

APPENDIX B

ORGANIZATION AND FUNCTIONS OF ARMY MEDICAL DEPARTMENT COMBAT STRESS CONTROL UNITS

B-1. Introduction

Combat stress control is now recognized as an Army Medical Department functional area for doctrinal and planning purposes. As such, it is distinguished from the other nine Army Medical Department functional areas of health service support which are—

- a. Patient evacuation and medical regulating.
- b. Hospitalization.
- c. Health service logistics/blood management.
- d. Dental services.
- e. Veterinary services.
- f. Preventive medicine services
- g. Area medical support.
- h. Command, control, communications, computers, and intelligence (C4I).
- i. Medical laboratory services.

B-2. Army Medical Department Combat Stress Control Program

a. Combat stress control refers to a coordinated program for the prevention and treatment of battle fatigue and other harmful stress-related behaviors. Combat stress control is implemented by mental health personnel organic to units and by specialized medical combat stress control units which are a corps-level (or echelon above corps) asset. The combat stress control organization must function flexibly across the

full range of combat intensities and operational scenarios including war and operations other than war.

b. There are six major combat stress control programs or functions which have different relative importance in different scenarios. The usual order of priority is as follows:

(1) *Consultation*. Liaison, preventive advice, education programs, planning, and stress control interventions to supported unit commanders and staff.

(2) *Reorganization (reconstitution) support*. Assistance at field locations to battle fatigue units which are withdrawn for rest, reorganization, and integration of new replacements.

(3) *Proximate neuropsychiatric triage*. Sorting battle fatigue cases based on where they can be treated to maximize return to duty, separating out true neuropsychiatric or medical/surgical patients.

(4) *Stabilization*. Immediate, short-term management and evaluation of severely disturbed battle fatigue casualties, neuropsychiatric, and alcohol and drug misuse cases to determine return to duty potential or to permit safe evacuation.

(5) *Restoration*. One to three days of rest, replenishment, and activities to restore confidence of battle fatigue casualties at "forward" medical units.

(6) *Reconditioning*. An intensive 4- to 21-day program of replenishment, physical activity, therapy, and military retraining for battle fatigue casualties and neuropsychiatric cases (including alcohol and drug misuse) who require this to return to duty.

B-3. Basic Tenets of Army Medical Department Combat Stress Control

a. Army Medical Department combat stress control is unit-identified and mission-oriented.

(1) The combat stress control concept differs from conventional clinic or community mental health in its explicit identification with and utilization of the strengths of Army organization and ethics.

(2) Mental health personnel assigned combat stress control duties are clearly identified as members of a specific Army TOE unit. They may be organic members of line medical units (such as the mental health section of the division's medical support company or the corps' area support medical battalion), or they may be members of a medical combat stress control unit which has a formal support relationship with the line units (such as a medical detachment or medical company, combat stress control).

(3) Combat stress control personnel work closely with the chain of command and the chain of support in the context of the supported units' changing missions. They work in the supported units' locations, or as close as is feasible under the tactical conditions.

(4) Mental health/combat stress control personnel also work with the individual soldiers and (in peacetime) with the soldier's family members. However, these soldiers and families are considered valued members of the supported unit; they are not labeled as patients or clients. Combat stress control personnel begin with a presumption of normality (that the soldier [or family member] is a normal, well-intentioned human being). They presume that these soldiers or family members are trying in good faith to master the sometimes excessive stressors of

military life and that they want to succeed. This presumption can only be displaced by a thorough evaluation which proves the contrary, or by failure to improve after sufficient expert treatment.

b. Army Medical Department combat stress control is proactive and prevention-oriented.

(1) Combat stress control personnel/units dedicate much of their time and resources to activities which assist the commanders of units in controlling stressors. They identify stress problems before they lead to dysfunction or stress casualties. This early identification permits the retention and recovery of mildly and moderately overstressed soldiers, in their units, on duty status.

(2) Even when providing reactive treatment to heavily overstressed soldiers who are in crisis, combat stress control personnel continually look for the primary causal factors (stressors). They work with the chain of command and the chain of support to gain control of the stressors or control stress which may adversely affect soldiers and their families. The objective is not only to help the afflicted soldiers and return them to effective duty, but also to prevent future affliction in others.

(3) Even when overcommitted to treating mass casualties, combat stress control units remain alert and prepared to reallocate resources. When necessary, combat stress control resources deploy to support units in forward areas. There, they provide early preventive intervention for stressed soldiers and assist command to gain control of the correctable stressors. The intent of early preventive intervention is to—

- Minimize the flow of battle fatigue casualties.

- Provide treatment for and return to duty of soldiers.
- Minimize the risk of future suffering and disability (prevent PTSD).

B-4. Organizational and Operational Concept for Army Medical Department Combat Stress Control

a. Organic Mental Health Sections. Mental health personnel are organic to medical elements of divisions, separate brigades, and the area support medical battalion.

(1) Division mental health sections have a psychiatrist, a social work officer, a clinical psychologist, and seven behavioral science specialists. At least one behavioral science NCO and one mental health officer should be allocated routinely to work in each maneuver brigade.

(2) The area support medical battalion has a psychiatrist, a social work officer, and eight behavioral science specialists. A behavioral science NCO may be allocated to work with each area support medical company.

(3) Separate heavy brigade medical companies will have three behavioral science specialists (currently no officer). Some SOF units have a clinical psychologist. Armored cavalry regiments currently have no organic mental health personnel.

b. Mission of the Organic Mental Health Section. The mission of the organic mental personnel is to provide command consultation, training, technical supervision, staff planning, and clinical evaluation (neuropsychiatric triage). They must be mobile—able to travel to military units. They can provide brief forward treatment to small numbers of cases

during combat operations. Their assets are not sufficient to provide longer treatment for large numbers of battle fatigue or neuropsychiatric casualties without sacrificing their other critical preventive and staff functions.

c. Combat Stress Control on Today's Battlefield. On today's battlefield, each maneuver brigade covers a larger and more fluid area and has greater fire power and responsibility than did a WWII division. The Army operations concept makes the brigades even more the basic war-fighting echelon. Winning the first battles will be critical and may require reconstitution of attrited units and rapid return of temporarily disabled soldiers to their units. The organic division mental health personnel must be reinforced if cases are to be restored in the brigade and division support areas. Separate brigades and armored cavalry regiments will also require this reinforcement.

(1) The combat stress control organization must achieve a balance between pre-positioning elements far forward and having other elements further to the rear. The far forward teams provide consultation, triage, and immediate treatment. The rearward teams support rear battle; these teams take the overflow and problem cases from forward areas. The rearward teams are ready on short notice to redeploy forward to the areas of greatest need, such as to the mass casualty or reconstitution sites.

(2) The organic mental health sections are essential to provide the infrastructure of mental health personnel who share familiarity and trust with unit leaders. These factors are necessary for effective consultation and prevention.

(3) Under the combat stress control concept, the organic mental health section provides the points of contact for reinforcing

elements from corps-level combat stress control units. These higher-echelon elements will deploy into the brigade, division, or corps area to assume the treatment role and assist in other functions. The point of contact is essential for coordinating, updating, orienting, and facilitating the attachment of reinforcing combat stress control elements. A combat stress control team which tries to join a unit during deployment, combat, or reconstitution will be less effective unless it has mental health points of contact. The mental health points of contact who have developed trust and familiarity with the supported units are of great assistance in facilitating the combat stress control support process.

d. Reinforcing Combat Stress Control Teams. The reinforcing combat stress control teams are small, mobile teams made up of various combinations of the five mental health disciplines. These teams may include a psychiatrist, social work officer, clinical psychologist, psychiatric nurse, occupational therapist, and their enlisted specialists. These teams will have their own tactical vehicles and bring a limited amount of supplies. These combat stress control teams will come from either the medical companies or medical detachments, combat stress control.

(1) The organizational concept for combat stress control packages the five sub-discipline (officers and enlisted specialists) of the mental health team into 4- or 11-person standard "modular teams." All combat stress control members have basic skills to direct the management of generalized stress casualties while each brings expertise to an area of specific responsibility, to be partially cross-trained to others. Teams are combined into larger task-organized combat stress control elements. The 4- or 11-person teams can be subdivided. Personnel may be cross-attached between teams by their parent combat stress control unit to fit the specific mission. The modified teams and task-organized combat stress control elements will be tailored to make best use

of available resources and the abilities and experience of the individual team members.

(2) The combat stress control modular "teams" are as follows:

- Combat stress control preventive team: Psychiatrist, social work officer, and two behavioral science specialists. The team is allocated one truck with trailer.

- Combat stress control restoration team: Psychiatric nurse, clinical psychologist, occupational therapy officer, two each of their enlisted specialists, noncommissioned officer in charge (NCOIC), and a patient administration specialist. This team is allocated two or three trucks with trailers.

(3) The combat stress control preventive and combat stress control restoration teams are incorporated into two units: medical detachment and medical company, combat stress control.

e. Medical Detachment, Combat Stress Control.

(1) One combat stress control detachment normally supports one division or two or three separate brigades or regiments.

(2) Each combat stress control detachment has three combat stress control preventive teams and one combat stress control restoration team.

(3) The detachment normally sends combat stress control preventive teams forward to the brigade support areas while the combat stress control restoration team staffs a "fatigue center" for restoration in the division support area or forward corps. While in these areas, the detachment is under operational

control of the supported unit. Parts of teams may go forward to ambulance exchange points or maneuver battalions not in contact.

f. Medical Company, Combat Stress Control.

(1) Each combat stress control company supports two or more divisions in the corps area. Each combat stress control company has six combat stress control preventive teams and four combat stress control restoration teams. These are normally task-organized into two or more elements, ideally one task-organized combat stress control element for each division supported. When total work load allows, each task-organized element staffs a combat fitness reconditioning center, collocated with a corps hospital; this may be augmented with elements of a medical company, holding.

(2) Each task-organized element sends teams to provide consultation to corps units and to reinforce area support medical companies when needed. It maintains contact with the supported division mental health section and combat stress control detachment in the divisions. The combat stress control company sends teams forward to reinforce combat stress control elements as required.

(3) The combat stress control company headquarters collocates with either a medical brigade, medical group, or area support medical battalion headquarters. Combat stress control company support personnel are detailed to the task-organized combat stress control elements. The combat stress control company exercises command and control for its task-organized combat stress control elements and for the combat stress control detachments which they support.

(4) The combat stress control company reports to and coordinates with the

mental health staff sections of the medical group and medical brigade. These small headquarters staff sections advise and assist the combat stress control company regarding the employment, support, and reallocation of combat stress control assets to support the corps' area of operations.

g. Combat Stress Control in Army Operations.

(1) The combat stress control organization is designed to be utilized for war and operations other than war. In war, their primary mission is prevention and rapid return to duty of battle fatigue casualties. Teams must be available in sufficient numbers, pre-positioned forward to react immediately, with rearward teams ready to reinforce forward where battle fatigue casualties occur.

(2) In operations other than war, fewer combat stress control units are needed. These combat stress control units are dispersed in support of division mental health and corps units. The focus of their support is the prevention of misconduct stress behaviors and perhaps treatment of substance misuse in theater.

(3) Prevention of PTSD by pre-deployment briefings, after-action debriefings, and prehomecoming debriefings is a concern at all intensities.

(4) In peacetime, combat stress control detachments (both Active Component and Reserve Component) must habitually train with the divisions they supported during wartime (and/or with other similar divisions). The combat stress control company must develop similar habitual relationships with units in their corps and with the corps' combat stress control detachments. Combat stress control teams should routinely augment organic mental health sections. They should work with maneuver brigades/regiments which lack organic mental

health to provide preventive consultation and practice their combat role.

B-5. Combat Stress Control in the Continuum of Army Life

Combat stress control is not simply a medical responsibility. Fundamentally, it is a leadership responsibility at all echelons. Since stress can have a monumental impact (positive or negative) on the military, stress control activities should be a part of many Army activities. The stress control effort must be concentrated in all three continuums of Army life which are—

- Responsibility.
- Location.
- Mission.

A weakness or a gap at any point defined by those three continuums can cause weakness, overload, or breakdown at points along the other continuums. All players along the dimensions of responsibility, especially the mental health/ combat stress control personnel, need to achieve and maintain the broad, three-dimensional system perspective.