APPENDIX A

COMBAT STRESS CONTROL (BRIGADE AND DIVISION SURGEON'S RESPONSIBILITIES)

A-1. Army Medical Department Functional Area

Combat stress control is a recognized AMEDD functional area. Combat stress control refers to a coordinated program conducted primarily by organic unit mental health personnel. These personnel are augmented (as needed) by corps or echelon above corps specialized medical CSC units. The composition, capabilities, and future allocations of CSC units are discussed in paragraph A-4.

a. The CSC mission is to assist commands and medical units with CSC. Assistance is provided with the prevention of strsss casualties and the triage and treatment of BFCs. This is accomplished through six CSC mission functions which include–

- *Consultation* to unit leaders and medical personnel.
- *Reconstitution* support to seriously attrited units.
- *Combat NP triage* of stress and neuropsychiatric cases.
- *Stabilization* of seriously disturbed disruptive cases.
- *Restoration* (1 to 3 day[s] of forward treatment) for BFCs.
- *Reconditioning* (7 to 21 days rearward treatment, as needed).

b. The objectives of the above mission functions are to–

- Prevent BF through control of stressors.
- Identify and provide early intervention for stress or NP disorders.
- Maximize RTD of BFCs.
- Minimize misconduct combat stress behaviors (MCSBs) and subsequent post-traumatic stress disorder.

c. An FM for CSC (tactics, techniques, and procedures) is now under development. This FM will also provide principles and background. When developed, it will be required reading for brigade and division surgeons. It will be recommended reading for all line unit leaders and all division medical officers and NCOs.

d. This appendix summarizes the specific responsibilities of the brigade and division surgeons for CSC.

NOTE

The acronym "PIES" is a handy method of remembering how to treat BFCs. This acronym stands for:

- *P*roximity (treat as close to the soldier's unit and the battle as possible; prevent overevacuation).
- *I*mmediacy (treat immediately without delay).
- *E*xpectancy (with expressed positive expectation of full and rapid recovery).
- *S*implicity (use simple, brief, nonmysterious methods to restore physical well-being and self-confidence; use "nonmedical" terminology and techniques).

Treating with PIES is the standard of care for treating BFCs. Overevacuating a BFC quickly without applying PIES is analogous to putting a tourniquet on the leg of a soldier with a superficial bleeding wound (one that could have been controlled with a pressure dressing), evacuating him, and having him lose the leg.

e. Control of combat stress is often the decisive factor–the difference between victory and defeat–at all intensities of conflict.

(1) In high-intensity battle, BFCs held for treatment may comprise 25 to 50 percent of all battle-related casualties. These usually come at times of mass casualties. Of all casualties who can RTD within 3 days, 15 to 30 percent will be BFC cases. These soldiers must be treated as quickly and as close to their units as possible; that is, they must be treated in the BSA and DEA. If overevacuated, they are likely to be lost to combat and develop chronic disability. Furthermore, if line units are not able to manage the large number of duty or rest cases of BF themselves, those cases become BFCs and could overwhelm the medical evacuation and treatment system.

(2) The threat of NBC weapons will intensify stress factors. The invisible, pervasive nature of many of these weapons creates a high degree of uncertainty and ambiguity, with fertile opportunity for false alarms, rumors, and maladaptive stress reactions. The use of NBC weapons will intensify the effects of BF and increase the number of BFCs. Their use will also complicate the delivery of immediate, proximate treatment and impose a greater logistical burden on such treatments.

(3) In low-intensity conflict and military operations short of war, BF is less frequent and can usually be treated in the soldier's own unit without requiring medical holding. In some contingency operations, however, special planning may be needed to assure immediate return of these mildly battle-fatigued soldiers to their units. If at all possible, the plan should also hold BFCs for 1 to 3 days restoration in the theater even when all surgical cases are being evacuated under a zero-day evacuation policy. Failure to provide such inexpensive proximate treatment will be paid for in greatly increased chronic psychiatric disability.

(4) In low-intensity conflict, terrorist/guerrilla tactics are deliberately designed to provoke MCSBs which demoralize the defender and invalidate his legitimacy in the eyes of the local people, the US home front, and the world. Misconduct combat stress behaviors, such as use of excessive force, commission of atrocities, self-inflicted wounds, indiscipline, and substance abuse, can be minimized through medical CSC assistance to command.

(5) Post-traumatic stress disorder (PTSD) can occur following high- or low-intensity combat experiences, as well as after training accidents and natural disasters. It occurs even in soldiers who performed very well at the time without obvious signs of distress. It is common in inadequately treated BFCs and in soldiers who committed misconduct stress behaviors. Post-traumatic stress symptoms may result in impaired duty performance, personal problems, and loss of valuable, experienced personnel who decide not to reenlist. Sound "preventive maintenance" at the time of the stress and in the period of demobilization greatly reduces the risk of PTSD.

f. Control of combat stress is every commander's responsibility y and every leader's business. Controlling stress and correctly managing stress casualties is a part of every medical unit's mission. The primary mission of CSC units and mental health sections includes prevention, triage, and treatment of stress casualties. They accomplish this mission through consultation and training of all Army units on CSC. The mission of mental health sections and CSC units does not eliminate the responsibility of all commands and non-CSC medical units to maintain the fighting strength. If CSC assets are not available to assist, the requirements still must be met. The most critical stage is far forward prevention and management of stress cases in the unit and at Echelons I and II medical facilities.

A-2. Brigade Surgeon's Responsibilities for Combat Stress Control

a. The brigade surgeon is responsible for the medical aspects of CSC within the brigade.

(1) He oversees CSC operations to ensure full utilization of CSC personnel.

(2) He advises and directs, as necessary, all CSC personnel operating within the brigade area.

(3) He provides tactical update on the brigade's mission and current operations to CSC personnel.

(4) He coordinates CSC support with unit commanders and leaders within the brigade.

b. The following CSC support is allocated to a brigade from the division mental health section (DMHS).

(1) The DMHS exercises technical supervision over the brigade/battalion combat psychiatry or CSC program.

(2) In all divisions, doctrine specifies that the DMHS should detail a behavioral science NCO (MOS 91G) to the BSA to assist the brigade surgeon with CSC. This NCO performs duties as the mental health liaison NCO and brigade combat stress control coordinator (BCSCC). The same NCO should work with the same brigade for both peacetime and combat operations.

(3) In separate brigades (and some divisions which have not converted to the L-edition TOES), the 91G NCO BCSCCs are organic to the medical company. They receive technical supervision from the DMHS officers or the most available CSC unit officer.

(4) The BCSCC coordinates through the DMOC, with approval from the brigade surgeon, for additional CSC support when needed. This support should be anticipated and integrated into the brigade prior to the actual requirement or crisis. It includes routine consultant/supervisory visits by the DMHS officers and/or corps-level CSC teams and temporary reinforcement.

c. Combat stress control actions in the brigade include–

(1) *Briefing* the brigade commanders, brigade staff, unit commanders, and all brigade medical elements, as required, on CSC prevention, treatment, planning, and training issues.

(2) *Emphasizing* CSC in the brigade for the prevention of BF and MCSB. This is accomplished by—

- Controlling stressors (such as sleep loss, dehydration, poor hygiene, lack of information or sense of purpose, boredom, frustration, and home front problems).

- Establishing the need for early identification and correct management of stress reactions within the soldier's own unit by comrades, leaders, and medics.

- Providing realistic training that promotes positive leadership, unit cohesion, and confidence in self, comrades, equipment, and support, including medical support.

(3) *Providing* immediate, forward evaluation of serious BFCs and NP disorders who need medical evaluation.

- Physicians and PAs perform an adequate screening examination for physical, neurological, and mental status to rule out or treat emergency conditions.

- They triage BF cases into the categories of "duty," "rest," "hold," or "refer," based on where they can be treated.

(4) *Treating* "duty" BFCs within the small unit, on duty status.

- The battalion surgeon, assisted by battalion medical personnel and the DMHS, trains unit leaders and combat lifesavers.

- The brigade surgeon, BCSCC, and DMHS officers provide technical supervision and assistance.

(5) *Sending* "rest" BF cases for 1 to 2 days of limited duty in the soldier's battalion headquarters and support company or battery. The supply and services or maintenance companies of the FSB could also be used.

- The BCSCC and other medical/CSC personnel visit these units frequently ("circuit-ride") to provide consultation and technical supervision.

- They assure correct management for rapid RTD and check to see that other diagnoses are not missed.

(6) Holding for treatment the "hold" BF cases who need medical observation. These cases should be able to receive "restoration" treatment at the FSMC for 1 day (or longer if necessary and feasible).

(a) The feasibility of holding BFC cases at the FSMC depends on the tactical situation, patient work load, and the soldier's symptoms.

(b) Restoration consists of–

- Reassurance that battle fatigue is normal and temporary.
- Respite from extreme danger or stress.
- Rehydration.
- Replenishment (food, hygiene).
- Rest (sleep).
- Restoration of confidence through activities.

(c) The activities maintain the soldier's identity as a soldier through encouragement to talk about what happened and regain perspective, physical exercise (sports), plus useful work. Food, water, shelter, and replacement clothing and gear (when necessary) are obtained through the FSB and FSMC.

(d) Cases with dramatic BF symptoms are kept separate from all patients until they calm down.

(e) Recovering BFCs and return-to-duty wounded in action (WIA) and DNBI patients are kept separate from all severely wounded and ill patients.

(f) Battle fatigue casualties' are kept under the supervision of the patient holding squad's 91Cs and 91As unless the latter are needed for other duties. The BFCs may sleep in the holding squad tents (when weather requires and when space is available within the limits for mixing BFCs).

(g) If patient holding capabilities are filled with WIA and DNBI patients, field expedient shelters or available buildings should be utilized. If patient work load (as during mass casualties) prevents patient holding personnel from providing supervision for BFCs, other personnel may be utilized as a temporary expedient. These personnel include cooks, mechanics, or patients (such as a line NCO with minor wound or injuries who cannot RTD for 1 to 2 days but who can lead a squad of recovering BFCs).

(h) The BCSCC is not available to provide continuous care, but provides technical supervision to these care givers and evaluates problem cases. He provides consultation to units for duty and rest cases as he "circuit rides" the BSA.

(i) When the tactical situation permits, the FSMC should be augmented with additional CSC personnel from DMHS or corps CSC units previously attached to DMHS. These reinforcements can be delivered to the BSA on short notice by air ambulances bringing lightweight supplies. These personnel can take responsibility for BFC triage and initial treatment. Food, water, shelter, and field services must still be provided by the FSMC/FSB.

(j) Additional CSC personnel can be requested by the DMHS from corps via the DMOC in order to provide restoration for more BFCs in a stable BSA. Ideally, these CSC teams should already have been fully introduced to and familiarized with the BSA. They can bring vehicles with additional supplies and tentage. These CSC reinforcements can be delivered to the BSA on short notice by air ambulance if necessary.

(k) For anticipated high-intensity conflict under Medical Force 2000 doctrine, the FSMC should routinely be reinforced by a combat stress control preventive (CSCP) team. This team will normally be deployed from the corps CSC medical company or detachment and attached to DMHS or the brigade FSMC. (Currently, a similar preventive team may come from the medical detachment, psychiatric, or "OM Team.") This CSCP team normally includes–

- Psychiatrist (or other mental health officer, based on availability).
- Social work officer.
- Behavioral science specialists (two).

This team has a 5/4-ton truck with trailer and two general purpose small tents with camouflage. Its mission is to reinforce the BCSCC in his circuit-riding mission, increase neuropsychiatric triage expertise, and allow 1- to 2-day restoration of small numbers of cases when feasible. It also supports unit reconstitution (see (8) below).

(l) The number and type of BFCs restored at the FSMC may be limited by the tactical situation. The requirement for tactical mobility (conducting unit movement) may require that BFCs be transported to a "division fatigue center" in the division rear.

(7) *Coordinating* transport for "refer" BFCs (those that cannot be held for treatment at the FSMC). These cases are usually sent to the next rearward MTF which is the main support medical company (MSMC) in the division.

- Always restate the positive expectation of their rapid and full recovery prior to their evacuation.

- Use nonmedical transport such as combat service support vehicles returning to the division rear to backhaul BFCs. This is coordinated through the FSB and DMOC.

- Use ambulances only when litter and physical restraints are required. The preferred method for transporting BFCs is by ground vehicle.

(8) *Providing* CSC reconstitution support, if required, to units withdrawn from combat for reconstitution.

- The BCSCC should deploy to the reconstitution site along with other CSS and medical teams.

- The BCSCC should be reinforced for the mission by the DMHS or corps CSC teams.

- The BCSCC and CSC should monitor and facilitate the provision (by the higher command) of field services, food, and shelter at the reconstitution site to assure hygiene, replenishment, and sleep for the entire unit, especially the unit leaders.

- Combat stress control personnel facilitate after-action debriefings in small groups of leaders and combat teams. They assist the command with the reintegration of surviving personnel and new replacements and leaders into a cohesive unit.

- The CSC personnel also provide on-site treatment for soldiers suffering from BF.

(9) Assisting the command with after-action debriefings following catastrophic actions and again when redeploying home from combat. Units or individuals who are rotating home should routinely be assisted by the DMHS or corps CSC unit. After-action debriefing will work through traumatic experiences, consolidate lessons learned, and prepare the troops for changes at home.

A-3. Division Surgeon's Responsibilities for Combat Stress Control

a. The division surgeon, as senior staff medical officer, is responsible for the staff support of medical CSC throughout the division.

(1) In divisions with a medical battalion, the division surgeon is also the medical battalion commander and has command responsibility for the DMHS which is part of the battalion headquarters.

(2) In those divisions under the MSB/FSB design, the DMHS is assigned to the MSB medical company which is under the DISCOM. The division surgeon does not have command authority, but does exercise technical control.

(3) In all divisions, the division psychiatrist is the principal advisor to the division surgeon on all psychiatric and CSC activities within the division. He is responsible for NP care of division personnel. He coordinates and reports to the division surgeon through medical channels IAW AR 40-216 and the division SOP.

(4) The social work officer, clinical psychologist, and other DMHS personnel provide input to the division surgeon through the division psychiatrist. When the division psychiatrist is not present, these personnel communicate directly with the division surgeon through medical channels as required.

b. Division surgeon actions in support of CSC include–

(1) *Developing* contingency and operational plans based on input from the DMHS.

(2) *Advising* the division commander and staff on the division CSC program. This program includes the CSC plan for prevention and treatment of stress cases and for training division personnel.

(3) *Providing* technical supervision and advice to the DISCOM and brigade surgeons.

(4) *Ensuring* that the DMHS remains proactive and supports the entire division. This support should include prevention-oriented training activities at the FSMCs and troop-unit level. Specifically, this includes—

(a) Ensuring that a behavioral science NCO is allocated to each brigade as BCSCC. This NCO should be trained and qualified to carry out his duties.

(b) Mentoring the division psychiatrist and other DMHS officers to assure their total familiarity with HSS operations within the division and with field survival skills and military organization and vocabulary. They should be familiar with the division's mission, HSS OPLAN/OPORD, and SOPS. The psychiatrist (like all senior medical officers in the division) must be prepared to assume the role of division surgeon if required.

(c) Asserting division influence at MACOM level to assure that adequate mental health/CSC personnel are assigned to the division and that corps-level (and/or MEDDAC-level) CSC/mental health backup and reinforcing support is provided.

NOTE

In peacetime, the DMHS has clinical responsibilities under AR 40-216 and is authorized to operate a clinic in the division area. This clinic is operated either separately or in conjunction with the MEDDAC community mental health service. This is a useful method of sustaining clinical credentials and expertise. However, when such clinics are operated, AR 40-216 states "clinical responsibilities in garrison must not interfere with participation in field exercises, deployment exercises, and maintenance of combat readiness."

c. In combat, the division surgeon supports the DMHS's triage and limited restoration activities in the MSMC.

(1) The division surgeon must not allow the reactive restoration activities to displace either proactive preventive consultation throughout the division, reconstitution support missions, or staff input for planning and coordinating CSC requirements.

(2) No BFC or NP case is evacuated from the division without individual clearance from the division psychiatrist (AR 40-216).

(3) The MSMC can provide a more stable facility for restoration than can the FSMCs. The MSMC can usually hold BFCs for up to 3 days. The DMHS officers provide continuous NP triage and treatment expertise, but must rely on patient holding squad personnel and tents unless reinforced by a corps CSC unit.

(4) When the MSMC is reinforced by a corps-level CSC team from the current medical detachment, psychiatric (Team OM), or a Medical Force 2000 medical company or medical detachment, CSC, this team can staff a "fatigue center." The fatigue center (one or more general purpose medium or large tents under camouflage) should be slightly separate from the MSMC to emphasize its "nonpatient care" status. Field

services, water, fuel, and maintenance for vehicles must be provided for the augmenting CSC restoration team and its caseload. Soldiers are temporarily "assigned" (not "admitted") to the fatigue center. They perform useful work details for the MSMC. They are, however, recorded on the MSMC's holding patient roster for personnel accountability.

(5) Stress casualties who recover with restoration in the MSMC or "fatigue center" should be returned to their original units for duty whenever possible by the same route as recovered minor wound or DNBI patients. Cases who do not recover sufficiently in 2 to 3 days to RTD should be transferred (preferably by nonmedical ground vehicles) to an Echelon III "reconditioning center" run by the OM Team or CSC company collocated with a designated corps hospital.

(6) When units are withdrawn from combat for reconstitution, the division surgeon coordinates DMHS or CSC unit team deployment to the reconstitution site.

(7) If a unit experiences a catastrophic event, the division surgeon coordinates the deployment of DMHS or CSC teams to assist command with unit debriefings. Catastrophic events may include—

- Serious training accidents.
- Aircraft crashes.
- Natural disasters.
- Terrorist acts.
- Suicides in the unit.

When appropriate, Army families are included in these debriefings.

d. When units are redeployed home from combat, the division surgeon recommends and coordinates DMHS or CSC unit assistance to the division units.

(1) He assists in conducting after-action debriefings at the small unit level. These debriefings will focus on the traumatic experiences of the troops and prepare them for changes at home. Debriefings should include and be facilitated by DMHS personnel, chaplains, supporting CSC units, and installation MEDDAC mental health personnel.

(2) He consolidates lessons learned by the DMHS, unit leaders, and medical elements into division SOPs.

A-4. Medical Force 2000 Combat Stress Control Unit Allocations

a. Projected fielding for the first medical companies and medical detachments, CSC, will be between 1991 and 1995. Full basis of allocations would provide—

- One CSC detachment (23 personnel) per division.
- One CSC detachment per two to three separate brigades.
- One CSC company (85 personnel) per two to three divisions in corps.

b. Personnel ceilings may reduce the allocation to one CSC detachment per division, one CSC company per corps, and require the CSC company to also support any separate brigades or regiments.

c. Division and brigade surgeons should strive to achieve a habitual training and health care support relationship between division medical units and their supporting corps-level CSC detachment.

(1) Active Component CSC detachment personnel should be assigned where they provide mental health, NP, and occupational therapy services. This could be at the division's post or regional medical center. These personnel must also be provided the opportunity for field training. They should train with the divisions and brigades and with their mental health sections.

(2) Reserve Component CSC detachment personnel should be in the same region as the division or brigades which they support. They should train with the DMHS and troop units on

weekend drills and during annual training and provide consultation and clinical support.

d. Combat stress control (mental health) personnel and units, more than any other medical personnel, need to be familiar with and trusted by the combat unit leaders. They must know the stressors of the battlefield and the missions and duties of the soldiers for them to credibly advise unit leaders on stress control and to declare a soldier psychologically ready for RTD. Because their mission takes them throughout the BSA and occasionally to reconstitution sites further forward (as part of reconstitution support convoys), they must be fully trained in combat survival skills so that they do not endanger their own lives or the missions and survival of the units they support. Giving them that confidence through training is, in part, the division and brigade surgeon's responsibility.