



Department of Defense DIRECTIVE

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ASD(HA)

SUBJECT: Combat Stress Control (CSC) Programs

- References: (a) [DoD Directive 6490.2](#), "Joint Medical Surveillance," August 30, 1997
(b) [DoD Instruction 6490.3](#), "Implementation and Application of Joint Medical Surveillance for Deployment," August 7, 1997
(c) DoD Inspector General Report No. 96-079, "Evaluation Report on the Management of Combat Stress Control in the Department of Defense," February 29, 1996
(d) Sections 801-940 of title 10, United States Code, "Uniform Code of Military Justice"

1. PURPOSE

This Directive:

1.1. Establishes policy and assigns responsibilities in accordance with references (a), (b), and (c) for developing CSC programs within the Military Services, the Combatant Commands, and Joint Service Operations.

1.2. Ensures appropriate prevention and management of Combat Stress Reaction (CSR) casualties to preserve mission effectiveness and warfighting, and to minimize the short- and long-term adverse effects of combat on the physical, psychological, intellectual, and social health of Service members.

2. APPLICABILITY AND SCOPE

This Directive:

2.1. Applies to the Office of the Secretary of Defense, the Military Departments (including the U.S. Coast Guard when it operates as a Military Service in the Navy), the Chairman of the Joint Chiefs of Staff, the Combatant Commands, the Defense Agencies, and the DoD Field Activities (hereafter referred to collectively as "the DoD Components"). The term "Military Services," as used herein, refers to the Army, the Navy, the Air Force and the Marine Corps Active and Reserve components.

2.2. Applies to Active and Reserve components during wartime contingencies, small-scale contingencies, and humanitarian operations other than war.

3. DEFINITIONS

Terms used in this Directive are defined in enclosure 1.

4. POLICY

It is DoD policy that:

4.1. CSC policies and programs shall be implemented throughout the Department of Defense to enhance readiness, contribute to combat effectiveness, enhance the physical and mental health of military personnel, and to prevent or minimize adverse effects of Combat Stress Reactions (CSRs).

4.2. Service CSC consultants shall meet periodically to develop, coordinate, and oversee implementation of CSC programs and to ensure joint interoperability of CSC programs, when necessary. The Army shall be responsible for scheduling meetings and for submitting periodic reports of the Services' progress to the Assistant Secretary of Defense for Health Affairs.

4.3. Leadership aspects of combat stress prevention shall be addressed in senior enlisted, officer, and flag-rank training programs. Protective factors against CSRs, such as frequent communication (in person) with troops, unit morale, and unit cohesion, shall be emphasized.

4.4. CSC units shall train with operational organizations or platforms on a regular basis. ("Train as you fight and fight as you train.")

4.5. The BICEPS (Brevity, Immediacy, Centrality, Expectancy, Proximity, Simplicity) principles of combat stress management shall guide management of CSRs.

4.6. Military units or Service members experiencing CSRs shall be managed within the unit or as close to the operational front or near the Service member's unit as possible. Rapid evacuation and separation of CSR casualties from his or her military unit greatly increases the risk of subsequent, serious, long-term social and psychiatric complications, and is, therefore, indicated only when absolutely mission essential.

4.7. Conduct that may violate the UCMJ (reference (d)), including conduct potentially associated with CSRs, shall be addressed by the commander or other convening authority pursuant to reference (d) procedures.

4.8. CSR casualty rates shall be collected as a discrete, separate category from other neuropsychiatric and disease and non-battle injury (DNBI) casualty rates. CSR, neuropsychiatric, and DNBI data shall be provided separately for inclusion in the Medical Analysis Tool, the Joint Staff outpatient DNBI surveillance system and any subsequent data system developed for casualty prediction methodologies.

4.9. Service CSC programs:

4.9.1. Shall consist of curricula, training, and exercise requirements for joint and Service-specific operations that focus on primary, secondary, and tertiary prevention of CSRs in settings from garrison to the battlefield. This includes a variety of command consultation activities. In addition to BICEPS training, the training shall address leadership, communication with troops, unit morale and cohesion, and individual psychosocial stressors, before, during, and after deployment in accordance with DoD Instruction 6490.3 (reference (b)).

4.9.2. Shall ensure training of all personnel in appropriate CSC principles. The amount, content, and type of training shall be appropriate to the rank and responsibility of the Service member.

4.9.2.1. Senior officers shall understand CSC policy and management strategies and shall integrate plans of CSC in strategic operational planning, both in wargaming and on the battlefield.

4.9.2.2. Officers shall develop strategies for primary prevention related to leadership, communication, unit cohesion, and morale. Leaders shall be able to recognize the signs and symptoms of CSRs in themselves and their unit(s) that may require consultation with CSC personnel.

4.9.2.3. Training standards for mental healthcare providers assigned to CSC units shall be appropriate to the CSC unit mission and shall include experiential learning using the BICEPS model.

4.9.2.4. All other non-mental health medical personnel shall be familiar with the BICEPS principles of CSC management.

4.10. CSC unit personnel shall: consult with line commanders about surveillance and prevention, identification, and management of CSRs in units or individuals; identify at-risk populations by assessing unit morale, cohesion, and stress levels; evaluate units after exceptionally stressful events and conduct Critical Event Debriefings (CEDs), as indicated; provide consultation to commanders about end-of-tour debriefings; and evaluate and treat those Service members suffering from serious mental disorders.

5. RESPONSIBILITIES

5.1. The Assistant Secretary of Defense for Health Affairs, under the Under Secretary of Defense for Personnel and Readiness, shall ensure compliance with this Directive, annually monitor the effectiveness of the CSC doctrine, and individual Services' policies and programs in joint and Service-specific operations, and issue such instructions and guidance as may be needed to implement this Directive.

5.2. The Assistant Secretary of Defense for Reserve Affairs, under the Under Secretary of Defense for Personnel and Readiness, shall ensure that policies for the Reserve components in the Service and Joint Service CSC Programs are consistent with the policies established for Active components.

5.3. The Secretaries of the Military Departments shall:

5.3.1. Ensure compliance with this Directive.

5.3.2. Establish in coordination with the Secretaries of the other Military Departments a Joint Service CSC Program.

5.3.3. Develop comprehensive CSC policies and programs, consistent with the Joint Service CSC Program, for Service-specific operations from garrison to the battlefield that:

5.3.3.1. Establish standardized policies for forward management of and rearward evacuation of CSR casualties;

5.3.3.2. Are interoperable with other Military Departments' CSC Programs during Joint operations; and

5.2.3.3. Address prevention and management of stress before deployment and CSRs during and after deployment.

5.3.4. Coordinate CSC policies and programs with the Joint Chiefs of Staff, the other Military Services, and the Office of the Assistant Secretary of Defense for Health Affairs.

5.3.5. Develop CSC unit organizational structure and determine the appropriate mix of administrative support staff and mental healthcare providers for CSC units that maximize interoperability among the Services during Joint Operations.

5.3.6. Develop CSR casualty rates as a discrete, separate category from other neuropsychiatric and DNBI cases. CSR, neuropsychiatric, and DNBI data shall be provided separately for inclusion in the Medical Analysis Tool, the Joint Staff outpatient DNBI surveillance system, and any subsequent data system developed for casualty prediction methodologies.

5.3.7. Ensure assignment of appropriately trained personnel to CSC units. Units shall be assigned to augment operational organizations or platforms and shall exercise with the assigned platform on a periodic basis.

5.3.8. Annually monitor, review, and evaluate CSC program activities and effectiveness, such as policy, curricula, and training schedules, in accordance with DoD Directive 6490.2 and DoD Instruction 6490.3 (references (a) and (b)) and this Directive and make recommendations for policy and program improvements, when indicated.

5.3.9. In coordination with the Chairman of the Joint Chiefs of Staff, oversee Joint Service and the Military Services' CSC Program implementation during combat and military operations other than war.

5.3.10. Assign mental healthcare providers to serve as consultants to the Combatant Command Surgeons and the CINCs, as needed. Two mental healthcare providers shall be selected from the Army, two from the Navy, and one from the Air Force.

5.3.11. Recommend changes or improvements to the CSC Programs to the Assistant Secretary of Defense for Health Affairs.

5.4. The Chairman of the Joint Chiefs of Staff, in coordination with the Commanders of the Combatant Commands and the Chiefs of Staff of the Military Services, shall monitor policies and implementation of CSC Programs.

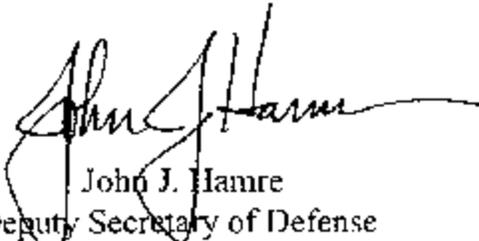
5.5. The Commanders of the Combatant Commands, in coordination with the Chairman of the Joint Chiefs of Staff and the Services, shall

5.5.1. Ensure that the policies of this Directive are executed during all operations.

5.5.2. Designate a mental healthcare provider with training and demonstrated experience in CSC management to serve as consultant on CSC issues to the Combatant Command Surgeon and the commander in chief (CINC), as needed. Prior to appointment as CSC consultant, the individual is encouraged to complete a Service or Joint Staff school.

6. EFFECTIVE DATE AND IMPLEMENTATION

This Directive is effective immediately. The Secretaries of the Military Departments and the Chairman of the Joint Chiefs of Staff shall forward implementing regulations and CSC program guidance to the Assistant Secretary for Defense (Health Affairs) within 120 days.



John J. Hamre
Deputy Secretary of Defense

Enclosures - 1

E1. Definitions

E1. ENCLOSURE 1

DEFINITIONS

E1.1. TERMS

Following are the definitions:

E1.1.1. BICEPS. An acronym for the management of CSRs: Brevity (usually less than 72 hours); Immediacy (as soon as symptoms are evident); Centrality of management (in a centralized CSC unit separate from, but proximal to, a medical unit); Expectancy (CSC unit personnel expectation that casualties will recover); Proximity (of treatment at or as near the front as possible); and Simplicity (the use of simple measures such as rest, food, hygiene and reassurance).

E1.1.2. Combat Stress Control (CSC). Programs developed and actions taken by military leadership to prevent, identify, and manage adverse CSRs in units; optimize mission performance; conserve fighting strength; prevent or minimize adverse effects of combat stress on members' physical, psychological, intellectual and social health; and to return the unit or Service member to duty expeditiously. In accordance with DoD Directive 6490.2 (reference (a)), CSC activities include routine screening of individuals when recruited; continued surveillance throughout military service, especially before, during and after deployment; continual assessment and consultation to line, medical and other personnel from garrison to the battlefield regarding physiologic, psychological and organizational stressors; personnel training about combat stress; CED; and individual and/or unit management of CSRs.

E1.1.3. Combat Stress Control (CSC) Consultant. A mental healthcare provider with training and demonstrated experience in CSC management who consults to the Combatant Command Surgeon and the commander in chief (CINC), as needed, about matters related to CS, such as unit cohesion, unit morale, leadership, effective communication, and perceived mission importance. Completion of a Service or Joint Staff school is recommended prior to appointment as CSC Consultant.

E1.1.4. Combat Stress Control (CSC) Personnel. Active and Reserve component mental healthcare providers or others trained in a mental healthcare role, such as enlisted specialists, who have training and experience in the BICEPS principles of CSC and administrative support personnel. Senior experienced CSC personnel serve as advisors to line commanders on leadership, communication, unit cohesion, morale, and training factors that prevent or minimize CSRs.

E1.1.5. Combat Stress Control (CSC) Policy. Doctrinal policy developed by the DoD Components to ensure comprehensive CSC programs in Joint and Service-specific operations.

E1.1.6. Combat Stress Control (CSC) Unit. A military unit within or attached to a parent medical unit composed of CSC and administrative support personnel. The accompanying or parent medical unit supports the CSC unit with sufficient equipment, materiel, communications, and transportation so that the CSC unit can function independently in concert with the mission of the operational platform. The CSC unit does not require either a separate command nor support infrastructure from its accompanying medical unit. The size and composition of the CSC unit depends upon the mission and the operational platform.

E1.1.7. Combat Stress Reactions (CSRs). The expected, predictable, emotional, intellectual, physical, and/or behavioral reactions of Service members who have been exposed to stressful events in combat or military operations other than war. CSRs vary in quality and severity as a function of operational conditions, such as intensity, duration, rules of engagement, leadership, effective communication, unit morale, unit cohesion, and perceived importance of the mission, etc. Terms for combat stress historically included Nostalgia, Soldier's Heart, War Neurosis, Combat Neurosis, Combat Fatigue, Combat Exhaustion, and Battle Fatigue.

E1.1.8. Critical Event Debriefing (CED). A debriefing conducted by Combat Stress Control (CSC) personnel after an exceptionally stressful event such as a unit member's death, witnessing noncombatant death or extreme suffering, receipt of friendly fire, etc., to help resolve mission misunderstandings, enhance communication, strengthen unit cohesion and readiness for further action, prevent or minimize psychological reactions to the event and return the unit to duty as soon as possible. The effectiveness of debriefing to ameliorate stress reactions and prevent long-term physical, psychological, intellectual, and poor social effects is optimized when all officers and enlisted personnel are debriefed together, as a team. Techniques of CED also may be used for a single individual, such as a returned prisoner of war, when appropriate.

E1.1.9. Prevention of Combat Stress Reactions (CSRs)

E1.1.9.1. Primary. The employment of effective leadership, enhancement of unit cohesion and morale, effective communication, and provision of realistic training ("train like you fight and fight like you train") that increase stress tolerance, and appropriate consultation by line commanders with CSC personnel to help prevent unit and individual CSRs. These leadership and training factors are equally important before, during and after deployment to optimize readiness for future operations and to facilitate homecoming.

E1.1.9.2. Secondary. Secondary prevention begins with training for early recognition of CSRs and employing self, buddy, and leader interventions to keep Service members at duty and to prevent contagion in a unit. Once a Service member who has shown CSRs related to stressors of the operation is evacuated to a CSC unit, secondary prevention consists of management using the BICEPS principles. CSC mental health providers shall determine if the referred Service member is experiencing a stress reaction or has a serious mental disorder.

E1.1.9.3. Tertiary. The employment of standard psychiatric evaluation and treatments to determine if a referred Service member has a CSR; other serious condition, such as psychotic, mood, anxiety, somatoform disorders or Post Traumatic Stress Disorder; and/or physical injury, such as head trauma, electrolyte imbalance, etc., any of which may or may not be related directly to stressors of the operation. Tertiary prevention includes a thorough mental health and medical evaluation, stabilization and treatment, pending medical evacuation to echelon V for definitive treatment and disposition. The goal of tertiary prevention is to minimize long-term effects of the psychiatric and/or medical condition.