. The COSC personnel provide consultation with key POC in the unit (leaders, UMTs, and trauma/health care specialist, usually by telecommunication).
- Deliberate reorganization is done to restore a unit to the specified degree of combat effectiveness. Usually, more time and resources are available further to the rear. Procedures are similar to immediate reorganization except that some personnel and weapons system

replacement resources may be available, equipment repair is more intensive, and more extensive cross-leveling is possible. When used in reorganization, cross-leveling involves the movement of personnel and/or equipment between units to achieve equalization. The process is accomplished while maintaining or restoring the combat effectiveness of the units involved.

- The role of COSC personnel in deliberate reorganization may require a COSC team to deploy to the reorganization site. They assess the stressors and stress reactions and advise the commanders on supportive actions, (such as those for the reorganization of small unit-level elements), assists command with transitions and integration of new replacements.
- When the reorganization involves battalion size or larger units the process becomes more like the coordinated operation described for unit regeneration, provided below. It is likely to draw upon fitness team expertise and Soldier restoration assets from rearward as well as on the forward deployed teams.

## REGENERATION

### ASSESSMENT PHASES

7-5. The defining characteristic of regeneration is the massive infusion of personnel, equipment, and assistance under the directions of higher headquarters. Assessment measures a unit's capability to perform its mission. It occurs in two phases. The unit commander conducts the first phase. He continually assesses his unit before, during, and after operations. If he determines it is no longer mission-capable even after reorganization, he notifies his commander. The higher headquarters either changes the mission of the unit to match its degraded capability or removes it from combat. External elements may also have to assess the unit after it disengages. This is the second phase. These elements do a more thorough evaluation to determine regeneration needs. They also consider the resources available.

7-6. The second phase of assessment begins with an initial survey by a team sent by the higher headquarters. This team determines the status and needs of the attrited and exhausted unit as it moves to the regeneration site. Some of the key issues in estimating the COSC needs of the unit include the—

- Percentage and nature of casualties.
- Duration of operations and environmental exposure.
- Status of hydration, nutrition, and sleep.
- Loss and current effectiveness of leaders.
- Attitudes, perceptions, and level of confidence of unit survivors.
- Traumatic events.

7-7. The COSC consultants at every level must provide consultation to all command surgeons on the importance of including BH/COSC personnel in all reconstitution operations. The initial evaluation team should include a subordinate commander COSC consultant. Task-organized CSC teams normally deploy to the unit during the second phase to provide UNA, consultation, and other COSC activities and interventions. Unit needs assessment with high formality may be requested by the higher headquarters for decision-making purposes. These assessments are feasible for selected units, with prior coordination, as much of the logistical complexity is reduced by the orchestrated planning at higher command echelons.

### Conducting Regeneration

7-8. Regeneration involves rebuilding a unit through large-scale replacement of personnel, equipment, and supplies. If required, it includes internally reorganizing; reestablishing or replacing essential C2 and conducting mission-essential training for the reconstituted unit. Regeneration is required when heavy losses of personnel and equipment leave a unit combat-ineffective and unable to continue its mission. The commander controlling assets to conduct regeneration decides whether to use resources for this purpose. Regeneration has two variations: incremental regeneration or whole-unit regeneration. Incremental regeneration is the massive infusion of individual personnel replacements and single items of equipment into the surviving unit elements. Whole-unit regeneration is the replacement of whole units or definable subelements, such as squads, crews, and teams. The S1/G1, S4/G4, and medical staffs coordinate the

dispatch of the regeneration task-force teams. These teams occupy the reconstitution site before arrival of the exhausted unit. The COSC assets that perform the indicated initial assessment are needed as part of this task force. The reconstitution task force guides each element of the arriving units into its designated areas. The regeneration task force provides for the immediate needs of the survivors. This should include personal gear and equipment to replace lost or damaged items, food services, personnel services, maintenance teams, and medical teams to provide sick call services while organic medical personnel rest. Replacement personnel are sent to the reconstitution site. The COSC personnel assist with their assimilation into the regenerated unit.

## **RECONSTITUTION RESOURCE REQUIREMENTS FOR COMBAT AND OPERATIONAL STRESS CONTROL**

7-9. Factors which influence the resource requirements for COSC in reconstitution (deliberate reorganization and regeneration) include the size of the unit, number of subunits which have suffered heavy casualties, the extent of emotional trauma, and time available. The focus of COSC for reconstitution support was provided in Paragraph 7-2. A guideline is provided in Table 7-1 for COSC personnel requirements. This staffing should not overly rely on organic COSC staff that will be in need of rest.

**Table 7-1. Reconstitution operations guideline for combat and operational stress control personnel requirements**

<i>Size of Unit</i>	<i>Personnel Required</i>
Company/Troop	2 to 4
Battalion/Squadron	6 to 12
BCT/Brigade Regiment	12 to 30
Division	30 to 60



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## Chapter 8

# Combat and Operational Stress Control Triage

## SECTION I — THE TRIAGE PROCESS FOR COMBAT AND OPERATIONAL STRESS CONTROL

### SOLDIER TRIAGE

8-1. The COSC triage process is the sorting of Soldiers based on an assessment of their needs and capabilities, and the location where they can best be managed in keeping with BICEPS principles. Triage is applicable at every level of care. The two key components of COSC triage are assessment and disposition.

8-2. Assessment is an evaluation of the Soldier's physical and BH needs, potential medical emergencies, and other safety risks. Assessment is performed by COSC personnel according to their professional training, expertise, and standards.

8-3. Disposition is the COSC intervention plan to address the needs identified in the assessment. Disposition has two components that include—

- Determining what intervention techniques best address the Soldier's needs and functional capabilities.
- Selecting the best location where the Soldier can be managed. The personnel conducting COSC triage should consider the needs, abilities, and the safety of the Soldier. They should also consider the unit's capacity to provide COSC interventions based on its OPTEMPO mission, resources, response to prior consultations, and willingness to participate in COSC interventions.

### TRIAS ALGORITHM FOR COMBAT AND OPERATIONAL STRESS CONTROL

8-4. Like surgical triage categories, COSR also uses triage categories. Each of the COSR triage categories are discussed in detail in the below paragraphs. The COSC triage algorithm presented in Table 8-1 uses some of the triage categories.

**Table 8-1. The combat and operational stress control triage algorithm**

Step 1	Is this a medical emergency?				
	Yes	Refer to nearest MTF	No	Go to Step 2	
Step 2	Does the Soldier require medical/behavioral observation?				
	Yes	Go to Step 3 A	No	Does Soldier have presumptive COSR or MH disorder?	
				Yes	Go to Step 3 B
				No	Help-in-place
Step 3	A. Can the Level II MTF or CSC Soldier Restoration Center provide adequate evaluation and intervention?		B. Can the Soldier's unit support the 5 R's or other treatment interventions?		
	Yes	HOLD*	Yes	UNIT	
	No	REFER	No	Is there a suitable support unit?	
				Yes	REST
				No	HOLD*
* When deciding between two or more potential Level II MTFs or CSC Restoration Centers, refer the Soldier to the one closest to his unit that meets his COSC needs.					
Step 4	Use on subsequent triages. Has the Soldier improved after appropriate duration of intervention?				

## TRIAGE CATEGORIES FOR COMBAT AND OPERATIONAL STRESS REACTION CASES

8-5. The following are triage categories that may be used for COSR cases. *Help-in-place* (HIP), *rest*, *hold*, and *refer* cases are discussed below.

### HELP-IN-PLACE CASES

8-6. *Help-in-place* is used to identify those cases that do not have severe COSR or BH disorders. They are provided COSC consultation and education, as appropriate, and remain on duty. These interactions may occur in any setting (for example, dining facility, workplace, or the post exchange). Individual identifying information is not retained or documented. There is no implicit or explicit therapist-patient or therapist-client relationship in HIP interactions.

8-7. The unit identifies those cases that remain with or return to their original unit, either for full duty with their section/platoon or for light duty with extra rest and replenishment within a headquarters element. This option depends on the unit's mission, resources, and the Soldiers symptoms. Personnel performing triage must, therefore, be familiar with the unit's situation and take that into account. When the Soldier's condition improves, the Soldier and/or unit may not feel that additional triage is necessary.

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*Note.* *Help-in-place* is a new triage category that replaces the old *duty* category and is also used for unit cases.

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## **REST CASES**

8-8. *Rest* identifies those cases that are provided rest and replenishment in a nonmedical support unit, usually one that is in support of their unit. These Soldiers do not require close medical or BH observation or treatment. They are unable to return immediately to their own unit either because their unit cannot provide an adequate environment for the 5 R's; or transportation is not available for at least a day; or the 5 R's can best be coordinated from the nonmedical support unit. This option depends on the resources and mission of the available CS/CSS units, as well as on the Soldier's symptoms. Someone must be designated to be in charge of the Soldier and ensure that the 5 R's are provided. There must be a reliable transportation link to return the Soldier to his original unit after a day or two. When the Soldier's condition improves sufficiently for him to return to his unit, the Soldier and/or the supporting unit may feel that additional triage is necessary.

## **HOLD CASES**

8-9. *Hold* refers to those cases that require close medical/BH observation and evaluation at a Level II MTF or COSC Soldier restoration center because the Soldiers symptoms are potentially too disruptive or burdensome for any available CSS unit or element. Soldier's symptoms may be caused by a BH disorder that could suddenly turn worse and require emergency treatment. The Level II MTF or COSC Soldier restoration center must have the capability to provide the necessary medical observation, diagnostic tools, and adequate stabilization for emergency treatment. When deciding among capable Level II MTFs or COSC Soldier restoration centers, refer the Soldier to the one closest to his unit that meets his COSC needs. Assessment of closeness considers speed and reliability of transportation and back. Consider transferring to another Level II MTF or COSC Soldier restoration center with increased capabilities before changing a Soldier's triage category to *refer*. All *hold* cases will be triaged again by COSC personnel or other trained medical personnel after they have been placed in this category.

## **REFER CASES**

8-10. *Refer* cases are similar to the *hold* cases, except that *refer* cases are too disruptive and burdensome for the MTF or the COSC Soldier restoration center that is not resourced to care for this particular case. The MTF or COSC Soldier restoration center cannot provide the necessary level of diagnostic and treatment capabilities. *Refer* cases requiring care at a COSC reconditioning center, a Level III MTF or higher levels of care will be triaged by COSC or other trained medical personnel prior to being transferred to these facilities.

## **TRIAGE PERSONNEL FOR COMBAT AND OPERATIONAL STRESS CONTROL**

8-11. All COSC personnel participate in the triage process according to their professional training, experience, and standards. Familiarization training among BH disciplines extends the effectiveness of all COSC personnel in triage skills. Medical care providers must be mentored to use the COSC triage process. A commander providing the 5 R's and placing a Soldier in a support unit for a temporary break does not equate to COSC triage.

## **TRIAGE CONSIDERATIONS**

- 8-12. Triage should be initiated when the—
- Soldier is a self-referral.
  - Chaplain has referred the Soldier.
  - Medical personnel have requested a COSC consultation and referred the Soldier.

- Unit member/buddy has referred the Soldier.
- Leader has requested an informal referral.
- Soldier is a command-directed referral (see DODD 6490.1 and DOD Instruction [DODI] 6490.4).
- Combat operational stress control personnel observe a Soldier's behaviors which indicate possible COSR or a BH disorder.

8-13. Factors that influence an assessment may vary in depth and duration due to several other factors. These factors may include the—

- Referral source.
- Nature of the complaint.
- Observed needs.
- Medical/psychiatric history.
- Availability of resources.
- Amount of privacy for conducting assessment.
- Operational Tempo.
- Environmental conditions.
- Professional training of the person making the assessment.
- Command interest.
- Soldier cooperation.

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*Note.* Regardless of these factors, COSC personnel are responsible for conducting the assessment in a timely manner within professional standards of practice.

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### DOCUMENTATION

- 8-14. An assessment is documented according to AR 40-66 whenever the Soldier—
- Is diagnosed with a BH disorder.
  - Has a condition (or suspected condition) requiring emergency medical evaluation or treatment.
  - Is prescribed medication.
  - Is assessed to be a high safety risk (for example, homicidal or suicide, cognitive impairment, substance abuse, and impulsivity).
  - Requests that documentation of his assessment be made in his medical records.
  - Is evacuated beyond Level II MTF for further assessment or treatment.
  - Is command-referred for a BH evaluation.

### TRANSFER AND EVACUATION

8-15. All COSC personnel are responsible for knowing the transfer/evacuation policies and procedures within their AO. Policies and procedural information are available through the command surgeon, medical regulating officer (MRO) of the medical command, control, communications, computers, and intelligence (C4I) headquarters or major MTF. All relevant background and/or clinical documentation must accompany the Soldier during the transportation or evacuation process.

### MODE OF TRANSPORTATION

8-16. Nonambulance transport is the preferred mode of transportation for COSR and nonurgent BH cases. Examples of nonambulance transportation include the Soldier's unit vehicles, supporting supply/logistics vehicles, and nonambulance medical vehicles. Ambulances convey patient status on Soldiers and often must be reserved for medical emergency. Under the provisions of the Geneva Conventions, ambulances must be used exclusively in the performance of humanitarian duties, therefore, they cannot be used to return Soldiers to duty and transport must be provided by the supported unit.

## **ESCORT**

8-17. Depending on a Soldier's condition, an escort (either medical or nonmedical) may be necessary to provide safety, monitoring, and accountability during transportation or evacuation. The escort should be an NCO or officer of equal or greater rank/grade as that of the escorted Soldier. Escorts must be emotionally mature, responsible, and capable of conducting their escort duties. Frequently escorts carry the Soldier's clinical documentation to the destination MTF.

## **FEEDBACK**

8-18. Good communication is essential for effective continuity of care during the transportation/evacuation process. The Soldier's unit must be informed about his location and status throughout the process. The sending party must provide sufficient documentation about the Soldier's condition, history, and administered interventions. The receiving party must provide feedback to the sending party regarding receipt of the Soldier and his documentation.

# **SECTION II — PRECAUTIONS AND DIFFERENTIAL DIAGNOSTIC PROBLEMS ASSOCIATED WITH COMBAT AND OPERATIONAL STRESS CONTROL TRIAGE**

## **PRECAUTIONS FOR COMBAT AND OPERATIONAL STRESS CONTROL TRIAGE**

8-19. Medical emergencies must be identified during COSC triage. Medical emergencies consist of physical illnesses or injuries and/or BH disorders that can result in permanent injury, disability, or death. Early identification of a medical emergency avoids unnecessary delay in definitive treatment. Medical emergencies can cause emotional and/or BH changes and may resemble COSR in presentation. The following conditions and behaviors could be medical emergencies. Therefore, it is important to ensure medical examinations and disposition of Soldiers that display the following conditions—

- Psychosis.
- Mania.
- Alcohol withdrawal.
- Substance intoxication.
- Delirium.
- Suicidal gesture, attempt, or high risk for suicidal behavior.
- Catatonia.
- Significant paresis, paralysis, and/or sensory loss.

8-20. Assessing for physical illnesses or injuries is a critical part of COSC triage. The COSC personnel must always consider physical illnesses or injuries that resemble COSR or BH disorders. Physical illnesses or injuries may not reach the threshold of a medical emergency, but must be recognized and appropriately treated. Assessing for physical illnesses or injuries requires an adequate review of body systems and a quick physical examination. The examination includes vital signs, examination of head, eyes, ears, nose, throat, chest, abdomen, and extremities with simple testing of reflexes and muscle strength. In field situations (Level I and II), negative or normal findings need to be documented on DD Form 1380 (US Field Medical Card). Refer to AR 40-66 for detailed information on patient accountability and management of individual health records. Any positive findings from the physical examination must be evaluated further. If the examiner has not checked various body systems, it is not reassuring to tell a Soldier that his physical or BH complaints are only COSR. All COSC personnel should receive familiarization training on basic medical examination techniques and in documenting medical information. Whenever a physical illness or injury is suspected, personnel should consult with their medical peers for further assistance. Some cases will require direct medical examination by a physician or physician assistant (PA). The COSC personnel should not order tests or procedures that do not directly influence case management. Medical tests may

promote the patient role in the mind of the Soldier. Needless tests may delay a Soldier's RTD and encourage secondary gains.

## **DEFER DIAGNOSIS OF BEHAVIORAL DISORDERS**

8-21. During assessment, COSC personnel must always consider BH disorders that resemble COSR, but defer making the diagnosis. The COSC personnel favor this default position to preserve the Soldier's expectations of normalcy (according to BICEPS). This is also done to avoid stigma associated with BH disorders and to prevent the Soldier identifying with a patient or sick role. Deferral is also preferred because some diagnoses require extensive history collection or documentation that is unavailable during deployment situations (such as personality disorders and attention deficit hyperactive disorder). It is possible that a Soldier can have a combination of COSR, BH disorders and physical illnesses/injuries at the same time. In such cases, COSC personnel must rely on their clinical experiences, training, and consultation with peers and medical personnel to distinguish among these sometimes overlapping conditions. Physical injuries/illnesses are treated at a MTF, however, the Soldier may return for further COSC interventions and activities. Deferral of diagnosis is preferred, but diagnosis can be considered if the Soldier—

- Presents for reemerging symptoms of a previously diagnosed and/or treated BH disorder.
- Presents for refill prescription of psychotropic medication.
- Has a medical condition or BH disorder listed above in paragraph 8-19.
- Is enrolled in a reconditioning program.
- Fails to improve after having received four to five days of continuous COSC interventions and activities at hold or refer status.
- Requires individual BH treatment.
- Is referred for multiple episodes of COSR.

## **DIAGNOSTIC CONSIDERATIONS FOR DIFFERENTIAL DIAGNOSTIC DISORDERS**

### **Low-Grade Environmental or Stress-Related Illnesses**

8-22. Low-grade environmental or stress-related DNBI illnesses can drain the Soldier's strength and confidence. For example, chronic diarrhea and slight fever may exhaust, demoralize, and contribute to COSR among Soldiers. These conditions should be treated medically, concurrently with physical replenishment, rest, reassurance and organized activities, which restore the Soldier's confidence. If they persist in spite of rest and symptomatic treatment, a more aggressive workup and treatment may be indicated.

### **Dehydration**

8-23. Dehydration deserves special mention because it can be very insidious. Soldiers under battlefield or heavy work conditions become extremely dehydrated without feeling thirsty. This is especially likely in CBRN equipment, or in a desert/arctic environment. Refer to FM 4-25.10 for additional information on the prevention of dehydration and FM 4-25.11 for first aid measures.

### **Hyperthermia**

8-24. Hyperthermia (overheating) in an otherwise healthy individual often first causes mild elation and excessive energy. This may be followed by irritability, disorientation, and confusion. When core body temperature climb above 106° Fahrenheit (F) or 41° Centigrade (C), the Soldier may become belligerent, combative, and have visual hallucinations. If brain temperature rises further, the Soldier collapses and convulses in heatstroke. Refer to FM 4-25.11 for first aid measures and FM 4-25.10 for additional information on prevention and first aid measures for heat injuries.

## **Hypothermia**

8-25. Hypothermia may cause an individual to become disoriented when core body temperature falls below 95°F (34.6°C). The person may move and speak slowly. His skin looks and feels warm, leading him to take off clothing. He becomes disoriented, then unresponsive and may appear to be dead. Hypothermia is as likely in cool or even warm, wet climates as it is in extremely cold ones. Refer to FM 4-25-10 for additional information on prevention and FM 4-25.11 for first aid measures.

## **Overuse Syndromes**

8-26. Overuse of muscles, joints, and bones that have not been prepared for the strain of field duties can lead to persisting stiffness, pain, swelling, and orthopedic injuries. If severe, these injuries may require evacuation to a hospital for evaluation. Even if these injuries are avoided, the unfit person who overexerts has days of stiffness, aching, and weakness. Such cases are likely to develop COSR if further demands are made on them.

## **Rhabdomyolysis**

8-27. Rhabdomyolysis is one potentially dangerous complication of severe muscle overuse (and of heatstroke or crush injuries) in which myoglobin from damaged muscle cells injures the kidneys. It can cause fatigue, seizures, muscle tenderness, and muscle aches. A warning sign is dark (tea-colored) urine, but without laboratory testing, this is not easily distinguished from the concentrated urine of dehydration. Rhabdomyolysis is a medical emergency.

## **Head Trauma**

8-28. Concussion may stun the individual and cause amnesia, residual confusion, and/or impulsive behavior. For any case of suspected head trauma or for any case of significant memory loss (especially for a discrete period of time), check scalp, eyes, ears, nose, cranial nerve signs, and vital signs for evidence of head injury. Cases with deteriorating mental status are medical emergencies. If one pupil becomes larger than the other, it is an extreme emergency requiring immediate hospitalization. Left untreated, the condition can progress rapidly to coma and respiratory arrest within hours. If a head injury is suspected, monitor mental status and vital signs periodically, especially respiration, even though physical findings are negative. Awaken the Soldier periodically to check mental status and pupil size (allowing sufficient time to recover from any grogginess on awakening). Continuous monitoring is appropriate if there are serious concerns about the risk.

## **Spinal Cord Trauma**

8-29. Pressure, bruising, and hematomas of the spinal cord, as well as severing of the spinal cord, can cause spinal shock, with loss of sensory and/or motor functions below the level of the injury in the affected dermatome and muscle group patterns. The loss of function may be bilateral, unilateral, or partial. These cases could be confused with paralysis or sensory loss presentations of COSR. Further manipulation of a fractured spine can worsen or make permanent the spinal cord damage. Information from the history of onset, a cautious physical and neurological examination, or complete relief of symptoms following hypnosis or strong positive suggestions could demonstrate convincingly that this is only COSR. It is best to be cautious and keep the spine immobile during care and transportation.

## **Postconcussion Syndromes**

8-30. Postconcussion syndromes may persist weeks to months beyond the period of acute concussion. Postconcussion syndromes may include perceptual or cognitive impairment, poor impulse control, and difficulty in planning ahead. These are often accompanied by cranial nerve deficits or soft neurological signs.



### Abdominal Trauma

8-31. Ruptured spleen or other intraperitoneal bleeding may cause shock. The Soldier may arrive in a fetal position and be unresponsive but have reflex guarding due to peritonitis.

### Air Emboli and Focal Brain Ischemia

8-32. High blast overpressures from incoming high explosive ordnance can produce air emboli (bubbles in the blood) and focal brain ischemia (small areas in the brain which cannot get oxygen because the blood flow has been interrupted). Nuclear explosions can do this, as can high explosives when shock waves are magnified by reflection within bunkers, buildings, and trenches. Ruptured eardrums, general trauma, and evidence of pulmonary damage should be detectable. Cases may have stroke symptoms (loss of muscle strength, loss of sensation in parts of the body, and/or speech disturbances), which may be subtle and mistaken for COSR.

### Laser Eye Injury

8-33. Laser range finders/target designators cause small burns on the retina if they shine directly into the eye, even at great distances and especially if viewed through optics. If the laser beam causes a small retinal blood vessel to bleed inside the eyeball, the person will see red. If blood inside the eye is confirmed on examination, the Soldier should be evacuated to a hospital with verbal reassurance that he may RTD soon. If the laser does not hit a blood vessel, the Soldier may see only flashes of light, followed quickly by some painless loss of vision. If the laser damage areas of the eye responsible for peripheral vision, the Soldier may never recognize a visual deficit. If the Soldier was looking directly at the laser source however, there will likely be a major loss of visual clarity. With simple retinal burns in the retina's periphery, most of the visual symptoms recover with hours to days of rest, reassurance, and nonspecific treatment the same as with COSR. Calm, professional treatment at each level of medical care should emphasize that the injury is not vision-threatening and the chances for some, if not total, recovery is good. Soldiers with the simple retinal burns should provide self-care to decrease the risk of assuming a patient mind-set and to promote their chances of RTD. For additional information on the management of laser eye injuries, refer to FM 8-50.

### Middle Ear Injuries/Diseases

8-34. Temporary loss of hearing can be caused by a decreased acoustic sensitivity following a brief extremely intense noise (explosive) or less intense, longer duration noise. Tinnitus (ringing in the ears) can also result from acoustic nerve damage or irritation, as well as from high doses of certain drugs, such as aspirin. Distinguishing physiologic from psychogenic hearing loss may require consultation with an otolaryngologist (ears, nose, and throat specialist).

### Peripheral Neuropathies

8-35. Peripheral neuropathies include compression neuropathies, which are especially likely in military settings (for example, *rucksack palsy*). Depending on severity, they may require temporary job reclassification during convalescence. As these injuries are not life-threatening, a hasty diagnosis should not precede a trial of Soldier restoration treatment.

### Uncommon Endemic Neurologic Disorders

8-36. These physical diseases can first manifest with cognitive emotional and/or behavioral symptoms. A comprehensive neurological examination is required for the definitive diagnoses. Examples include—

- Guillain-Barre Syndrome manifests with muscle paralysis, usually without sensory loss, which ascends the legs and arms, then the trunk, over hours to days. It is sometimes triggered by immunizations, as might be given to troops deploying overseas. It often progresses to a life-threatening situation as the muscles of respiration become involved. This requires evacuation to EAC and continental United States (CONUS). Fortunately, recovery is usually complete, but it takes months to years.

- Multiple sclerosis is a disease that can mimic many types of COSR/BH disorders with its sometimes transitory, shifting motor, sensory, speech, and cognitive/emotional symptoms. It is made worse by stress and may be difficult to diagnose. Once confirmed, multiple sclerosis cases should be evacuated to CONUS, as should other rare, progressive diseases like Lou Gehrig's disease (amyotrophic lateral sclerosis).
- True convulsive seizure can manifest after head injury or a sublethal or chronic nerve agent exposure. These are treated with normal anticonvulsant medications. Fear of nerve agent exposure may lead some Soldiers to experience psychogenic seizures. These psychogenic seizures are also called pseudo-seizures. In addition to falling unconscious and convulsing, urinary and fecal incontinence can occur during a pseudo-seizure.

## **SUBSTANCE ABUSE/DEPENDENCE**

### **ALCOHOL**

8-37. Substance abuse is an example of misconduct stress behaviors and not necessarily COSR. Drug and alcohol abuse may occur in active CZs and nearby areas where use is explicitly prohibited and severely punished. Personnel performing the COSC assessment should be familiar with evaluation and treatment of substances abuse and dependency. Combat operational stress control providers should consider the following:

- Heavy habitual use of alcohol, even by otherwise capable officers and NCOs, may go unnoticed in peacetime. However, alcohol abuse it may degrade necessary mission performance demanded by combat and may result in withdrawal symptoms when access to alcohol is interrupted. Alcohol withdrawal is potential medical emergency; consultation with medical personnel is essential.
- Intoxication or withdrawal from alcohol, barbiturates, and tranquilizers may be mistaken for COSR or another BH disorder. Intoxication or withdrawal requires medical treatment. Withdrawal seizures or impending or ongoing delirium tremens need emergency medical treatment.

### **OVERUSE OF STIMULANTS**

8-38. Stimulants may cause panic attacks, hyperactivity, mania, rage attacks, psychosis or paranoia. Cessation of amphetamines after prolonged use causes a crash characterized by extreme sleepiness, lethargy, overeating depression and suicidal thinking. This condition may require one to two weeks of hospitalization to assure safe recovery.

### **HALLUCINOGENIC DRUGS**

8-39. Hallucinogenic drugs cause sensory distortion, panic, bizarre thoughts, and potentially dangerous behaviors. These drugs may be employed by the enemy as chemical or biological warfare agents. Phencyclidine hydrochloride (PCP) is especially problematic since it also blocks pain and tends to make those under its influence paranoid, violent, and abnormally strong. Hallucinogenic drug psychosis should not be treated with antipsychotic drugs. Physically restrain and sedate patients as necessary.

### **INHALATION OF FUMES**

8-40. Inhalation of fumes (either by accident or as deliberate abuse) and carbon monoxide poisoning can cause disoriented, abnormal behavior. Supportive treatment and, specific antidotes/medication may be needed.

### **ANTICHOLINERGIC DELIRIUM**

8-41. In combat, atropine delirium may occur. Soldiers are equipped with atropine injectors to use as first aid against nerve agents. Two milligrams (mg) (one atropine injector) without nerve agent challenge can cause rapid pulse, dry mouth, slightly dilated pupils, decreased sweating (hot, dry, flushed skin), and

urinary retention. In some individuals, 6 mg of atropine (equal to three atropine injectors) may cause hallucination and disorientation in the absence of a nerve agent challenge. Such side effects may be more pronounced in sleep-deprived Soldiers. Overheated Soldiers are more susceptible to the atropine side effects. Atropine compounds the complications of overheating by diminishing the body's ability to lose heat through sweating. One dose (2 mg) of atropine can reduce the efficiency of heat-stressed Soldiers. Two doses (4 mg) will sharply reduce combat efficiency, and 6 mg will incapacitate troops for several hours. Some plants can also cause anticholinergic delirium when eaten.

### **ANTICHOLINESTERASES**

8-42. A nerve agent is an anticholinesterase similar to many insecticides. Low-dose nerve agent exposure may produce miosis (pinpoint pupils) without other signs. Miosis decreases vision except in very bright light and may cause eye pain when attempting to focus. This miosis may take hours to days to improve spontaneously, depending on the degree and type of exposure. Evidence gathered from farm workers poisoned by insecticides suggests that mild personality changes, insomnia, nightmares and chronic persistent depressive symptoms may be seen even after use of an antidote. Low-dose nerve agent exposure may lower the seizure threshold of many Soldiers. True epileptic seizure cases must be distinguished from those Soldiers who may have pseudo-seizures.

## **BEHAVIORAL DISORDERED PATIENTS IN THE THEATER**

### **PRIMARY BEHAVIORAL DISORDERS**

8-43. Primary BH disorders (especially schizophrenic-form/schizophrenic disorder, major depression, and bipolar disorder) will continue to occur at approximately the same rate as in peacetime. Some Soldiers may hide their disorders by receiving care through civilian channels. Once in the theater they may experience a relapse or self-refer to a MTF when their medication supply is exhausted.

### **PERSONALITY DISORDERS**

8-44. Preexisting personality disorders may make a Soldier unable to adapt to military life. However, studies have failed to show a relationship between personality disorders and the likelihood of breakdown in combat. Once Soldiers with personality disorders have developed COSR or a BH disorder, they may have greater difficulty recovering and RTD. Diagnosis should never be made in haste; diagnostic criteria must be supported with adequate historical information.

## Chapter 9

# Combat and Operational Stress Control Stabilization

## SECTION I — EMERGENCY STABILIZATION

### STABILIZATION

9-1. Emergency stabilization is the acute management of disruptive behavior resulting from COSR and/or a behavioral disorder. The disruptive behavior severely impacts unit functioning by posing a danger to self and/or others. In some cases, an underlying medical condition leads to the disruptive behavior and may present an additional threat to the Soldier's life. Emergency stabilization consists of interventions that temporarily reduce a disturbed Soldier's threat of self or others, thereby allowing further medical evaluation and/or treatment. Some behavioral disorders are associated with violent behavior, such as psychotic disorders, bipolar manic disorders, antisocial personality disorder, and borderline personality disorder. Violent behavior is also associated with disruption of brain functioning due to organic factors such as intoxication, hyperthermia, metabolic imbalance, or CBRN exposure.

9-2. The COSC triage process will be repeated throughout the emergency stabilization and will determine the disposition of the Soldier. After emergency stabilization, subsequent triage could result in an immediate RTD, transfer to a COSC Soldier restoration program for observation, or further evacuation.

### METHODS USED FOR EMERGENCY STABILIZATION

9-3. Methods that may be used for emergency stabilization include—

- Providing verbal reassurance and reorientation are the best methods for controlling an agitated or disruptive Soldier. If these fail, a nonthreatening show of strength or force may suffice, or sedating medications may be offered to the Soldiers. If all other means fail to reduce the threat to self and/or others, physical restraint must be considered. Given the risk for violence, it is inadvisable to attempt subdue/restraint method one-on-one.
- Applying physical restraints is reserved for subduing and restraining agitated or disruptive Soldiers who fail to respond to safer and less restrictive forms of restraint (for example, verbal warnings or show of strength). Placing a disturbed Soldier into physical restraint increases the risk of injury to the Soldier and restraint team. Prolonged or improper application of physical restraint can cause injury to the disturbed Soldier. Given the potential for injury, it is paramount that COSC personnel receive training in proper physical restraining methods. Safe medical evacuation by ground (preferred) or air ambulance.
- Regardless of the method, the restrained Soldier must be checked frequently to guard against nerve injuries or impaired circulation, which may lead to skin ulcers or gangrene. It is important to check periodically to ensure the Soldier is not secretly escaping from restraints. The Soldier is provided verbal reassurances with positive expectations for his recovery each time he is checked.
- Chemical restraints (such as medication) can be administered to a disturbed Soldier to reduce the risk of harm to self or others. Medication may be offered to the Soldier in conjunction with verbal reassurances and reorientation. Chemical restraints may only be ordered by a medical professional who is authorized to prescribe medication when a Soldier is incompetent to make medical decisions for himself and/or when the Soldier's behavior places himself or others in danger. Once administered, medical personnel must observe for side effects and adverse reactions, and must consider administering additional medications as needed. When a Soldier is in physical restraints, medication may no longer be essential, but may serve to reduce the risk of escape, limb damage, and overheating. As a secondary benefit, once the medications reduce the

Soldier's agitation, others in the vicinity may feel safer and calmer. Before prescribing an antipsychotic medication, there are a few things to consider. First, some antipsychotic drugs may take several hours or days to take effect. Second, early administration of an antipsychotic drug may confuse the clinical picture for the next evaluator in the evacuation chain. The recommendation for most cases is to use no medication unless it is truly necessary for management.

## **SECTION II — COMBAT AND OPERATIONAL STRESS CONTROL FULL STABILIZATION**

### **FULL STABILIZATION**

9-4. Full stabilization is normally the mission of the Level III MTF such as a CSH specialty clinic's psychiatric service. Full stabilization goes beyond securing the safety of the Soldier and those around him. It provides a safe environment for the Soldier to receive treatment interventions, continued evaluation, and assessment for RTD potential. If RTD within the evacuation policy is not feasible, the full stabilization process helps to prepare the patient for a safe, long-distance evacuation. If a Level III MTF is not available, full stabilization may be accomplished by COSC personnel when appropriately supported or by using equipment diverted from the COSC Soldier restoration capability. Considerations for full stabilization may include—

- Conducting full stabilization for NP patients is desirable for the sake of the Soldier's future treatment and for the potential of returning some Soldiers to duty. However, full stabilization is personnel intensive with a relatively low RTD payoff. Providing only sufficient stabilization to allow evacuation from the theater may be acceptable in order to maintain the other COSC functions.
- Ensuring appropriate timely evacuation of Soldiers with NP/behavioral disorders according to the theater evacuation policy. It is preferred that full stabilization is achieved for all NP patients to facilitate appropriate and timely evacuation according to the theater evacuation policy.
- Assessing and triaging of COSR Soldiers undergoing full stabilization is an ongoing process. In subsequent triages, if a Soldier becomes stable the potential for RTD, they may be transferred to a COSC Soldier restoration or reconditioning program, or may be RTD directly.

### **TENETS OF FULL STABILIZATION**

9-5. The COSC full stabilization includes ongoing evaluation of RTD potential. This requires assessment of mental status and performance capability overtime without excessive drug effects or limitation on activity. Contact with the Soldier's unit may be needed to get information on prior history and functioning. The further from the unit the Soldier has been evacuated, the more difficult it may be to contact the Soldier's unit. Full COSC stabilization normally takes several days. To the extent compatible with safety, the stabilization program should adhere to the principles and methods for treating COSR and behavioral disorder (such as BICEPS and 5 R's).

9-6. During full stabilization, special efforts should be made to maintain and reinforce the Soldier's identity as a Soldier. Techniques that may be helpful in maintaining the Soldier mind-set include—

- Keep Soldiers in duty uniform, not pajamas, as soon as they can be allowed.
- Maintain rank distinctions and appropriate military courtesies.
- Encourage self-care and helping behaviors.
- Engage in military work activities appropriate to the Soldiers' level of function and MOS.

9-7. Initial and ongoing assessments are essential to tailor the treatment to the Soldier's individual needs. It is essential that clinical documentation is available for these assessments. The Soldier's condition is an evolving one, and must be monitored throughout full stabilization. If assessed capable to RTD, efforts should be made to return the Soldier to duty.

9-8. Ongoing treatment and/or therapeutic modalities are essential to improving a Soldier's chances to RTD whether in theater or after evacuation. Therapeutic modalities are similar to those used on inpatient units, but must remain consistent with COSC principles. These modalities include medication, individual psychotherapy, group psychotherapy, and appropriate therapeutic occupations. Observed responses to therapeutic modalities allow informed recommendation for RTD status.

## **FULL STABILIZATION FACILITIES**

9-9. Full stabilization is commonly conducted in the CSH. The CSH can provide more sophisticated procedures, laboratory and x-ray capabilities than are available at a medical company MTF. If a medical unit, CSC is providing emergency or full stabilization, the Soldier must be kept separate from other Soldiers in Soldier restoration or reconditioning.

9-10. If the Level III MTF (CSH) cannot provide sufficient inpatient psychiatric treatment for Soldiers requiring stabilization and preparation for evacuations, the theater/AO COSC consultant may recommend up to two temporary COA until the shortfalls resolve. He can recommend to the higher medical command that COSC personnel from one or more medical unit, CSC augment the Level III MTF psychiatric service until the caseload decrease or until replacements or additional COSC personnel are brought into theater or the MTF. Lastly, the medical C2 headquarters may direct that a COSC Soldier restoration or reconditioning assets be collocated with the Level III MTF to provide an "overflow" ward as well as augmenting staff. Definitive information is provided on the CSH NP ward staff capabilities in FM 4-02.10.

9-11. The MF2K CSH has a psychiatrist, three psychiatric nurses and a medical/surgical nurse, a social worker, nine mental health specialists and an OT sergeant at full strength. It has a modular hospital tent to provide a 20-bed hospital ward. The MF2K hospitals were designed to be at one location, but may follow the MRI doctrine of splitting off a portion to a remote site, taking with it some of the psychiatry service personnel. One portion would not have the psychiatry ward module, and would need to function similarly to the MRI CSH psychiatry service.

9-12. The MRI CSH has a psychiatrist, a psychiatric nurse, and two MH specialists. The service does not have an organic psychiatric ward where NP patients are admitted. There is normally an intermediate care ward with medical ward staff designated to receive NP patients. Some of these patients seen by the NP clinic will already be stable, and are being evaluated and prepared for RTD or evacuation. Most patients who are admitted for emergency or full stabilization will be on the designated ward, although a few with serious medical complications could require the intensive care ward. If the hospital has a high census of medical and surgical patients, most of the NP patients will need to occupy beds on the intermediate care ward. The MRI hospital may be augmented by staff from a medical company/detachment, CSC to operate a NP ward, as required.

9-13. Full stabilization facilities in theater can be categorized into two types:

- Mobile facilities use general purpose (GP) large or medium tents as used in medical units, CSC and can also be available to a CSH or a tent, expandable, modular, personnel (TEMPER) tent as used in a CSH.
- Fixed facilities use buildings that were previously hospitals or buildings converted to hospitals.

9-14. Facilities used for full stabilization include tents, Deployable Medical Systems (DEPMEDS) TEMPER tents, and fixed facilities. The adaptation of these facilities have both advantages and disadvantages that include—

- The principal advantage of the (hospital) TEMPER tents, as assembled into DEPMEDS hospital, is their climate control capability. This may be a significant safety advantage for treating seriously disturbed patients in restraints with high-dose medication, which can disrupt body's ability to regulate normal body temperature. The TEMPER and standard tents both pose greater problems for security than do fixed facilities. The staff may, therefore, have to rely more than is ideal on physical restraints and medications for sedation of some cases. Blankets or screens can be used to isolate or segregate problem patients from others. Such partitions reduce mental contagion but provide little true protection.

- Standard hospital beds are on high, lightweight metal legs with wheels. For full stabilization purposes, these should be replaced with standard low, stable cots to hold strong, agitated patients in restraints. The cots also make a more “military” setting and can be used as seats for group activities.
- When feasible, it is best to have a separate “closed” (high security) and “open” (moderate/minimal) security area. The latter could be a standard GP large tent (the same as those of the minimal care wards [MCWs] located close to the TEMPER tent of the official NP ward). The specialists (MOS 68WM6 [practical nurse] and 68W [health care specialist]) of the MCW could be given on-the-job training in supervision and military group activities for the moderate/minimum security cases if the NP staff is too small.

## Chapter 10

# Combat and Operational Stress Control Soldier Restoration

### SECTION I — SOLDIER RESTORATION

#### SOLDIER RESTORATION PROGRAM

10-1. Soldier restoration is normally a 24- to 72-hour (1- to 3-day) program in which Soldiers with COSR receive treatment. Soldier restoration is accomplished using the principles of BICEPS and the 5 R's as discussed in the previous chapter. The 5 R's are tailored to the needs of the Soldier. Soldier restoration is conducted as close to the Soldier's unit as possible. Soldier restoration can be conducted by medical units/elements throughout the theater with the assistance of organic and/or augmented COSC personnel. The medical company/detachment, CSC is staffed and equipped to establish Soldier restoration programs. Soldier restoration may also be accomplished at a Level III MTF (CSH). The tenets remain the same but implementation may differ in the duration of Soldier restoration and the specialized skill and knowledge of available providers. There are three subcategories of Soldier restoration (referred to as lines of Soldier restoration) based on location and available resources that are discussed in Section II of this chapter.

#### SOLDIER RESTORATION PROCESS

10-2. The process of Soldier restoration involves several steps that include screening, assessment, and interventions, reintegration/coordination, and movement of Soldiers. A discussion of each of the steps in the process is provided below.

##### SCREENING

10-3. Adequate medical screening and treatment as necessary must be done before the Soldier begins the Soldier restoration program. Minor medical conditions can be treated during routine sick call. Soldiers entering a Soldier restoration program should be only those *hold* cases that require continuous medical and/or BH evaluation and observation for 24 hours or more. The criteria for *hold* cases are discussed under COSC triage in Chapter 8. Tending to and restoring physiological status (such as sleep and hydration) is a priority. Some Soldiers who need Soldier restoration will also have a mental disorder. Treatment for the mental disorder may continue or be initiated during the Soldier restoration process.

##### ASSESSMENT AND INTERVENTION

10-4. Initial assessment and subsequent COSC interventions depends upon the severity of the COSR and to what extent the reactions interfere with the Soldier's ability to function. More thorough interviews are conducted only after the Soldier's physiological status has been restored.

##### REINTEGRATION

10-5. Coordination is required to assist Soldiers with reintegration back into their units. Soldiers are reassessed regularly. When a Soldier experiencing COSR begins to improve, the COSC interventions shift toward the reintegration of the Soldier back into his unit. The COSC personnel must work with the COSC consultant of their area or other resources to assist with this reintegration.



## **MOVEMENT**

10-6. Movement of Soldiers from one line of Soldier restoration to another that has greater capabilities or security may be required. When movement of these Soldiers is required, vehicles used to transport them should be nonambulance vehicles, if possible, and accompanied by escorts from their unit. If nonmedical unit members are not available to perform escort duties, medical augmentation may be required.

## **PRINCIPLES AND PROCEDURES OF SOLDIER RESTORATION**

10-7. Initial Soldier restoration begins as close to the Soldier's unit as possible, normally near an MTF where the Soldier can get a reprieve from extreme stress but at the same time can be close to his unit. Normally, Soldier restoration facilities are established in the BSA near or adjacent to the FSMC/BSMC Level II MTF. Soldier restoration is not feasible at locations that are consistently under artillery, air, or direct-fire attack, but ideally are still within the sound of the artillery or other reminders of battle. If there is potential for attack, there must be cover and defensive positions. The location should not be one from which a move is likely within 24 hours. If there is a significant possibility of a move, only those cases that can participate actively in the move with minimal supervision should be managed at this location. The specific site of the Soldier restoration facility should be adjacent to the medical company's area and be out of the immediate (close) sight of the medical triage and treatment areas

## **REASSURANCE**

10-8. Immediate reassurance is given to the Soldier with COSR beginning with the COSC triage as discussed in Chapter 8. Tell the Soldiers that they are temporarily joining the unit, not as patients, but as Soldiers who need a few days to recover from COSR. Emphasize that COSR is a normal response to extremely abnormal conditions. Rapid recovery is also normal and RTD is expected. Reassure the Soldiers about safety and what to do in the event of an attack or march order. Lastly, orient the Soldiers to the Soldier restoration program.

## **STRUCTURED MILITARY ENVIRONMENT**

10-9. An emphasis should be placed on maintaining a highly structured military unit environment and schedule of activities in order to keep the Soldier from adopting a patient role. Assign the Soldier to a squad under supervision of a specific squad leader. The squad leader may be a CSC unit/MH section member or a member of the BSB subordinate unit. The squad leader may also be one of the Soldiers there for Soldier restoration, if their condition allows. The newly arrived Soldier is assigned to a tent that has been designated/erected for the Soldier restoration program. Soldiers with more dramatic COSR or BH symptoms should be temporarily quartered separately from other Soldiers receiving Soldier restoration. In remaining consistent with the principle of treating Soldiers with COSR as Soldiers instead of patients, it is recommended that Soldier restoration facilities do not display the Red Cross as displayed on the MTF. This could affect their protection under the Geneva Conventions. See FM 4-02 for information on the Geneva Conventions.

## **SUPPORT THE SOLDIER'S MILITARY IDENTITY**

10-10. Maintain appropriate rank distinctions, titles, and military courtesies within the confines of the tactical situation. Expect the Soldier to maintain military bearing and personal appearance. They should be in duty uniform. Conduct basic Soldiering skills. Do not take personal possessions away from the Soldier. This includes weapons, unless there is significant concern for the Soldier's safety. If the Soldier arrives with a weapon, SOPs of the AO will guide whether or not the weapon is secure for the Soldier. Also, encourage the unit to maintain contact with its Soldier.

## **REPLENISHMENT OF PHYSIOLOGICAL STATUS**

10-11. Get the Soldier under shelter and cool down if overheated, warm up if cold, and dry off if wet. Providing hot beverages and/or soup will also assist with restoring body temperature. Replenish hydration with palatable beverages and meals. Unless the Soldier is totally exhausted, institute some personal

hygiene. If the Soldier needs uniforms or equipment, coordinate with the BSB S4 or supporting logistic element. Restorative sleep should be as normal as possible. Soldiers are typically able to fall asleep when reassured of safety, and do not routinely require medication to induce sleep. They should be informed that they may awaken with vivid and frightening dreams, and be instructed on quick relaxation techniques to go back to sleep. If those measures are insufficient, one-time medication with a sedative/hypnotic may be considered, coordinated, and prescribed by a physician or PA from the supporting medical company. The duration of sleep should be sufficient to make substantial progress in repaying the sleep debt. It should also begin the process of restoring a reasonable sleep/wake cycle that is consistent with the Soldier's duties in his unit.

### RESTORE CONFIDENCE

10-12. Restoring a Soldier's confidence may include—

- Providing regularly scheduled formations to keep Soldiers informed of daily activities and the tactical situation, including information about their unit, when available.
- Providing therapeutic occupations that are based on the Soldier's current functional ability. The OT (or COSC team members under the guidance of the OT) selects therapeutic occupations that support the Soldier's military identity and enhance the Soldier's sense of competence. Therapeutic occupations may include activities of daily living (such as physical fitness or uniform maintenance); educational activities (selected common and collective Soldier task training or life skills training); work/productive activities (militarily relevant tasks such as vehicle maintenance or site maintenance); leisure/recreational activities (enjoyable, relaxing activities, games, and sports); social participatory activities (cooperative/competitive sports, games, ceremonies, or celebrations). Therapeutic occupations provide the casualty with a challenge but afford successful performance that shows the Soldier that he is still capable and competent. This realization plays the dominant role in restoring the Soldier's sense of confidence, functional capacity, and ability to RTD.
- Training and teaching Soldier on methods for managing excessive stress.
- Facilitating factual review of precipitating event that has caused the Soldier's COSR through talking (ventilating) and coaching. Combat and operational stress control personnel (or health care providers trained by COSC personnel) facilitate these discussions. They help Soldier restore perspective with questions and coaching. The factual review (debriefing) is often best done individually unless several Soldiers experienced the same event.

## SECTION II — LINES OF SOLDIER RESTORATION

### FIRST-LINE SOLDIER RESTORATION

10-13. First-line Soldier restoration is usually provided at the BSMC/FSMC in the BSA. It is provided by personnel organic to the BSMC/FSMC usually assisted and supervised by COSC personnel organic to the medical company and/or from CSC unit personnel. This also applies to a cavalry regiment. Because of the high mobility of the BSMC/FSMC, Soldier restoration will often be a 24- to 72-hour process. First-line Soldier restoration also may occur in relative secure locations in division, corps, and theater AOs. First-line Soldier restoration in the division is provided near and supported by a Level II MTF such as a MSMC with its organic MH and/or minimal augmentation from a CSC unit. First-line Soldier restoration in corps and theater is provided by ASMCs with responsibility for their AO. It is provided by COSC personnel organic to the medical company and/or from CSC unit personnel. The MSMC and ASMCs will be relatively unlikely to move on short notice so Soldier restoration up to 72 hours should be feasible. Support provided for Soldier restoration is a responsibility of the MH sections of supporting medical companies. Tasking for support of Soldier restoration programs is accomplished through the command surgeon.

## **SECOND-LINE SOLDIER RESTORATION (SOLDIER RESTORATION CENTER)**

10-14. Each of the first-line Soldier restoration locations listed above should be backed up by a second-line Soldier restoration capability at a location that is less likely to have to move on short notice and has more COSC capabilities. Soldier restoration centers may be located near the MSMC, ASMC, or with a CSC medical company or detachment. They can be located in the BSA near the BSMC/FSMC when it is at a stable base camp. The Soldier restoration center may receive *hold* cases that are transferred from the first-line medical companies, as well as Soldiers from nearby units. Second-line Soldier restoration has more equipment and a greater range of COSC expertise. This permits a 72-hour holding capacity for a stable well-organized Soldier restoration center and may provide full stabilization.

## **THIRD-LINE SOLDIER RESTORATION**

10-15. In some scenarios, units with Soldiers in need of Soldier restoration may be significantly closer to a Level III MTF such as a CSH than to a medical company or CSC unit. On order, a Soldier restoration program may be conducted by the CSH specialty clinic NP staff, which may also be augmented with personnel from a medical company/medical detachment, CSC. In such cases, a Soldier restoration program may be conducted by the CSH specialty clinic NP staff. It may be augmented with personnel from the medical company or detachment, CSC. Soldier restoration near a CSH must be kept clearly separate from the patient ward. It may be done at a MCW or in separate tents.

## **RETURN TO DUTY OF RECOVERED COMBAT AND OPERATIONAL STRESS REACTION SOLDIERS**

10-16. Most COSR symptoms do not necessarily improve completely while the prospect of combat continues. The Soldiers should be given the positive expectation that they will RTD. Every possible effort should be made to return Soldiers to their original unit. The RTD of Soldiers following Soldier restoration depends on how near the Soldier's unit is, the availability of a means of transportation, and the tactical situation. Ideally, their units are contacted to send someone to get the Soldier or he may be returned to his unit by way of the personnel replacement company. Mental health personnel coordinate directly with the unit to which the Soldier is returning and/or with COSC, other medical personnel, or UMT supporting the unit's AO. These contacts can consult with the leaders of the Soldier's unit and facilitate the Soldier's acceptance back into his unit.

## **DOCUMENTATION**

10-17. Soldiers receiving Soldier restoration interventions must be tracked from the initial contact until they are returned to their unit. A record must be maintained of interventions and activities provided during Soldier restoration, as well as the Soldier's response. A notation of the dates, any pertinent medical data, and providing unit is entered in the Soldier's medical record. An administrative summary of Soldier restoration services may be developed, stored, and disposed of as directed by the Soldier restoration center SOP. If the Soldier received BH treatment, documentation should be maintained as delineated in AR 40-66. A statistical record is maintained and sent to higher medical headquarters according to SOP.

## Chapter 11

# Behavioral Health Treatment

### SECTION I — BEHAVIORAL HEALTH CARE

#### TREATMENT FOR BEHAVIORAL DISORDERS

11-1. Behavioral health treatment exists when there is an explicit therapist-patient or therapist-client relationship. Behavioral health treatment is provided for Soldiers with behavioral disorders to sustain them on duty or to stabilize them for referral/transfer. This is usually brief, time-limited treatment as dictated by the operational situation. Behavioral health treatment includes counseling, psychotherapy, behavior therapy, occupational therapy, and medication therapy. Treatment assumes an ongoing process of evaluation, and may include assessment modalities such as psychometric testing, neuropsychological testing, laboratory and radiological examination, and COSC providers' discipline-specific evaluations.

#### COMBAT AND OPERATIONAL STRESS CONTROL BEHAVIORAL HEALTH PROVIDER

11-2. There are five professional disciplines and two enlisted specialties that serve as BH/COSC providers, see Chapter 3. Army BH/COSC providers are officers who hold active individual clinical privileges granted by an MTF according to AR 40-68. Providers also include enlisted medical specialist who do not hold individual clinical privileges, but who work under direct supervision of a professional COSC provider. Behavioral health treatment is provided within the scope of the providers' clinical privilege, training, and experience.

### SECTION II — BEHAVIORAL HEALTH TREATMENT PROTOCOLS AND MEDICATIONS

#### BEHAVIORAL HEALTH TREATMENT FOR SOLDIERS

11-3. Behavioral health treatment is provided to Soldiers with diagnosed behavioral disorders (see Chapter 8), and who require more intentions for their diagnoses. It is both inappropriate and detrimental to treat Soldiers with COSR as if they are a BDP. A therapeutic relationship may promote dependency and foster the "patient" role. Likewise, medication therapy and the highly structured treatment modalities imply the "patient" role. Medication for transient symptom relief (insomnia or extreme anxiety) may not be detrimental if there is no expectation that medication will continue to be prescribed.

#### BEHAVIORAL HEALTH PROTOCOLS AND PROCEDURES FOR TREATMENT

11-4. Behavioral health treatment is provided within a context of preventing symptoms of behavioral disorder from progressing in severity and improving the level of functioning. The principles of BICEPS apply. Treatment should not impede activities for other prevention levels (for example, universal, selective, and indicated). Treatment should not interfere with the Soldier's duties or the unit's mission. The COSC provider should emphasize Soldier's identity as a Soldier despite having a diagnosis. Transportation of the Soldier to the provider (or vice versa) and ability to assure reliable meeting times can be limiting factors, depending on the operational environment. Medication refills must be coordinated for availability.

## **Standards of Treatment**

11-5. Treatment standards are the same in the deployed environment as in garrison. When operational requirements dictate that clinical standards of treatment/care are waived or relaxed, it must be approved by the AO COSC consultant. (AR 40-68 provides additional information.) Treatment should be tailored to the anticipated availability of the Soldier and COSC provider. Short-term interventions are more practical than long-term commitments. If longer-term treatment is necessary, design the intervention in time-limited modules. Under no circumstances should treatment diminish the Soldier's ability to provide self-care and to defend himself. Exceptions include emergency stabilization and preparation for evacuation. In addition, the VHA/DOD Clinical Practice Guidelines website (<http://www.oqp.med.va.gov/cpg/cpg.htm>) offer clinicians evidence-based assessment and treatment algorithms for acute stress disorder, PTSD, and many other behavioral disorders.

## **Army Regulations Governing Evaluations**

11-6. Fitness for duty evaluations are conducted as necessary within the priorities of the supported commanders according to AR 40-501; psychiatrists should not initiate a medical evaluation board without first ensuring the Soldier has received adequate treatment. This treatment may not be available in theater. Command-directed evaluations are conducted as necessary within the priorities of the supported commanders according to DODD 6490.1 and MEDCOM Regulation 40-38. Clinical documentation should be safeguarded according to AR 40-66 and local command policy. Treatment should be conducted in a location that is as private as possible. Information can be released to a third party if the Soldier consents. Combat and operational stress control providers need to notify command when the Soldier's safety is in question (suicidal, homicidal) or if the Soldier is removed from his unit for medical observation. Additional release of information to command is on a need-to-know basis. For any questions on release of information on COSR and NP patients, consultation with supporting JAG office is advised. Also, maintaining the Soldiers health record with clinical data is required and accomplished according to AR 40-66 and supplemental theater policy as appropriate. Treatment should occur throughout the evacuation process and follow-up is expected at home station.

## Chapter 12

# Reconditioning

### SECTION I — RECONDITIONING PROGRAM

#### LOCATION

12-1. Reconditioning programs are intensive efforts to restore those Soldiers triaged as a *refer* case, but who still have good potential for RTD. Referral to reconditioning can be from Level II MTF, COSC Soldier restoration program, or from Level III MTF. Reconditioning includes the rehabilitation of Soldiers with mental disorders, such as substance abuse/dependency. Reconditioning programs are conducted by COSC personnel and Soldiers usually participate for up to 7 days. Soldier participation may be extended by a case-by-case exception to theater evacuation policy. Reconditioning is conducted only in a theater where there are adequate COSC elements and supplies. When COSC resources are needed for other functional areas, any ongoing reconditioning program reduces its scope of services or closes. Reconditioning is provided at first-, second-, or third-line centers determined by location and available resources.

#### PROVIDERS

12-2. Conducting reconditioning programs is a mission of the medical company, CSC and the medical detachment, CSC (MRI). Reconditioning can also be done on a small-scale by a CSC medical detachment (MF2K) under some circumstances.

### SECTION II — TENETS AND PROCEDURES OF RECONDITIONING

#### RECONDITIONING

12-3. Reconditioning may be considered an extension of Soldier restoration. Reconditioning is similar to Soldier restoration, but with potentially longer stay, treatment strategies focus on preventing atrophy of skills and assisting Soldiers in regaining skills needed for duty. Reconditioning makes more use of BH treatment modalities.

#### STRUCTURED MILITARY ENVIRONMENT TO SUSTAIN SOLDIER'S IDENTITY AS A SOLDIER

12-4. Like Soldier restoration, reconditioning emphasizes a highly structured military unit environment and schedule of activities in order to keep the Soldier from adopting a "patient" role. Maintaining a military environment is even more critical when colocated with hospitals or other service support elements.

#### REPLENISHMENT OF PHYSIOLOGIC STATUS AND CONFIDENCE

12-5. Reconditioning initially emphasizes physical replenishment and hygiene, but later shifts the emphasis to more closely match the conditions that the Soldier should expect when RTD. In order to restore confidence in the Soldier, unit formations are held on a regularly scheduled basis, and include the Soldiers receiving reconditioning.

#### OCCUPATIONAL THERAPY

12-6. Therapeutic occupations may include—

- Activities of daily living (for example, hygiene, physical fitness, and uniform maintenance).

- Educational activities (for example, common and collective Soldier task training, and life skills training).
- Militarily relevant work details according to the current functional level and MOS/duties of the Soldier.
- Leisure/recreational activities (for example, enjoyable, relaxing activities, including cooperative physical and mental activities, and basic relaxation techniques).
- Social participatory activities (for example, games and ceremonies).
- Group training in relaxation techniques.
- Ventilation and coaching where COSC (or medics trained by COSC personnel) encourage discussion about stressors and their impact on mental well-being. This technique helps the Soldier to restore personal perspective with questions and coaching. Individual counseling and therapy may improve the Soldier's functions as well.

12-7. When reclassification recommendations are considered, an adjacent CS or CSS unit may be able to provide a job that will match the Soldier's abilities. This provides an opportunity to demonstrate the Soldier's abilities and build confidence. The reconditioning personnel may recommend to S1/G1 that the Soldier be reclassified to another MOS.

## **FIRST-LINE RECONDITIONING PROGRAM**

12-8. First-line reconditioning programs in the corps are staffed by task-organized CSC elements from the CSC company or by an MRI CSC detachment. Reconditioning can be conducted by an MF2K CSC detachment, but would preempt its Soldier restoration capability. If the inpatient NP workload is light, a small reconditioning center may be staffed by personnel from the NP ward and consultation service of an MF2K CSH. The first-line reconditioning center usually collocates with a CSH but must maintain its separate, nonhospital identity. It should not be situated among the hospital wards, or near the morgue, triage area, or helicopter pad. Within a theater/AO, the preferred option is to have one or two reconditioning centers placed such as to allow easy access from Soldier restoration centers. Under major, prolonged combat conditions, it may be more appropriate to have one reconditioning center behind each division. The reconditioning center is dependent on the hospital for support. The reconditioning center works with the supporting hospital by sending work parties of Soldiers in the program to assist in food preparation and delivery and cleanup chores. These Soldiers may also be used for assisting with work details throughout the hospital, but must be under direct supervision of either hospital or BH personnel. The reconditioning center uses the supporting hospital's medical records section to maintain the permanent case records. Cases in the reconditioning center are counted as patients in the reconditioning center on the daily hospital census. The cases are not counted as occupied beds when reporting the hospital bed occupancy. Upon disposition from the reconditioning center, whether for RTD, retraining for other duty, or evacuation, the reconditioning center prepares the chart for further evacuation or writes the discharge summary and closes the hospital's chart.

12-9. Some reconditioning cases will be able to return to far forward CS or CSS duty. However, many of the Soldiers who need reconditioning will be unable to return to their original unit, due to combat operations or the nature of their symptoms. Soldiers who undergo a 4- to 7-day Soldier restoration program in the corps should not be crossed off the division's personnel rolls (as specified in AR 40-216). Continuing contact with the unit increases RTD rates. For Soldiers who recover but are no longer on the division's rolls, every feasible effort should be made to return them to their original units. The chief, division MH and the CSC unit teams that are attached to reinforce the division should maintain frequent contact with the reconditioning centers that support the division. Coordination efforts, through the division support command (DISCOM) sustainment brigade and the personnel replacement system by division BH personnel, should attempt to facilitate return of recovered Soldiers to their original units. If recovered Soldiers cannot be returned to their previous small unit, consider forming them into cohesive pairs or small groups which can be reassigned to a new unit together. The standard corps evacuation policy is seven days, but some Soldiers with good potential for RTD may need a few more days at the reconditioning center. The corps evacuation policy is at the discretion of the theater commander. The principle purpose of a short

evacuation policy is to keep hospital beds available for mass casualties and to minimize the expense and labor required to treat serious surgical and medical cases.

## **SECTION III — EVACUATION POLICY**

### **EXTENDING THE THEATER EVACUATION POLICY**

12-10. If need assessment indicates that a longer period of time (more than seven days) will achieve a Soldiers' RTD, the theater COSC consultant can request permission to extend the theater evacuation policy (up to 14 days). He submits the request for authority via the commander, MEDBDE, through the corps surgeon to the corps commander. The following facts apply: The reconditioning program, because of its austerity, is not a significant logistical burden to the corps. Soldiers in reconditioning perform useful work details and perimeter defense. Lastly, the increase in RTD is important in operations such as stability and reconstruction operations, where reducing personnel attrition becomes an important factor.

### **EVACUATION**

12-11. Reconditioning cases that do not recover sufficiently to return to some duty within the designated evacuation period are evacuated from corps to EAC. They are best transported in cargo trucks and buses, bus ambulances, or an ambulance train. In the latter two cases, they should be assigned helper tasks. Use air evacuation only if there is no other alternative.

### **SECOND-LINE RECONDITIONING**

12-12. Second-line reconditioning is conducted in the intermediate staging base outside the CZ in the theater. This center could be at a CSH, a fixed MTF, or a CSC unit element. The second line reconditioning center continues to emphasize physical fitness, Soldier skills, work details, and individual/group counseling/psychotherapy. Cases will be retrained for CSS duties at corps and theater levels. As soon as the recovering Soldiers are ready, the retraining site can shift to on-the-job training at a nearby CSS unit.

### **THIRD-LINE RECONDITIONING**

12-13. Third-line reconditioning is for Soldiers with COSR and/or mental disorders who did not improve sufficiently at lower lines of reconditioning but still have RTD potential. These Soldiers are transferred to a reconditioning program at a regional MEDCEN or home station MEDDAC. These reconditioning centers, like the others, must maintain a military atmosphere and provide opportunities to engage in occupational therapy. Some Soldiers may also require retraining for other duty/MOS reclassification.



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## **Appendix A**

# **Combat and Operational Stress Control and Religious Support**

### **ROLE OF UNIT MINISTRY TEAM**

A-1. This appendix addresses the general role of the UMT in the commander's program for COSC. The UMT, imbedded within units down to battalion level, provide immediate support to leaders in fulfilling their COSC responsibilities. The UMTs also assist in training leaders to recognize combat and operational stress identification and intervention responsibilities. In cooperation with unit medical personnel, UMTs serve as a primary referral agency to BH resources.

### **RELIGIOUS SUPPORT FOR COMBAT AND OPERATIONAL STRESS CONTROL**

A-2. Soldiers' inner resources are generally rooted in their religious and spiritual values. In combat, Soldiers often show more interest in their religious beliefs. When religious and spiritual values are challenged by the chaos of combat, Soldiers may lose connection with the inner resources that have sustained them. The UMT is the primary resource available to Soldiers experiencing such dilemmas and is a valuable resource in assisting them as they seek to refocus their spiritual values.

### **Unit Ministry Team Support for Combat and Operational Stress Control**

A-3. The UMT provides preventive, immediate, and restorative spiritual, emotional support and care to Soldiers experiencing COSR.

### **Preventive Religious Support for Combat and Operational Stress Reaction**

A-4. The UMT assists in preventing COSR and misconduct stress disorders through spiritual fitness training. Ministry of presence with Soldiers, assigned Department of Army civilians, and contractors is critical. The UMT provides a stabilizing influence on personnel and assists them in strengthening and regaining personally held spiritual values. Preventative activities include—

- Worship opportunities.
- Private and group prayer opportunities.
- Religious literature and materials.
- Scripture readings.
- Sacraments and ordinances.
- Assistance to personnel and families prior to deployment, emphasizing family strengths.

### **Immediate Religious Support for Combat and Operational Stress Reaction**

A-5. The UMT assists commanders in the identification of personnel experiencing negative reactions to combat and operation stress, COSR, and misconduct stress behaviors. The UMT works closely with the unit's leaders and medical personnel to care for COSR cases through religious support and comfort. Immediate religious support activities may include—

- Conversation focused upon fears, hopes, and other feelings.
- Prayer for fallen comrades and memorial ceremonies and services.
- Rites, sacraments, and ordinances, as appropriate.
- Sacred scripture.

### **Restorative Religious Support for Combat and Operational Stress Control**

A-6. Following an operation, a unit may require reconstitution. Surviving Soldiers may need to rebuild emotional, psychological, and spiritual strength. Depending upon the spiritual, emotional, and physical condition of the unit's Soldiers, the organic UMT may need augmentation from higher echelons or other units. Restorative religious support activities may include—

- Worship, sacraments, rites, and ordinances.
- Memorial ceremonies and services.
- Religious literature and materials.
- Grief facilitation and counseling.
- Reinforcement of the Soldiers' faith and hope.
- Opportunities for Soldiers to talk about combat experiences and to integrate those experiences into their lives.

## **Appendix B**

# **Medical Detachment, Combat and Operational Stress Control**

## **CONCEPT OVERVIEW**

### **BACKGROUND**

B-1. The current medical units, CSC in the Army inventory were initially developed over ten years ago. The MF2K redesign resulted in the development of the MRI. Recent events in the Global War on Terrorism in both Afghanistan and Iraq have indicated a need to update these units from MRI medical detachment, CSC to a multifunctional COSC detachment. The 2003 US Army Surgeon General's Mental Health Advisory Team (MHAT) report and observations indicate a need to update the unit in terms of modularity, multifunctionality, and its working relationship with support units and command surgeons from brigade to theater levels.

### **PROPOSED MEDICAL DETACHMENT, COMBAT AND OPERATIONAL STRESS CONTROL**

B-2. The proposed medical detachment, COSC (TOE 08660G000) consists of a detachment headquarters, a main support section, and a forward support section. The main support section consists of its headquarters and an 18-Soldier BH team made up of social workers, clinical psychologists, psychiatrists, occupational therapists, psychiatric nurses, MH specialists, and OT specialists. The forward support section consists of an 18-Soldier BH team only. Each BH team is capable of breaking into six 3-person subteams, for battalion/company prevention and fitness support activities. This provides for a total of 12 subteams for each detachment, giving supported commanders more teams and more flexibility in the utilization of those teams, yet maintaining all of the capabilities of COSC.

### **Operational Environment**

B-3. Soldiers will continue to experience the physical and mental impacts of high stress in both combat and stability and reconstruction operational environments. Advances in technology which will increase effectiveness, and the impact of the individual Soldier, will also increase dispersion and add to isolation and stress levels of Soldiers. The enemy of the future will look for methods that will have the greatest psychological impact on our future Soldiers; future enemies will not be our technological equals and will increasingly rely on terror and nontraditional methods to unnerve, injure, and demoralize both Soldiers and civilians. There is an identified need to update COSC units in terms of flexibility, modularity, multifunctionality, and its relationship to supported units and the surgeons responsible to commanders for the BH mission. The current configuration of the COSC units resulted in an uneven use of available COSC resources and that there was a greater need for preventive and limited fitness services forward. Commanders have communicated there is a greater need for active outreach and consultation.

### **Assumptions**

B-4. Power projection will likely remain the fundamental strategic and operational imperative of our forces for the foreseeable future. The new medical detachment, COSC will be well suited to the future force, designed to move with and support the division and corps of the future force, and division and corps equivalents. The medical detachment, COSC will be assigned to a MEDBDE, MMB, or MEDCOM and will be operationally attached to supported units.

B-5. Each BCT has a MH section with one BH officer and one MH specialist and that all division and brigade MH sections are filled. The medical detachments, COSC will be able to augment BCTs MH

sections. The medical detachment, COSC will require additional logistical, finance, maintenance, personnel, legal, FHP, and administrative services support.

### **Implication for Combat and Operational Stress Control**

B-6. Future forces must be emotionally and mentally fit before deploying and resilient in battle in order to endure the fast pace and intense lethality of the battlefield. Commanders will need to be able to apply COSC capabilities at every level quickly and effectively. Reorganization of the medical detachment, CSC to a combined, multifunctional medical detachment, COSC will provide greater flexibility and greatly increase outreach and preventive services while maintaining capability for the entire spectrum of COSC.

### **Operational Concept, Mission**

B-7. The medical detachment, COSC may be attached to a theater or division medical C2 headquarters in order to provide COSC casualty prevention, treatment, and management on an area basis.

B-8. The AUTL (see FM 7-15 ) linkage includes—

- ART 6.5. Provide Force Health Protection in a Global Environment.
- ART 6.5.1. Provide Combat Casualty Care.
- ART 6.5.1.5. Provide Mental Health/Neuropsychiatric treatment.
- ART 6.5.4. Provide Casualty Prevention.
- ART 6.5.4.5. Provide Combat Operational Stress Control Prevention.

### **Method of Employment**

B-9. The medical detachment, COSC deploys with a division-sized force into a theater or with a task force of up to 25,000 Soldiers in stability and reconstruction operations. The medical detachment, COSC is attached for OPCON to the division/corps/theater medical C2 headquarters. The medical detachment, COSC is assigned to the MMB of units that have reorganized under the future force design. It is normally tasked by the command surgeon to support units within the command. The detachment commander as authorized by his medical C2 headquarters will coordinate operations with the command surgeon or the division/corps/theater psychiatrist. In the absence of a psychiatrist, the detachment commander will advise and consult with the command surgeon and the commander as required. Subteams may be task-organized and further attached for operational control to maneuver BCTs, and will operate in and forward from BSA, working closely with medical assets and combat religious support team (CRST). The detachment commander will coordinate efforts with the division and the CRST to provide in-theater prevention programs as required (suicide prevention, reunion, COSC training, TEM, and PTE stress management).

### **Detachment Headquarters**

B-10. Plans, supervises and monitors the activities of the medical detachment, COSC in support of the COSC mission. See Table B-1 for a listing of personnel assigned to the detachment headquarters. The commander will establish a command post (CP) collocated with the supported unit surgeon (either division or sustainment brigade) and coordinate all activities of the detachment through the surgeon section. The detachment commander provides C2 and works closely with supported unit surgeon to provide logistics and other required services for the detachment. The field medical assistant and/or the detachment sergeant also establishes and coordinates logistics and required services support through the supported command staff for all detachment personnel and operations.

**Table B-1. Detachment headquarters personnel**

Detachment Commander (LTC/05, AOC 05A00)
Medical Operations Officer (CPT/03, AOC 70B67, MS )
Chaplain (CPT/03, AOC 56A00, CH)
Detachment Noncommissioned Officer in Charge (NCOIC) (SFC/E7, MOS 68X40)
Supply Sergeant (SGT/E5, MOS 92Y20)
Human Resources Specialist (SPC/E4, MOS 42A10)
Wheeled Vehicle Mechanic (SPC/E4, MOS 63B10)
Patient Administration Specialist (SPC/E4, MOS 68G10)
Religious Support Specialist (SPC/E4, MOS 56M10)
Cook (PFC/E3, MOS 92G10)
<b>Note.</b> The position of detachment commander may be filled by a (LTC, AOCs 73A00, 73B00, 60W00, 65A00 or 66C00). For description of duties, see Section I of the TOE and Department of Army (DA) Pamphlet 611-21.

***Main Support Section***

B-11. Included in the main support section is the detachment headquarters personnel identified in Table B-1 above and an 18-personnel BH team. See Table B-2 for list of personnel assigned to the BH team. This BH team can break into 6 three-person subteams, each with one officer, one NCO, and one specialist to conduct prevention and limited fitness operations in the battalion/company level in a maneuver BSA. Teams are collocated with a BCT medical unit. Modularized subteams may be combined and task-organized to provide or support any other COSC function, which includes larger scale Soldier restoration reconstitution, or any other COSC or BH mission as determined by its headquarters. Tasks for the main support section BH team includes:

- Consultation and coordination with commanders at team level (battalion and company).
- Coordination with CRST.
- Prevention and fitness support activities.
- Reconstitute any other COSC function as required.

B-12. When attached for support to any medical company Level II MTF, the grouped subteams are dependent on the supporting medical company for logistical support and quarters. The subteam can provide 3-day restoration for up to 50 Soldiers. With additional logistical support and quarters from supported command, the team can accommodate additional Soldiers under surge conditions.

**Table B-2. Main section behavioral health team**

Team Leader/Psychiatrist (MAJ/04, AOC 60W00)
Occupational Therapist (MAJ/04, AOC 65A00)
Social Work Officer (MAJ/04, AOC 73A67)
Behavioral Science Officer (CPT/03, AOC 67D00)
Clinical Psychologist (CPT/03, 73B67)
Psychiatric Nurse (CPT/03, 66C7T)
Occupational Therapy NCO (Four)—(Two SSGs/E6 and Two SGTs/E5, MOS 68W30/68W20)
Mental Health NCO (Four)—(One SSG/E6 and Three SGTs/E5, MOS 68X30/68X20)
Mental Health Specialist (Six)—(SPC/E4, MOS 68X10)
<b>Note.</b> For description of duties, see Section I of the TOE and DA Pamphlet 611-21.

***Forward Support Section***

B-13. This section consists of an 18-Soldier BH team. It is comprised of a section leader and five other BH officers, six MH/OT NCOs, and six MH specialists. This BH team can break into six three-person subteams, each with one officer, one NCO, and one specialist to conduct prevention and limited fitness operations in the BCT medical company in the BSA. Modularized subteams may be combined and

## Appendix B

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task-organized to provide or support any other COSC function, which includes larger scale Soldier reconstitution, or any other COSC or BH mission as determined by its headquarters. The forward support section is dependent on the supported unit for C2 and logistical support. See Table B-3 for list of personnel assigned to the forward support section BH team.

**Table B-3. Forward support section behavioral health team**

Team Leader/Psychiatrist (MAJ/04, AOC 60W00)
Psychiatric Nurse (MAJ/04, 66C7T)
Clinical Psychologist (MAJ/04, 73B67)
Occupational Therapist (CPT/03, AOC 65A00)
Social Work Officer (CPT/03, AOC 73A67)
Behavioral Science Officer (CPT/03, AOC 67D00)
Occupational Therapy NCO (Two)—(One SSG/E6 and One SGT/E5, MOS 68W30/68W20)
Mental Health NCO (Four)—(One SSG/E6 and Three SGTs/E5S, MOS 68X30/68X20)
Mental Health Specialist (Six)—(SPC/E4, MOS 68X10)
<b>Note.</b> For description of duties, see Section I of the TOE and DA Pamphlet 611-21.

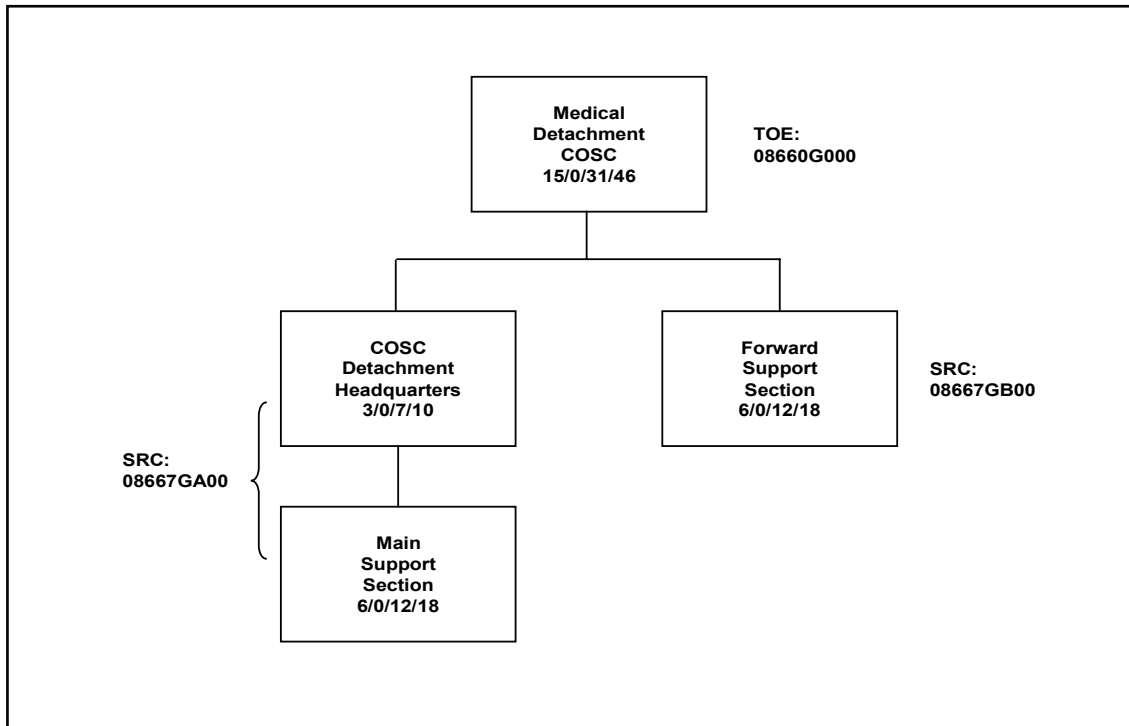
### Organizational Concept

B-14. Required capabilities require the unit to—

- Deploy to power projection platform or point of debarkation and deploy with supported unit or deploy to theater and join supported unit.
- Provide all functions of COSC from company to theater level in close coordination with and under the direction of the supported unit surgeon.
- Provide prevention, assessment, treatment, and referral BH activities.
- Provide consultation with commanders from company to theater level.
- Conduct and coordinate administrative and logistical support to sustain operations.

### Basis of Allocation Total Army Analysis

B-15. The basis of allocation is 0.333 per BCT; 1 per division; 2 per theater. In support of a theater, a COSC detachment provides support on an area basis and provides additional support to the division/corps on order. See Figure B-1 for breakdown of separate standard requirement codes (SRCs) of the medical detachment, COSC sections.



**Figure B-1. Medical detachment, combat and operational stress control**

***Concept of Transition***

B-16. Transition begins with the four active component detachments, one at a time. Personnel, transportation, and equipment changes will be minimal; transition should take a short amount of time and money to accomplish. Changes in the detachments are congruent with Force Modernization designs and personnel proponency issues. The proposed COSC detachment is designed with the Future Force in mind.

***Patient Medical Records***

B-17. The Surgeon General’s MHAT report notes that there is a need to standardize BH reporting and documentation. The BH charts were inconsistently maintained and documentation did not always accompany patients through the evacuation chain. An additional finding was that there was no standardized method of collecting BH workload or clinical data and that no database that tracked evacuees provided reliable clinical information. The patient administration specialist (MOS 68G10) will supervise or perform functions as outlined in DA Pamphlet 611-21 for the Soldier caseload; maintain Soldier/patient accountability and records; interface with patient administration division of supported/collocated medical units.

***Role of Religious Support Specialist***

B-18. Findings of the MHAT include the need for chaplains to be aware of their role in COSC and that an aggressive chaplain outreach program should be executed. This requires that supervisory chaplains be involved in CRST integration with BH and primary care providers, and educate primary players in role of CRST in COSC. These activities require that the COSC chaplain be mobile and have an active presence in the maneuver brigades. This position is required to fulfill the full-time force protection requirements for the chaplain while in theater. The religious support specialist assists the COSC chaplain by screening individuals seeking counseling, coordinates for convoy security when the CRST goes out on site visits; assists chaplain with fund request; develops and coordinates needed religious support projects within the



unit; coordinates with detachment for all vehicle services, communication system repairs, detachment training requirements and section accountability. This Soldier is cross-trained to develop skills for COSC.

### **Multifunctionality**

B-19. The MH sections have a priority of prevention activities, but also have the capability to conduct or support any combat operational stress function as required. The COSC teams will be outfitted to a standard to gain the capability of prevention and limited fitness activities.

### **Modularity, Command and Control**

B-20. The medical detachment, COSC attached early to supported units will have a better-integrated relationship. Detachment commanders and NCOICs will collocate with and coordinate all activities through supported unit surgeons. Detachments are designed to support a division in combat or a joint task force of up to 25,000 personnel in noncombat operations. The BH teams are designed to support and operate within maneuver BCTs in support of maneuver battalions for area coverage, collocating in BSA with the BSMC. Teams may be combined for task-organization to meet the entire spectrum of COSC as required.

### **Limitations**

B-21. The medical detachment, COSC does not have its own logistics or services capability and must depend on the supported unit for logistical, legal, FHP, food service, finance, and personnel and administrative services. The COSC teams are small (one or two vehicles) and are dependent upon supported units for convoy and security operations. The logistical support necessary (space, tents, cots, and so forth) to provide Soldier restoration/reconstitution functions must be furnished by the supported element (division, corps, or theater).

### **Assumptions**

B-22. Wartime activities will continue to cause physical and mental impacts of extremely high stress in both direct combat and the support operational environment. Advances in technology will impact the individual Soldier by increasing dispersion, and adding to their isolation and stress levels. The enemy of the future will look for methods that will have the greatest psychological impact on our future Soldier; future enemies will not be our technological equals and will increasingly rely on terror and nontraditional methods to unnerve, injure, and demoralize both Soldiers and civilians. Commanders will need to be able to quickly and effectively apply COSC capabilities at every level of the unit.

## Appendix C

# Medical Company and Medical Detachment, Combat Stress Control (Medical Force 2000)

### SECTION I — MEDICAL COMPANY, COMBAT STRESS CONTROL (TOE 08467L000) (MEDICAL FORCE 2000)

#### MISSION

C-1. The mission of the AOE medical company, CSC is to provide comprehensive COSC support through directed interventions activities and COSC training for supported corps units. It provides DS to maneuver brigades lacking organic BH officers; augments units with BH assets; and provides area support. The medical company, CSC reconstitutes other COSC assets. The medical company, CSC provides COSC interventions and activities to indigenous populations as directed in stability and reconstruction operations, to include domestic support operations, humanitarian assistance, disaster relief, peace support operations, and detention facility operations. The medical company, CSC provides COSC interventions and activities to units in support of their readiness preparation and throughout their deployment cycle.

#### ASSIGNMENT

C-2. The AOE medical company, CSC (TOE 08467L000) is assigned to a corps MEDBDE (TOE 08422A100) or corps MEDCOM (TOE 08411A000).

#### EMPLOYMENT

C-3. Company headquarters usually locates with the corps medical headquarters. The employment of its teams includes their dispersal throughout the corps AO. Teams may be attached to an ASMB; a division or brigade medical company; a CSH; or other corps medical unit headquarters.

#### CAPABILITIES

C-4. At TOE Level 1, the medical company, CSC includes—

- Dividing the preventive section into six mobile COSC preventive teams.
- Dividing the restoration section into four mobile restoration teams with each team being equipped to hold 40 Soldiers at the same time. With additional logistical support, each team can accommodate additional Soldiers under surge conditions.
- Assisting higher headquarters BH staff with planning and coordination of COSC support, identifying the stress threat and mental and physical stressors, and the implementation of COSC functional areas.

#### DEPENDENCY

C-5. This unit is dependent on—

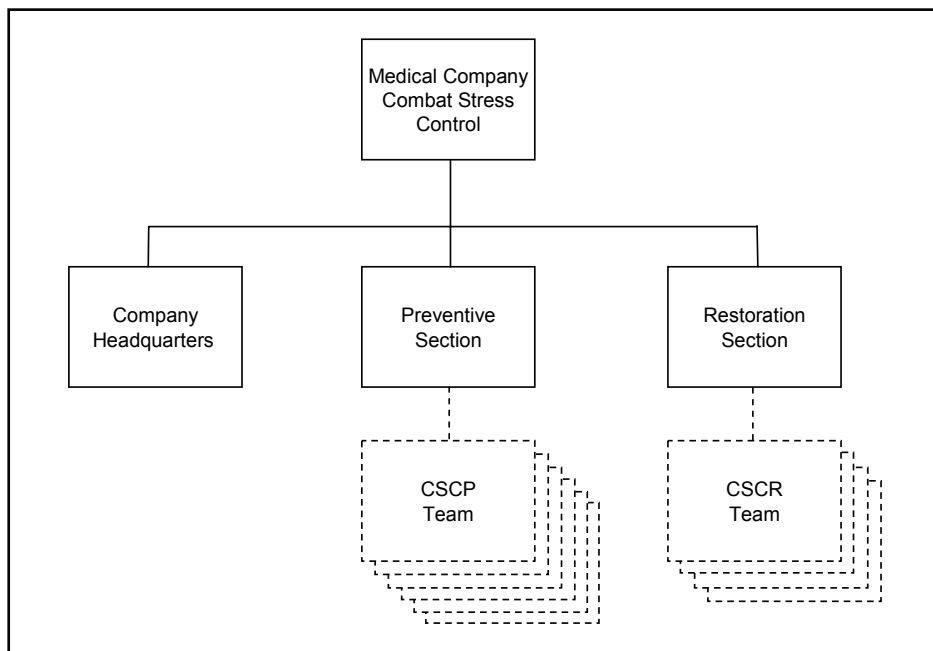
- Appropriate elements of the corps for legal; finance; field feeding; personnel and administrative services support; laundry and clothing exchange; mortuary affairs support; and security of EPW, detainee, and US prisoner patients.
- The medical headquarters to which it is assigned/attached for FHP; medical administration; logistics (including MEDLOG); medical regulating of patients; evacuation; coordination for RTD; and unit-level equipment and CE maintenance.

## MOBILITY AND SECURITY

C-6. This unit is 100-percent mobile. It requires 100 percent of its organic personnel and equipment be transported in a single lift, using its organic vehicles. Upon relocation, Soldiers being held will require additional transportation. This unit is responsible for perimeter defense of its immediate operational area. However, it is dependent on appropriate elements of the corps for additional security, to include security of convoy operations. Personnel of the company (except the chaplain) are provided weapons for their personal defense and for the defense of their patients and/or held Soldiers.

## ORGANIZATION

C-7. The AOE medical company, CSC (Figure C-1) is organized into a headquarters section, a preventive section with six (modular) CSCP, and a restoration section with four (modular) combat stress control restoration (CSCR) teams. The medical company, CSC is only present in the MF2K and is an RC organization that is programmed to be in the Army inventory until the year 2010. Under the MRI a new medical detachment, CSC, TOE 08463A000, will replace this unit.



**Figure C-1. Medical company, combat stress control**

### Company Headquarters Section

C-8. The company headquarters section provides C2 and unit-level administrative and maintenance support to its subordinate sections when they are collocated with the company. Personnel from the headquarters section are deployed with teams or task-organized COSC elements, as required. Personnel assigned to this section are identified in Table C-1.

**Table C-1. Company headquarters section personnel 3/0/14**

Company Commander (LTC/05, AOC 60W00, MC)
Chaplain (CPT/03, AOC 56A00, CH)
Field Medical Assistant (CPT/03, AOC 70B67, MS)
First Sergeant (1SG/E8, MOS 68W5M)
Mental Health NCO (SFC/E7, MOS 68X40)
Motor Sergeant (SSG/E6, MOS 63B30)
Supply Sergeant (SGT/E5, MOS 92Y20)
Equipment Record/Parts Sergeant (SGT/E5, MOS 92A20)
Wheeled Vehicle Mechanic (SGT/E5, MOS 63B20)
Human Resource Specialist (SPC/E4, MOS 42A10)
Nuclear, Biological, and Chemical Specialist (SPC/E4, MOS 74D10)
Wheeled Vehicle Mechanic (SPC/E4, MOS 63B10)
Unit Supply Specialist/Armorer (SPC/E4, MOS 92Y10)
Power-Generation Equipment Repairer (SPC/E4, MOS 52D10)
Cook (Three)— (Two SPC/E4 and One PFC/E3, MOS 92G10)
<b>Note.</b> The cook is deployed to assist the unit providing food service support to the company. He may participate in other CSC unit missions including outreach surveillance and stress control training.

**Preventive Section**

C-9. The 24-person preventive section staff is identified in Table C-2. The preventive section is task-organized to conduct COSC interventions and activities. Preventive section personnel may be task-organized with personnel of the COSC restoration section into teams for specific missions. The preventive section can divide into six CSCP teams. The section (and team) leader position may be held by any of the officers assigned to the section. The preventive section can augment or reconstitute the medical detachment, CSC teams.

**Table C-2. Preventive section personnel 12/0/12**

Psychiatrist (Three)—(MAJ/04, AOC 60W00)
Social Worker (Two)—(MAJ/04, AOC 73A67)
Psychiatrist (Three)—(CPT/03, AOC 60W00)
Social Worker (Four)—(CPT/03, AOC 73A67)
Team Chief (Six)—(SGT/E5, MOS 68X20)
Mental Health Specialist (Six)—(SPC/E4, MOS 68X10)

**Restoration Section**

C-10. The 44-person restoration section staff is identified in Table C-3. The restoration section may be task-organized to perform its COSC mission. Combat stress control restoration section personnel may also be task-organized with personnel of the CSCP section into teams for specific missions. This section can be divided into four CSCR teams. Each CSCR team can deploy a four-person mobile team using their HMMWV.

**Table C-3. Restoration section personnel 12/0/32**

Occupational Therapist (MAJ/04, AOC 65A00)
Psychiatric/Mental Health Nurse (Two)—( MAJ/04, AOC 66C00/7T)
Clinical Psychologist (MAJ/04, AOC 73B67)
Occupational Therapist (Three)—(CPT/03, AOC 65A00)
Psychiatric/Mental Health Nurse (Two)—(CPT/03, AOC 66C00/7T)
Clinical Psychologist (Three)—(CPT/03, AOC 73B67)
Mental Health NCO (Two)—(SFC/E7, MOS 68X40)
Occupational Therapy NCO (SSG/E6, MOS 68W30/N3)
Team Chief (Four)—(SSG/E6, MOS 68X30)
Patient Administration NCO (SGT/E5, MOS 68G20)
Occupational Therapy Sergeant (Two)—(SGT/E5, MOS 68W20/N3)
Mental Health NCO (Four)—(SGT/E5, MOS 68X20)
Patient Administration Specialist (Three)—(Two SPC/E4 and One PFC/E3, MOS 68G10)
Occupational Therapy Specialist (Five)—(SPC/E4, MOS 68W10/N3)
Mental Health Specialist (Ten)—(Six SPC/E4 and Four SPC/E3, MOS 68X10)

**SECTION II — MEDICAL DETACHMENT, COMBAT STRESS CONTROL (TOE 08463L000) (MEDICAL FORCE 2000)**

**MISSION**

C-11. The mission of the AOE MF2K medical detachment, CSC is to provide COSC interventions and activities to supported units in its AO. It augments division and brigade MH sections; provides direct support to combat brigades without organic BH officers; and provides area support in its AO. The medical detachment, CSC reconstitutes other brigade and division COSC assets. The medical detachment, CSC provides COSC interventions and activities to indigenous populations as directed in stability and reconstruction operations, to include domestic support operations, humanitarian assistance, disaster relief, peace support operations, and detention facility operations. The medical detachment, CSC provides COSC interventions and activities between deployments to units in support of their readiness preparation and throughout their deployment cycle. Under MRI this detachment will be replaced with medical detachment, CSC, TOE 08463A000.

*Note.* The MF2K and MRI medical detachments, CSC conduct COSC support operations very similarly. However, in the MRI medical detachment, CSC, psychiatry assets are assigned to the restoration section and psychology assets are assigned to the preventive section whereas in the MF2K detachment, the manning strategy for psychology and psychiatry is reversed: psychologists are in the restoration section and psychiatrists are on the preventive teams.

**ASSIGNMENT**

C-12. The MF2K medical detachment, CSC (TOE 08463L000), is assigned to a corps MEDBDE (TOE 08422A100), or a corps MEDCOM (TOE 08411A000), or other medical task force C2 elements. Its teams may be attached to a medical company, CSC (TOE 08467L000); an ASMB (TOE 08456A000); a brigade or divisional medical company; or a CSH.

## **EMPLOYMENT**

C-13. Detachment headquarters is usually located in the DSA. Its teams disperse and are employed throughout its AO.

## **CAPABILITIES**

C-14. The MF2K medical detachment, CSC provides—

- Mobile COSC interventions from the preventive section which can divide into three preventive teams.
- Holding for 40 Soldiers by the restoration team for COSC interventions such as restoration. With additional logistical support, the team can accommodate additional Soldiers under surge conditions.

## **STAFF RESPONSIBILITIES**

C-15. The medical detachment assists the C2 headquarters (to which it is assigned or attached) regarding planning and coordination of COSC support, stress threat, mental and physical stressors, stress behaviors, principles of COSC, and implementation of COSC functional areas.

## **DEPENDENCY**

C-16. This unit is dependent on—

- Appropriate elements of the supporting unit for FHP; religious support; legal; finance; field feeding; personnel and administrative services support; laundry and clothing exchange; mortuary affairs support; and security of EPW, detainee, and US prisoner patients.
- Supporting unit for medical administration; logistics (including MEDLOG); medical regulating; evacuation; coordination for RTD; and unit-level equipment and CE maintenance.

## **MOBILITY AND SECURITY**

C-17. This unit is 100-percent mobile. It requires 100 percent of its organic personnel and equipment be transported in a single lift, using its organic vehicles. Upon relocation, Soldiers being held will require additional transportation. This unit is responsible for perimeter defense of its immediate operational area. However, it is dependent on appropriate elements of the supporting unit for additional security, to include security of convoy operations. Personnel of the detachment are provided weapons for their personal defense and for the defense of their patients and/or held Soldiers.

## **ORGANIZATION**

C-18. This 25-person unit (see Table C-4) is composed of a headquarters, a combat stress preventive section with three preventive teams, and a CSCR. The modular CSC teams found in the MF2K CSC medical detachment are similar to those found in the CSC medical company.

**Table C-4. Detachment teams**

<i>Headquarters</i>	<i>Preventive Section</i>	<i>Restoration Section</i>
	CSCP#1	CSCR
	CSCP#2	
	CSCP#3	

C-19. The detachment headquarters provides C2 for the detachment. It is responsible for planning, coordinating, and implementing COSC interventions and activities for supported units. It consists of three personnel: a detachment Commander (05, 60W00, MC), a detachment sergeant (E7, 68X40), and a wheeled-vehicle mechanic (E4, 63B10). The detachment commander also serves as a treating physician with the preventive section. The detachment NCOIC (a senior MH NCO) also serves as the restoration team sergeant. Detachment officers and NCOs from the prevention team and the restoration team may be

## Appendix C

assigned additional duties, which enhance the overall effectiveness of the headquarters section. See Table C-5 for personnel assigned to detachment headquarters.

**Table C-5 Detachment headquarters personnel**

Commander (LTC/05, AOC 60W00)
Detachment Sergeant (SFC/E7, MOS 68X40)
Wheeled Vehicle Mechanic (SPC/E4, MOS 63B10)
<b>Note.</b> The commander also serves as the psychiatrist in the preventive section.

### Preventive Section

C-20. The 12-person preventive section staff is identified in Table C-6. The preventive section may be task-organized to conduct its COSC mission. Preventive section personnel may also be task-organized with personnel of the restoration section into teams for specific missions. The preventive section can divide into three preventive teams. The section (and team) leader position may be held by any of the officers assigned to the section. This section's COSC interventions and activities are—

- Unit needs assessment; consultation and education; critical event and transition management; COSC triage; stabilization (emergency); and BH treatment.
- Assisting with restoration and reconditioning at the CSC detachment program. Overseeing a 1- to 3-day COSC restoration program in a brigade, division, or ASMC holding section or in another area suitable for Soldiers experiencing COSR and/or other stress-related disorders.

**Table C-6. Preventive section 7/0/6**

Psychiatrist (LTC/05, AOC 60W00)
Clinical Psychologist (Three)—(MAJ/04, AOC 73B67)
Social Worker (Three)—(CPT/03, AOC 73A67)
Team Chief (Three)—(SGT/E5, MOS 68X20)
Mental Health Specialist (Three)—(SPC/E4, MOS 68X10)
<b>Note.</b> The psychiatrist is also counted in the headquarters section.

### Restoration Team

C-21. The 9-person restoration team staff is identified in Table C-7. The restoration team is task-organized to provide COSC interventions and activities. Restoration team personnel may also be task-organized with personnel of the CSC preventive section into teams for specific missions. Each restoration team can deploy a four-person mobile team with a HMMWV. The CSCF usually collocates with a supported divisional medical company to provide mobile COSC support within a DSA and conduct restoration programs, as required. The CSCF provides staff and equipment for operating a restoration or reconditioning center. This section's COSC interventions and activities are—

- Unit needs assessment; consultation and education; critical event and transition management; COSC triage; stabilization; and BH treatment.
- Conducting Soldier restoration and reconditioning programs.
- Assisting the CSH psychiatric section when psychiatric ward capability is required (refer to FM 8-10-14).

**Table C-7. Restoration team 3/0/6**

Psychiatrist (MAJ/04, AOC 60W00)
Psychiatric/Mental Health Nurse (MAJ/04, AOC 66COO/7T)
Occupational Therapist (CPT/03, AOC 65A00)
Occupational Therapy NCO (SSG/E6, 68W30/N3)
Team Chief (SSG/E6, MOS 68X30)
Occupational Therapy Sergeant (SGT/E5, MOS 68W20/N3)
Mental Health NCO (SGT/E5, MOS 68X20)
Mental Health Specialist (Two)—(One SPC/E4 and One PFC/E3, MOS 68X10)



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# Glossary

## SECTION I — ACRONYMS AND ABBREVIATIONS

<b>AAR</b>	after-action review
<b>ABCA</b>	American, British, Canadian, and Australian
<b>ACR</b>	armored cavalry regiment
<b>AMEDD</b>	Army Medical Department
<b>AN</b>	Army Nurse Corps
<b>AO</b>	area of operations
<b>AOC</b>	area of concentration
<b>AOE</b>	Army of Excellence
<b>AR</b>	Army regulation
<b>ART</b>	Army tactical task
<b>ASMB</b>	area support medical battalion
<b>ASMC</b>	area support medical company
<b>AUTL</b>	Army Universal Task List
<b>BAS</b>	battalion aid station
<b>BCT</b>	brigade combat team
<b>BDP</b>	behavioral disordered patient
<b>BF</b>	battle fatigue
<b>BH</b>	behavioral health
<b>BICEPS</b>	brevity, immediacy, contact, expectancy, proximity, and simplicity (See Section II for definition.)
<b>BSA</b>	brigade support area
<b>BSB</b>	brigade support battalion
<b>BSMC</b>	brigade support medical company
<b>C</b>	Centigrade
<b>C2</b>	command and control
<b>C4I</b>	command, control, communications, computers, and intelligence
<b>CBRN</b>	chemical, biological, radiological, and nuclear
<b>CE</b>	communications-electronics
<b>CH</b>	chaplain
<b>CHL</b>	combat health logistics
<b>CHS</b>	combat health support
<b>COA</b>	course(s) of action
<b>CONUS</b>	continental United States
<b>COSC</b>	combat and operational stress control (See Section II for definition.)
<b>COSR</b>	combat and operational stress reaction (See Section II for definition.)

<b>CP</b>	command post
<b>CPT</b>	captain
<b>CRST</b>	combat religious support team
<b>CS</b>	combat support
<b>CSC</b>	combat stress control
<b>CSCF</b>	combat stress control fitness
<b>CSCP</b>	combat stress control preventive
<b>CSCR</b>	combat stress control restoration
<b>CSH</b>	combat support hospital
<b>CSR</b>	combat stress reaction
<b>CZ</b>	combat zone
<b>DA</b>	Department of the Army
<b>DD</b>	Department of Defense
<b>DEPMEDS</b>	Deployable Medical Systems
<b>DISCOM</b>	division support command
<b>DMHS</b>	division mental health section
<b>DNBI</b>	disease and nonbattle injury(ies)
<b>DOD</b>	Department of Defense
<b>DODD</b>	Department of Defense Directive
<b>DODI</b>	Department of Defense Instruction
<b>DS</b>	direct support
<b>DSA</b>	division support area
<b>EAB</b>	echelons above brigade
<b>EAC</b>	echelons above corps
<b>EAD</b>	echelons above division
<b>EMT</b>	emergency medical treatment
<b>EPW</b>	enemy prisoner(s) of war
<b>ETOD</b>	end-of-tour debriefing
<b>F</b>	Fahrenheit
<b>FAP</b>	Family Advocacy Program
<b>FHP</b>	force health protection
<b>1LT</b>	first lieutenant
<b>1SG</b>	first sergeant
<b>FM</b>	field manual
<b>FMC</b>	United States Field Medical Card (Department of Defense Form 1380)
<b>FRAGO</b>	fragmentary order
<b>FSB</b>	forward support battalion
<b>FSMC</b>	forward support medical company
<b>G-1</b>	Assistant Chief of Staff (Personnel)
<b>G-2</b>	Assistant Chief of Staff (Intelligence)
<b>G-3</b>	Assistant Chief of Staff (Operations and Plans)

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<b>G-4</b>	Assistant Chief of Staff (Logistics)
<b>G-5</b>	Assistant Chief of Staff (Plans and Policy)
<b>G-9</b>	Assistant Chief of Staff (Civil-Military Affairs)
<b>GP</b>	general purpose
<b>HBCT</b>	heavy brigade combat team
<b>HHD</b>	headquarters and headquarters detachment
<b>HIP</b>	help-in-place
<b>HMMWV</b>	high-mobility multipurpose wheeled vehicle
<b>HSL</b>	health service logistics
<b>HSS</b>	health service support
<b>IED</b>	improvised explosive device
<b>JAG</b>	Judge Advocate General
<b>LTC</b>	lieutenant colonel
<b>MAJ</b>	major
<b>MC</b>	Medical Corps
<b>MCW</b>	minimal care ward
<b>MEDBDE</b>	medical brigade
<b>MEDCEN</b>	medical center
<b>MEDCOM</b>	medical command (US Army)
<b>MEDDAC</b>	medical department activity
<b>MEDLOG</b>	medical logistics
<b>METT-TC</b>	mission, enemy, terrain and weather, troops and support available, time available, and civil considerations
<b>MF2K</b>	Medical Force 2000
<b>mg</b>	milligram(s)
<b>MH</b>	mental health
<b>MHAT</b>	Mental Health Advisory Team (US Army)
<b>MMB</b>	multifunctional medical battalion
<b>MOS</b>	military occupational specialty
<b>MP</b>	military police
<b>MRI</b>	Medical Reengineering Initiative
<b>MRO</b>	medical regulating officer
<b>MS</b>	Medical Service Corps
<b>MSB</b>	main support battalion
<b>MSMC</b>	main support medical company
<b>MTF</b>	medical treatment facility
<b>MTOE</b>	modification table of organization and equipment
<b>NATO</b>	North Atlantic Treaty Organization
<b>NCO</b>	noncommissioned officer
<b>NCOIC</b>	noncommissioned officer in charge
<b>NP</b>	neuropsychiatric

## Glossary

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<b>OEF</b>	Operation Enduring Freedom
<b>OIF</b>	Operation Iraqi Freedom
<b>OPCON</b>	operational control
<b>OPLAN</b>	operation plan
<b>OPORD</b>	operation order
<b>OPTEMPO</b>	operational tempo
<b>OSAT</b>	operational stress assessment team
<b>OSR</b>	operational stress reaction
<b>OT</b>	occupational therapy
<b>PA</b>	physician assistant
<b>PCP</b>	phencyclidine hydrochloride
<b>PD</b>	psychological debriefing
<b>PERSTEMPO</b>	personnel tempo
<b>PIES</b>	proximity, immediacy, expectancy, and simplicity
<b>POC</b>	point of contact
<b>PTE</b>	potentially traumatizing event
<b>PTSD</b>	posttraumatic stress disorder
<b>pub</b>	publication
<b>PVNTMED</b>	preventive medicine
<b>R&amp;R</b>	rest and relaxation
<b>RC</b>	Reserve Component
<b>RTD</b>	return to duty
<b>S1</b>	Adjutant (US Army)
<b>S2</b>	Intelligence Officer (US Army)
<b>S3</b>	Operations and Training Officer (US Army)
<b>S4</b>	Supply Officer (US Army)
<b>SBCT</b>	Stryker Brigade Combat Team
<b>SGT</b>	sergeant
<b>SOI</b>	signal operation instructions
<b>SOP</b>	standing operating procedure
<b>SP</b>	Army Medical Specialty Corps
<b>SPC</b>	specialist
<b>SRC</b>	standard requirement code
<b>SSG</b>	staff sergeant
<b>TC</b>	training circular
<b>TDA</b>	table of distribution and allowances
<b>TEM</b>	traumatic events management
<b>TEMPER</b>	tent, expandable, modular, personnel
<b>TG</b>	technical guide
<b>TOE</b>	table(s) of organization and equipment
<b>TRADOC</b>	United States Army Training and Doctrine Command

<b>TSOP</b>	tactical standing operating procedures
<b>UCMJ</b>	Uniform Code of Military Justice
<b>UMT</b>	unit ministry team
<b>UNA</b>	unit needs assessment
<b>US</b>	United States
<b>USAMEDDC&amp;S</b>	United States Army Medical Department Center and School
<b>USAMRMC</b>	United States Army Medical Research and Materiel Command
<b>USAR</b>	United States Army Reserve
<b>USMC</b>	United States Marine Corps
<b>VHA</b>	Veterans Health Administration

## SECTION II — TERMS

### **brevity, immediacy, contact, expectancy, proximity, and simplicity**

An acronym used for the management of combat and operational stress reactions—*brevity* (usually less than 72 hours); *immediacy* (as soon as symptoms are evident); *contact* (chain of command remains directly involved in the Soldiers recovery and return to duty), *expectancy* (combat stress control unit personnel expectation that casualties will recover); *proximity* (of treatment at or as near the front as possible); *simplicity* (the use of simple measures such as rest, food, hygiene, and reassurance). Also known as BICEPS.

### **combat and operational stress control**

A coordinated program for the prevention of and actions taken by military leadership to prevent, identify, and manage adverse combat and operational stress reactions in units. Also known as COSC.

### **combat and operational stress reaction**

The expected, predictable, emotional, intellectual, physical, and/or behavioral reactions of Service members who have been exposed to stressful events in combat or military operations other than war. Also known as COSR.

### **5 R's**

Actions used for combat and operational stress reaction control that include—**R**eassure of normality; **R**est (respite from combat or break from the work); **R**eplenish bodily needs (such as thermal comfort, water, food, hygiene, and sleep); **R**estore confidence with purposeful activities and contact with his unit; **R**eturn to duty and reunite Soldier with his unit.

### **reconditioning program**

An intensive 4- to 7-day program (may be extended by exception to theater evacuation policy) of replenishment, physical activity, therapy, and military retraining for combat and operational stress control casualties and neuropsychiatric cases (including alcohol and drug abuse) who require successful completion for return to duty or is evacuated for further neuropsychiatric evaluation.

### **Soldier restoration**

A 24- to 72-hour (1- to 3-day) program in which Soldiers with combat and operational stress reactions receive treatment.

### **stabilization**

The initial short-term management and evaluation of severely behaviorally disturbed Soldiers caused by an underlying combat and operational stress reaction, behavioral health disorder, or alcohol and/or drug abuse reaction.

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