CHAPTER 3

COMBAT STRESS CONTROL OPERATIONS IN THE COMBAT ZONE

Section I. DIVISION MENTAL HEALTH/COMBAT STRESS CONTROL OPERATIONS

3-1. Division Mental Health Section Deployment

If the division deploys tactically, the division mental health section deploys the brigade CSC teams by echelon with the brigade FSMCs. A team consists of one mental health officer plus an NCO. When the division is assembled in an assembly area or garrison, the mental health officers may consolidate at the MSMC. The division psychiatrist deploys with the MSMC or earlier as needed. The division psychiatrist covers the MSMC in the DSA and uses it as a base of operations. Those division mental health section assets that were not deployed with the FSMCs will establish the division mental health section near the area support squad treatment element (division clearing station). As stated in Chapter 2, the division mental health section routinely details one behavioral science NCO to each of the brigades; these NCOs perform the functions of brigade CSC coordinator. The mental health officers from the division mental health section are designated as the brigade mental health officers. They join the brigade CSC coordinators to form the brigade CSC teams when the brigades deploy away from the MSMC. Other division mental health section personnel are deployed to the supported BSAs to augment/reinforce the brigade CSC teams as required. The division psychiatrist actively supports the brigade CSC teams in their unit-based preventive mental health and training programs and will also deploy to brigade level to provide assistance, or make consultation site visits to the FSMCs. During tactical operations, the division psychiatrist provides a 24-hour NP triage capability at the MSMC. He trains and supervises MSMC treatment platoon personnel in all areas pertaining to NP and CSC to include handling and treatment of NP patient and combat stress-related casualties. The psychiatrist also initiates the coordination for corps CSC augmentation as required.

3-2. Division Combat Stress Control Estimate and Plan

a. Mental Health/Combat Stress Control Estimates. The division psychiatrist, assisted by the division mental health section staff, prepares mental health/CSC estimates as directed or required for CHS operations. Mental health/CSC estimates are developed in accordance with FM 8-55, FM 8-42 and division CHS TSOPs (see Appendix B). Mental health/CSC estimates are submitted via technical medical channels to the DMOC which collects them for the division surgeon. Estimates are provided via command channel (if formal tasking) through the MSMC and MSB headquarters to the DMOC which collects them for the division surgeon. The division psychiatrist may coordinate directly with the division surgeon or DMOC to obtain division/DISCOM staff input. These estimates are used by the division surgeon and DMOC to develop the division CHS OPLANs/OPORDs. The mental health/CSC estimate may include—

- Mental health status of the division.
- Current status of morale and unit cohesion in division units.
- Status of mental health/CSC personnel/elements.

- Battle fatigue casualty estimates.
- Fatigue, sleep loss.
- Percent of casualties; intensity of combat.
- Home-front stressors (natural disaster, unpopular support of the conflict, terrorist attacks in or around home base).
- Restoration requirements.
- Corps CSC support requirements.

The mental health/CSC estimate should include any assumptions required as a basis for initiating, planning, or preparing the estimates. Any mental health/CSC deficiencies are identified, using those tactical courses of action listed in the commander's estimate. The advantages and disadvantages of each tactical course of action under consideration from the mental health/CSC standpoint are provided. In addition, the estimate provides methods of overcoming deficiencies or modifications required in each course of action.

b. Mental Health/Combat Stress Control Plan. The division psychiatrist, assisted by the division mental health section staff, develops the mental health/CSC input for the division CHS OPLAN/OPORD in accordance with FMs 8-55 and 8-42. This input is based on the mental health/CSC estimate and feedback from the commander, MSB support operations section, DMOC, and division surgeon. The division psychiatrist and mental health officers must ensure that all mental health/CSC requirements for the division are included in their input for the division OPLAN/OPORD. The mental health/CSC subparagraph in the CHS annex of the division OPLAN/OPORD should include—

- Providing divisionwide mental health/CSC coverage.
- Ensuring policies and procedures for the prevention, acquisition, restoration, and treatment for BF, misconduct stress behavior, and NP disorders are clearly defined and disseminated.
- Providing consultation services.
- Establishing restoration areas as required at division MTFs.
- Coordinating requirements for mental health/CSC augmentation.
- Providing reconstitution support.
- Coordinating for corps-level mental health/CSC support.
- Establishing procedures for the timely and accurate reporting of BF, misconduct stress behavior, and NP disorders seen by division mental health section elements/personnel.

The division psychiatrist, assisted by the mental health staff, is responsible for supervising and coordinating the implementation of the division mental health/CSC support operations. Implementing the mental health/CSC support in accordance with CHS annex of the division OPLAN/OPORD should include—

- Ensuring that DSA and BSA consultation duties are delineated.
- Coordinating as required and permitted by the MSMC and MSB commander with the DMOC and supporting corps CSC elements.

- Coordinating the establishment of restoration and reconditioning centers with supporting corps-level CSC elements.

- Establishing procedures for units to request mental health/CSC support.

- Deploying and reinforcing brigade CSC teams and other division mental health section personnel, as required, to support CSC requirements.

- Ensuring transportation of BF casualties in nonambulance vehicles (such as cargo trucks returning empty after delivering their loads) is coordinated by the DMOC in accordance with the TSOP.

3-3. Division Mental Health Section Employment

The employment concept for mental health support in the division is dependent on the effectiveness of the division combat, mental fitness program. It is also dependent on the assignment and proper distribution of division mental health personnel. It is essential that medical commanders promote training which include field experience and cross-training of critical nonmedical skills. For division mental health personnel to fill their roles in combat, they must be thoroughly familiar with the units they support. They must also be known and trusted by the leaders and personnel of the supported units.

a. Division Mental Health/Combat Stress Control Support. The MSMC commander prioritizes division mental health section missions based on input from the division psychiatrist and on the provisions of the division CHS plan. The division mental health section coordinates through the MSMC commander, MSB support operation, and the DMOC when requesting mental health/CSC augmentation. Request for corps-level mental health/CSC support is normally coordinated by the DMOC with the supporting medical brigade or group. The deployment of the medical detachment, CSC is discussed in Section III of this chapter. It must be recognized that corps CSC assets can be diverted to other areas of the corps by the medical brigade or medical group even during heavy combat. The medical detachment, CSC may be deployed for peacetime contingency operations. The medical detachment, CSC support is likely to be intermittent and selective in OOTW (conflicts). The division mental health section plans must be prepared to provide CSC coverage without augmentation.

b. Brigade Mental Health/ Combat Stress Control Support.

(1) A behavioral science NCO is routinely detailed to each FSMC to assist the brigade with CSC. This NCO performs duties as the mental health liaison NCO and brigade CSC coordinator. He works for the brigade surgeon under the general supervision of a division mental health section officer. Specifically, one mental health officer from the division mental health section is designated as the brigade mental health officer. The brigade CSC coordinator routinely circulates throughout the brigade to train and advise brigade and supporting personnel to include—

- Medical personnel.
- Chaplains.
- Combat lifesavers.
- Unit leaders.
- Soldiers (unit members).

The brigade CSC coordinator establishes and conducts unit preventive mental health and training programs for the supported brigade and attached units operating with the brigade.

(2) When a brigade is deployed forward, the brigade mental health officer (with a division mental health section vehicle) and (optionally) a behavioral science specialist will also deploy to the BSA. The brigade mental health officer and the brigade CSC coordinator together form the brigade CSC team. The brigade CSC team visits supported units regularly within the BSA and goes forward for consultation to the supported maneuver battalions, as transportation and other missions permit. The brigade mental health officer advises the FSMC on mental health/CSC issues and provides technical supervision for treatment of NP or BF casualties. He provides direct supervision for other division mental health section personnel deployed to the BSA. The brigade mental health officer ensures adequate professional standards for all counseling by CSC coordinators and for command consultation activities.

(3) Severe BF or NP cases which cannot be managed at the FSMCs clearing stations are evaluated by the brigade CSC team. These cases may be sent to the MSMC for evaluation by the division psychiatrist or his representative. No NP or BF casualty is evacuated from the division without being evaluated by the division psychiatrist or his representative.

(4) The division psychiatrist may also deploy to units throughout the division in response to requests for consultation. The division psychiatrist regularly visits the brigade CSC teams in the BSA and reinforces them at times of special need. He identifies problems in units and provides or coordinates consultation following critical events such as a fatal accident, rear battle incident with loss of life, or other catastrophic events. The psychiatrist and mental health officers provide CSC prevention training, consultation, critical event debriefing, and restoration support when indicated.

(5) The brigade CSC teams deploy with the supported brigade CSS elements to their BSAs. The brigade CSC teams maintain knowledge of the tactical situation, normally through the brigade surgeons. They assist the brigade surgeons with planning and projecting requirements for stress casualty prevention and reconstitution support. It is important that the brigade CSC teams keep the brigade surgeons and supported commanders updated on CSC issues. The brigade CSC teams also have a responsibility to keep the division psychiatrist informed in accordance with the TSOP. The brigade CSC teams request reinforcement from the division mental health section, as required, especially when there is an increase in the stress casualty and NP caseloads that are beyond their capability to handle. When reinforced, the brigade CSC team orients and updates the mental health/CSC augmenting personnel on CSC issues and requirements. The brigade CSC teams use the clearing stations of the FSMCs as the centers of their operations but must not be confined to that location. The priorities of functions for brigade CSC teams in support of the brigades are—

(a) Deploying forward to ambulance exchange points (AXPs) and combat trains to provide preventive support and immediate stress control intervention when possible.

(b) Triaging BF casualties, misconduct stress behaviors, and NP disorders prior to their evacuation, and advising the attending physician to prevent overevacuation.

(c) Facilitating the treatment of BF REST category cases in their battalions' field trains.

(d) Advising FSMC health care providers on treatment requirements for BF casualties.

(e) Coordinating the RTD process for recovered BF casualties.

(f) Facilitating postcombat stress debriefings at small units.

(6) The employment. of the medical detachment, CSC provides for a CSC preventive team to augment the brigade CSC team at the FSMC in each BSA. The CSC preventive team has a psychiatrist, social work officer, and two behavioral science specialists. This team has a 5/4-ton vehicle for transportation. This corps CSC preventive team could be diverted elsewhere. The brigade CSC team and brigade must be prepared to function without them. The mission of the CSC preventive team is discussed in Section III of this chapter.

c. *Unit-Level Mental HealthlCombat Stress Control Support.* Unit-level mental health/CSCsupport is provided by the brigade CSC team and the division psychiatrist, as required. The brigade CSC team officer and the NCO (or the brigade CSC coordinator alone) conduct site visits to all the units in the BSA on a frequent basis. The brigade CSC team ideally has preestablished points of contact (officers and NCOs) in each unit. Site visits by the brigade CSC team to supported units are performed for several reasons which involve both the units and the brigade CSC team. The primary reasons for these frequent site visits include—

- Establishing trust and confidence between the brigade CSC team and unit personnel.
- Establishing familiarity with the unit's operations, mission, and tasks and being able to converse with unit personnel and understand about what they do.
- Monitoring units for morale, unit cohesion, and indicators of excessive stress/stressors.
- Advising unit commanders, leaders, and personnel on stress management and coping techniques.
- Identifying, providing, or coordinating training on mental health/CSC subject areas.
- Providing preventive consultation.
- Providing feedback to the brigade surgeon and division psychiatrist on the mental health status of supported units.
- Monitoring the progress of REST and DUTY category BF soldiers that are recovering in their units.

(1) When a division mental health section's vehicle is in the BSA, the brigade CSC team uses this vehicle to visit supported units. If a designated vehicle from the division mental health section is not available (as when the brigade CSC coordinator is working without the brigade mental health officer being present), it is necessary to find alternative means of getting to the supported units. The transportation needs are dependent on the size of the BSA and the amount of traffic movement between units. In some situations when there are short distances between units, it may be feasible for the brigade CSC team to walk to the supported units located in the BSA or to coordinate rides with unit vehicles. The unit ministry teams (chaplains) can be especially helpful because of the common features of CSC and the chaplains' ministry and CSC support.

(2) The brigade CSC team must keep the FSMC informed of their whereabouts. This is done by reporting to the FSMC (using the visited unit's radio or land lines) immediately upon arriving and again just before departing, specifying the next destination. The brigade CSC team provides updates on the CSC situation at the unit just visited by using short brevity-coded messages. This constant contact with the FSMC permits the redirecting of the brigade CSC team to areas of special need.

(3) When combat is imminent or ongoing, the brigade CSC team may deploy forward to the AXPs to provide rapid evaluation and CSC intervention. The brigade mental health officer and brigade CSC coordinator may be at different locations. In some situations, one or both may go forward to a battalion aid station (BAS) located in the combat trains area.

(4) During lulls before or after combat actions, the brigade CSC coordinator may go forward to unit combat trains and BASS for preventive consultation. They meet with a unit in reserve that has experienced intensive combat or other problems. The brigade CSC team may use the division mental health section vehicle, ride in ambulances, or travel with the logistic package convoy or reconstitution teams going forward. The brigade CSC team updates and assists any mental health/CSC personnel sent to the brigade for reinforcing/augmentation support.

d. Clinical Duties of the Brigade Combat Stress Control Team in the Brigade Support Area. The brigade CSC team provides assistance to unit-level medical officers and physician assistants, as required, to ensure correct disposition for BF, misconduct stress behavior, and NP cases. At the BSA, the brigade CSC team assists in patient triage and in the evaluation of problematic BF and NP cases. The brigade CSC team assists the attending physician and patient-holding wardrnaster in providing general guidance and training for patient-holding squad personnel. The CSC team's guidance and training will include the emotional and behavioral aspects of patient care for the minimally sick and wounded as well as for BF and NP cases. Following the treatment protocol established by the division psychiatrist, and in accordance with the mental health/CSC plan, the brigade CSC team makes recommendations on the triage, management, and treatment of combat stress-related cases. Triaging of BF cases into the appropriate categories is essential for effective management and treatment. Management and treatment of the following triage categories are examples of how the brigade CSC team can manage combat stress-related casualties in the BSA. Additional information on combat NP triage, restoration, and consultation is provided in subsequent chapters. The BF casualty may be triaged and placed in one of the following categories:

- DUTY
- REST
- HOLD
- REFER

(1) Mild BF cases who reach the brigade MTF will be triaged as DUTY category. Some of these cases will require a brief time to recuperate (less than an hour to no more than 6 hours). This short period for recovery may include—

- Food and nourishment.
- Fluid to drink.
- A quiet place to nap.
- Reassurance to the soldier.

- The opportunity for talking about his experiences.

The DUTY category cases are sent back to their units with recommendations for full duty. If the soldier's unit is known to be in reserve status where everyone is resting and recovering, a lower level of combat functioning could still qualify as DUTY BF. However, if a soldier is classified as DUTY, he must be capable of caring for himself and responding appropriately to his duties if the unit comes under attack.

(2) REST category cases from maneuver units may require being away from far-forward areas for a few days. Normally, these cases are sent for 1 to 2 days of duty in the soldiers' own battalion HSC or battery. Alternatively, these soldiers may be held in BSA units under the control of the FSMC or brigade Adjutant (US Army) (S1) for 1 or 2 days. In both situations coordination is required, and the soldier must be accounted for until he returns to his own unit. REST category cases placed in units are monitored by the brigade CSC team. The brigade CSC team monitors these cases either by direct interview or by talking with the soldier's supervisors. The brigade CSC team listens to the soldier's story and gives perspective-reorienting counseling when indicated. REST cases are returned to the FSMC and placed in the HOLD category if symptoms persist and they fail to improve. These cases will be provided restoration treatment and additional evaluation at the FSMC. These cases are accounted for until they RTD with their own units.

(3) HOLD category BF cases are those who require medical observation and assistance. If feasible, these cases are provided restoration treatment at the FSMCs for 1 day (or up to 3 days if RTD is expected). When these cases are held in the FSMC's patient-holding area, it should be emphasized to them that BF soldiers are not patients, just tired soldiers. The feasibility of holding BF casualty cases at the FSMC depends on the tactical situation, patient work load, and the soldiers' symptoms. Restoration treatment for HOLD category cases placed in the patient-holding area of the FSMC includes—

- Reassuring that BF is normal and temporary.
- Providing a respite from extreme danger or stress.
- Ensuring dehydration.
- Providing replenishment (food and hygiene).
- Providing the opportunity for rest (sleep).
- Recounting (verbally reconstructing) the recent stressful events and regaining perspective.
- Restoring confidence through activities which maintain the individual's identity as a soldier.

(4) REFER category are BF and NP cases which cannot be safely held or treated at the FSMC. These cases may be triaged into the REFER category at the initial evaluation or they may be cases that have not responded to initial restoration treatment at the FSMC. These cases are evaluated at the FSMCs by the division psychiatrist or mental health officers if they are in the forward areas, or they are sent to DSA clearing station for evaluation and disposition by division mental health section or the designated alternates. The preferred method of evacuating these cases is by nonmedical vehicle, but ground ambulances are used, as necessary. Physical restraints and/or medication are used during transportation only if necessary for safety.

NOTE

A few BF or NP symptoms could also be caused by life- or limb-threatening medical/surgical conditions. These casualties may be evacuated directly to a corps-level hospital as determined by the attending physician.

Wounded casualties with concurrent BF or NP symptoms, who are either combative or violent, are placed in patient restraints as determined by the attending physician. If these types of patients are evacuated by air ambulance, physical restraints are required. The preferred method of transporting an unwounded BF casualty is by a nonmedical vehicle. The use of a nonmedical vehicle would help prevent the BF casualty from thinking that his condition is anything other than just being a very tired soldier. On the other hand, by placing the BF casualty in an ambulance which is clearly marked with the symbol of the red crosses, the BF casualty is under a protected status according to the rules established by the Geneva Conventions. The decision that confronts the health care provider is which of two methods is more beneficial for the overall safety and recovery of the BF casualty.

e. Mental Health/Combat Stress Control Support in the Division Support Area. The division mental health section personnel locate near and work with the DSA clearing station to ensure mental health/CSC coverage to support the DSA is available. They evaluate BF, misconduct stress behavior, and NP cases referred from throughout the division AO. The initial triage of cases from the DSA is the same as performed in the BSAs. The division mental health section staff in the DSA spends substantial time with evaluating the REFER category BF casualty sent from the forward areas of the division. Any of the REFER cases with good potential for RTD within 72 hours are held for treatment and placed in the MSMC patient-holding section. The total period of time for holding BF casualties in the division is 72 hours. If the BF casualty is held in the BSA for 24 hours, he can be held in the DSA only for an additional 48 hours. These cases are provided restoration treatment at the MSMC for up to 3 days. The feasibility of holding BF casualty cases at the MSMC depends on the tactical situation, patient work load, and the soldiers' symptoms. Restoration treatment for HOLD category cases placed in the patient-holding section of the MSMC is the same as identified for the FSMCS. The number of days (within the 72-hour time frame) of restoration that the MSMC can provide could be shortened or lengthened, depending on the tactical situation, available resources, and the actual or projected caseloads.

(1) The division psychiatrist, assisted by the clinical psychologist and social work officer (if they are not deployed to the BSAS), exercises technical supervision for the management of BF soldiers and NP patients placed in the patient-holding section. If possible, these cases are housed away from the ill, injured, or wounded patients.

(2) The division psychiatrist may designate a behavioral science specialist to assist the patient-holding squad with treatment of BF casualties. This treatment consists of replenishing sleep, hydration, nutrition, hygiene, and general health and restoring confidence through group activities, appropriate military work details, and individual counseling, as needed. These activities include those patients with minor wounds, injuries, and illnesses who do not need continual bed rest and who may have BF symptoms.

(3) The division psychiatrist follows the soldiers' progress, reevaluates, and gives individual attention, as needed. Medication is prescribed sparingly and only when needed to

temporarily support sleep or manage disruptive symptoms. Those cases who (on initial evaluation or after a period of observation) have a poor prognosis for RTD, or whose behavior is too disruptive or dangerous to manage in the holding facility, are evacuated to the supporting corps-level hospital. Such patients must be suitably restrained and medicated for transport. The evacuation priority for these NP patients is routine.

(4) Those cases who (on initial evaluation or after observation) require longer than the holding policy at the division-level MTF allows but who have reasonable prognosis for RTD within the corps evacuation policy are transferred to a corps-level restoration and reconditioning facility. Corps restoration and reconditioning facilities are staffed and operated by the medical company, CSC.

(5) Soldiers sent directly from a division MTF to a restoration and reconditioning center will ideally be transported in trucks, not ambulances. Prior coordination with the division Assistant Chief of Staff (Personnel) (Gl) and corps Adjutant General (AG) personnel replacement system may facilitate the returning of recovered BF casualties to their original units.

(6) For all recovered BF soldiers returned to duty from the DSA, the division mental health section coordinates with the division G1 and with the soldier's unit. The coordination is made directly or through the CSC coordinator in the DSA or brigade CSC team in the BSAS, the chaplains' ministry, or other channels. This is to ensure successful reintegration of these soldiers back into their units.

f. Division Support Area Combat Stress Control Coordinator. The CSC coordinator in the DSA performs functions similar to those of the brigade CSC coordinators for units located in the division rear but on a less independent scale. He works under the direct supervision of the division psychiatrist or the division mental health section NCOIC. The CSC coordinator's activities can be closely supervised and reinforced by the division psychiatrist; this position requires less experience and independence than the brigade CSC coordinators. This is a suitable preparatory training assignment for less senior behavioral science specialists before they become brigade CSC coordinators. However, the special problems of BF in CS and CSS units in the rear area make the DSA CSC coordinator's role no less important to the success of the division. It is essential to assign an individual with whom the units can identify and develop trust.

(1) During lulls in tactical activities, the DSA CSC coordinator conducts classes on mental fitness; provides consultation for unit leaders; provides crisis intervention counseling for soldiers; and gives counseling and referral for troubled soldiers.

(2) During tactical operations, the DSA CSC coordinator keeps current on the location and status of CS/CSS units, continues to provide consultation to these units, and coordinates the resting of DUTY and REST BF soldiers in or near their units.

3-4. Reinforcement of Brigade Combat Stress Control Team Using Division Mental Health Section Assets Only

a. Consultation Visits. Frequent visits to the BSAs and their brigade CSC teams should be scheduled on a routine basis by the division psychiatrist. These consultation visits may last hours or even 1 to 2 days. The division psychiatrist, in coordination with the MSMC commander, the DMOC, and the division surgeon, should consider enhancing support in the forward areas—

(1) When increased numbers of cases are being evaluated and followed at an FSMC such that the brigade CSC team cannot provide continuous coverage and still perform their consultation mission.

(2) If a member of the brigade CSC team becomes a casualty.

(3) When (in a static tactical situation) there are more cases who can be held for treatment at a particular BSA clearing station than its holding squad staff can manage.

(4) When conditions do not permit REFER cases to be evacuated to the DSA for evaluation.

(5) When there is a mass casualty situation and additional BF and NP diagnostic expertise is needed to triage those patients who require immediate evacuation and those who can be treated locally for quick RTD.

(6) When a battalion- or company-sized unit stands down (pulled back) for rest and recuperation or for regeneration. When the reconstitution process requires regeneration of heavily attrited units, mental health/CSC personnel should deploy along with other CSS contact teams to assist surviving members, assuring that all members get good quality rest and physical recuperation. During the "after-action debriefing," mental health/CSC personnel assist surviving members to review their recent combat experiences and restore a positive coping perspective to the group. Mental health/CSC personnel also assist with integrating survivors and replacements into cohesive teams (see Chapter 5).

b. Options for Reinforcing the Brigade Mental Health/Combat Stress Control Support. The division psychiatrist may use the following options to reinforce the brigade CSC teams in the forward areas with division mental health section assets:

(1) Send one behavioral science specialist to reinforce a brigade CSC team at the FSMC holding facility.

(2) Place two brigade CSC teams temporarily in support of a brigade that has large numbers of BF casualties.

(3) Deploy himself forward to supervise and assist the brigade CSC team until the situation or crisis has been resolved.

3-5. Corps-Level Mental Healtl/Combat Stress Control Support Reinforcement

The division psychiatrist should consider requesting additional corps-level mental health/CSC augmentation when—

- Caseload and/or geographical dispersion prevents the division mental health section from providing divisionwide consultation services.
- Combat stress-related casualties are beyond the treatment capabilities of division mental health section and whatever corps CSC assets that are attached.
- A battalion or brigade is withdrawn from a forward area back into the DSA for rest and reconstitution.
- Enemy forces have used NBC weapons.
- Other high stress factors (such as heavy losses as a result of prolonged and intense battles) are present.

The division psychiatrist may request, through the MSMC commander, the MSB support operations section, and the DMOC, reinforcing CSC support from corps. The DMOC coordinates corps CSC support with the medical brigade or group. Mental health/CSC support from the corps will be provided by the medical detachment, CSC or by elements from the medical company, CSC. Both the medical company, CSC and medical detachment, CSC operations are discussed in Sections III and IV of this chapter.

Section II. AREA SUPPORT MEDICAL BATTALION MENTAL HEALTH/COMBAT STRESS CONTROL SUPPORT OPERATIONS

3-6. Mental Health Section Employment

a. *Area Support Medical Battalion Mental Health Support.* The ASMB mental health section deploys with the HSC of the ASMB. When the ASMB deploys tactically, the mental health section collocates with the battalion headquarters but disperses its personnel and resources to support the ASMB's entire AO. The ASMB commander prioritizes the area mental health support mission based on input from the ASMB psychiatrist and battalion medical operations center in accordance with medical brigade/group and ASMB CHS plans. Battalion CP personnel coordinate with the ASMB psychiatrist and the ASMCs for the deployment of the mental health section's assets to support their AO. Each ASMC is normally allocated one NCO CSC coordinator. The battalion CP, in consultation with the ASMB psychiatrist, should consider enhancing mental health/CSC resources within an ASMC's AO when—

- Stress-related casualties are beyond the treatment capabilities of an ASMC and its CSC coordinator.
- A battalion- or company-sized unit is withdrawn from a forward area back into the ASMC AO for rest and regeneration.
- Enemy forces have used NBC weapons.
- Other high stress factors occur, to include—
  - Major accidents or disasters to a unit.
  - Heavy losses as a result of rear battles.
  - Friendly fire incidents.
  - Heavy casualties or suffering among noncombatants.

The ASMB psychiatrist may use four options to reinforce mental health support within the supported AO:

(1) Send one junior behavioral science specialist to the patient-holding section of the ASMC to reinforce the CSC coordinator previously deployed from the mental health section.

(2) Send the social work officer or the ASMB psychiatrist to the ASMC. This allows the CSC coordinator to relocate to other areas, as necessary. This officer can go unaccompanied to other locations within the supported AO. The CSC coordinator coordinates the requirements for such actions with the ASMC headquarters element.

(3) Use one mental health officer and one behavioral science specialist for a mobile team. They are provided a vehicle for movement to each location. The mobile team has the flexibility to move and provide CSC support at successive locations.

(4) Augment the mental health section with a CSC team from the supporting CSC company or detachment. Augmentation of mental health personnel should be considered (or planned) for all scenarios in which increases in BF and NP casualties are anticipated. The mental health section coordinates through the ASMB commander and battalion CP when requesting additional mental health/CSC support. The ASMB CP (medical operations center) forwards requests for mental health/CSC augmentation through the medical brigade/group to the CSC company. In the COMMZ, the request is sent to the medical brigade.

b. Area Mental Health/Combat Stress Control Support Operations. Upon deployment of the ASMB to its AO, area mental health support operations begin. The psychiatrist and one or two junior behavioral science specialists routinely locate at and work with the HSC clearing station. The social work officer and NCOIC (senior behavioral science specialist) may also locate with the HSC clearing station or with the battalion headquarters.

(1) The social work officer and NCOIC as directed by the battalion psychiatrist coordinate mental health section activities with the battalion CP. Coordination includes activities such as traveling to ASMCs and supported units and obtaining status updates of ASMCs and supported units. The social work officer and NCOIC actively support the CSC coordinators in their unit-based preventive mental health and training programs. They provide technical supervision and quality assurance over all the CSC coordinators' counseling and command consultation activities.

(2) One behavioral science NCO from the mental health section is allocated to each ASMC where he routinely serves as the mental health section's CSC coordinator for the supported AO. The CSC coordinator provides behavioral science advice to the ASMC commanders and treatment teams in assessment and triage. He trains the patient-holding squad personnel in management of stress casualties who must be held for restoration and treatment. The CSC coordinator also trains patient-holding squad personnel in stress intervention techniques for other DNBI patients. He visits units throughout the AO to routinely support recovery of DUTY and REST category BF soldiers. In addition to the above, the CSC coordinator will—

- Assist with the reintegration of recovered BF casualties into their original or new units.
- Provide command consultation.
- Conduct training for leaders in stress control principles and techniques.
- Facilitate after-action debriefings.
- Conduct critical incident stress debriefings, as necessary.

(3) To foster a good working relationship with supported units, the CSC coordinator (and all mental health personnel) should deploy to observe the unit at work or in tactical training exercises. The mental health/CSC mission objective is to become familiar with each of the different types of units and includes the—

- Unit's mission.
- Equipment.
- Vocabulary (words and operational or technical terms which are commonly used in the unit).
- Working conditions.
- Typical stressors.

This knowledge is essential to gain the trust and confidence of the unit's leaders and troops. It is necessary information for evaluating soldiers and their mental fitness to perform duties.

3-7. Disposition of Battle Fatigue and Neuropsychiatric Cases from the Area Support Medical Battalion

The ASMCs refer BF and NP cases who cannot be managed at the ASMC clearing stations to the psychiatrist at the HSC clearing station as soon as tactical conditions permit.

a. Preferred Method of Transport for Battle Fatigue and Neuropsychiatric Cases. The preferred method of transport for those BF and NP cases that are manageable without the use of medication or restraints is by a nonambulance ground vehicle. If physical restraints and/or medications are required during evacuation, the preferred method of transport is by ground ambulance. An air ambulance should be used only if no other means of transportation is available. Physical restraints are used only during transport and medications are given only if needed for reasons of safety.

b. Time and Distances Factors. When time and distance factors preclude the evacuation of BF and NP cases to the HSC, these cases may be evacuated to the nearest CSH, field hospital (FH), or general hospital (GH) for evaluation and treatment by that hospital's NP service. (These cases are not evacuated to a mobile army surgical hospital [MASH].) Consultation with the ASMB psychiatrist via telephone or radio is appropriate prior to evacuation. Direct evacuation from the ASMC clearing stations is accomplished without consultation when the BF or NP patient also has a life- or limb-threatening medical or surgical condition, or a life-threatening NP condition (for example, a suicide attempt) which cannot be stabilized at the ASMC clearing station. This decision is made by the attending physician, but ideally, the CSC coordinator should be advised. Cases with true NP disorders, or who do not respond to brief restoration treatment, are evacuated to supporting corps hospital or to the medical company, CSC.

Section III. SUPPORT OPERATIONS CONDUCTED BY THE MEDICAL DETACHMENT, COMBAT STRESS CONTROL

3-8. Medical Detachment, Combat Stress Control Employment

a. Medical Detachment, Combat Stress Control Support Operations. The CSC medical detachment is assigned to a medical group or other medical C2 headquarters and may be further attached to supported medical companies or medical company, CSC. Its employment in the theater depends on the intensity of the conflict. The medical detachment, CSC is employed in all intensities of conflicts whenever

a division or two separate brigades/regiments are deployed.

b. Support for Division Combat Operations During War. The medical detachment, CSC may be attached to the CSC medical company for C2. The detachment receives administrative and maintenance support from the CSC company headquarters. The detachment's teams are reinforced or provided personnel replacements by CSC teams or task-organized CSC elements from the company when necessary. A CSC detachment. which supports a division is usually attached to the supported division's MSMC of the MSB. It is under the operational control of the MSB and MSMC but works under the technical supervision of the division psychiatrist and division surgeon. Long-term relationships of CSC detachments with specific divisions are standard. However, as a corps asset, the detachment (or its modular teams) may be cross-attached to support other units or missions as work load requires. It depends on the unit(s) to which it is attached for administrative and logistics support.

(1) Upon the initial attachment of the detachment, its three 4-person CSC preventive teams are usually further attached. One CSC preventive team is attached to each FSMC well before combat is imminent. This permits them to link up with and augment the brigade's CSC team and the FSMC. Each CSC preventive team provides another mental health officer and a psychiatrist (with a behavioral science specialist and vehicle) to increase triage, stabilization, and restoration capability at the FSMC. The CSC preventive team performs the following:

- Conducts regular visits to the BSA to provide consultation throughout the FSB while the CSC restoration team is further forward.
- Operates further forward during ongoing combat by cross-exchanging personnel with the brigade CSC team.
- Deploys to provide reconstitution support to units undergoing hasty or deliberate reorganization.

In some operations, however, some or all of the CSC preventive team personnel may remain back at the supporting corps-level medical company or be concentrated at another brigade or reconstitution site with a heavier work load.

(a) While the brigade is on the move, BF soldiers who cannot return immediately to their forward units may be rested and transported by their own unit's field trains. They eat, drink, restore hygiene, catch up on sleep, talk, and perform useful duties while regaining full effectiveness on the move. The readiness of units to keep such cases will depend on their knowing that trusted CSC personnel are present as backup. The BF cases who require medical observation for only a few hours are transported with the CSC preventive teams and the FSMC.

(b) Any stress casualties who require *more* extensive restoration must be transported to the rear echelon of the medical detachment, CSC at the MSMC. Transportation in backhaul supply trucks is preferred to ground or air ambulances for most BF casualties. If the distances involved require the use of supply helicopters or air ambulances, the CSC personnel must assure that the BF casualties do not overfly the next echelon and are not evacuated further to the rear than necessary.

(2) The medical detachment, CSC's 11-person CSC restoration team (including the NCOIC of the headquarters section) remains with the division mental health section at the MSMC in the DSA. The detachment has tents and equipment to operate a restoration center and provides expertise in clinical psychology, psychiatric nursing, and OT. The center provides intensive restoration treatment for RTD within 3 days. The CSC restoration team provides triage and stabilization at the MSMC and consultation

to nearby division units. The CSC restoration team staff may go forward by truck or air ambulance to temporarily reinforce or reconstitute a CSC preventive team at the brigade, or to escort BF casualties in truck backhaul to the restoration center. The CSC restoration team personnel give reconstitution support to attrited units, especially when the units return to the DSA. The C3C restoration team supplements the division psychiatrist, brigade CSC teams, CSC preventive teams, and chaplains and leaders in after-action debriefings. They help integrate the recovered soldiers and new replacements into the units during reorganization activities.

(3) The medical detachment, CSC and its elements are dependent on the units to which they are attached for food, water, fuel, maintenance, and administrative support.

(4) When the DSA is tactically too unstable to allow restoration, the CSC restoration team and perhaps the CSC preventive section may locate further to the rear. They may locate with an ASMB or a corps hospital which is close enough for them to continue their support to the division.

(5) When all three CSC preventive teams are forward at the brigades, the detachment commander/psychiatrist is forward with one of the CSC preventive teams. This is usually acceptable, as the detachment is attached (operational control [OPCON]) to the MSMC under the supervision of the division psychiatrist. Under some situations, the detachment commander may elect to remain with the CSC preventive team. He may leave his CSC preventive team with only one social work officer and two behavioral science specialists if work load at the BSA is light. In other situations, he may elect to send the clinical psychologist from the CSC restoration team to take his place. The detachment NCOIC and the officers of the CSC restoration team keep the commander informed and represent him as needed. If the division has only two maneuver brigades, the CSC preventive team which includes the detachment commander normally remains with the division mental health section and CSC restoration team in the DSA.

c. Support to Separate Brigades or Armored Cavalry Regiments During War. A separate brigade or ACR in a mid- to high-intensity conflict is dependent on division or corps CSC assets for support.

(1) A medical detachment, CSC which supports two or three separate brigades or regiments is normally attached to the medical group or the medical company, CSC which supports the AO.

(2) If two brigades or ACRs are supported, two of the detachment CSC preventive teams are deployed forward and attached to the FSMCs of the two supported brigades or ACRs. The detachment commander's team locates where it can best provide backup support to the forward elements and coordinates administrative and logistical support. The CSC preventive teams with each separate brigade operate as described above for divisional brigades, except they are reinforcing a brigade CSC team which has only a behavioral science NCO in charge. The ACRs have no CSC team to reinforce. The CSC preventive team, therefore, needs to be much more active in making contact and establishing trust and cohesion with the following elements and personnel:

- Medical company personnel.
- Battalion or squadron medical platoons.
- Brigade or regiment chaplain and unit ministry teams.
- Unit commander and leaders at all levels.

It is especially important that this process begins as far in advance of the onset of combat operations as possible, preferably before deployment.

(3) If a third separate brigade is supported, the detachment commander's CSC preventive team deploys to it.

(4) The CSC restoration team either locates with the detachment commander and provides restoration treatment at that location or augments a corps-level MTF where cases from the supported brigades can best be treated. It integrates its restoration and reconditioning programs with those of the other supporting CSC units.

d. Combat Stress Control Detachment in Operations Other Than War. In a prolonged conflict involving a contingency corps with one or more divisions and/or several separate brigades and regiments, only CSC medical detachments (no CSC medical company) maybe mobilized. For contingency operations of short duration, task-organized CSC elements from the CSC medical detachments could be deployed.

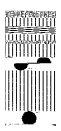
(1) The CSC preventive teams supporting the brigades may operate out of a central base of operations. The teams go forward to the BSAS (base camps or fire bases) when coordinated by the division mental health section. Such visits would be in response to—

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

(2) Several CSC restoration and CSC preventive teams 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 corps. This may also function as an alcohol/drug detoxification rehabilitation program.

required, the task-organized CSC elements may reinforce or provide replacement personnel for those CSC medical detachments. Maximal communications are encouraged between the CSC medical detachments and the task-organized CSC elements directly through technical channels. The mental health staff sections of the medical brigade and medical group ensure that CSC medical companies are updated. They provide the medical company, CSC headquarters and the relevant task-organized CSC elements with information copies of all status reports received from the CSC medical detachments in their AO. For detailed information pertaining to medical company, CSC headquarters and task-organized CSC elements, see Section IV. Normally, the detachment is attached for OPCON to an MSMC of the MSB in the divisions. If it is supporting in the corps area, then it could be attached to a medical company, CSC, an ASMB, or directly to the medical group. Interface and coordination are essential if CSC support requirements are to be accomplished.

a. Interface Between the Detachment and Its Higher Headquarters. The medical detachment, CSC interfaces with its higher headquarters pertaining to its assigned mission. It provides estimates and has input to the OPLANs. The detachment receives its OPORDs from the higher headquarters. Interface between the detachment and the staff of its higher headquarters will focus on providing CSC which includes preventive activities and consultation support. Interface between the detachment and higher headquarters staff elements will include the following subject areas:



Combat stress control operations.

Assignment or attachment of the medical detachment, CSC elements.

Daily personnel and equipment status reports.

- Class VIII (medical supply) status and supply requirements.

Casualty Feeder Reports.

Statistical summaries pertaining to work load, including consultation and triage activities, restoration or reconditioning center censuses, and special reconstitution support activities.

Operation plans.

Operation orders.

Personnel replacement for the detachment.

- Medical intelligence information.
- Mental health / CSC consultation taskings and results.
- Maintenance requirements and request.
- Replacement and reconstitution operations.
- Civil-military operations.
- Host-nation support.
- Communications (signal operation instructions [SOI], access to message centers and nets, and transmission of CSC messages through medical and other channels).

Mass casualty plan.

Road movement clearances.

Tactical updates.

Contingency operations.

- Return-to-duty and nonreturn-to-duty procedures.
- Medical evacuation procedures (air and ground ambulances).
- Changes in locations of supported unit.

b. Interface and Coordination with the Unit That Has Operational Control of the Medical Detachment. Combat Stress Control. The headquarters of the unit with OPCON is responsible for providing the administrative and logistical support requirements of the detachment. These requirements are normally identified in the attachment order. If not identified in the attachment order, they must be coordinated by the detachment's higher headquarters prior to deployment. The CSC detachment must coordinate daily with the headquarters staff and section leaders (if required) of the unit to which they are attached. The staff shares information with the detachment commander or his representative. Daily updates pertaining to the threat, tactical situation, patient/BF casualty status, and changes in CHS requirements are provided to the detachment. Coordination activities and subject area information exchange should include—

- Command and control procedures.
- Status of FSMCs and CSC preventive teams.
- Communications (SOI).
- Operational support requirements.
- Civil-military operations.
- Restoration operations.
- Reinforcement and personnel replacement.
- Maintenance.
- Personnel replacement.
- Road movement and clearantes.
- Casualty reporting and accountability.
- Patient-holding procedures.
- Nuclear, biological, and chemical defensive operations.

Section IV. SUPPORT OPERATIONS CONDUCTED BY THE MEDICAL COMPANY, COMBAT STRESS CONTROL

3-10. Medical Company, Combat Stress Control Employment

a. Medical Company, Combat Stress Control Support Operations. The medical company, CSC is assigned to a MEDCOM, medical brigade, or medical group. The medical company, CSC is employed for a war when estimates indicate large numbers of BF casualties. During war, one medical company, CSC may support from two to five divisions depending on the level of operations. The company is reinforced by attachment of a variable number of CSC medical detachments. Normally, one CSC detachment is allocated per division and one per two or three separate brigades or regiments in the corps. The medical detachment, CSC is discussed earlier in Section III.

b. Methods of Operations for the Medical Company, Combat Stress Control. Methods of operations for the medical company, CSC are dependent on the CSC support requirements and the tactical situation. The CSC medical company commander can deploy modular CSC preventive and CSC restoration teams from the company's preventive and restoration sections. He also has the option to combine elements from both sections to form task-organized CSC elements, depending on CSC requirements. The personnel in the preventive and restoration sections do not have to be task-organized in rigid compliance with the modular CSC preventive and CSC restoration team building blocks. For example, one task-organized CSC element may be given most of the psychiatric nursing assets, while another may receive more of the OT resources. This decision would be based on the shifting requirements set by the reconditioning or restoration caseloads at different places and other priority missions. The intent is to give the commander flexibility to accomplish his changing mission requirements for CSC.

(1) Task-organized CSC element employment. The task-organized CSC elements are employed to provide CSC support in their area of responsibility. They must coordinate with the supporting ASMB and hospital NP resources within their AO. The task-organized CSC element leader is responsible for allocating the CSC resources which the medical company, CSC commander has given his element. He must meet the changing requirements for—

- Preventive consultation and CSC education in the corps (supporting the ASMB) (see Chapter 4).
- Reconstitution support (a major, but intermittent priority mission tasked by the higher headquarters) (see Chapter 5).
- Neuropsychiatric triage (shared with the ASMB and hospital NP consultation services) (see Chapter 6).
- Stabilization under emergency situations; normally, this is the mission of the hospital NP ward/service (see Chapter 7).
- Restoration (in areas where the task-organized CSC element is closer to the soldier's units than an ASMC, or by sending a team to reinforce an ASMC) (see Chapter 8).
- Reconditioning (the unique mission of the CSC company's task-organized CSC elements in corps and in most scenarios, but of lower priority than the missions listed above) (see Chapter 9).
- Temporary support (sending CSC teams to reinforce the medical detachment, CSC which are operating forward in the division and brigade areas, or when reconstitution support and restoration work loads require).
- Reinforcement of the medical detachment, CSC, division mental health section, or ASMB mental health section, if necessary or providing replacement personnel.

(2) Restoration and especially reconditioning are provided for BF soldiers and selected NP and alcohol/drug misuse cases from the supported division and corps units. The task-organized CSC elements attach to or collocate with medical units as near to the supported units as is tactically feasible. In the initial intensive phase of conflict, CSC teams may be dispersed to reinforce the CSC medical detachments in the divisions. They may be attached to an ASMC or a CSH where they can readily support the divisions and heavily committed corps units. In this phase, reconditioning treatment in the corps area will rarely continue beyond 3 days, in addition to the initial 3 days of restoration. As the conflict stabilizes and the requirement for restoration decreases, reconditioning extends to seven days. If feasible, and with approval of the corps commander, it is extended to 14 days. The

task-organized CSC element's combat fitness and reconditioning center is usually attached (not OPCON) to a CSH.

(3) A task-organized CSC element from the medical company, CSC usually deploys in the corps area behind each supported division. The task-organized CSC element behind each division has two or three CSC preventive teams and one to three CSC restoration teams, depending on support requirements. Each task-organized CSC element may be reinforced by one or two support personnel (cook, mechanic) detailed from the medical company, CSC headquarters. Each task-organized CSC element sends modular teams forward to reinforce the medical detachment, CSC in the supported division, as needed. Table 3-1 shows the ways that teams could be distributed as task-organized CSC elements to support two to five divisions.

(4) When not task-organized with a CSC preventive team, the CSC restoration teams normally collocate with a CSH or with the HSC of an ASMB. Both the CSH and headquarters and support company of the ASMB provide a psychiatrist. This is of lesser importance if the psychiatric nurse of the CSC

Table 3-1. Distribution of Six Combat Stress Control Preventive and Four Combat Stress Control Restoration Teams into Task-Organized Combat Stress Control Elements to Support from Two to Five Divisions

NUMBER OF DIVISIONS SUPPORTED	TOCSCE-A	TOCSCE-B	TOCSCE-C	TOCSCE-D	TOCSCE-E	HQ
2 or 4*	CSCP[3]/R[2]	CSCP[3]/R[2]	—	—	—	—
3 or 5*	CSCP[2]/R	CSCP[2]/R	CSCP[2]/R	—	—	(CSCR)**
4	CSCP/R	CSCP/R	CSCP/R	CSCP/R	—	(CSCP2)**
5	CSCP/R	CSCP/R	CSCP/R	CSCP[2]/R**	CSCP	—
5	CSCP[2]/R[4]	CSCP	CSCP	CSCP	CSCP	—
5	CSCP	CSCP/R[2]*	CSCP	CSCP/R[2]*	CSCP	(CSCP)**

* TASK-ORGANIZED CSC ELEMENTS SUPPORTS MORE THAN ONE DIVISION.
** MEDICAL COMPANY, CSC HEADQUARTERS DETAILS THESE TO THE TASK-ORGANIZED CSC ELEMENTS WITH GREATER NEED AT A SPECIFIC TIME.
[2,3,4] NUMBERS INDICATE NUMBER OF MODULAR PREVENTIVE (P) OR RESTORATION (R) TEAMS.

LEGEND:
CSCP—combat stress control preventive team.
CSCR—combat stress control restoration team.
TOCSCE—task-organized combat stress control element.

NOTE: Medical company, CSC headquarters routinely shifts CSC teams or personnel from one task-organized CSC elements to another as work load in and behind each division fluctuates. It tries to keep at least a small task-organized CSC elements behind each division. It could, for instance, redistribute all of its CSC restoration section temporarily behind one division while keeping a CSCP dedicated to each of the other divisions.

restoration team is a clinical nurse specialist or if the psychologist is especially trained to prescribe medications. A CSC restoration team may be deployed forward without a CSC preventive team to support a heavily committed division or an ASMC in the corps.

c. Reconditioning Centers. The medical company, CSC will use task-organized CSC elements to staff separate, small reconditioning centers behind each division. However, under some circumstances, the medical company, CSC may consolidate teams to establish a large reconditioning center which supports two or three divisions. Reconditioning facilities normally locate near a CSH. Figure 3-1 illustrates the task-organized CSC elements of the CSC medical company operating a reconditioning center near a CSH. For definitive information on reconditioning center operations, see Chapter 9.

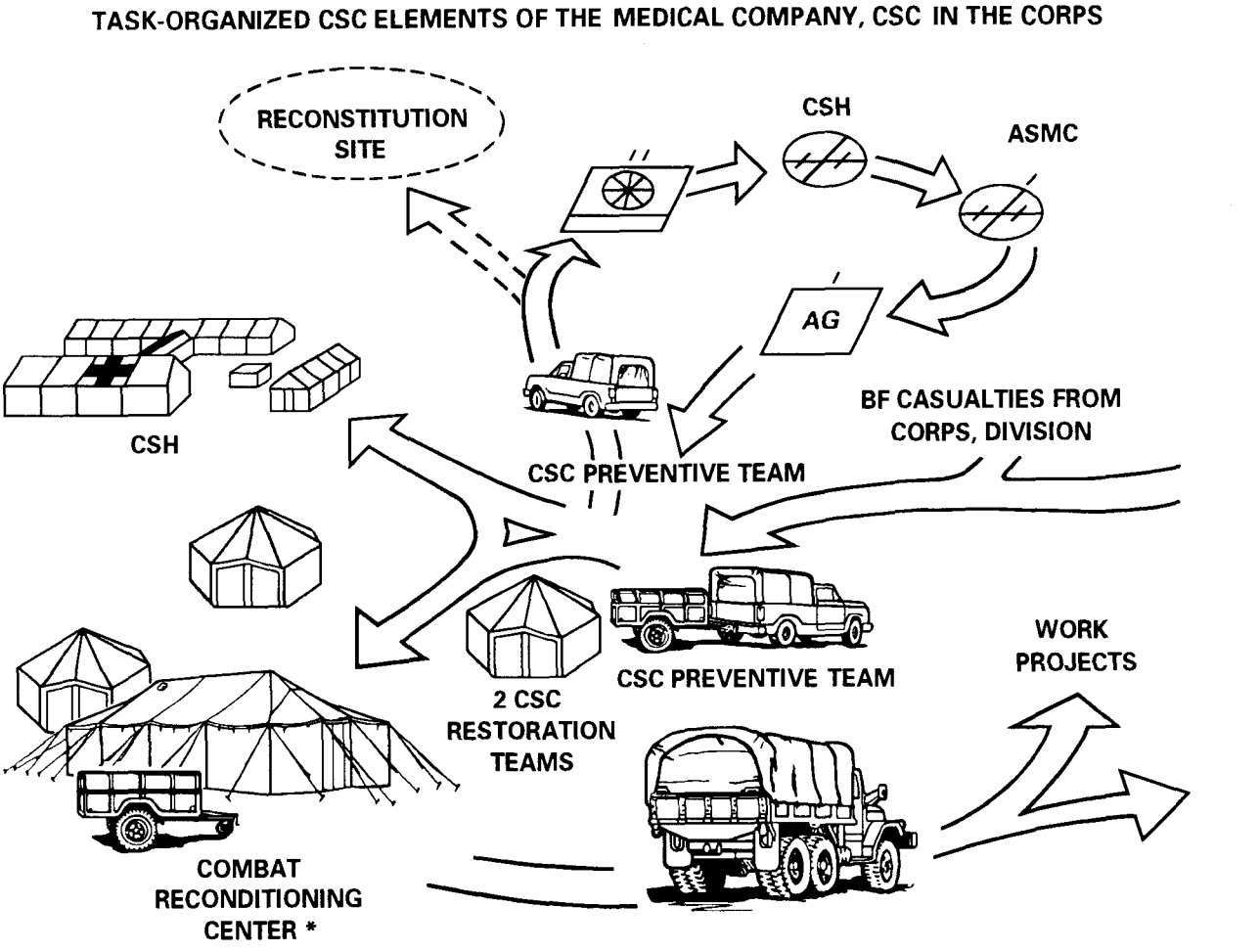


Figure 3-1. Pictorial figure of a reconditioning center.

3-11. Medical Company, Combat Stress Control Coordination and Interface Requirements

The medical company, CSC coordinates with its higher medical headquarters element and with the units to which the company's CSC elements will be attached. The higher headquarters may be the medical brigade or medical group. Interface and coordination are essential for providing and ensuring CSC support requirements to prevent or limit the effects of combat stress and the number of BF casualties are accomplished.

a. *Coordination and Interface between the Medical Company and Its Higher Headquarters.* The medical company, CSC coordinates with its higher headquarters pertaining to its assigned mission. The mental health staff section of the medical brigade and medical group are points of contact for this coordination. It provides estimates and has input to the OPLANs. The company receives its OPORDs from the higher headquarters. Interface between the company and the staff of its higher headquarters will focus on providing CSC, which includes preventive activities and operating restoration and reconditioning centers for the support divisions. This interface between the company and higher headquarters staff elements will include the following subject areas:

- Combat stress control operations.
- Assignment or attachment of the CSC preventive teams, CSC restoration teams, or task-organized CSC elements from the company.
- Daily personnel and equipment status reports.
- Class VIII status and resupply requirements.
- Casualty feeder reports.
- Work load summaries including consultation and triage activities, restoration or reconditioning center censuses, and special reconstitution support activities.
- Operation plans and orders
- Personnel replacement for the detachment..
- Medical intelligence information.
- Status of restoration center(s).
- Status of reconditioning center(s).
- Mental health / CSC consultation.
- Maintenance requirements and requests.
- Replacement and reconstitution operations.
- Civil-military operations.
- Host-nation support.
- Communications (S01, access to message center and nets, and transmission of CSC messages through medical and other channels).
- Mass casualty plan.
- Road movement clearances.
- Tactical updates.
- Contingency operations.

- Return-to-duty and nonreturn-to-duty procedures.
- Medical evacuation procedures (air and ground ambulances).
- Locations of supported units or changes in their location.

b. Interface and Coordination with the Unit that has Operational Control of the Medical Company, Combat Stress Control Teams or Task-Organized Combat Stress Control Elements. The headquarters of the unit with OPCON is responsible for providing the administrative and logistical support requirements of the company's teams or task-organized CSC elements. These requirements are normally identified in the attachment order. If not identified in the attachment order, they must be coordinated by the medical company, CSC headquarters prior to the deployment of its elements. Deployed teams or task-organized CSC elements from the medical company, CSC coordinate daily with the headquarters staff and section leaders (if required) of the unit to which they are attached. That headquarters transmits the CSC element's messages and reports to the receiving medical headquarters via medical C2 channels. The team/task-organized CSC elements' leader shares information with team members and updates the medical company, CSC commander as required. The medical company, CSC elements are provided daily updates from the headquarters element of the unit to whom attached. These daily updates may include information pertaining to:

- Threat situation.
- Tactical situation.
- Patient/BF casualty status.
- Changes in CHS requirements.

Coordination activities and exchange of subject area information should include—

- Command and control procedures.
- Status of F'SMCs and CSC preventive teams.
- Communications.
- Operational support requirements.
- Civil-military operations.
- Restoration operations.
- Reinforcement and reconstitution.
- Reconditioning center operations.
- Maintenance.
- Personnel replacement.
- Road movement and clearantes.
- Casualty reporting and accountability.
- Patient-holding procedures.
- Nuclear, biological, and chemical defensive operations.
- Hospital admission and disposition procedures.