

APPENDIX B

COMBAT STRESS CONTROL ESTIMATES AND PLAN

Section I. GUIDE FOR THE DEVELOPMENT OF THE COMBAT STRESS CONTROL ESTIMATE OF THE SITUATION

B-1. Combat Stress Control Estimate

The CSC planner must prepare the CSC estimate in cooperation with the senior staff surgeon who is responsible for preparing the overall CHS estimate. The overall CHS estimate, and especially the PVNTMED estimate, provide important information (see FMs 8-55 and 8-42).

a. Some issues may require the CSC planner to work directly with the staff sections of the combat command: S1/G1, S2/G2, S3/G3, S4/G4, and, G5 when appropriate. The staff chaplains (unit ministry teams), JAG, and Provost Marshal and MP units are also important sources of information.

b. The level of detail of the CSC estimate depends upon which echelon is preparing it.

(1) The division mental health section works with the division surgeon and the PVNTMED section. The division mental health section is concerned with brigades which are likely to have the most BF cases or other combat stress and NP problems. This may determine how many assets are pre-positioned and at which BSAs. Within the brigades (and in the DISCOM), the division mental health section may need to identify specific battalions, companies, and platoons in order to focus preventive consultation or reconstitution support activities.

(2) The CSC units which provide backup support and reconditioning in the corps are concerned with divisions, separate brigades/regiments, and other corps units which are likely

to generate the most stress casualties. The medical detachment or CSC company—

- Receives the CSC estimates from the division mental health section or ASMB mental health section and coordinates directly with each.

- Develops its CSC estimate in conjunction with its higher medical C2 unit.

- Prepares to receive reconditioning cases at different regions of the battlefield.

- Sends CSC augmentation teams or personnel to reinforce the forward units that have the greatest need.

NOTE

The medical group and medical brigade headquarters will have a small mental health staff section to help coordinate these activities.

c. The primary objective of the CSC estimate is—

- To predict where and when the greatest need is likely to arise among the supported units.

- To initiate preventive efforts early.

- To develop contingency plans so that limited resources can be allocated and prepared for their reallocation as needed.

(1) Quantification of the projected restoration and reconditioning caseloads will not be precise. Absolute values should not be given too much weight. However, quantification provides a useful analytical tool for estimating relative risk. The historical ratios of the incidence of BF casualties to the incidence of WIAs provide a baseline for estimates in future operations.

(2) This analysis is most valid when applied to specific units in a specific combat operation. It is less precise when applied to larger, composite units. The analyst must estimate what percentage of subunits of different types (combat, CS, and CSS) will encounter particularly negative factors (stressors). He must also estimate what percentage will be protected by beneficial protective factors.

(3) The prediction for the incidence of WIA requiring hospitalization in the CHS estimate provides a starting point. In moderate to heavy conventional fighting (mid-intensity conflict), the CSC planner can begin with the average ratio of one BF casualty for five WIA (1:5). Then he can examine the nature of the mission for each of the specific units involved and use protective (Positive) and risk (Negative) factors to judge whether 1:5 is likely to be an overestimate or an underestimate.

(4) For discussion later in this appendix (paragraph B-2), the protective and risk factors for BF are referred to by their parenthetical subparagraph numbers and are identified as either (Positive) or (Negative).

(5) Each of these factors could be given a numerical weight (0, +1, +2 for positive factors; 0, -1, -2 for negative factors). The factor scores are added algebraically to give a rough total score. The weight must be based on subjective expert judgment and experience.

(6) The same analyzing process used to estimate BF casualties in relation to WIAs

can be applied to estimating the potential for substance misuse/abuse patients and other misconduct stress behaviors compared with their normal rates of occurrence in the troop population.

(7) The protective (Positive) and risk (Negative) factors for misconduct stress behaviors in paragraph B-3 will be similarly designated, but with a letter "m" (for "misconduct") after the parenthesis. Each factor will be identified as either Positive or Negative.

B-2. Estimating Battle Fatigue Casualty Work Load

a. Protective Factors. The following protective (Positive) factors reduce BF casualties relative to WIA:

(1) High unit cohesion (Positive). Troops and their leaders have trained together (and, ideally, have been in successful combat) with little continual turnover of personnel. For example, Operational Readiness Training companies and battalions are presumed to have high unit cohesion provided the leaders have had time and training to develop "vertical cohesion" with positive factors (5) and (6), below.

(2) History of very tough, realistic training (for example, militarily sound and dangerous preparation to prepare troops for war) (Positive). Successful combat with few casualties is good training. Airborne and Ranger training and realistic live-fire exercises (both small arms and artillery) also help to "battle proof" soldiers.

(3) Unit leaders and medical personnel are trained to recognize BF (Positive). They can manage DUTY and REST cases at unit level and reintegrate recovered HOLD and REFER cases back into units.

(4) Units are withdrawn from combat periodically to rest, refit (reconstitute if necessary), and absorb new replacements (Positive). Replacements arrive and are integrated as cohesive teams, not as individual soldiers.

(5) Leaders demonstrate competence, courage, and commitment (Positive). Leaders care for their soldiers and make provisions for physical and mental well-being as the tactical situation permits. Noncommissioned officers know and are given responsibility for sergeant's business (taking care of their troops). Command also shows concern for soldiers' families.

(6) Leaders keep troops informed of commander's intent and the objectives of the operation and the war (Positive). If necessary, they focus the soldiers' appraisal of the situational stressors to maintain positive coping.

(7) Victorious pursuit of a retreating enemy (Positive). This reduces BF casualties but may release misconduct stress behaviors unless command retains tight control.

(8) Hasty withdrawal (Positive). During hasty withdrawals, few BF casualties enter medical channels. However, BF soldiers may be lost as KIA, missing in action (MIA), or captured instead of becoming medical patients, and other soldiers who are stressed may desert or surrender.

(9) Beleaguered friendly unit which cannot evacuate any (or only the most severely wounded) casualties (Positive). Here, too, some soldiers may be combat ineffective due to BF or go AWOL without becoming medical patients.

b. Assessment of the Positive Protective Factors.

(1) Positive factors (1) through (6), above, can be assessed using standard

questionnaire surveys of unit cohesion and morale, such as the Unit Climate Profile found in DA Pam 600-69.

(2) Many leaders and soldiers want to believe that their unit is elite and will have far fewer than one BF casualty for ten WIA, even in the most intensive battles. The CSC planner should not discourage this belief since it may be a necessary first step toward becoming true. However, the CSC estimator should not make plans on the strength of the belief alone. Remember, CSC expertise is managed wisely if it is far forward, assisting command in proactive prevention rather than reactive treatment of BF casualties.

(3) Even if tough realistic training, high cohesion, and fine leadership can be independently verified (as with unit survey questionnaires), the BF casualty estimate should not be too much less than the average until the unit has proved itself in successful combat. Even then, estimates should continue to consider the potential negative impact of cumulative attrition, new replacements, and other adverse factors which may eventually overcome the positive factors.

(4) Positive factors (8) and (9), above, are, of course, not truly "Positive." While they decrease the expected requirement to evacuate BF casualties for treatment, they indicate a need to redouble efforts for prevention of misconduct stress behavior. Positive factor (7), above, also should alert command to the need to maintain firm control to prevent misconduct stress behavior.

c. Risk Factors. Increases in the following risk (Negative) factors add to the proportion of BF casualties in relation to WIA:

(1) Combat intensity—indicated by the rate of KIA and WIA (percent of battle casualties [out of the total troops engaged] per hour or day) (Negative).

(2) Duration of continuous operations—the number of days which the troops (small units) have been in action without respite, especially if there is little opportunity for sleep (Negative). The operation may begin well before the actual shooting. Preparation time and rapid deployment (jet lag) effects should also be considered.

(3) Cumulative combat duration—the total number of days (cumulated over days, weeks, months) in which the small units (platoons, companies) have suffered casualties (Negative).

(4) Sudden transition to the horrors of war—many new troops with no prior combat experience being confronted with surprise attack or new weapons of mass destruction (Negative).

(5) Extent to which the troops are subjected to artillery and air attack (with some allowance for the strength of their defensive fortification, dispersion, and concealment) (Negative). This is especially true if they involve sudden mass devastation.

(6) Casualties from friendly fire (including direct fire, artillery, and air attack) (Negative). This, of course, is not part of the plan of operation but is a special hazard of the fast-moving battle. When such incidents are reported, CSC teams should respond immediately.

(7) High NBC threat—a state of alertness requiring periods in MOPP Levels 1 through 4, frequent false alarms, and concerns and rumors about escalation (Negative). Actual NBC use: What type agents? (Persistent contamination? Potential for contagion?) What casualties? What are the implications for increased MOPP levels, rumors, concerns of escalation, and worries about home?

(8) Being on the defensive, especially in static positions (unless the fortifications

are very strong and comfortable, complacency may be a problem) (Negative).

(9) Attacking repeatedly over the same ground against a stubborn, *strong* defense (Negative).

(10) Casualties among armor or mounted infantry crews, such as when armor must operate in highly restrictive terrain (Negative).

(11) Casualties from mines or booby traps (Negative).

(12) Extent and intensity of the rear battle (Negative). The introduction of CS/CSS soldier to the stress of battle when attacked. These soldiers are confronted with dangers and horrors of war for which they may not have been adequately trained or mentally prepared.

(13) Failure of expected support, such as fire support, reinforcement, or relief; inadequate resupply; inadequate CHS support (Negative).

(14) High personnel turbulence, resulting in low unit cohesion and inadequate unit tactical training (Negative).

(15) Loss of confidence in leaders, in supporting or allied units, and in equipment as compared to the enemy's (Negative).

(16) Popular opposition to the war at home; lack of understanding or belief in the justness of the effort (Negative).

(17) Families left unprepared by rapid mobilization and deployment (Negative). Lack of a believable plan for evacuating families from the theater; lack of plans for keeping them secure under a reliable authority if they cannot be evacuated. This can also contribute to misconduct stress behaviors, especially AWOL.

(18) Home front worries (Negative). Lack of visible command program for ensuring support to Army families.

(19) Inadequate water available for drinking (Negative).

(20) Adverse weather, especially cold-wet; any harsh climate if troops are not properly trained, equipped, and acclimatized (Negative).

(21) Unfamiliar, rugged terrain (jungle, desert, mountain, or urban) if troops are not specifically trained and equipped (Negative).

(22) High prevalence of endemic minor illnesses, especially if this reflects inadequate command emphasis on self-aid and buddy aid preventive measures (Negative).

(23) Last operation before units (or many soldiers in them) rotate home, or if the war is perceived as already won, lost, or in final stages of negotiation (Negative).

(24) Many civilian women and children casualties resulted from the fighting (Negative). This may be a stronger factor in brief OOTW (conflict) than in war where the magnitude of the horror and the preoccupation with personal and unit survival may quickly harden soldiers to these casualties.

B-3. Estimating Substance Abuse and Misconduct Stress Behaviors

a. *Protective Factors.* Positive Factors (1) through (6), above, reduce alcohol/drug misuse and other misconduct stress behaviors (Positive). They can also become misconduct behaviors as shown in (b), below.

(1)m High unit cohesion is positive if the unit's "identity" forbids abuse of substances

and emphasizes adherence to the Law of Land Warfare, United States Code of Military Justice, and tolerance for cultural differences (Positive).

(2)m History of tough and realistic training is positive if it includes faithful adherence to rules of engagement which support the Law of Land Warfare and cultural issues (Positive).

(3)m Unit leaders, medical personnel, and chaplains are trained to recognize BF and early warning signs of misconduct stress (Positive).

(4)m Units are withdrawn from combat periodically to rest, refit (reconstitute, if necessary), and absorb new replacements who arrive and are integrated as cohesive teams, not individuals (Positive).

(5)m Leaders have demonstrated competence, courage, candor, and commitment (Positive). Leaders show caring for the soldiers and make provisions for their physical, mental, and spiritual well-being as the tactical situation permits.

(6)m Leaders keep troops informed of the objectives of the operations and war (including psychological operations and diplomatic, political, and moral objectives) (Positive). They focus the soldiers' appraisal of the situation to maintain positive coping against the temptations to misconduct stress behaviors.

NOTE

These preventive factors will protect only if leaders and troops maintain and enforce a unit's self-image that regards the misconduct behaviors as unacceptable. If this unit's self-image is lacking, these factors may even contribute to substance abuse and violations of the laws of war.

b. *Risk (Negative) Factors Which Increase Substance Misuse and Other Harmful Combat Stress Behaviors.*

(1)m Permissive attitude and availability and use of drugs in the TO and also in the US civilian community, especially around posts/garrison areas and in the regions and age groups from which recruits are drawn (Negative).

(2)m Inadequate enforcement of the unit's ADAPCP before deployment in identifying and treating (or discharging) misusers (Negative).

(3) Availability and distribution networks (both legal and illegal) for alcohol and different types of drugs in the theater (Negative). Some drugs are more available and cheaper in some foreign countries or regions.

(4)m Unsupervised use of amphetamines and other strong stimulants to remain awake in continuous operations (Negative). This can produce dangerous (usually temporary) neuropsychiatric illness. Also, it may lead to dependency and addiction in originally well-intentioned, good soldiers, including leaders.

(5)m Boredom and monotonous duties, especially if combined with chronic frustration and tension (Negative).

(6)m High threat of nerve agent use with false alarms that result in self-administration of atropine causing mental symptoms and perhaps temporary psychosis (Negative).

(7)m Victorious pursuit of a retreating enemy. This reduces BF casualties, but may not inhibit commission of atrocities (the criminal acts of killing of EPWs, raping, looting) or alcohol/drug misuse (as supplies are "liberated") unless command retains tight moral control (Negative),

(8)m Hasty withdrawal. Here, too, soldiers may loot or abuse substances "to keep them from falling into enemy hands" (Negative). Rape, murder, and other reprisal atrocities (criminal acts) can occur if retreating troops feel hindered by EPWs, or if the civilians being left behind are hostile. Leaders must not encourage too zealous a scorched-earth policy. This means that only those items except medical that would be of potential use to the enemy are destroyed. If leaders lose tight control, overstressed soldiers may desert or surrender.

(9)m Beleaguered units which cannot evacuate any (or only the most severely wounded) casualties. Here, too, some soldiers may commit misconduct stress behaviors due to BF or go AWOL without becoming medical patients (Negative).

(10)m Commission of atrocities by the enemy, especially if against US personnel but also if against local civilians (Negative).

(11)m Racial and ethnic tension in the civilian world and in the Army (Negative). Major cultural and physical/racial differences between US and the local population,

(12)m Local civilian population perceived as hostile, untrustworthy, or "sub-human" (Negative). This is more likely to result when soldiers have little knowledge or understanding of cultural differences.

(13)m Failure of expected support, such as reinforcement or relief; inadequate resupply; inadequate CHS (Negative). Soldiers who feel abandoned and on their own may resort to illegal measures to get what they think they need. Combat soldiers naturally tend to feel "entitled to claim what they have earned," and this may lead to looting and worse.

(14)m High personnel turbulence, lack of unit cohesion, especially "vertical cohesion"

between leaders and troops (Negative). A “substance-of-choice” can become a “ticket” for inclusion into a group.

(15)m Loss of confidence in leaders, in supporting or allied units, and in equipment as compared to the enemy’s (Negative). These produce the same effects as negative factors (13)m, above, and (16)m, below.

(16)m Popular opposition to the war at home; lack of understanding or belief in the justness of the effort (Negative). Some soldiers will find this an excuse to desert or refuse lawful orders. Others who continue to do their duty may show their resentment by lashing out at the local population or by using drugs and alcohol.

(17)m Lack of a believable plan for protecting families in the theater, either by evacuating them or keeping them secure under reliable authority (Negative). Some soldiers may go AWOL to stay with them.

c. *Estimate of Substance Abuse and Misconduct Stress Behavior.* The purpose of this estimate of potential substance misuse and other misconduct stress behaviors is the same as for the estimate of BF casualties. It is to predict when and where (in which units) problems are most likely to occur so that preventive actions can be focused. Also, provisions can be made for the medical/psychiatric treatment of substance abuse cases in the TO. The CSC estimator must work closely with the JAG staff, MP, and the chain of command to compare the projections with what is actually being found.

Section II. THE COMBAT STRESS CONTROL PLAN

B-4. Format

The format for the CSC plan is the standard outline (see FM 8-55). The CSC planner must analyze the operations order and CHS estimate for direct or implied CSC missions. He must assess the available CSC resources and analyze alternative ways of using them to accomplish the missions. Frequently, it is necessary to prioritize the missions and recommend to higher command which of the alternate courses should be taken.

B-5. Combat Stress Control Planning Considerations in Deployment and Conflict

a. The requirements for each of the CSC program functions (consultation, reconstitution support, NP triage, restoration, reconditioning, and stabilization) and the ability of CSC units

to satisfy those requirements will be influenced by the factors listed below:

(1) The nature, mobility, and intensity of combat operations which influence the number of BF soldiers; the severity of symptoms; and the feasibility of resting cases in or near their units.

(2) The type of threat force, especially the threat to CSC activities themselves. For example, the likelihood of air and artillery attack; the security of “rear areas” for rest; the electronic warfare threat and target detection capability for concentrations of troops; and the NBC and directed-energy threat.

(3) The availability of other health service units on which the CSC elements can rely for local logistical/administrative support and for patient transportation or evacuation.

(4) The geographical AO, terrain, and climatic conditions which limit mobility of CSC units and require additional shelter for patients.

(5) The disease, drug, alcohol, and environmental hazards of the region which threaten resting BF cases and produce other preventable nonbattle injuries which, historically, resulted from there being a complication of BF.

b. The CSC planner must determine the actual strengths of the CSC resources in organic unit mental health sections and specialized units. They may not be at the authorized levels for personnel or equipment. The level of training, degree of familiarity, and cohesion with the supported units must be assessed.

B-6. Combat Stress Control Planning Considerations for War

a. The more intense the combat, the higher the rate of WIA and the higher the ratio of BF casualties to WIAs. If the WIA rate doubles there will be four times as many BF cases requiring treatment. Furthermore, high-intensity combat causes a shift towards more severe symptoms and slower recovery.

b. The CSC organization must achieve a balance between pre-positioning elements far forward and having other elements further to the rear that can take the overflow of cases and be redeployed to areas of special need.

c. In Army operations, each maneuver brigade covers a larger and more fluid area and has greater firepower and responsibility than did a WWII division. Winning the first battle will be critical and can be accomplished only by reconstitution of attrited units and rapid return of temporarily disabled soldiers to their units. The

division mental health section must be reinforced if cases are to be restored in the BSA and DSA.

d. Small CSC teams must be pushed forward to reinforce the maneuver BSA well before the fighting starts. Although BF casualties will not be evenly distributed among all brigades, those cases which occur must be evaluated and treated immediately at that level.

(1) At critical times, this will be under mass casualty conditions. Other logistical requirements and enemy activity may make it impossible to respond quickly with CSC personnel once the battle has begun. Any newly arriving CSC personnel who join a new unit under such circumstances will take critical hours to days to become efficient.

(2) The purpose of these CSC "preventive" teams is NOT to hold BF casualties for treatment in the highly fluid BSA. Their purpose is to prevent the evacuation of DUTY and REST BF casualties who could remain with their units. These teams also ensure correct initiation of treatment and evacuation of the refer cases to the division fatigue center in the DSA. If circumstances allow, they could hold a small number for overnight observation/restoration.

(3) Combat stress control teams which are with a brigade not in action will use this time productively in consultation activities. These activities will reduce the incidence of stress casualties and better enable the unit to treat its cases far forward when the time comes.

e. Combat stress control elements in the DSA provide NP triage and prevent any unnecessary evacuation. They staff the division fatigue center which assures 2- to 3-days restoration within the division. They provide preventive consultation and reconstitution support throughout the division rear. They can send personnel, tents, and supplies forward to reinforce the teams at the BSA.

f. Combat stress control elements in the corps area must provide the back-up "safety net" to catch the overflow from hard-pressed divisions, as well as providing reconstitution support to units which are withdrawn from battle and preventing and treating local rear-area BF cases. Those in the corps area can be transferred laterally within the corps or temporarily sent forward to divisions which are in greatest need. With somewhat greater difficulty, these assets can be transferred from one corps to another.

g. Combat stress control teams need 100 percent ground mobility and communications capability to function in their local areas. They need a small vehicle to visit the units in the BSA, DSA, or corps support area and to deploy to reconstitution sites with other CS/CSS teams. Combat stress control teams should not wonder around the battlefield alone. When they move outside the defensive areas, they should be in convoy with other CSS vehicles or be provided security by the echelon commander.

h. Combat stress control units provide the expertise of their personnel with little requirement for heavy equipment. Therefore, if time, distance, or the tactical situation prevents a CSC element from traveling by ground to reinforce another CSC element which is already in place, the key personnel and light specialized equipment can be moved by air.

NOTE

Combat stress control personnel can be sent forward in air ambulances that are going to the forward medical companies to evacuate the wounded.

Additional supplies, equipment, and vehicles can follow as sling-loaded or air-droppable cargos. The key requirement is that a familiar CSC team

with vehicle and preestablished contacts are already at the destination expecting to be reinforced.

i. If the division mental health section or CSC unit is given the mission to support a separate brigade or ACR, it is important to establish contact and send a liaison officer or NCO to its medical company as early as possible before the battle.

NOTE

Because of their unique missions, armored cavalry units have special need for consultation, preventive education, and staff planning.

Because of their elite self-image, it is important that the liaison is someone who has trained with the unit and is known by personnel. In some scenarios, cavalry units suffer extreme attrition in the first days of continuous operations, yet they are cited as prime candidates for reconstitution to return the survivors quickly to battle.

j. Combat stress control support is expensive and offers great potential pay-off in RTD soldiers at critical times and places in the battle and for reconstitution support after the battle.

(1) If not required to treat BF casualties and attrited units, the same few personnel will be active in consultation to unit leaders. This preventive consultation could reduce BF and improve the potential RTD of unit members if anyone should become a BF casualty.

(2) Combat stress control assets also assist with treatment of other WIA and DNBI cases who have rapid RTD potential. Many of these will also have severe BF symptoms which require treatment.

(3) Finally, CSC personnel have a crucial role in preventing PTSD in troops (including those who did not become casualties) by assisting command with after-action debriefings.

B-7. Combat Stress Control Planning Considerations in Operations Other Than War

a. In OOTW, the total requirement for CSC support is significantly less than in war. There is less need to pre-position CSC elements far forward except during specific operations which approach war.

(1) The total ratio of BF cases to WIA cases may still be high, but the average number of WIA cases is less than two per thousand per day, so there are fewer cases. Most BF cases can be managed in their units as DUTY or REST cases.

(2) Few of the cases are HOLD or REFER casualties who need to be held under medical observation, so the BF casualty: WIA ratio is usually less than 1:10. However, relatively more of those who are casualties will need stabilization on a hospital ward.

(3) Reconstitution support is still important for units following battle, but the units will usually be small (squad, platoon, company).

b. Contingency operations pose special problems if they involve rapid deployment to an undeveloped theater. The CHS plan for care of all wounded and sick who cannot return immediately to full duty may be to evacuate them as quickly as possible to the nearest COMMZ- or CONUS-based MTFs. The tendency will be to err on the side of caution and evacuate anyone whose status is in doubt.

(1) This zero-day evacuation policy may continue for the duration of a brief operation or until formal medical-holding facilities can be deployed behind the forward area surgical teams.

(2) Early deploying medical personnel, as well as CSC planners and treaters, must make a concerted effort to encourage units to keep soldiers with DUTY BF in small units and to keep REST cases in their own CSS elements for a day or two of light duty, then return them to full duty.

(3) If at all possible, the plan should also hold BF casualties at the forward medical facilities for 1 to 3 days of restoration as an exception to the usual evacuation policy. This holding can be done under very austere conditions and need not add significant additional logistical burden to the system. Failure to provide such inexpensive, proximate treatment will greatly increased chronic psychiatric disability among soldiers.

c. In OOTW, while the need for restoration of BF casualties is less than during war, the incidence of misconduct stress behaviors increases, specifically—

- Behavior disorders, including indiscipline and violations of the Law of Land Warfare and the UCMJ.
- Drug and alcohol abuse.
- Other disorders of boredom and loneliness.

There is still a need for a reconditioning program in the corps to salvage those cases who do not improve in the divisions. In conflict, it may be practical to increase the evacuation policy for these cases, extending the policy from 7, 14, or 30 days; this maximizes RTD and minimizes the development of an evacuation syndrome, where

stress symptoms, misbehavior, or drug and alcohol misuse become a “ticket home.” Increasing the length of stay increases the reconditioning program census. The preventive consultation programs remain important for corps-level CSS units with no mental health sections.

d. Conflict requires rigorous preventive programs and after-action debriefings to minimize subsequent PTSD. These are especially important because of the ambiguous and often vicious aspects of enemy tactics and their effects on our soldiers.

B-8. Considerations When Units or Individual Soldiers Redeploy Home (After Military Operations)

a. Unit mental health personnel and supporting mental health/CSC units assist leaders in preparing soldiers for the transition back to garrison or civilian life. A period of several days should be scheduled for memorial ceremonies, group debriefings, and discussions of—

- What has happened in combat, especially working through painful memories.
- What to expect in the soldiers’ own reactions on returning to peacetime.
- How family and society may have changed since deployment and how to deal with these changes constructively.

b. More intensive programs are scheduled for individuals or units with prolonged intensive combat or other adverse experiences. Coordination with the rear detachment and family support groups is required to schedule similar education briefings and working-through sessions at the home station, both before the unit

returns and in combined sessions after the return. The debriefings should also address—

- How the service member, spouse, children, and society may have changed.
- How to cope with those changes positively.

Welcome home ceremonies and memorial services provide a sense of completion and closure.

B-9. Combat Stress Control Planning Considerations in Peacetime

a. To be effective, CSC must form a continuum with the Army mental health services. The peacetime utilization and training of mental health personnel must prepare them for their mobilization missions and develop strong unit cohesion among themselves and with supported units. Future operations may leave little time for on-the-job-training or to develop familiarity and cohesion before the crucial battle starts.

b. Army Regulation 40-216 states that patient care duties must not interfere with the division mental health section’s training with its division.

c. Echelon III psychiatric and mental health personnel who will provide CSC support should have peacetime duties which bring them into close working relationships with the organic mental health sections, chaplains, line commanders, and NCOs of the units they will support in war.

(1) Active Component CSC personnel should be assigned to MEDDACs. They will work in the following areas:

- Community mental health/community counseling centers.

- Drug and alcohol abuse prevention and control programs.
- Family advocacy and exceptional family member programs.

The CSC personnel should be working at the posts or garrisons of the Active Component divisions, brigade, regiments, and corps units they will support during war and OOTW. They should also participate with those units in field training exercises.

(2) Reserve Component CSC personnel should train with units they will support on mobilization. They should also use available training time to establish and implement CSC programs in those units.

B-10. Briefing the Combat Stress Control Plan

a. Depending on the echelon, the CSC plan may be briefed to a senior medical commander or line commander for approval. In

some headquarters, the CSC planner may give the briefing. In others, it may be given by the unit surgeon as part of the overall CHS plan.

b. In any case, the CSC briefing must be short and simple. The senior commander does not need all the details which went into the analysis (although those details should be available, if asked for). The commander needs to know the "bottom line." What will it cost? What is the return, especially in reduced casualties and rapid RTD? What is the risk if it is not done?

c. Many commanders are highly knowledgeable about the nature and importance of combat stress reactions and home front issues. However, many others are not. The CSC briefing may have to overcome the prejudice that mental health (CSC) interventions are things that pamper the troops and ruin them for combat or just burden the unit with weaklings who would be better purged from the Army.

d. Educating the senior commander, using language he knows and understands, is the first essential step of CSC.