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FORCE HEALTH PROTECTION

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Force Health Protection

1. This change replaced the term "gender" with "sex" in accordance with Executive Order 14168.

2. A plus character (+) marks new material.

3. ATP 4-02.8, 08 August 2025, is changed as follows:

Change Version Pages	Change Description
page 2-31	corrects text in paragraph 2-152
page 4-10	corrects text in paragraph 4-41

4. An updated Authentication Page has amended the prior authentication reflected after Change 1 and in the rear of this publication.

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Preface

Force health protection (FHP) is the Army Medical Department's (AMEDD's) mission in the protection warfighting function and is comprised of the medical functions of preventive medicine (PVNTMED); veterinary services; area medical laboratory (AML) services; and the preventive aspects of the medical functions of dental services and combat and operational stress control (COSC). It falls under the overarching concept of providing Army Health System (AHS) support, which encompasses both health service support under the sustainment warfighting function and FHP missions.

This publication focuses on FHP support to unified land operations. The FHP doctrine presented in this publication is based on Department of Defense (DOD) and Department of the Army (DA) policies; Department of Defense directives (DODDs); Department of Defense instructions (DODIs); Army regulations (ARs); Army doctrine publications (ADPs); Army doctrine reference publications (ADRPs); field manuals (FMs); Army technique publications (ATPs); technical bulletins (medical) (TB MEDs); technical manuals (TMs); technical guides (TGs); training circulars (TCs); lessons learned from recent military operations; and approved Army doctrine.

The principal audience for ATP 4-02.8 is all commanders, their staffs, command surgeons, and all medical personnel in support of the FHP mission as a guide to understanding their roles, responsibilities, functions, and duties.

Commanders, staffs, and subordinates ensure their decisions and actions comply with applicable United States (U.S.), international, and, in some cases, host-nation laws and regulations. Commanders at all levels ensure their Soldiers operate in accordance with the law of war and the rules of engagement (see FM 27-10).

This publication implements or is in consonance with the following North Atlantic Treaty Organization (NATO) standardization agreements (STANAGs); American, British, Canadian, Australian, and New Zealand (Armies) (ABCA) standards; and ABCA Publication 256, Coalition Health Interoperability Handbook. For information on multination force interoperability refer to AR 34-1.

NATO STANAG	***ABCA STANDARD***	***TITLE***
	423	Levels of Medical Support
	815	Blood Supply in the Area of Operations
2048		Deployment Pest and Vector Surveillance and Control—AMedP-4.2
2060		Identification of Medical Material for Field Medical Installations—AMedP-1.5
2122		Requirement For Training In Casualty Care And Basic Hygiene For All Military Personnel - AMedP-8.15 Edition A
2132		Documentation Relative to Initial Medical Treatment and Evacuation— AMedP-8-1
2136		Requirements for Water Potability During Field Operations and in Emergency Situations—AMedP-4.9
2454		Road Movements and Movement Control—Allied Movement Publication (AMovP)-1(A)
2556		Food Safety, Defense, and Production in Support of NATO Operations—AMedP-4.5, AMedP-4.6, AMedP-4.7, and AMedP-4.12
2885		Emergency Supply of Water in Operations

NATO STANAG	ABCA STANDARD	TITLE
2931		Orders for the Camouflage of Protective Medical Emblems on Land in Tactical Operations—Allied Tactical Publication-79
2937		Requirements of Operational Rations for Military Use— AMedP-1.11
2939		Minimum Requirements for Blood, Blood Donors and Associated Equipment

Army Techniques Publication 4-02.8 uses joint terms where applicable. This publication is not the proponent for any Army terms.

Unless otherwise stated in this publication, the use of masculine nouns and pronouns does not refer exclusively to men.

As used in this publication, the terms community health and public health are synonymous.

The staffing and organization structures presented in this publication reflect those established in the base tables of organization and equipment (TOEs) and are current as of this publication's print date. Such staffing is subject to change in order to comply with manpower requirements criteria outlined in AR 71-32. Those requirements criteria are also subject to change if the modified TOEs are significantly altered.

This publication applies to the Active Army, Army National Guard/Army National Guard of the United States, and United States Army Reserve unless otherwise stated.

The proponent and preparing agency of ATP 4-02.8 is the United States Army Medical Center of Excellence. Send comments and recommendations on DA Form 2028 *(Recommended Changes to Publications and Blank Forms)* to **Commander, United States Army Medical Center of Excellence, ATTN: MCCS-FD (ATP 4-02.8), 2377 Greeley Road, Suite D, JBSA Fort Sam Houston, TX 78234-7731**; by e-mail to usarmy.jbsa.medical-coe.mbx.ameddcs-medical-doctrine@mail.mil or submit an electronic DA Form 2028. A rational for each proposed change is required to aid in the evaluation and adjudication of each comment.

Introduction

Force health protection encompasses all of the preventive aspects of the AHS. The AHS is a system of health which promotes the physiological and psychological well-being of Soldiers and their Families from their accession into the U. S. Army, throughout their careers, and into their retirement or separation from military service. Force health protection promotes healthy and positive lifestyle changes which result in healthy and fit Soldiers, facilitates and enhances resilience, and ensures a combat-ready force. The cornerstone of this philosophy is the performance triad—sleep, activity, and nutrition.

This publication addresses the preventive aspects of the various functions which comprise FHP. Although the design of this publication discusses each function separately, the reader must keep in mind the AHS is a system of systems that is interdependent and interrelated and requires continual planning, coordination, and synchronization to prevent and mitigate health risks to deployed Soldiers and to provide the highest quality of care to our wounded, injured, and ill Soldiers. This publication is organized as follows:

- Chapter 1, Force Health Protection and the Performance Triad. This chapter provides an introduction to the performance triad and its importance to maintaining a healthy and fit combat-ready force.
- Chapter 2, Preventive Medicine. The medical function of PVNTMED is described including all programs and services which are encompassed by this function. The chapter also discusses the levels of PVNTMED support and the PVNTMED assets as they are arrayed on the battlefield.
- Chapter 3, Veterinary Services. The Defense Health Agency (DHA) exercises management responsibility for shared services, functions, and activities in the Military Health System and its common business and clinical processes. As such, veterinary support is provided to all Services with the exception of food inspection on United States Air Force installations by United States Army veterinary resources.
- Chapter 4, Combat and Operational Stress Control. The medical function of COSC covers both the FHP aspects of behavioral health (BH) and the health service support (treatment) aspects of neuropsychiatric and BH support. For a discussion of the treatment aspects refer to ATP 4-02.5. This chapter discusses stress prevention and combat and operational stress reaction (COSR) management, resilience, and programs.
- Chapter 5, Preventive Dentistry. This chapter has been superseded by ATP 4-02.19.
- Chapter 6, Area Medical Laboratory. Area medical laboratory services and support fall under the protection warfighting function and the FHP mission area because of its capability to identify chemical, biological, radiological, and nuclear (CBRN) warfare agents. Although it is also capable of providing direct support to hospital clinical laboratories in support of medical diagnosis and treatment, it is the only laboratory in theater which can identify and confirm the presence of CBRN agents.
- Appendix A, Determination of Eligibility for Care of Military Working Dogs and Other Government-Owned Animals. This appendix provides the considerations for determining the eligibility for care in a U.S. Army veterinary facility of military working dogs, contractor animals, government-owned animals, unit mascots if authorized by command, and personal pets.

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Chapter 1

Force Health Protection and the Performance Triad

The performance triad is the essential building block of the Soldier component of a healthy and fit force. A Soldier who is well nourished, physically and mentally fit, and well rested is better able to withstand the rigors of deployment, to perform at a higher level, and to be more resistant to the effects of the existing environmental and occupational health threats, and more resilient in overcoming any adverse effects.

SECTION I – FORCE HEALTH PROTECTION

1-1. Force health protection encompasses measures to promote, improve, conserve or restore the mental or physical well-being of Soldiers. These measures enable a healthy and fit force, prevent injury and illness, and protect the force from health hazards. These measures also include the prevention aspects of a number of AMEDD functions (PVNTMED, including medical surveillance and occupational and environmental health (OEH) surveillance; veterinary services, including the food inspection and animal care missions, and the prevention of zoonotic disease transmissible to man; COSC; dental services [preventive dentistry]; and laboratory services [AML support]). Each of these functions will be discussed in separate chapters of this publication.

1-2. Force health protection is a component of the AHS under the protection warfighting function. Both the FHP mission and health service support are planned and executed by the same medical planning staffs and personnel, but these missions are addressed under separate annexes in operation plans and orders. Health service support is addressed in the sustainment annex and FHP is addressed in the protection annex. For additional information on the protection warfighting function refer to ADP 3-37 and ADRP 3-37 and for additional information on the sustainment warfighting function refer to ADP 4-0 and ADRP 4-0.

SECTION II – PERFORMANCE TRIAD

1-3. As the Army Medical Department transitions from a health care system to a system of health, the paradigm for Army health care is being refocused on promoting the adoption of a healthy lifestyle, preventing casualties from preventable illnesses, physical fitness, medical treatment, and health improvement. The three cornerstones of the performance triad are sleep, activity, and nutrition.

SLEEP

1-4. The importance of sleep cannot be overstated. Getting the needed sleep is a shared responsibility of the Soldier, small-unit leaders, and commanders. For optimal performance and effectiveness, 7 to 8 hours of good quality sleep (uninterrupted) is needed. As total sleep time decreases below this optimal level, the extent and rate of performance decline increases.

1-5. When in a deployed environment unit leadership develops sleep plans to ensure that all Soldiers (including unit leaders) receive adequate sleep. The priorities for sleep include-

- Leaders making decisions critical to mission survival. Adequate sleep both the speed and accuracy of decision making (top priority).
- Soldiers who have guard duty, who are required to perform tedious tasks such as monitoring equipment for extended periods, and those who judge and evaluate information (second priority).
- Soldiers performing duties only involving physical work (third priority).

1-6. For an in-depth discussion on sleep refer to FM 6-22.5.

ACTIVITY

1-7. Activity is an essential element of the performance triad. The commander uses physical training programs and physical readiness training to develop his Soldier's strength, endurance, and mobility. When combined, these components increase muscular strength and endurance, aerobic and anaerobic conditioning, endurance, and mobility.

1-8. To reduce injuries to Soldiers, commanders should consider the following when developing and conducting training:

- Precision: Training is conducted using proper technique to reduce injury.
- Progression: Training gradually increases intensity and duration to allow the body to adapt to the strain and stress of the activity.
- Integration: Includes a variety of activities to achieve balance in the development of strength, endurance and mobility.

1-9. In addition to physical conditioning, physical readiness programs require activities that minimize the risk of injuries while maximizing the Soldier's performance. Resources available to commanders in developing their programs are health care providers and master fitness trainers. These personnel are trained to assist the commander in identifying, alternate physical readiness programs for injuries or profiles, and fitness tools for Soldiers. For additional information refer to the U.S. Army Public Health Center (Provisional) Web site.

NUTRITION

1-10. Nutrition and hydration have a direct impact on Soldier fitness and endurance. Nutrients, derived from food sources, provide the essential substances to maintain the functioning of the body while proper hydration provides a balance between the body's water and electrolyte requirements. Commanders and Soldiers need to recognize the correlation between proper nourishment and hydration with positive performance benefits and conversely the performance detriments caused by poor nutrition and hydration habits.

1-11. There are three main sources of nutrients that provide the body with energy; carbohydrates, fats and proteins. The following nutrients are referred to as macronutrients, which are essential nutrients required by the body in relatively large amounts to produce energy:

- Carbohydrates- Preferred food for endurance and resistance training.
- Fat-Provides taste to food and satisfies hunger and absorbs certain vitamins.
- Protein-Provides for building new tissue and tissue repair.

1-12. A Soldiers nutritional management or choices can be influenced by nutritional education and the availability of healthy food selections. Soldiers are provided with the training and educational tools to make well-informed choices in their nutritional selection and consumption of food. The Army has implemented programs to assist Soldiers with the opportunity to make nutritional choices and offer healthy options in dining facilities, commissaries, fitness centers, and when available, fast food restaurants, snack shops, convenience stores, vending machines, and worksites.

1-13. For additional information on nutrition and the Army Food Program, refer to AR 30-22, AR 40-25, ATP 4-02.5, FM 6-22.5, and the U.S. Army Public Health Center (Provisional) Web site.

Chapter 2
Preventive Medicine

History has shown that more Soldiers are lost due to disease and nonbattle injury (DNBI) than to combat wounds. Therefore, maintaining the health and fighting fitness of Soldiers is a vital responsibility of all leaders. Commanders can reduce the health threat by emphasizing preventive measures. All leaders must be active in promoting the importance of personal hygiene, field sanitation, adequate rest, counseling, and treatment of COSRs.

SECTION I – DISEASE AND NONBATTLE INJURY AND THE HEALTH OF THE COMMAND

2-1. Commanders and unit leaders are responsible for protecting and preserving both Army personnel and equipment against injury, damage, or loss from a wide range of sources

PROTECTION WARFIGHTING FUNCTION

2-2. Preventive medicine falls under the protection warfighting function and is concerned with both the enemy threat and the health threat (see Table 2-1, on page 2-2). The enemy threat produces combat casualties. This threat depends on the types of weapons used, the will of the enemy to fight, and other operational concerns. The health threat is a composite of all ongoing potential enemy actions and environmental conditions (DNBIs) that may render a Soldier combat ineffective. Commanders and unit leaders are responsible for protecting and preserving Army personnel against injury or loss that may result from risks of communicable and vector-borne diseases; food- and waterborne diseases; hearing and vision injuries; venomous or toxic flora and fauna; musculoskeletal injuries from training and recreation; occupational illness and injury; and environmental injury (for example, heat, cold, humidity, and significant elevations above sea level). Army policy stated in AR 11-35 requires commanders to provide timely assessment of OEH risks to personnel under their command; minimize those risks, balanced with operational requirements; ensure operational plans include OEH risk management elements; provide timely risk information to their personnel; and make informed OEH risk management decisions. To counter the health threat, comprehensive medical surveillance activities, OEH surveillance activities, individual PVNTMED measures, inspection of potable water and field feeding facilities, and field hygiene and sanitation are instituted and should receive command emphasis. Preventive medicine measures can include immunizations, pretreatments, chemoprophylaxis, and physical and chemical barriers. Field hygiene and sanitation combined with individual PVNTMED measures, to include correctly wearing the uniform and using insect repellent, sunscreen, and insect netting can protect Soldiers when implemented appropriately. Leaders must enforce and Soldiers must practice these activities continuously during the force projection and postdeployment process

Table 2-1. Health threat

Diseases	Endemic and epidemic. Food borne. Waterborne. Arthropod borne. Zoonotic. Vectors and breeding grounds.
Occupational and environmental health hazards	Climatic (heat, cold, humidity, and significant elevations above sea level). Toxic industrial materials. Accidental or deliberate dispersion of radiological and biological material. Disruption of sanitation services or facilities (such as sewage and waste disposal). Disruption of industrial operations or industrial noise.
Poisonous or toxic flora and fauna	Toxic poisonous plants and bacteria. Poisonous reptiles, amphibians, arthropods, and animals.
Medical effects of weapons	Conventional (to include blast and mild traumatic brain injury/concussion). Improvised (to include improvised explosive devices). Chemical, biological, radiological, and nuclear warfare agents. (See ATP 4-02.83/MCRP 4-11.1B/NTRP 4-02.21/AFMAN 44-16 [I]). Directed energy. Weapons of mass destruction.
Physiologic and psychological stressors	Continuous operations. Combat and operational stress reactions. Wear of mission-oriented protective posture ensemble. Stability tasks. Home front issues.

PREVENTIVE MEDICINE SERVICES

2-3. Field PVNTMED services encompass the following AMEDD functions:

- Preventive medicine services.
- Veterinary services.
- Combat and operational stress control (prevention aspects).
- Dental services (preventive dentistry).
- Area medical laboratory

PREVENTIVE MEDICINE MEASURES

2-4. Preventive medicine measures are those actions taken to counter the health threat and to prevent DNBI. These measures include proper field sanitation practices; medical surveillance; pest and vector control; disease risk assessment; OEH surveillance; proper waste disposal (human, hazardous, solid wastewater, and medical); food safety inspection; and potable water surveillance. A key point to remember is that most DNBI casualties are preventable by applying proactive PVNTMED measures. The application of basic PVNTMED measures reduces and, in some cases, eliminates the incidence of DNBI. However, the success of reducing or eliminating DNBI depends upon commanders and unit leaders who are charged with protecting the health and safety of their Soldiers, as well as upon the individual Soldiers who are responsible for executing prescribed individual PVNTMED measures.

2-5. Preventive medicine measures are critical in protecting all Soldiers, since healthy Soldiers may be the difference between mission accomplishment and mission failure. Soldiers who do not become DNBI

casualties remain part of the fighting force. Therefore, if a military force can minimize the number of DNBI casualties, more Soldiers can focus on accomplishing their wartime mission, unit cohesion is maintained, and medical evacuation and treatment assets are conserved and focused on treating combat casualties.

SECTION II — PURPOSE OF PREVENTIVE MEDICINE

2-6. The Army has established a multifaceted PVNTMED program to identify and address the health threat to Soldiers, their Family members, and the civilian workforce that supports them.

2-7. Preventive medicine is the anticipation, prediction, identification, prevention, and control of communicable diseases, illnesses (including vector-, food-, and waterborne diseases), illnesses, injuries, and diseases due to exposure to OEH threats, including nonbattle injury threats, COSRs, and other threats to the health and readiness of military personnel and units.

SECTION III — MEDICAL DETACHMENT (PREVENTIVE MEDICINE)

2-8. The mission of the medical detachment (preventive medicine) TOE 08429A000 (Figure 2-1) is to provide technical consultation support on PVNTMED issues throughout the theater. It provides mission command for the headquarters and organic PVNTMED teams. For an in-depth discussion of the PVNTMED mission refer to Section IV on page 2-4.

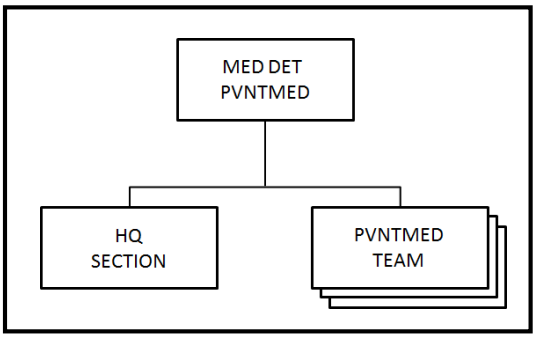

Figure 2-1. Medical detachment (preventive medicine)

2-9. The PVNTMED detachment is assigned to a medical command (deployment support) (MEDCOM [DS]), medical brigade (support) (MEDBDE [SPT]), medical battalion (multifunctional) (MMB), medical company (area support), or a medical task force control headquarters in echelons above brigade (EAB). The PVNTMED detachment may also be attached to a unit in a brigade combat team (BCT) or EAB. The detachment is allocated based on one per 17,000 troops supported at EAB.

2-10. This unit is dependent upon the appropriate elements of the theater for religious, legal, AHS support, finance, and personnel and administrative services.

2-11. When this unit is attached to EAB units, the detachment collocates on a temporary basis with the supported unit until the mission is completed or mission priorities change. When attached to a BCT, the detachment collocates with the PVNTMED section the medical company (brigade support battalion) to ensure coordination of support efforts. When deployed in general support, the detachment collocates with a medical unit or headquarters.

2-12. This unit provides—

- Ability to gather information systematically to input into an automated medical surveillance system to produce real time tactically significant health threat profiles.
- Guidance to the command concerning PVNTMED measures by performing a medical assessment of the command the potential impact of DNBIs on military operations.
- Epidemiological investigations to include case-contact interviewing, contact tracing, and outbreak investigations.
- On-site water quality analysis.

- Monitoring of water and field ice production and distribution.
- Collection of water, soil, and air samples from sources that may pose environmental, occupational, or industrial hazards to U.S. troops for definitive analysis by EAB laboratories or reachback to laboratories located in the continental United States (CONUS).
- Food service sanitation inspections of field feeding sites.
- Monitoring and guidance on proper field sanitation and waste disposal techniques.
- Guidance on the prevention of climatic injuries (heat, cold, and altitude).
- Direct pest management support including aerial spray missions using aerial spray equipment.
- Direct medical entomology consultation on: arthropod-borne diseases; use of pesticides; poisonous and toxic plants and animals; and measures to control or avoidance of disease vectors or military significance.
- Collection of water and ice samples for CBRN surveillance and establishes and maintains a chain of custody for samples, and forwarding samples to supporting medical laboratories for identification.
- Coordination with Chemical Corps CBRN reconnaissance and biological detection units for collection of air and soil environmental samples for laboratory analysis.
- Information on specific PVNTMED measures to counter health threats.
- Training and certification for field sanitation team and food service personnel.
- Health promotion education.
- Inspection of cargo destined out of theater for plants, arthropods, rodents, soil, and other items as specified to prevent their introduction to the U.S., its territories and possessions, or other nations.
- Assistance in the issuance of vessel clearances for entry into the destination ports, as authorized.
- Staff estimates of health threats in the area of operations (AO).
- One wheeled vehicle mechanic (military occupational specialty [MOS] 91B) to augment the maintenance capability of the unit that performs maintenance on its organic vehicles.
- Three teams as necessary to perform missions.

2-13. This unit does not perform field maintenance on any organic equipment including communications security equipment. Individuals of this organization can assist in the coordinated defense of the unit area.

2-14. In the headquarters section, the detachment provides mission command of assigned personnel and coordinates with supporting units to ensure the detachment's administrative, communication, general and medical supply, and maintenance needs are being provided while attached to medical or other supporting units. When divided into teams, the teams are responsible for conducting evaluations within their assigned AO and/or to be task-organized to provide direct PVNTMED support to the BCT and EAB units as required. This unit requires 100 percent mobility of its TOE equipment be transported in a single lift using its authorized organic vehicles.

SECTION IV — PREVENTIVE MEDICINE MISSION

2-15. Unlike most TOE units whose mission is normally conducted in a deployed setting, the PVNTMED TOE mission begins in garrison and continues to expand in the deployed setting. To be effective, PVNTMED assets (to include veterinary services, preventive dentistry, COSC, and AML services) must be involved in the early planning stages of every military operation to perform health threat assessments and to identify effective PVNTMED measures to counter these threats. Adequate PVNTMED resources must be deployed during theater opening operations to prevent disease among early-entry forces and to prepare the way for follow-on forces. In this way, PVNTMED capabilities enable commanders to meet AR 11-35 responsibilities and promote mission accomplishment and operational success through conservation of the fighting strength.

2-16. Preventive medicine provides essential information, services, and countermeasures to commanders, unit leaders, and individual Soldiers. Preventive medicine capabilities are critical to establish and sustain the health of the force at all times, especially during mobilization and the phases of the Army Force Generation (ARFORGEN) process. For a discussion of the ARFORGEN process refer to AR 525-29.

2-17. Preventive medicine contains specialized fields, such as the following:

- Epidemiology.
- Clinical PVNTMED.
- Medical entomology.
- Occupational medicine.
- Industrial hygiene.
- Environmental health sciences.
- Environmental health engineering.
- Ergonomics.
- Hearing conservation and readiness (components of the Army Hearing Program).
- Health promotion and wellness.
- Vision conservation and readiness.
- Health physics.
- Public health nursing.

2-18. The field of PVNTMED also has trained personnel in public health nursing (formerly referred to as community health nursing); toxicology and laboratory support sciences (to include environmental, occupational, and radiological chemistry and microbiology); and health risk assessment and communication. These PVNTMED personnel cover only a portion of the capabilities needed for the comprehensive application of military public health principles throughout the Army. Personnel trained in veterinary medicine, preventive dentistry, COSC, nutrition science, and other medical disciplines play key roles in preventing DNBI by operating independently or in coordination with the PVNTMED specialties identified above. For a discussion of nutrition care refer to ATP 4-02.5.

OPERATIONAL HEALTH ASSESSMENT

2-19. The application of specialized PVNTMED fields to military operations enables commanders and noncommissioned officers to manage health risks to their personnel while balancing mission requirements. Operational health risks associated with actual and potential health threats must be incorporated into the commander's risk-management process during all phases of operations. The Army program for managing health risks associated with Army operations is outlined in AR 11-35. Threat anticipation and identification, risk assessment and communication, and the use and evaluation of countermeasures must be integrated into all mission planning and operational phases. Preventive medicine personnel must provide timely and useful health risk information if such risks are to be successfully managed through the commander's risk management process.

HEALTH SURVEILLANCE

2-20. Preventive medicine personnel play a significant role in health surveillance. Health surveillance is the regular or repeated collection, analysis, and interpretation of health-related data and the dissemination of information to monitor the health of a population and to identify potential health risks, thereby enabling timely interventions to prevent, treat, reduce, or control disease and injury, which includes occupational and environmental health surveillance and medical surveillance subcomponents.

OCCUPATIONAL AND ENVIRONMENTAL HEALTH SURVEILLANCE

2-21. Occupational and environmental health surveillance is the regular or repeated collection, analysis, archiving, interpretation, and dissemination of OEH-related data for monitoring the health of, or potential health hazard impact on, a population and individual personnel, and for intervening in a timely manner to prevent, treat, or control the occurrence of disease or injury when determined necessary.

2-22. In particular, OEH surveillance includes data describing potential or actual exposures of individuals or populations to OEH hazards that can cause short-term or long-term adverse health effects. Occupational and

environmental health surveillance consists largely of sampling and analyzing air, water, and soil for hazardous materials, noise, or environmental extremes (heat, cold, humidity, and significant elevations above sea level), surveillance and analysis of arthropod-borne disease vectors, and using that information to communicate and document health risks and recommend appropriate countermeasures.

2-23. Data from OEH surveillance is also used to document potential and actual exposures, including CBRN exposures to military personnel. Occupational and environmental health surveillance capabilities can also be used to monitor and document communicable diseases, as well as potential and actual exposures.

MEDICAL SURVEILLANCE

2-24. Medical surveillance is the ongoing, systematic collection, analysis, and interpretation of data derived from instances of medical care or medical evaluation, and the reporting of population-based information for characterizing and countering threats to a population's health, well-being, and performance.

2-25. In particular, medical surveillance includes medical data related to individual patient encounters and the use of that data to calculate both DNBI and battle injury rates for a defined population, primarily for preventing and controlling health and safety hazards. Medical surveillance provides commanders with an estimate of the overall health of their commands, as well as some of the actual and potential health threats to their commands, so that they can take appropriate risk management actions.

SECTION V — MAJOR PREVENTIVE MEDICINE PROGRAMS AND SERVICES

2-26. Preventive medicine support is divided into ten programs and services. These programs and services are discussed below. Due to the interrelated topics addressed in PVNTMED programs, some overlap in the programs may be noted. Additionally, the emphasis in this ATP is on deployment-related activities, comprehensive PVNTMED programs also address garrison-related topics and are briefly addressed to provide the reader with the complexities of the entire PVNTMED programs.

DISEASE PREVENTION AND CONTROL

2-27. Communicable diseases can rapidly degrade the medical readiness of military units and their ability to carry out their mission. Communicable diseases can also cause significant suffering and excess utilization of military health care services among the beneficiary population. Therefore, primary care, PVNTMED, and other health care providers in both table of distribution and allowances (TDA) and TOE medical organizations are required to deliver disease prevention and control services whether Soldiers are in training, conducting their garrison missions, or in the field. These services, delivered in clinical and nonclinical settings, are initiated to prevent the occurrence and reduce the severity and consequences of diseases in individuals and populations. The disease prevention and control programs are delineated in Table 2-2.

Table 2-2. Disease prevention and control programs

Disease prevention and control programs	*Activities*
Communicable disease prevention and control	• Screening and monitoring procedures for early detection of disease (using a variety of clinical examinations and laboratory tests). • Health risk communications; immunizations, as appropriate, and chemoprophylaxis.
Travel medicine	• Health risk communications; immunizations, as appropriate, and chemoprophylaxis.
Population health management	• Health promotion and wellness. • Medical surveillance. • Health risk communications. • Epidemiology. • Preventive medicine. • Occupational and environmental medicine.
Hospital-acquired infection control	• Medical surveillance. • Infection control measures and quality assurance program within the hospital. • Records and reports.

FIELD PREVENTIVE MEDICINE

2-28. Field PVNTMED focuses on improving and sustaining the health and fitness of the force and the operational management of health risks. The overall objectives of field PVNTMED are to provide commanders with healthy and fit deployable forces; to sustain health and fitness in military operations; and to prevent casualties from DNBIs. Preventive medicine capabilities to achieve these objectives enable commanders to effectively manage OEH risks when planning and conducting operations. For a discussion of field PVNTMED programs and activities refer to Table 2-3 on page 2-8.

2-29. Field PVNTMED services are provided according to the policies and responsibilities established in AR 40-5 and Department of the Army Pamphlet (DA Pam) 40-11. Field PVNTMED services include capabilities from the following AMEDD functions:

- Preventive medicine services.
- Veterinary services.
- Combat and operational stress control (preventive aspects).
- Dental services (preventive dentistry).
- Area medical laboratory services.

2-30. Essential to the success of field PVNTMED is ensuring Soldiers are aware before, during, and after CONUS and outside the continental United States (OCONUS) deployments of significant health threats and the corresponding medical prophylaxis, immunizations, and other unit and individual protective measures for the deployment AO. Health threat information for an OCONUS AO can be obtained from the National Center for Medical Intelligence. Commanders must be kept informed before, during, and after deployments of the health of the force, health threats, stressors, risks, and available countermeasures.

2-31. For field PVNTMED to be effective—

- Soldiers must apply the basic individual PVNTMED measures prescribed in TC 4-02.3 on field hygiene and sanitation.
- Unit leaders must motivate, train, and equip subordinates prior to and during field training exercises and all deployments to negate health threats through the use of individual and unit PVNTMED measures and health risk communications.
- Company-sized units must establish and employ manned, trained, and equipped unit field sanitation teams.

- Medical and OEH surveillance must be provided for each Soldier from accession through the entire length of his military service commitment. Such surveillance must be accomplished as required by AR 40-5 and DA Pam 40-11.
- Field PVNTMED information management needs must be met using standard military medical and nonmedical information and communication systems.
- Health risk communication must be conducted in the field through planning and implementation using proven processes and tools.

Table 2-3. Field preventive medicine programs

Field preventive medicine	*Activities*
Unit field sanitation team	• Organic company-level team appointed by commander and trained to provide unit-level field hygiene and sanitation support. • Main emphasis is placed on those measures necessary to maintain basic sanitation and hygiene.
Field preventive medicine measures	• Command emphasis and commander responsibility. • Ensure unit personnel use sound preventive medicine measures to address basic sanitation and hygiene, water potability, waste handling and disposal, field food service, pest management, environmental and industrial hazards.
Individual preventive medicine measures	• Measures a Soldier can take to protect himself from the health threat, such as sunglasses, sunscreen, mosquito netting, and insect repellent.
Monitoring potable water in a tactical environment	• Includes ice, bulk water supplies, and bottled and packaged water.
Conducting food service sanitation inspections	• Ensures food is prepared, maintained, and stored at appropriate temperature. • Ensures proper handling of potentially hazardous foods (such as poultry). • Ensures sanitary conditions are correct and upheld within the field feeding facility. Ensures proper disposal of waste and waste water.
Occupational and environmental health site assessments	• Conducts preliminary site assessment prior to establishment of the unit area. • Develops plan to prevent or mitigate health hazards or potential health hazards. • Conducts periodic site assessments to identify any existing hazards.
Occupational and environmental health surveillance	• Conducts continuous occupational and environmental health surveillance activities to identify any new health hazards. • Implements preventive medicine measures to prevent or mitigate the effects of new health hazards.

ENVIRONMENTAL HEALTH

2-32. In Army PVNTMED, environmental health consists of those capabilities and activities necessary to anticipate, identify, assess, communicate, and manage the risks of immediate- and delayed-onset of DNBI from exposures encountered in the environment. These exposures include risks from chemical, biological, radiological, and physical hazards. These risks will be evaluated using standardized risk assessment

principles and procedures. For a discussion of the environment health programs and services refer to Table 2-4. (See ATP 3-34.5/MCRP 4-11B for further information.)

Table 2-4. Environmental health programs

Environmental health programs	*Activities*
Drinking water to include ice manufacturing	• Includes field water supplies, garrison water supplies, bottled or packaged water, and requirements for contracted services. • Surveillance. • Inspection. • Records and reports.

Recreational waters	• Sanitary control and operation of—
	  • Swimming pools.
	  • Ponds, lakes, rivers or other natural swimming areas.
	• Microbiological sampling and analysis.
	• Periodic inspections.

Pest and disease vector prevention and control	• Collection, processing, and identification of vector/pest arthropods. • Surveillance and analysis of surveillance data. • Plan for and conduct retrograde washdown operations, as appropriate. (Refer to Armed Forces Pest Management Board Technical Guide 31 for additional information.) • Handling, using, and storing pesticides in a safe and lawful manner (to include application and disposal of pesticide containers and materials.
Waste treatment and disposal	• Includes solid waste, hazardous waste, regulated medical waste, and wastewater. • Ensures waste is disposed of according to United States laws, host-nation agreements, and host-nation laws. • Ensures waste is disposed of in proper manner to reduce development of pest and vector breeding sites. • Spillage control to reduce environmental contamination from toxic industrial materials. • Groundwater and subsurface release of hazardous contaminants.
Occupational and environmental hazards	• Air quality control to include volume of air and airflow. • Environmental noise control to include hearing protection, barriers, and surveillance. • Environmental (heat, cold, humidity, and significant elevations above sea level) injury prevention and control.
Sanitation and hygiene	• Includes troop housing sanitation, barber and beauty shops, dry cleaning operations, recreational areas, laundry operations, confinement and internment facilities, food service sanitation, and sports facilities, gymnasiums, and fitness centers.

OCCUPATIONAL HEALTH

2-33. In Army PVNTMED, occupational health consists of those capabilities and activities necessary to anticipate, recognize, evaluate, and control hazards that can cause sickness, impaired health, or significant discomfort among workers.

OCCUPATIONAL HEALTH THREATS

2-34. Occupational health threats may occur in both a standard worksite or in a deployed setting and may include chemical, biological, radiological, psychological, and physical hazards. These hazards are evaluated using standardized risk assessment methodologies.

ARMY OCCUPATIONAL HEALTH PROGRAM

2-35. The Army Occupational Health Program includes services that promote the health and safety of the individual, the unit, the workplace, and the community. Services may focus on hazard education and medical surveillance to facilitate early detection of adverse outcomes associated with the occupational environment.

2-36. The Deputy Assistant Secretary of the Army for Environment, Safety, and Occupational Health provides policy, goals, guidance, and management oversight of the Army Occupational Health Program, as the Army component of the DOD Safety and Occupational Health Program (refer to DODI 6055.01 for additional information). The objectives of the Army Occupational Health Program are to—

- Ensure that Army personnel are physically, mentally, and psychologically suited to their work at the time of their assignment and that physical and BH is monitored to detect early signs of job-related injury or illness.
- Protect Army personnel from the adverse effects of health and safety hazards in the work environment to include field operations, garrison, industrial, and administrative workplaces.
- Ensure proper medical care, rehabilitation, and return-to-duty programs for the occupationally ill and injured.
- Reduce loss (manpower and economic) caused by occupationally related injuries and illnesses of Army personnel.
- Prevent decreased operational readiness caused by occupational illness and injury of Army personnel throughout the range of military operations.

OCCUPATIONAL HEALTH PROGRAM AND SERVICES

2-37. Occupational health programs, services, and capabilities are discussed in Table 2-5.

Table 2-5. Occupational health programs and services

Programs and services	*Activities*
Medical surveillance examinations and screenings	• Focuses on the early detection of occupational diseases or illnesses that may be associated with work tasks and workplace exposures of a physical, chemical, biological, or radiological nature.
Health hazard education	• Communicates health risk on a variety of health hazard risk to include chemical, biological, radiological, nuclear, and blood-borne pathogens, hearing conservation, and reproductive health hazards.
Surety programs	• There are specialized programs for chemical, biological, and nuclear surety. • Medical aspects of these programs include the Personnel Reliability Program, special handling and screening of medical treatment, and treatment of potential and actual casualties.
Reproductive hazards	• Both males and females are vulnerable to reproductive hazards. • These programs communicate health risks in the work area and support health surveillance activities.

Table 2-5. Occupational health programs and services (Continued)

Programs and services	*Activities*
Blood-borne pathogens	• Prevention and control of blood-borne pathogens is conducted according to federal regulations published in Section 1910-1030, Chapter XVII, Title 29, Code of Federal Regulations (29 CFR Chapter XVII, 1910-1030).
Hearing conservation and readiness	• Hearing conservation, an element of the Army Hearing Program; it focuses on protecting military and civilian personnel from hearing loss due to occupational and industrial noise exposures in fixed facilities.
Vision conservation and readiness	• Program promotes and optimizes vision and optical readiness and is essential in assuring a safe and healthy working environment and applies to all garrison, field training, and deployment environments.
Workplace epidemiological investigations	• Uses commonly accepted epidemiological methods and tools to investigate incidences of infectious diseases, occupational illnesses, and injuries presumed to be associated with the workplace.
Ergonomics	• Is comprised of five critical elements—workplace analysis, hazard prevention and control, health care management, education and training, and program evaluation.
Radiation safety and dosimetry	• Provides a comprehensive Army Radiation Safety Program to include control of radiation sources, protective clothing and equipment, radiation detection and measuring equipment, and radiologic facility shielding analysis.
Industrial hygiene	• Consists of the anticipation, recognition, evaluation, and control of those environmental factors and stresses associated with work operations that may cause sickness, impaired health and well-being, or significant discomfort or inefficiency among workers.
Personal protective equipment	• Determines requirements for use of personal protective equipment (when, where, and what type of equipment).
Respiratory protection	• Reduces the risk from respiratory hazards through use of respirator, reducing the air concentrations of hazardous substances by substitution with a less toxic substance and engineering and administrative controls.
Asbestos exposure control and surveillance	• Performs health risk assessments of asbestos-containing buildings and/or building materials to determine need for corrective action. Maintains records and reports of potential or actual exposure.
Injury prevention and control	• Establish a comprehensive injury prevention and control program to enhance medical readiness and costs through deployment injury surveillance, population-based injury prevention analysis, identification of injury prevention *best practices* and tools, and education products.

Table 2-5. Occupational health programs and services (Continued)

Programs and services	*Activities*
Occupational illness and injury prevention and mitigation	• Establish program as required by the Federal Employees Compensation Act Program, Subchapter B, Chapter 1, Title 20, Code of Federal Regulations (20 CFR, Chapter 1, Subchapter B).
Work-related immunizations	• Provides immunizations to personnel with increased risk of infection related to potential job hazards and when related to foreign travel.
Recordkeeping and reporting	• Establish uniform requirements for the collection and compilation of Federal employees' occupational safety and health records.
Worksite evaluations	• Conduct yearly evaluations and/or worksite visits. At a minimum, these evaluations should include hazardous material identification, type of engineering controls needed if applicable, type of personal protective equipment required, and posting of appropriate signs needed.
Other federal programs	• Implements other federal programs by issuance of an Occupational Safety and Health Administration standards or Office of The Surgeon General policy letters or directives.
Evaluation of occupational health programs and services	• Conducts self-audits and external assessments of Army occupational health program and services to evaluate the outcomes and effectiveness of programs and services.
Other programs	• Includes Army aviation medicine, health hazard assessment of Army equipment and materiel, medical facility and systems safety, health, and fire prevention; and nonoccupational illness and injury.

HEALTH SURVEILLANCE AND EPIDEMIOLOGY

2-38. Occupational and environmental health and endemic disease threats can seriously impact a commander's mission and affect short- and long-term military operations. Traditionally, they have been separately assessed and independently managed. As a result, they can be misunderstood as unrelated aspects of the battlefield—both in doctrine and policy. The Army PVNTMED program considers these hazards to be integrally related and manages them consistently.

2-39. Health surveillance and epidemiology are critical components of the Army PVNTMED program. They include identifying the population at risk, anticipating and recognizing hazardous exposures of all types, employing specific PVNTMED measures to minimize health impact, communicating health risks, and monitoring the health of individual Army personnel and of the entire force. Each of these health surveillance functions includes tasks to accomplish before, during, and after every deployment. Early deployment of relevant OEH and epidemiology augmentation teams can assist the theater or joint task force surgeon in identifying and assessing threats and recommending countermeasures. Refer to Section VII on page 2-24 for information on both OEH and medical surveillance.

2-40. Deployments vary markedly in duration, urgency, number of participants, geographic region, and projected OEH and endemic disease threats. Consequently, PVNTMED personnel need to determine specific surveillance practices by assessing the unique characteristics of each deployment. Many sophisticated surveillance activities require access to data maintained in various formats and by many different agencies. The components of Army health surveillance capabilities are detailed in DA Pam 40-11. They include, but are not limited to, the Defense Occupational and Environmental Health Readiness System (an electronic database used to store data and to provide individual exposure records and OEH exposure histories for all

DOD personnel, both military and civilian); and any other deployment OEH and endemic disease hazard and exposure surveillance systems; as well as the Defense Medical Surveillance System; and other epidemiology resources and databases. The most valuable DNBI surveillance data is near real time. Timely DNBI monitoring permits early casualty identification, potential adverse health trends, assessment of PVNTMED measure effectiveness, and indications for enhanced PVNTMED measures.

SOLDIER, FAMILY, COMMUNITY HEALTH, AND HEALTH PROMOTION

2-41. Army PVNTMED provides programs and services that improve the health and quality of life for Soldiers, Families, and communities by moving them from a focus on sickness and disease to one based on prevention and wellness. These PVNTMED activities support the goals of readiness, combat efficiency, work performance, and quality of life for all Military Health System beneficiaries.

2-42. Effective Soldier, Family, community health, and health promotion activities can enable individuals and Families to—

- Better understand their health problems and coping strategies.
- More easily change their behavior or environment to improve their health and safety.
- Obtain health care and other services they may need but cannot provide for themselves.
- Obtain health care in times of stress as an interim measure while they learn to resolve or accept their situation.

2-43. Programs and services are developed and implemented as discussed in AR 600-63, AR 40-5, and DA Pam 40-11. The programs and services are provided to support Soldier health, Family, community health, and health promotion programs and services.

2-44. Refer to Tables 2-6 and Table 2-7 on page 2-14 for a discussion of the programs and services for these categories of programs. For additional information on community health refer to DA Pam 40-11.

Table 2-6. Soldier health services and programs

Programs and services	*Activities*
Soldier medical readiness	• Prepares Soldiers for deployments across the range of military operations in both the continental United States and outside the continental United States. • Provides direct oversight of the pre- and post-deployment screening process. • Provides direct oversight of the distribution of predeployment health information products. • Provides health threat briefings. • Provides advocacy of health issues affecting military women.
Soldier dental readiness	• Is the state of optimal oral function and well-being. • Is the absence of disease, injury, or parafunctioning of the oral tissues. • Considered dentally ready if they are categorized in Dental Fitness Classification 1 or 2.
Public health support of Army operations	• Are designed to support operational missions, in both the continental United States and outside the continental United States. • Has a strong public health component, such as humanitarian assistance and disaster relief.
Communicable disease prevention and control	• Focuses on health education, disease screening, and individual counseling activities that complement and support the ongoing communicable disease control activities. (Refer to Centers for Disease Control and Prevention Web site for more information.)

Table 2-7. Health promotion programs and services

Programs and services	*Activities*
Health risk appraisal	• Are self-reporting tools that aid in estimating an individual's risk of experiencing morbidity or mortality from one or more health risks. • Used by providers of public health services for individual counseling in risk modification and identification or, when data are aggregated, to identify population health risks.
Tobacco use (cessation)	• Impacts readiness by impairing physical fitness, increasing susceptibility to disease, and increasing health care costs.
Nutrition	• Impacts a Soldier's mental, physical, and emotional health. Inadequate and over nutrition negatively impact a Soldier's ability to perform mentally and physically.
Stress management	• Is provided in both deployed areas and in garrison. • Consists of stress management classes and psychoeducational meetings and forums.
Alcohol and substance abuse prevention and control	• Provides education and other treatments for the reduction and prevention of abuse.
Suicide prevention	• Is preventable. • Identifies, intervenes, counsels, and treats individuals displaying behaviors and engaging in discussions that indicate the Soldier has suicide ideation or intent.
Spiritual health and fitness	• Contributes to medical readiness and Soldier performance by improving a person's sense of well-being and confidence.
Oral health	• Includes dental readiness, preventive dentistry for children, clinical preventive dentistry, and community preventive dentistry.

2-45. Health promotion is concerned with the promotion of wellness through health education and related activities designed to facilitate behavioral and environmental changes that are designed to foster good health as prescribed in AR 600-63. For a discussion of the performance triad, refer to Chapter 1. For a discussion of nutrition care-related information refer to ATP 4-02.5.

PREVENTIVE MEDICINE TOXICOLOGY

2-46. Toxic substances contained in products and materials in the military system, military waste products, and occupational and environmental chemical hazards can result in adverse effects on human health and the environment. Preventive medicine toxicology, laboratory, and consultative services are provided to help identify, assess, and eliminate or control the potential human health threats posed by these factors as a result of military activities and operations.

2-47. Preventive medicine toxicology capabilities include—

- Toxicity screening and exposure-specific testing of military-relevant material and chemicals (not including chemical warfare agents), their degradation products, and toxic industrial and agricultural chemicals. This includes new and developmental substances and materials. Testing capabilities include short-term single dose tests, as well as longer-term repeated dosing by various exposure routes in mammalian and nonmammalian species.
- Gross pathology and histopathology services, clinical chemistry, and hematology testing in support of toxicity evaluation of material being considered for military use.

- Development and use of chemical- and biological-based methods and test systems to rapidly identify and determine the health effects of toxic material and its transport through all environmental media.
- Development and use of methods to improve the prediction and assessment of human health and ecological effects from military environmental contaminants.

PREVENTIVE MEDICINE LABORATORY SERVICES

2-48. Occupational and environmental health hazards, risks, and exposures are assessed and documented using PVNTMED laboratory services. These services are normally provided by EAB PVNTMED assets, based on the locations, types, and amounts of laboratory service required. In a deployed setting, theater validation PVNTMED laboratory services are normally provided by the AML supporting the theater (refer to Chapter 6). Definitive PVNTMED laboratory services are provided by reachback elements assigned to the United States Army Public Health Center (Provisional), other DOD or federal laboratories, and contracted commercial laboratories. The U.S. Army Medical Command laboratory services assets include the U.S. Army Public Health Center (Provisional), medical centers, and medical department activities.

2-49. In addition to the necessary analytical capabilities, laboratory programs and services are provided for—

- Certification and accreditation.
- Quality control and quality management.
- Department of Defense Cholinesterase Monitoring Program.

HEALTH RISK ASSESSMENT

2-50. Health risk assessment, an element of health risk management, is a process for evaluating the potential for adverse consequences to human life, health, or the environment resulting from exposures to substances of concern. This process is used to identify hazards; determine exposure pathways and magnitude; consider toxic response; and estimate, qualitatively or quantitatively, negative impacts. Substances of concern may include chemical, biological, and radiological materials.

2-51. Health risk assessment programs, services, and capabilities are established and provided for all PVNTMED programs and service areas. Health risk assessment is also a tool for decisionmakers and is part of the Army's risk management process in deployment scenarios.

HEALTH RISK COMMUNICATION

2-52. Health risk communication is the timely process of effectively communicating the nature of health and safety hazards and risks (probability and severity), their countermeasures, health outcomes, necessary medical follow-up, and other health-related information to commanders, Soldiers, Family members, and others in a manner that fosters trust in the process.

2-53. Health risk communication includes the process of building and maintaining strategic partnerships that are the foundation for information exchange, dialogue, and collaborative problem solving among interested stakeholders about health and safety issues. Health risk communication is also the interactive exchange of information and/or opinions among Soldiers, civilians, and community groups to—

- Build strategic partnerships before the health threat occurs.
- Plan carefully and evaluate all efforts.
- Deliver consultation to senior leadership.
- Coordinate and collaborate with other credible sources.
- Respond to emergency and crisis situations.
- Meet the needs of the media.

2-54. The Army approach to health risk communication involves using generally accepted concepts and techniques to—

- Identify and analyze Army personnel health concerns and issues.
- Develop and implement proactive strategies.
- Comply with hazard communication requirements as mandated by Title 42 (The Public Health and Welfare), U.S. Code (Comprehensive Environmental Response, Compensation, and Liability Act of 1980, Chapter 103, Section 9601).

SECTION VI — EMPLOYMENT OF PREVENTIVE MEDICINE ASSETS

2-55. his section describes the four levels of PVNTMED support in the theater with a reachback capability to Level V support in CONUS.

Note. These levels of PVNTMED support are different from the roles of care, which refer to medical treatment. For a discussion of the roles of care, refer to FM 4-02.

LEVEL I — INDIVIDUAL, LEADER, AND UNIT PREVENTIVE MEDICINE MEASURES

2-56. Level I PVNTMED support is the individual Soldier's and the unit's implementation of PVNTMED measures. If properly and routinely practiced, PVNTMED measures will protect Soldiers from the majority of DNBIs. Using PVNTMED measures is an individual and unit leader responsibility. The unit commander, when deploying, is required to establish, train, equip, and employ two unit field sanitation teams (see ATP 4-25.12). Each team consists of at least two Soldiers to assist with the implementation of unit PVNTMED measures. The unit field sanitation teams also serve as the principal PVNTMED advisor to the commander.

SOLDIER

2-57. The individual Soldier is the first line of defense in countering the health threat posed by DNBI. Throughout his career, the Soldier is trained in the importance of a healthy lifestyle which promotes wellness and facilitates physical and mental fitness. From his initial entry into the Armed Forces, the individual Soldier is trained on how to implement PVNTMED measures, which will limit his exposure to and mitigate the effects of a variety of health threats to which he may be exposed.

2-58. In addition to his initial entry training, unit training on field hygiene and sanitation (to include health risk communications) is conducted periodically throughout his career to refresh, reinforce, and augment this training.

UNIT LEADERS

2-59. Unit leaders are an essential link in ensuring that effective PVNTMED measures are implemented by all Soldiers. Unit leaders set the example for subordinates by personally practicing basic soldiering skills in PVNTMED and by ensuring that subordinates are trained in their use and have the required supplies and equipment to implement PVNTMED measures.

COMMANDERS

2-60. Commanders are responsible for the health of their Soldiers and establish the climate in which PVNTMED measures are implemented. Preventive medicine programs and measures are ineffective unless they are properly and continuously emphasized by the unit chain of command. As prescribed in AR 40-5 and DA Pam 40-11, company-sized units will establish and employ unit field sanitation teams. Commanders are responsible for appointing, training, and equipping these teams.

UNIT FIELD SANITATION TEAMS

2-61. The unit field sanitation teams supervise unit (collective) and individual PVNTMED measures as an additional duty. The teams are trained and equipped to supervise and conduct Level I PVNTMED services. These services include base camp site selection, water testing and treatment, arthropod and rodent control, solid waste management, and prevention of climatic and noise injuries. The teams also train unit personnel in individual PVNTMED measures.

2-62. Each unit field sanitation team is a unit-organized, two-Soldier team comprised of one noncommissioned officer and one Soldier identified on orders whose normal duties allow them to devote sufficient time to field sanitation activities. If available, one member should be the unit's organic combat medic (health care specialist). Selected team members should have at least six months service remaining with their unit.

2-63. Preventive medicine personnel certify unit field sanitation teams through a 40-hour course that includes online instruction, demonstrations, hands-on training, and certification testing. Standards for the course are established and maintained by the Academy of Health Sciences, USAMEDDC&S, HRCoE, at Fort Sam Houston, Texas. This course should be attended as soon as a unit identifies its unit field sanitation teams Soldiers. Preventive medicine personnel can also provide refresher training prior to deployments and field training exercises.

LEVEL II — ORGANIC PREVENTIVE MEDICINE PERSONNEL AND BRIGADE PREVENTIVE MEDICINE STAFF SUPPORT

2-64. Depending upon their assignment, PVNTMED personnel fall within two categories—operational and support staff. Operational personnel execute the PVNTMED plan and conduct surveillances, implement PVNTMED measures, inspect field sanitation materials and supplies, and inspect potable water containers, and inspect field dining facilities. Staff members are assigned to the various staffs of the major deployed headquarters (such as such as division or corps headquarters). These personnel are the advisors to the commander on all PVNTMED issues, they provide PVNTMED input to operation plans and orders and they consolidate PVNTMED information submitted by subordinate units to determine if trends are developing.

OPERATIONAL PREVENTIVE MEDICINE PERSONNEL

2-65. Level II PVNTMED support refers to PVNTMED personnel who are organic to specific units. Depending on the unit, these organic personnel may be staff members who assist in PVNTMED support planning, while others may have staff and operational responsibilities.

2-66. Level II PVNTMED support is provided by PVNTMED personnel who are organic to a unit and is divided into operational and staff sections. Level II PVNTMED operational support is found in nonmedical units such as BCTs, military police battalions (internment/resettlement), and some special operations command units.

2-67. Personnel providing PVNTMED operational support are expected to directly interact with the supported population and they are equipped to conduct PVNTMED surveillance and control.

2-68. Level II operational tasks include, but are not limited to—

- Preparing a running estimate to identify the health threat in the BCTs AO. Preparations should include acquiring past after action reports and data from higher headquarters, United States Army Public Health Center (Provisional), Armed Forces Health Surveillance Center, and the National Center for Medical Intelligence.
- Advising the commander on impacts of the health threat to his forces and providing recommended techniques and procedures to defeat/minimize the health threat.
- Preparing essential PVNTMED information for inclusion into the operation plan, operation order, and briefings to ensure awareness of both the health threat and the corresponding PVNTMED measures.
- Performing sanitary inspections of supported units' food service, field site, latrine, shower, and other sanitation facilities.

- Performing sanitary inspections and providing PVNTMED recommendations for detainee facilities. For additional information on AHS support to detainee operations, refer to ATP 4-02.46 and FM 3-63.
- Providing early warning of any breakdown in basic sanitation practices so that corrective action may be initiated before diseases are transmitted.
- Providing early detection and warning of potential disease epidemics or suspected biological warfare agent employment within the BCT AO.
- Providing limited pest management services and vector surveillance to supported units.
- Monitoring field water supplies, to include possible CBRN and toxic industrial materials contamination.
- Collecting environmental samples from suspected CBRN or toxic industrial material-contaminated sources.
- Preparing samples for submission to supporting laboratories for analysis.
- Providing input and recommendations to contracting services to ensure PVNTMED requirements are adequately addressed.
- Preparing chain of custody documents and ensuring that the samples are not contaminated from sources outside the sampled site.
- Providing staff oversight of and assisting in the training in the proper use of PVNTMED measures.

DIVISION HEADQUARTERS PREVENTIVE MEDICINE PERSONNEL

2-69. Division headquarters PVNTMED staff support consists of the PVNTMED staff officers organic to the division headquarters. The chief, PVNTMED section is the principal PVNTMED consultant to the division surgeon. This section provides PVNTMED guidance to the division surgeon and provides oversight, data analysis, and technical supervision to operational PVNTMED personnel (such as organic BCT or PVNTMED personnel). The section also provides technical consultation in the areas of OEH, medical surveillance and epidemiology, industrial hygiene, health promotion, health threat profile, and health hazard assessments.

PREVENTIVE MEDICINE PERSONNEL ASSIGNED TO OTHER NONMEDICAL UNITS

2-70. Preventive medicine personnel may also be assigned to nonmedical units. Based upon their mission, these units may have organic PVNTMED personnel on their approved TOE.

Special Operations Forces

2-71. Preventive medicine personnel are assigned to the staff and medical sections of special operations forces (SOF) units, including special forces, Ranger Regiment, sustainment brigade, military information support operations, and civil affairs units. Other Army SOF units, such as the signal battalion and Special Operations Aviation Regiment have no dedicated PVNTMED assets. In SOF units, PVNTMED personnel provide sustainment training to special forces medics, special operations medical sergeants, and civil affairs medical sergeants who perform PVNTMED services for their teams and attached personnel.

2-72. Organic PVNTMED personnel are assigned down to battalion level in special forces groups and the civil affairs brigade where they are equipped to perform Level II PVNTMED and execute the OEH surveillance mission. Personnel at the group- or brigade-level perform most of the duties of the brigade PVNTMED staff and are also equipped to perform Level II PVNTMED support and the OEH surveillance mission.

2-73. Army SOF PVNTMED personnel provide technical consultation in the areas of OEH surveillance, medical surveillance, epidemiology, industrial hygiene, health promotion, and assessment of health threats and hazards. They also recommend PVNTMED measures to the commander or assigned unit surgeon to combat the health threat. Some Army SOFs operations may require PVNTMED resources from conventional assets.

Civil Affairs Units

2-74. Winning indigenous population support is an important facet of military operations. Stability tasks are an important part of that effort. As part of stability tasks, PVNTMED can make a significant contribution to this support. Preventive medicine support may be provided by personnel organic to civil affairs units or may be provided by deployed TDA and TOE personnel and units. Any PVNTMED participation in stability tasks is first coordinated and approved with the mission command authority, then with the agencies designated by that headquarters to conduct the project. Command approval is required when substantial resources are involved.

2-75. In civil affairs units, assigned PVNTMED personnel assess the PVNTMED capabilities of another country or area; however, they are not responsible for providing direct PVNTMED services to them. The type and number of PVNTMED personnel assigned is dependent upon the unit's TOE. Since the staff's role is advisory, it has no organic equipment and must coordinate support from PVNTMED detachments and the supporting AML. If available, civil affairs units are also supported by PVNTMED detachments.

Engineer Units

2-76. A PVNTMED staff is assigned to the facility engineer section in an engineer command. This staff serves as technical advisors to the command on pest management, environmental health, and sanitation issues. Furthermore, they serve as the liaison between the medical and engineer communities.

Military Police Units

2-77. Preventive medicine personnel play a vital role in the oversight of health and sanitation standards in temporary camps and detainee facilities. The same PVNTMED standards applied to U.S. and other multinational forces are applied to detainee populations. For additional information on AHS support to detainee operations, refer to ATP 4-02.46.

2-78. To perform this mission, PVNTMED personnel are assigned to military police internment and resettlement units, as well as military police confinement battalions. The type and number of PVNTMED personnel assigned to each military police unit is dependent upon the assigned unit's mission. The PVNTMED element can range from a PVNTMED staff officer to an operational section consisting of an environmental science and engineer officer, a PVNTMED noncommissioned officer, and PVNTMED specialists. Preventive medicine personnel serve as technical advisors to the command on PVNTMED issues associated with supported populations.

Quartermaster Units

2-79. A PVNTMED noncommissioned officer/specialist is assigned to some quartermaster units to ensure that water quality standards are maintained.

2-80. Preventive medicine assets from other Services, as part of the joint deployed force, can assist Army PVNTMED personnel in the Army FHP mission. Army PVNTMED assets can also be used to provide FHP support to other Services. Coordination for such assistance is usually conducted through the joint command surgeon's office.

LEVEL III — PREVENTIVE MEDICINE DETACHMENT AND ECHELONS ABOVE BRIGADE PREVENTIVE MEDICINE SUPPORT

2-81. Level III PVNTMED support refers to PVNTMED detachments and EAB PVNTMED staff support. Preventive medicine detachments provide direct support to other units without organic PVNTMED assets, as well as general support to units with organic PVNTMED assets. These units have additional capabilities not found in Level II PVNTMED services. Echelons above brigade PVNTMED staff support consists of PVNTMED staff officers organic to the MMB, MEDBDE (SPT), MEDCOM (DS) and division and corps headquarters' surgeon sections. These staff officers serve as the commander's principal PVNTMED FHP advisors.

MEDICAL DETACHMENT (PREVENTIVE MEDICINE)

2-82. The medical detachment (preventive medicine) is a Level III PVNTMED asset. For a discussion of the medical detachment (preventive medicine), refer to Section III, page 2-3.

COMBAT SUPPORT HOSPITAL PREVENTIVE MEDICINE SUPPORT

2-83. Preventive medicine personnel assets assigned to the combat support hospital are limited and consist of a public health nurse (area of concentration [AOC] 66B) and a preventive medicine specialist (MOS 68S) in the specialty clinics section. These assets provide oversight, data analysis, and technical collaboration in support of the FHP mission. They also collaborate with Level II and Level III PVNTMED assets in the AO and reachback support relevant to the PVNTMED mission of the combat support hospital. In addition, they function as the designated PVNTMED advisors to the combat support hospital commander. Specific operational tasks include, but are not limited to—

- Planning and conducting medical surveillance activities and conducting epidemiologic investigations of DNBIs.
- Planning and conducting OEH surveillance and associated health risk assessments.
- Analyzing and interpreting health surveillance information using health risk communication tools and techniques to disseminate health information.
- Promoting, protecting, optimizing, and preserving the health and readiness of combat support hospital personnel.
- Conducting population-based community/rapid health assessments to identify and monitor health threats.
- Developing countermeasures and recommending courses of action for the combat support hospital commander to prevent, contain, and minimize health threats.
- Identifying and integrating host-nation assets and resources supporting the combat support hospital's role of promoting population health and quality of life.
- Providing health promotion and education on conditions of military importance.
- Acting as liaison with, and in support of, military, civilian, and other governmental health authorities in support of military operations.

ECHELONS ABOVE BRIGADE PREVENTIVE MEDICINE STAFF SUPPORT

2-84. Corps-level PVNTMED staff support consists of PVNTMED staff officers organic to the MMB, MEDBDE (SPT), and corps surgeon section.

2-85. The PVNTMED section of the MMB serves as the commander's principal consultant and the command's PVNTMED and FHP advisors. This section develops, plans, and implements PVNTMED policies and programs for the MMB. These programs include medical and OEH surveillance, pest management activities, epidemiological investigations, hearing conservation, food service sanitation and hygiene, surveillance of potable water supplies, nonpotable water usage, and health risk communications. This section monitors and analyzes DNBI reports submitted by subordinate medical units. Trend analysis is used to identify shifts from the baseline of diseases within the AO, as a shift may indicate a potential disease outbreak or the use of biological warfare agents against the deployed force. Furthermore, this section advises the commander on the medical aspects of CBRN defensive measures. These include, but are not limited to, policies, programs, and procedures pertaining to immunizations, chemoprophylaxis, barrier creams, and pretreatments.

2-86. The MEDBDE (SPT) directs AHS support for all operational-level Army medical elements in the AO and maintains technical linkages to various AHS activities at the strategic level. The MEDBDE (SPT) serves as the senior medical mission command organization in the division and corps. Within the MEDBDE (SPT) headquarters, the PVNTMED section provides the brigade commander with technical consultation in the areas of OEH surveillance, OEH engineering, DNBI surveillance and epidemiology, industrial hygiene, health promotion, health threat profiling, and health hazard assessments throughout the corps and division AO.

2-87. The corps PVNTMED staff serves as the commander's principal PVNTMED consultant and environmental sciences advisor. This section develops, plans, and implements PVNTMED policies and programs for the corps. It provides technical assistance and oversight for medical and OEH surveillance, pest management activities, disease investigations, food service sanitation and hygiene, and inspection of potable water supplies and the use of nonpotable water. The staff evaluates and interprets DNBI reports submitted by subordinate medical units to identify trends and provide recommendations.

LEVEL IV — ARMY-LEVEL PREVENTIVE MEDICINE STAFF SUPPORT

2-88. Level IV PVNTMED support refers to the AML and Army-level PVNTMED staff support. The AML is a field laboratory that provides rapid health threat identification and assessment within the AO and will be discussed in Chapter 6. Health threats include CBRN warfare agents, infectious communicable diseases, and other health threats (see Table 2-1, on page 2-2). The AML is designed to receive and analyze samples from Level II and III PVNTMED assets. The MEDCOM (DS) and Army PVNTMED staff support consists of PVNTMED staff officers organic to the MEDCOM (DS) and the Army Service component command surgeon section. These staff officers serve as the commander's principal PVNTMED consultant and environmental science advisors.

2-89. The senior PVNTMED staff officer at the MEDCOM (DS) facilitates the development of PVNTMED policies and programs for all operating forces in the AO. He also performs the duties and responsibilities discussed in paragraph 2-87 above.

2-90. The Army Service component command PVNTMED staff supports, develops, plans, and implements PVNTMED policies and programs at the Army level. This section also evaluates host-nation capabilities and integrates PVNTMED policy with joint and multinational forces.

LEVEL V — PREVENTIVE MEDICINE REACHBACK SUPPORT

2-91. The operational support mission of PVNTMED TDA activities is to provide reachback technical consultation, laboratory analytical support, PVNTMED sustainment training, and backup sampling and analytical equipment and supplies. Operational support activities include preparation and maintenance of health threat databases and health threat information dissemination.

2-92. These activities are located within the sustaining base and in locations outside the CONUS. These TDA activities provide day-to-day PVNTMED support to military installations. During predeployment and mobilization activities, TDA PVNTMED personnel assist TOE PVNTMED personnel by providing—

- Training.
- Health risk communication.
- Assistance in obtaining a list of required equipment.
- Identification of the health threat in the unit's assigned AO.
- Assurance that the unit's personnel complete their required individual medical readiness requirements.

2-93. Some TDA activities continue to support the deployed units by deploying teams in the AO for specific PVNTMED missions and surveillance activities.

UNITED STATES ARMY PUBLIC HEALTH CENTER (PROVISIONAL)

2-94. The U.S. Army Public Health Center's (Provisional) mission to Soldiers is to promote health and prevent disease, injury, and disability. This mission also applies to Families, military retirees, and Army civilian employees. In support of the Army and DOD, it provides public health, veterinary, and PVNTMED services to promote healthy Soldiers and beneficiaries, government-owned animals, workplaces, and military communities. Its support to deployed forces focuses on consultative and direct assistance in assessing health threats arising from OEH concerns, as well as consequence management during events that warrant an additional response such as CBRN incidents. This TDA organization provides on-site assistance only on order from higher headquarters (such as the U.S. Army Medical Command).

2-95. Reachback capabilities of United States Army Public Health Center (Provisional) include, but are not limited to—

- Establishing and fielding effective risk-assessment and risk-management processes to include providing current sustainment training on risk assessment, risk management, and risk communication.
- Providing an effective sampling and analysis capability.
- Identifying subject matter experts for PVNTMED consultations.
- Developing and updating appropriate military exposure guidelines for use during various deployment durations.
- Providing technical input to evolving PVNTMED and CBRN defense policy and doctrine for current and newly identified threats.
- Providing sustainment training for PVNTMED units and DOD civilian personnel reflecting the most recent technical information and procedures.
- Developing and maintaining expertise and procedures for health-based risk management decisions to address current and newly identified health threats.
- Training and maintaining subject matter experts to provide technical reachback capabilities.
- Providing exposure guidelines for low-level chemical warfare agent concentrations and nuclear and/or radiological materials (see ATP 4-02.83/MCRP 4-11.1B/NTRP 4-02.21/AFMAN 44-161(I).
- Providing technical assistance and support for field exercises on a recurring basis.
- Providing epidemiological assistance when needed.
- Performing OEH surveillance when requested.
- Developing and documenting procedures and equipment for collecting and assessing field samples (involving any media) to provide quick evaluation.
- Assuring that sufficient sampling equipment, supplies, and ancillary components (along with distribution capabilities) remain available for United States Army Public Health Center (Provisional) missions.
- Establishing a working agreement with one or more accredited laboratories capable of handling and analyzing contaminants beyond the capabilities of the United States Army Public Health Center (Provisional) laboratory, to include highly concentrated chemical warfare agents and biological safety Level 4 samples.
- Developing a reliable transport plan for samples.
- Providing health risk communication training and consultation support to commanders, as well as medical and environmental personnel responsible for identifying and communicating risks to prevent casualties.

ARMED FORCES PEST MANAGEMENT BOARD

2-96. The Armed Forces Pest Management Board (AFPMB) recommends policy, provides guidance, and coordinates the exchange of information on all matters related to pest management throughout the DOD. The AFPMB's mission is to ensure that environmentally sound and effective programs are present to prevent pests and disease vectors from adversely affecting DOD operations. In support of this mission, the AFPMB—

- Develops and recommends policy for the Under Secretary of Defense for Acquisition, Technology, and Logistics.
- Coordinates pest management activities within the DOD.
- Develops, issues, and maintains manuals and other guidance necessary to implement the technical requirements of the Federal Insecticide, Fungicide, and Rodenticide Act.
- Implements the DOD plan for the certification of pesticide applicators and develops comprehensive training guidance for DOD pest management personnel.
- Coordinates DOD contingency disease vector and pest management activities with the Joint staff, the combatant commands, and other contingency planning organizations.

- Serves as an advisory body to the DOD Service components and provides timely scientific and professional pest management advice.
- Develops and distributes technical information and guidance on pest management to the Service components by means of technical information memoranda and bulletins, disease vector ecology profiles, and similar publications.
- Reviews and approves any introduction, stockage, and deletion of pest management material (excluding disinfectants and biocides) by the Defense Logistics Agency in the DOD supply system.
- Coordinates and develops requirements for pest management research, development, testing, and evaluations in the DOD.

UNITED STATES ARMY MEDICAL RESEARCH INSTITUTE OF CHEMICAL DEFENSE

2-97. The U.S. Army Medical Research Institute of Chemical Defense is the DOD lead laboratory for the development of medical countermeasures against chemical threat agents. This organization provides technical teams to assist medical commanders and leaders in preparing units to provide AHS support in a chemical threat environment. Their technical teams are called upon to provide expert analytical and consultative information related to the medical aspects of chemical defense research and the medical management of chemical warfare agent casualties. They also provide technical data for use in protecting U.S. forces from the effects of chemical warfare agents.

UNITED STATES ARMY RESEARCH INSTITUTE OF ENVIRONMENTAL MEDICINE

2-98. The U.S. Army Research Institute of Environmental Medicine engages in internationally recognized medical research concentrating on the medical effects of stressors on personnel and optimizing Soldiers health and performance during training and on the battlefield. Its research divisions focus upon biophysics and biomedical modeling, military nutrition, military performance, and thermal and mountain medicine. They provide technical guidance to commanders and leaders on the effects of heat; cold; humidity; significant elevations above sea level; hydration; nutrition; and recommend measures to protect personnel and improve performance. They also conduct research on physical training, biomechanics, and injury risk. For example, their efforts are designed to reduce or eliminate musculoskeletal injury to Soldiers, especially with respect to the design of load-bearing equipment.

UNITED STATES ARMY MEDICAL RESEARCH INSTITUTE OF INFECTIOUS DISEASES

2-99. The U.S. Army Medical Research Institute of Infectious Diseases is the lead DOD research laboratory for medical biological defense research. It conducts research to develop strategies, products, information, procedures, and training programs for medical defense against biological warfare agent threats and infectious diseases. This organization plays a key role in national defense and in infectious disease research as the only biological containment laboratory within DOD with the capability to study highly hazardous viruses and infectious agents requiring biological safety Level 4 maximum containment. Medical products developed to protect military personnel against biological warfare agent attack or against endemic infectious diseases include vaccines, drugs, diagnostic tests, and medical management procedures. Medical and scientific subject matter experts at the United States Army Medical Research Institute of Infectious Diseases provide technical guidance to commanders and senior leaders on prevention and treatment of hazardous diseases and management of biological warfare agent casualties. In addition, this research organization serves as the DOD reference center for identification of biological warfare agents from clinical specimens and other sources.

WALTER REED ARMY INSTITUTE OF RESEARCH

2-100. The Walter Reed Army Institute of Research is the largest biomedical research facility currently serving both DOD and United States Army requirements. Its Infectious Disease Research Center of Excellence conducts research in naturally occurring infectious diseases, which have traditionally been the greatest threat to a Soldier's health and readiness both in the field and garrison. It is involved in the development of vaccines and drugs for the prevention and treatment of infectious diseases. Research areas include malaria and other vector-borne diseases; diarrheal diseases; bacterial diseases (including meningitis)

and viral diseases (including hepatitis and acquired immunodeficiency syndrome). It also conducts graduate medical education in PVNTMED. The institute conducts military psychiatry and neuroscience research, consisting of such areas as applied neurobiology, behavioral biology, closed head brain injury, military neuropsychiatry, and resilience training research.

MEDICAL CENTERS AND MEDICAL DEPARTMENT ACTIVITIES

2-101. Preventive medicine organizations at medical centers and medical department activities usually provide a comprehensive set of PVNTMED capabilities to the installations and military units they support, including local Reserve Component and National Guard units, when directed. They can provide operational PVNTMED support during the ARFORGEN process to Active Army and Reserve Component TOE PVNTMED personnel. Such support capabilities include technical consultation, determination of medical readiness requirements, unit field sanitation team training, health risk communication, health threat and operational planning, sustainment training, assistance in obtaining supplies and equipment, augmentation, and laboratory support.

NATIONAL CENTER FOR MEDICAL INTELLIGENCE

2-102. The Defense Intelligence Agency's National Center for Medical Intelligence produces all-source medical intelligence in support of the DOD and its components, national policy officials, and other federal agencies. Before troops are deployed to foreign areas, a National Center for Medical Intelligence assessment of potential health risks and foreign health care capabilities allows the medical community to plan for the proper medical countermeasures, health care support, and medical personnel support. Assessments, forecasts, and databases are prepared on foreign—

- Military and civilian medical systems.
- Infectious disease risks.
- Environmental health risks.
- Life sciences and biotechnology.

SECTION VII — HEALTH SURVEILLANCE

2-103. One of the primary focuses of AHS support is the prevention of injury and illness and the protection of the force from both natural and artificial environmental, occupational, operational, industrial, behavioral, and CBRN warfare health threats. The fundamentals of prevention and protection include the responsibility of the command in controlling DNBI, identifying health threats, implementing countermeasures to these threats, risk communication, and health surveillance.

2-104. Health surveillance requires that all environmental sampling and exposure monitoring data be collected and archived so that it may be linked with deployed units and personnel and with health outcome data that would enable identification of personnel who might be similarly exposed. Comprehensive and continuous health surveillance is necessary to counter health hazards which can adversely affect military personnel. The Army conducts comprehensive, continuous, and consistent health surveillance to implement early intervention and control strategies, using joint technologies, practices, and procedures in a manner consistent across all Service components.

2-105. Commanders provide their personnel with appropriate AHS support and training, equipment, and supplies to implement unit and individual surveillance and PVNTMED measures. Soldiers are made aware of significant health threats and corresponding PVNTMED measures using risk communication tools and techniques. Upon deployment, they are provided with updates to health threats and countermeasures based upon need and encountered situations.

2-106. Health surveillance systems are continuously in effect throughout each Soldier's career. These systems capture data about individual health status; instances of disease and injury; medical interventions such as immunizations, treatments, chemoprophylaxis, pretreatments, and physical and chemical barriers; and exposures to potential and actual health hazards associated with military occupation, deployments, and lifestyle.

OCCUPATIONAL AND ENVIRONMENTAL HEALTH SURVEILLANCE

2-107. Occupational and environmental health surveillance consists largely of sanitary surveys, sampling, and analyzing air, water, and soil for hazardous materials, chemicals, or radiation and using that information to document exposures to personnel and identifying the need for specific mitigation measures to reduce any associated health risks. It also entails monitoring communicable diseases in the local populations, as well as the documentation of exposures to CBRN warfare agents.

SPECIFIC CONSIDERATIONS FOR HEALTH SURVEILLANCE

2-108. Medical and OEH surveillance systems begin upon an individual's entry into military service, encompassing periods before, during, and after deployment to—

- Establish a baseline health status for each individual so that subsequent exposures can be adequately assessed.
- Assess DNBI, stress-induced casualties, and combat casualties (including those produced by CBRN or explosive weapons).
- Monitor environmental, occupational, and other health threats and diverse stressors.
- Reinforce command-directed and individual PVNTMED measures, as well as the provision of optimal medical care during and after deployments.

2-109. Medical and personnel information systems are designed, integrated, and used so as to be compatible with health surveillance objectives. Health surveillance activities are prioritized based upon the greatest beneficial impact on commanders' AHS support planning, response, and decisionmaking. Timeliness in the collection and analysis of surveillance data is crucial to guiding actions that benefit the health of the force. Commanders are informed about the findings of surveillance pertaining to the health of the force they command and associated health threats, stressors, risk factors, and available countermeasures. Data collection must begin at the lowest level possible and be supported by the appropriate automation infrastructure. Applicable health surveillance activities include essential DOD civilian personnel under DODD 1404.10 and essential contractor personnel under DODI 1100.22.

2-110. Surveillance data collected on individual Soldiers during their careers is provided to the Department of Veterans Affairs upon their separation or retirement from the military. There is a DOD Serum Repository for medical surveillance for clinical diagnosis and epidemiologic studies. This repository is for the identification, prevention, and control of diseases associated with military service.

PROCEDURES FOR CONDUCTING HEALTH SURVEILLANCE

2-111. The ultimate goal of health surveillance is to create a total health picture of the Soldier. This is accomplished by combining the suspected or actual exposure history of an individual (deployment exposures, day-to-day work-related exposures, and exposures resulting from training and participation in emergency responses) and the Soldier's documented medical history (illnesses, immunizations, treatments, and medical monitoring).

HEALTH SURVEILLANCE AND READINESS REQUIREMENTS

2-112. Commanders at all levels must ensure effective implementation of health surveillance and readiness requirements using quality assurance measures. It is a leadership responsibility to monitor and maintain a high state of predeployment health readiness among their personnel. They must direct actions to resolve health surveillance and readiness deficiencies, use risk management to identify health and safety hazards, and ensure implementation of PVNTMED measures to reduce or control unavoidable risks. (Refer to ATP 5-19 for more information on risk management.)

2-113. Deployment health activities are based on a health risk assessment of the AO, length of deployment, location of the deployment, and the availability/type of U.S. medical assets present. Some activities will take place regardless of the nature of deployment (daily location reporting) and other activities will be at the

discretion of the commander based on the risk assessment of the operation. Department of Defense Instruction 6490.03 contains details and requirements for deployment health activities based on level of risk.

2-114. Requirements for the electronic health record and individual medical readiness are considered continuous readiness requirements, independent of deployment.

ELECTRONIC HEALTH RECORD

2-115. Health surveillance, consisting of medical and OEH surveillance, is a continuous process that begins prior to the predeployment planning process (well before a deployment order or warning order is issued). The process actually begins upon accession, when an electronic medical record is initiated for each new Soldier.

2-116. The Military Health System electronic health record is the longitudinal digital electronic record for all Soldiers. The electronic health record is maintained on the Armed Forces Health Longitudinal Technology Application.

2-117. The electronic health record functions as the repository for all medical and OEH information throughout a Soldier's eligibility for care under the Military Health System. It contains specific medical surveillance information, exposure documentation, context information regarding actual exposures, and appropriate information describing significant potential exposures.

2-118. The electronic health record is initiated at all military training sites by collecting baseline health data from all accessions using a standardized health history questionnaire and a baseline serum collection. Data collected from these questionnaires is compiled and transferred to the Defense Medical Surveillance System. Serum samples are drawn and submitted to the DOD Serum Repository at the United States Army Public Health Center (Provisional). Methods should be developed to gather and analyze retrievable, electronically stored health data for the Reserve Component. At a minimum, records of military immunizations are established. These records contain information from baseline health assessments (questionnaire and serum samples) and periodic health assessments.

INDIVIDUAL MEDICAL READINESS

2-119. Populations at risk will be identified and their readiness to deploy validated. Mission success is optimized when Soldiers are medically ready to deploy upon notification. Decreased mobilization times demand that individual Soldier fitness and medical readiness be emphasized to ensure mission accomplishment.

2-120. Health surveillance and readiness requirements are included in all planning orders, operations plans, engagement plans, and operations orders.

DEPLOYMENT HEALTH SURVEILLANCE PLAN

2-121. A health surveillance plan is developed as part of each operations plan or operations order. The plan will identify the processes and resources needed for the regular collection, analysis, archiving, interpretation, and distribution of health-related data used to monitor the health of a deployed force and to intervene in a timely manner to prevent, treat, or control the occurrence of disease or injury.

2-122. Requirements for specialized medical units or capabilities are planned for and resourced. This includes PVNTMED, medical laboratory, veterinary service, preventive dentistry, and COSC assets/units. Health and safety hazards are identified and assessed. Health and safety hazards are identified and assessed. Medical intelligence, lessons learned, and other information sources from past deployments are used to identify potential health and safety hazards. A deployment OEH surveillance sampling plan must be established for each site to be assessed.

Predeployment

2-123. The OEH site assessments must be included as part of the predeployment health surveillance planning process. A health surveillance plan is developed as part of each operations plan or operations order.

2-124. The first step in the OEH site assessment process is the completion of the predeployment health assessment surveys. The predeployment health assessment survey should be completed as early as possible to identify and quantify OEH hazards and to tailor surveillance requirements directed at location-specific threats considered in operational planning as part of operational AHS support. Deploying medical units begin the OEH site assessment by completing a predeployment health assessment survey using industrial hazard assessments and other relevant intelligence information for all permanent or semipermanent basing locations (as identified in the combatant commander's operations plan). Refer to NTRP 4-02.9/AFTTP 3-2.82_IP/ATP 4-02.82 for an in-depth discussion of the OEH site assessment.

2-125. Based on input from the supporting PVNTMED unit, combatant commanders establish countermeasures or risk control actions to mitigate specific OEH risks identified in the industrial hazard assessment and predeployment health assessment survey as part of the overall operational planning process.

Deployment Surveillance

2-126. Preventive medicine personnel complete the OEH site assessment and health risk assessments at all permanent basing or semipermanent contingency locations. They use appropriate field environmental and industrial hygiene sampling and laboratory analysis techniques to complete these assessments in the least time required to accurately assess the OEH risks.

- High and extremely high risk estimates require rapid health risk assessment using on-site methods when possible. On-site methods may require field confirmatory and theater validation laboratory analysis.
- Moderate risk estimates may be assessed by collecting samples for off-site analysis.
- Low risk estimates may be assessed off-site, using mathematical models to assign risks, with sampling and laboratory support as operational resources allow.

Note. Confirmatory laboratory analyses will be performed, but if there will be a significant delay which may compromise the health of personnel, then confirmation should not impede initial risk management decisions.

2-127. Based on the preliminary hazard assessment and findings from the initial and ongoing environmental health site assessment, the Army develops and maintains an appropriate OEH surveillance and monitoring program for the deployment. The Army ensures that—

- Adequate PVNTMED assets, including laboratory analysis capability, are available to analyze deployment exposure data in near real time and respond appropriately.
- Operational surveillance elements are capable of expanding from smaller early entry modules to larger composite units capable of supporting all surveillance operations, if necessary. They will effectively employ active Army and Reserve Component elements and take advantage of host-nation support.
- Preventive medicine teams are light, mobile, and have presumptive sampling and analysis equipment to maximize their ability to do immediate exposure assessments.
- If it is anticipated or becomes known that the resource requirements are beyond the capabilities of organic PVNTMED assets, commanders request the required capability and/or expertise and oversee the assignment of technically specialized units or detachments to do these functions in the AO.

2-128. Preventive medicine personnel ensure waste management and pest management activities are maintained to minimize health risks to personnel for deployments of 30 days or more with extremely high, high, and moderate risks (across the range of military operations). They document the use of pesticides (including herbicides) and other chemical applications following current theater guidance with dates and times, pesticide nomenclatures, amounts, uses, and locations of pesticide application. Record pesticide use on DD Form 1532 (Pest Management Report) or equivalent as prescribed by DODI 4150.07. For information on pest management training and certification refer to DOD Manual 4150-07, Volumes 1, 2, and 3.

OCCUPATIONAL AND ENVIRONMENTAL HEALTH SITE ASSESSMENTS

2-129. Occupational and environmental health site assessments are initiated by completing a preliminary hazard assessment for all permanent or semipermanent basing locations. Units may conduct early site assessment reconnaissance using PVNTMED personnel to—

- Validate the preliminary hazard assessment.
- Identify any previously unknown site-specific health and safety threats and potential health risks.
- Assess waste management, disease vector control, vulnerabilities for food and water distribution and storage, and vulnerabilities for toxic industrial materials exposures.

2-130. Preventive medicine personnel develop and implement risk management and health risk communications. Appropriate health risk communications are based on health risk assessments and include a predeployment health threat briefing and identified PVNTMED measures.

DEPLOYMENT HEALTH ASSESSMENTS

2-131. The health of deploying Soldiers is formally assessed three times during the deployment process. The formal process consists of three DOD-directed health assessments: predeployment health assessment, postdeployment health assessment, and postdeployment health reassessment. This is in addition to medical assessments conducted during Soldier visits to a Role 1 or Role 2 medical treatment facility (MTF) or health care facility for acute/routine care during a deployment.

2-132. Department of Defense (DD) Forms: DD Form 2795 (Pre-Deployment Health Assessment); DD Form 2796 (Post-Deployment Health Assessment (PDHA)); and DD Form 2900 (Post Deployment Health Re-assessment (PDHRA)) filled out during the assessment process must be submitted electronically through the Medical Protection System or from an external location in Army Knowledge Online to the Defense Medical Surveillance System. The Medical Protection System was developed by the AMEDD to track all immunizations, medical readiness, and deployability data for all active Army and Reserve components, as well as Army civilians and contractors. It allows the chain of command to determine the medical and dental readiness of individuals, units, and task forces and to measure their medical readiness status.

2-133. The Defense Medical Surveillance System receives the DD Form 2795, DD Form 2796, and DD Form 2900 and makes the data (aggregated, anonymous, statistical data) available (read-only) to health care providers worldwide via TRICARE online.

Predeployment Health Assessment

2-134. The DD Form 2795 must be completed or reconfirmed within 60 days of expected deployment date. Forms downloaded from the Internet may be locally reproduced. Electronic submission of the completed DD Form 2795 to Defense Medical Surveillance System is mandatory.

Postdeployment Health Assessment

2-135. The DD Form 2796 must be completed not earlier than 7 days before the expected redeployment date and not later than 30 days after redeployment. Copies of completed DD Forms 2796 must be submitted electronically to Defense Medical Surveillance System. The Armed Forces Health Surveillance Center may be contacted by phone (commercial [301] 319-3240/Defense Switched Network 285-3240). For instructions on form submission, the e-mail address is provided in the reference section of this publication.

Postdeployment Health Reassessment

2-136. The DD Form 2900 must be completed within 90 to 180 days after return to home station from a deployment. For individuals who received wounds or injuries that required hospitalization or extended treatment at a military MTF before return to home station, the reassessment will be administered 90 to 180 days following their return home.

RESPONSIBILITIES FOR HEALTH SURVEILLANCE

2-137. The senior commander, unit commanders, leaders, individual Soldiers, and the AHS share the responsibilities for health surveillance.

Senior Commander

2-138. Senior commanders have overall responsibility for health surveillance of their troops and must—

- Support surveillance activities within their units with appropriate planning, resources, policy, enforcement, education, and training.
- Use surveillance information as the basis for unit health reporting in all phases of planning.
- Report individual unit DNBI rates and medical readiness according to DODI 6490.03, AR 40-5, DA Pam 40-11, operations plan, and operations order.
- Provide unit personnel strength figures to supporting medical units for calculation of unit-specific DNBI rates and trends.
- Consolidate DNBI report information from subordinate units in determining health status and health threat. For example, the BCT incorporates reports from subordinate battalions and separate companies; the division headquarters uses the consolidated brigade reports; and information continues up the reporting chain.
- Require that Soldiers complete deployment health assessment forms and other requirements as prescribed by DODD 6490.02E.

Unit Commanders and Leaders

2-139. Unit commanders and leaders have unit-level responsibilities to include—

- Informing troops of illness, injury, and disease threats; the risks associated with these health threats; and the PVNTMED measures in place or those to be used to minimize these health risks while deployed.
- Promoting COSC programs and policies.
- Ensuring completion of pre- and postdeployment health assessments and reassessments.
- Ensuring completion and monitoring of all individual medical readiness requirements.
- Emphasizing, implementing, monitoring, and enforcing the use of PVNTMED measures within the unit.

Soldiers

2-140. Soldiers—

- Comply with PVNTMED measures recommendations for health and safety and appropriate practice individual PVNTMED measures.
- Answer truthfully, to the best of their knowledge and ability, all questions on deployment health assessment forms.
- Inform leaders of any and all health-related problems they develop while deployed and seek medical treatment for them.

Medical Commanders

2-141. Medical commanders—

- Ensure that each identified case reported as a DNBI is reported through command channels to the appropriate medical surveillance activity (such as Armed Forces Health Surveillance Center and Defense Medical Surveillance System).
- Ensure Soldier concerns related to real or perceived health and/or environmental exposures are also highlighted when reported.

- Enforce completion of electronic health record entries for all patient encounters according to theater policy.
- Ensure local risk communication efforts are implemented to address specific deployment medical concerns and develop a better understanding of an issue.

Preventive Medicine Officers

2-142. Preventive medicine staff officers—

- Assist command surgeons in tabulating, interpreting, and reporting surveillance data.
- Provide technical assistance to supported units and staffs in deriving and applying health surveillance data.
- Maintain oversight of medical surveillance reporting in supported units.
- Provide technical assistance to supported units and staffs to address and discuss real and perceived health-related concerns of Soldiers.
- Advise commanders on the deployment-related health risks to their command and provide guidance on reducing health problems and concerns. This may involve requesting support from the DOD Deployment Health Clinical Center, United States Army Public Health Center (Provisional), the Navy and Marine Corps Public Health Center, or the United States Air Force School of Aerospace Medicine.

MEDICAL SURVEILLANCE

2-143. Medical surveillance includes medical data related to individual patient encounters and the use of that data to calculate DNBI and battle injury rates for a defined population. This information is used primarily for preventing and controlling health and safety hazards.

GENERAL GUIDELINES FOR MEDICAL SURVEILLANCE

2-144. Medical surveillance goes hand-in-hand with OEH surveillance and some of the activities taken during the predeployment, during deployment, and postdeployment processes will overlap. The combination of successful, comprehensive medical surveillance and OEH surveillance gives commanders at all levels of command accurate, actionable DNBI data.

2-145. Medical surveillance provides the clinical encounter information, including the reporting and analysis of incidents of disease and injury. It includes epidemiological trend analysis of reported clinical outcomes from DNBI casualties.

2-146. Medical surveillance is used to monitor the status of health and fitness of military populations and individuals. It is an essential capability to help document the nature, magnitude, and distribution of health threats and exposures; focus PVNTMED and health risk communication efforts; and document the efficacy of interventions and PVNTMED measures. For a discussion of deployment-related health assessments and forms refer to paragraphs 2-135 through 2-141 on page 2-28.

2-147. Emerging deployment-related health issues resulting from medical (as well as OEH) surveillance must be promptly reported to the chain of command, joint staff surgeon, and the Director, Deployment Health Support Directorate. Information from deployment health assessments is analyzed in conjunction with other current and historical databases to prepare summaries of reportable diseases, trends of illnesses of special surveillance interest, and field reports describing outbreaks and case occurrences.

2-148. Information on endemic diseases, environmental contamination, toxic industrial materials hazards, and foreign medical capabilities may be obtained through the National Center for Medical Intelligence.

DISEASE AND NONBATTLE INJURY

2-149. Disease and nonbattle injury is defined as all illnesses and injuries not resulting from direct enemy or terrorist action or caused by conflict with the exception of diseases or illnesses resulting from biological warfare agents. Indigenous disease pathogens, heat, cold, hazardous noise, altitude, environmental/ occupational and/or industrial exposures, and other naturally occurring disease agents may cause DNBIs.

Disease and nonbattle injuries include injuries and illnesses resulting from training or from occupational, environmental, or recreational activities and may result in short- or long-term, acute, or delayed illness, injury, disability, or death.

2-150. The DNBI rates can be likened to the vital signs of a unit's well-being. Once unit wellness baselines are established (from the predeployment health assessment and in garrison DNBI surveillance), DNBI rates that are above the mean indicate a problem exists which could negatively impact unit readiness. If abnormal DNBI rates are identified, they could indicate a breakdown in PVNTMED measures and the need to implement, monitor, or enforce PVNTMED measures.

2-151. Unit wellness baseline rates must be continually tracked and reported. The DNBI monitoring must be initiated in garrison to establish a baseline for each unit and to allow for the tracking of outbreaks and other medical problems within the unit.

2-152. The DNBI report is based on reviewing data from the daily disposition log (refer to ATP 4-02.3), electronic health record, inpatient admissions, and/or accident reports which must record at a minimum the following information on every patient encounter:

+ ● Patient's name, social security number, sex, unit identification code, and duty location.
- Type of visit (new, follow-up, or administrative).
- Primary complaint and final diagnosis.
- Injuries must be classified into recreation/sports, motor vehicle accident, work/training, or other. (Battle injuries are also recorded but are not included in the DNBI rate computations.)
- Final patient disposition is made into one of the following categories:
  - Return to unit.
  - Hospital inpatient admission.
  - Evacuation.
  - Other.
  - Death (all deaths will be counted in DNBI/battle injury reporting).

3-153. When determining DNBI cases and rates, the following guidelines should be used:

- Initial visit is the only visit counted. Do not count follow-up visits in DNBI/battle injury rates. Record them in a category below the DNBI totals.
- All initial sick call visits should be placed in a category. Some patients with multiple ailments may occasionally need to be counted in multiple categories.
- If in doubt about which category, use judgment in determining the best selection.
- Disposition for each case resulting from initial visits are counted.

4-154. Compare computed rates for each category with the suggested reference rates for that category (comment is required under the section Problems Identified—Corrective Actions for all categories where rates are markedly above the suggested reference rate). When comparing rates, keep the following information in mind:

- The Army or joint task force surgeon establishes the initial suggested reference rates based upon theater-/deployment-specific predeployment analysis.
- Use common sense in interpreting the DNBI rates. Attention to each individual category is appropriate and necessary in this situation. Track DNBI and battle injury rates over time and compare current rates with your unit's past rates for comparable situations. Rates with marked elevations (greater than or equal to twice the unit baseline or suggested reference rates) require investigation, explanation, and comment, as well as potential intervention.

5-155. Consult the Armed Forces Health Surveillance Center Web site for the most current Tri-Service Reportable Medical Event guidelines as they are subject to change.

Medical Surveillance In Support Of Deployments

2-156. There are four steps in the medical surveillance process for a deployment:pre-mobilization/mobilization, predeployment, during deployment, and postdeployment. Each step has critical

elements that must be completed and approved by the commander before going on to the next stage of a unit's deployment.

Premobilization/Mobilization

2-157. During this process, ensure all Soldiers have an electronic health record and that all individual medical readiness requirements are completed. Individual medical readiness statistics will be obtained from the Medical Protection System via the Internet. The individual medical readiness discrepancies will be corrected and the overall health of the force is continually monitored and evaluated by conducting medical surveillance activities.

Predeployment

2-158. The following actions and processes are taken to determine the health baseline of deploying individuals and units:

- Preventive medicine personnel monitor the daily disposition log (refer to ATP 4-02.3) or admission data from all MTFs and periodically analyze this data to develop baseline rates of DNBI within a nondeployed force.
- Baseline rates are used, in conjunction with suggested reference rates, during deployment to determine if the DNBI rates in deployed forces differ from nondeployed DNBI rates.
- Preventive medicine personnel review the predeployment health assessment to assist the commander in determining the Soldier's deployability.

During Deployment

2-159. The following processes and actions are taken to monitor the health of deployed units in an AO. This data is used to maintain a healthy deployed force and advise commanders on health-related risks to their commands.

- Preventive medicine personnel receive the daily disposition log or admission data from all MTFs and analyze this data to determine DNBI rates within the deployed force.
- Disease and nonbattle injury rate must be reviewed daily to detect potential adverse health trends or exposures, assess effectiveness of PVNTMED measures, and recommend enhanced PVNTMED measures.
- The DNBI rate must be compared to unit baselines and/or suggested baseline DNBI rates to determine illness/incident trends.
- Significant differences between the two surveys indicate a possible health problem and may require epidemiological investigation.
- Disease and nonbattle injury and suspected Tri-Service Reportable Medical Events must be reported via approved and available electronic data collection and transmission devices.
- Preventive medicine personnel provide guidance on PVNTMED measures and advise the commander on health-related redeployment concerns.

Postdeployment

2-160. Daily disposition logs, electronic health records, and other records of raw data compiled to create DNBI and battle injury reports must be retained by the medical unit at the conclusion of the deployment and the unit must coordinate with the DOD Deployment Health Clinical Center and the Armed Forces Health Surveillance Center for archiving. No records will be destroyed.

2-161. Collect medical information on all redeploying Soldiers (to include Reserve Component members who are separating from active duty) and units. All Soldiers must complete the postdeployment health assessment to identify medical concerns related to the deployment. Individuals and/or units in coordination with medical authorities arrange for appropriate evaluations, treatments, and follow-ups.

2-162. Preventive medicine personnel monitor the daily disposition log from MTFs that are servicing redeploying personnel. They monitor and analyze the data for unusual trends within the redeploying force, as well as its correlation to predeployment DNBI rates. Medical surveillance for redeployed personnel is in

place to identify emerging (latent) health effects while still on active duty, and the Assistant Secretary of Defense (Health Affairs) is promptly notified of emerging problems that may be deployment-related.

SECTION VIII — BASE CAMP DEVELOPMENT

2-163. Preventive medicine expertise and services are an essential part of the base camp development process. Preventive medicine personnel must be incorporated early into the base camp planning and design phase to ensure a thorough assessment of the proposed area is accomplished, health risk communications are clearly articulated to the commander and base camp planners, a prevention and mitigation plan is developed to counter any existing health risks, and a viable PVNTMED plan is developed and implemented to sustain the base camp once it becomes operational. A base camp is an evolving military facility that supports the military operations of a deployed unit and provides the necessary support and services for sustained operations. Base camps are nonpermanent by design and designated as a base only when the intention is to make them permanent. Base camps may have a specific purpose or they may be multifunctional. While base camps are not permanent bases or installations, the longer they exist the more they exhibit many of the same characteristics in terms of the support and services provided and types of facilities that are developed. For an in-depth discussion of base camp strategic system and policy integration, planning and design, construction, operations, and transfer and closure refer to ATP 3-37.10/MCRP 3-17.7N.

2-164. Upon determination of the proposed site, PVNTMED personnel must conduct an occupational and environmental health site assessment as addressed in NTRP 4-02.9/AFTTP 3-2.82_IP/ATP 4-02.82. Regardless of whether the site is new or has been previously occupied the OEH assessment is required. The site assessment also includes the surrounding terrain to ensure there are no vector-breeding grounds or areas contaminated by toxic industrial materials which could pose a threat to the new base camp.

2-165. During the site preparation and construction phase, the PVNTMED personnel consult with engineers, quartermaster, and other base planners to ensure no inadvertent hazards occur from the design and placement of structures, that ventilation and airflow requirements are correctly calculated, that sewage and waste disposal processes meet established standards, and the pest management activities are actively pursued.

2-166. Once the base camp becomes operational, PVNTMED services are still required to ensure health risks are mitigated or completely prevented. Issues such as feral animal control, the prevention of zoonotic diseases transmissible to man (such as rabies), and pest management are on-going issues which must be addressed throughout the life cycle of the base camp.

2-167. Preventive medicine support is provided by the EAB PVNTMED units on an area support basis. These units also provide general support to BCT units when the support required exceeds the BCT's organic PVNTMED assets.

2-168. When base camp development includes the development of medical treatment facilities, plans and designs must be coordinated with the United States Army Health Facility Planning Agency to ensure the design of the facility is in compliance with regulatory guidance on such issues as barrier construction and protection when operating x-ray equipment, facilitates and enhances internal infectious disease control within the MTF, and disposal of regulated medical waste.

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Chapter 3
Veterinary Services

This chapter outlines the functions and operations of each veterinary element within an AO. It provides techniques and procedures for veterinary support. The information provided in this publication will assist veterinary commanders and staffs to operate efficiently in the EAB arena. This chapter will not discuss the U. S. Air Force Military Working Dog (MWD) Program. For information on this program refer to AR 190-12, DA Pam 190-12, ATP 3-39.34, and AFI 31-121.

SECTION I — VETERINARY SUPPORT IN MILITARY OPERATIONS

3-1. The veterinary mission is to execute veterinary service support essential for FHP and to project and sustain a healthy and medically protected force; train, equip, and deploy the veterinary force; and promote the health of the military community.

FOOD PROTECTION AND QUALITY ASSURANCE

3-2. The food safety, protection, and quality assurance mission is conducted during all stages of procurement, storage, and distribution and requires that veterinary personnel—

- Ensure food ingredients and food products are safe, wholesome, free from unintentional or intentional contamination/adulteration, and meet quality standards.
- Perform surveillance inspections of operational rations and food and food storage in dining facilities.
- Perform sanitation audits of commercial facilities that produce such items as dairy products, seafood (fish), red meats, poultry, eggs, pork, baked goods, fresh fruits and vegetables, bottled water, and block or packaged ice. See AR 40-657/NAVSUP 4355.4H/MCO P10110.31H and the most current version of DOD Manual 1338.10 for definitive information on sanitation audits of commercial food establishments.
- Perform surveillance inspections of all Service-owned subsistence received, stored, issued, sold, or shipped from/to military installations (including those items received from depots and supply points). See AR 40-656/NAVSIUPINST 4335.10A/MCO10110.48 for definitive information on veterinary surveillance inspections.
- Conduct basic food screening and field confirmatory microbiological and presumptive chemical laboratory procedures on food and bottled water to ensure adherence to food safety standards and to identify potential food-borne pathogens.
- Advise theater logistics, ration breakdown points, and dining facilities on storing subsistence to minimize the threat of CBRN contamination.
- Inspect and monitor subsistence or food-producing animals that are contaminated or suspected of being contaminated by CBRN agents, and collect and submit samples to the appropriate laboratory for analysis, as directed. Refer to United States Army Public Health Center (Provisional) TG 361 for additional information.
- Provide units with guidance and instructions for the proper handling or decontamination of subsistence. Refer to ATP 4-02.7/MCRP 4-11.1F/NTTP 4-02.7/AFTTP 3-42.3 for definitive information.
- Protect the financial interests of the government as it affects the use and disposition of wholesome, government-owned subsistence.

- Participate in defense support of civil authorities and foreign humanitarian assistance tasks, as directed.
- Conduct food and water risk assessments during early deployments, exercises, and other short-term operations conducted OCONUS.
- Assist in food vulnerability assessments on the food distribution system and on base camps in contingency environments.
- Assist with suspected food-borne disease epidemiological investigations, as requested.
- Conduct the hazardous food and nonprescription drug recall program according to the provisions of AR 40-660/DLAR 4155.26/NAVSUPINST 10110.8C/AFR 161-42/MCO 10110.38C.

VETERINARY MEDICAL CARE

3-3. Veterinary medical care is provided to MWDs and other government-owned animals within the joint operational area with additional rehabilitative and convalescent care provided in CONUS. The veterinary roles of medical care are discussed in Section IV below. Veterinary personnel—

- Provide complete veterinary care for all MWDs in the AO.
- Provide veterinary Role 1 through Role 3 care to contract working dogs.
- Provide limited veterinary care to other DOD-owned animals and other government-owned animals when time and resources permit and to indigenous animals, as directed.
- Provide CBRN decontamination instructions for MWDs and other government-owned animals.
- Participate in defense support of civil authorities, stability tasks, and foreign humanitarian assistance, as directed.

VETERINARY PREVENTIVE MEDICINE

3-4. Veterinary PVNTMED includes those activities which identify and mitigate zoonotic disease threats to military units, individual Soldiers, and their Families. These activities include—

- Supporting prevention and control programs to protect Soldiers from food-borne diseases.
- Evaluating zoonotic disease data collected in the AO and advising PVNTMED elements and higher headquarters on potential hazards to humans.
- Establishing animal disease prevention and control programs to protect Soldiers and their Families and other DOD and multinational personnel from zoonotic diseases.
- Assessing the presence of animal diseases that may impact the CONUS agriculture system if contaminated equipment or personnel are allowed to redeploy.
- Performing investigations of unexplained animal deaths to include livestock and wildlife.
- Participating in defense support to civil authorities, stability tasks, and foreign humanitarian assistance, as directed.

VETERINARY SERVICES AND SUPPORT

3-5. The United States Army Veterinary Corps is the sole provider of veterinary services in the DOD. Multiservice food storage facilities located on United States Air Force installations are subject to inspection by United States Army veterinary personnel. Refer to DODD 6400.04E for additional information. Veterinary services are also provided upon request and subject to availability of resources for government-owned animals of other federal agencies. In some instances and when authorized, animal care is provided to multinational forces and/or host-nation agencies. The U.S. Government agencies that may be provided this support include—

- Departments of—
  - Agriculture.
  - Commerce.
  - Transportation.

  - Homeland Security (Transportation Security Administration, United States Coast Guard, United States Customs and Border Protection, and United States Secret Service).
  - Justice (Drug Enforcement Administration).
  - State.
- Federal Bureau of Investigation.
- Central Intelligence Agency.

3-6. As the mission requires, veterinary personnel may be attached to U.S. military mission command units or be under the operational control of civilian management elements, but remain under military mission command to provide veterinary support in operations with a preponderance of stability tasks or when providing support in defense support to civil authorities activities.

EMPLOYMENT AND DEPLOYMENT OF VETERINARY UNITS

3-7. Veterinary units are designed with the flexibility and mobility to deploy numerous teams or individuals to accomplish diverse and decentralized food inspection support and animal veterinary care to meet requirements of a larger military operation. The size of the supporting veterinary unit is dependent upon the total number of DOD military personnel and MWDs and other government-owned animals being supported. Veterinary units may serve as general support to the theater Army, theater sustainment command, and EAB-level Class I logistics units. Veterinary teams may be under the operational control of BCTs to provide forward food safety support. Veterinary teams/personnel coordinate and report their mission support activities with the appropriate headquarters medical staff elements.

VETERINARY FACILITIES

3-8. Veterinary units must establish facilities at sites best suited to support their mission. This might include collocation with United States Navy, United States Marine Corps, and United States Air Force units. Veterinary facilities are usually located in secure areas where logistical support is available. The sites selected are adjacent to or collocated with other units (either medical or logistical or both). These sites facilitate the inspection of subsistence that must be performed from the time it is procured or received until it is issued for consumption. They also facilitate the medical evacuation of military working dogs.

FACILITIES DESIGN

3-9. The commander of the veterinary unit is responsible for the internal layout of veterinary facilities. Veterinary equipment is laid out in a tent or in buildings of opportunity to provide the best possible operation. In the facility design, factors that should be considered are military and contractor working dogs and/or other government-owned animal populations supported, unit administration, and personnel living requirements. Additionally, in order to perform surgical procedures, a controlled environment with a stable temperature to minimize contamination of the patient and ensure proper operation of equipment is required. In order to provide field confirmatory microbiological and presumptive chemical laboratory analysis of food and bottled water, a controlled environment is required to minimize contamination of specimens and samples and ensure proper operation of equipment. A decontamination station for animals is established using the same techniques and procedures used to establish a patient decontamination station (see ATP 4-02.7/MCRP 4-11.1F/NTTP 4-02.7/AFTTP 3-42.3). The specific site selected to establish a decontamination station must be downwind of the unit and treatment areas.

LOGISTICAL SUPPORT

3-10. Veterinary units require administrative and logistical support. Support should be obtained from the MEDCOM (DS), MEDBDE (SPT), or MMB to which the unit is assigned or attached. When detached from its higher headquarters, support arrangements should be specifically documented in attachment orders to address all support requirements for the veterinary unit.

VETERINARY PERSONNEL AND THE GENEVA CONVENTIONS

3-11. Medical and veterinary personnel are separate and exclusive groupings in the Geneva Conventions. The presence of veterinary personnel in a medical unit is not enough to entitle them to special protection and privileges under the Geneva Conventions. Nor does their presence alter the special protection afforded other members of the medical unit. Veterinary personnel will be treated as combatants if captured or interned. An exception is made when veterinary personnel are assigned to a medical unit and exclusively perform the full-time duty of transporting the sick and wounded, administering the medical care of patients, and saving human lives, or perform full-time staff duties concerning these tasks. In these special cases, they may wear the brassard, carry a DD Form 1934, (Geneva Conventions Identity Card for Medical and Religious Personnel Who Serve in or Accompany the Armed Forces), and be entitled to protection under the Geneva Conventions. Refer to FM 27-10 for information on Geneva Conventions.

SECTION II — VETERINARY SUPPORT STRUCTURE

3-12. This section discusses the medical detachment (veterinary service support [MDVSS]). Until fiscal year 2015, one other additional veterinary unit (medical detachment [veterinary services]) was in the Army inventory. Although the mission of these two organizations were similar, the design of the MDVSS facilitates more efficiently and effectively executing the mission.

MEDICAL DETACHMENT (VETERINARY SERVICE SUPPORT)

3-13. The MDVSS is the sole provider of veterinary services for all Service components of the DOD. (Refer to Section V for a discussion on the levels of food microbiological and chemical laboratory testing.)

MISSION

3-14. The MDVSS (TOE 08300R000) (Figure 3-1) provides equipment and personnel to provide dispersed veterinary Role 1 and veterinary Role 2 medical and resuscitative surgical care; veterinary Role 3 medical care consisting of comprehensive canine veterinary medical/surgical care and evacuation/hospitalization support for military and contractor working dogs; endemic zoonotic and foreign animal disease epidemiology surveillance and control; animal facility and kennel inspections; commercial food source audits for DOD procurement; food protection, quality assurance, and sanitation inspections; food defense vulnerability assessments; food and water risk assessments; field confirmatory and presumptive microbiological and chemical laboratory diagnostics of food and bottled water; and veterinary support to operations characterized by a preponderance of stability tasks and to defense support to civil authorities activities. This unit is the sole provider of veterinary services for all Service components of the DOD. (Refer to Section V for a discussion on the levels of food microbiological and chemical laboratory testing.)

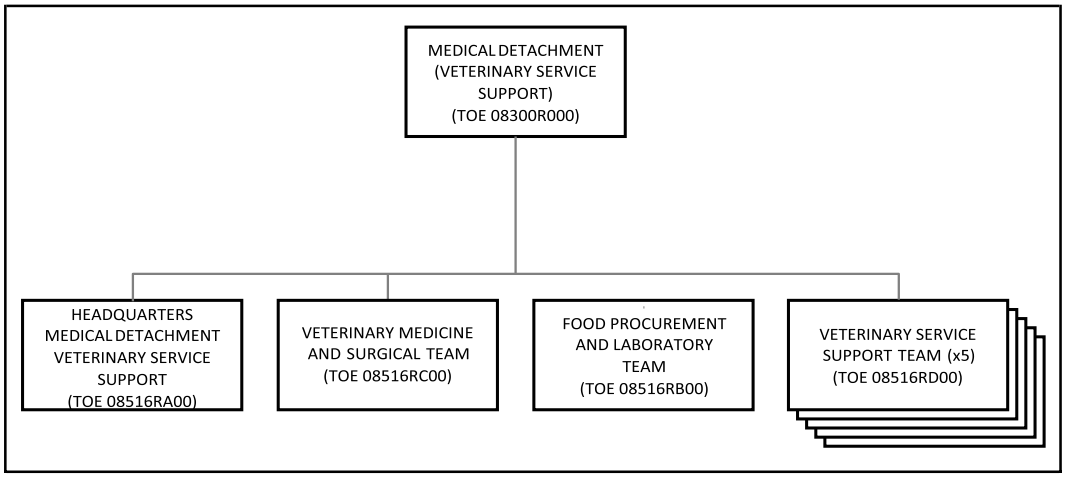

Figure 3-1. Medical detachment (veterinary service support)

ASSIGNMENT

3-15. The MDVSS is assigned to a headquarters and headquarters company, MEDCOM (DS) (TOE 08640G000), headquarters and headquarters company, MEDBDE (SPT) (TOE 08420G000), MMB (TOE 08485R000) or an equivalent sister Service organization.

DEPENDENCIES

3-16. This unit is dependent on—

- Appropriate elements of the theater for religious, legal, AHS support, finance, and personnel and administrative services.
- Sustainment vehicle and generator maintenance support from higher headquarters, consolidated motor pools, or sister units.
- Transportation services when single lift requirements exceed unit capability, vehicle recovery operations, and administrative services.
- Medical maintenance support from the supporting medical logistics company for veterinary medical equipment.
- Reachback capability for theater validation for food microbiological and field confirmatory/theater validation for chemical testing of food and bottled water and for veterinary Role 4 medical care of MWDs.

3-17. When attached or assigned to U.S. Navy, U.S. Air Force, or U.S. Marine Corps units, requirements for support are the same as those stated in paragraph 3-15.

BASIS OF ALLOCATION

3-18. For contingency and major combat operations, one MDVSS per 60,000 personnel of any Service supported; one per 300 MWDs. For stability tasks, one MDVSS per 3 brigades (12,000 personnel). For foreign humanitarian assistance missions and defense support of civil authorities, one MDVSS per 3 brigades (12,000 personnel).

CAPABILITIES

3-19. The unit's capabilities consist of the following:

- Early initial entry capabilities for establishment of initial veterinary Roles 1 and 2 medical and surgical care to military and contractor working dogs and food inspection support in theaters of operation.
- Veterinary Role 3 advanced canine veterinary medical and surgical care.
- Veterinary Role 3 evacuation/hospitalization support for military and contractor working dogs.
- Endemic zoonotic and foreign animal disease epidemiology surveillance and control.
- Animal facility and kennel inspections.
- Commercial food source audits for DOD procurement.
- Food safety, quality assurance, and sanitation inspections.
- Food defense vulnerability assessments.
- Food and water risk assessments.
- Field confirmatory microbiological and presumptive food microbiological and chemical laboratory diagnostics.
- Veterinary support to stability tasks and defense support of civil authorities tasks (see ATP 4-02.42 for further information).

FUNCTION

3-20. See paragraphs 3-36, 3-49, 3-62, and 3-75 for subordinate TOE functions and requirements information.

EMPLOYMENT

3-21. The MDVSS (TOE 08300R000) is employed in the AO and consists of the headquarters, MDVSS (TOE 08516RA00), the veterinary medicine and surgical team (TOE 08516RC00), the food procurement and laboratory team (TOE 08516RB00), and, five veterinary service support teams (VSST) (TOE 08516RD00). The veterinary teams may be geographically dispersed to align with their primary customers or those units/activities such as aerial/sea ports of debarkation, or EAB-level Class I supply points requiring support. The unit can be task-organized across team lines or subdivided to meet a variety of functional scenarios within the stated mission. The headquarters section may be located in the center of operations or near other medical units with mission command functions. The MDVSS provides one or more VSSTs for initial early entry capability to provide veterinary Role 1 and veterinary Role 2 medical and surgical care and to support initial theater food inspection requirements. The MDVSS may be aligned with civil-military operations centers at BCTs, with civil affairs units, or with task-organized provincial reconstruction teams when directed for support of stability tasks. The VSST supports Joint forces in execution as the sole provider of veterinary services to the DOD.

Note: The MDVSS coordinates and functions well in conjunction with PVNTMED units.

MOBILITY

3-22. See paragraphs 3-35, 3-46, 3-57, and 3-68 for subordinate TOE for its mobility requirements and capabilities.

SUBORDINATE TABLES OF ORGANIZATION AND EQUIPMENT TO THE MEDICAL DETACHMENT (VETERINARY SERVICE SUPPORT)

3-23. To ensure deployability and flexibility, the MDVSS has four subordinate TOE structured/numbered teams (see Figure 3-1 on page 3-4). This structure enables the AHS planner to tailor and deploy only required capabilities when troop ceilings are imposed for specific operations.

HEADQUARTERS, MEDICAL DETACHMENT (VETERINARY SERVICE SUPPORT)

3-24. The headquarters element for this organization provides mission command and administrative support for assigned and attached teams. The subordinate teams may be collocated with the headquarters or may conduct split-base operations at numerous sites.

Mission

3-25. The mission of the headquarters, MDVSS (TOE 08516RA00) is to provide mission command, to include mission analysis, task organization, supervision, and responsibility for mission accomplishment of the unit's subordinate teams.

Assignment

3-26. The headquarters, MDVSS is assigned to a MEDCOM (DS), MEDBDE (SPT), or MMB.

Dependencies

3-27. The headquarters, MDVSS is dependent upon the following:

- Appropriate elements of the theater for religious, legal, AHS support, finance, personnel, and administrative services.
- Sustainment vehicle and generator maintenance support from higher headquarters, consolidated motor pools, and sister units.
- Transportation services when single lift requirements exceed unit capability, vehicle recovery operations, and administrative services.

- Medical maintenance support from the supporting medical logistics company for veterinary medical equipment.
- Reachback capability for theater validation of microbiological and field confirmatory/theater validation chemical levels of analysis for food and bottled water for veterinary Role 4 medical care for MWDs.

3-28. When attached or assigned to U.S. Navy, U.S. Marine Corps, or U.S. Air Force units, requirements for support are the same as those stated in paragraph 3-26.

Basis of Allocation

3-29. The headquarters, MDVSS is allocated one per three to six subordinate units (teams and detachments). For contingency and major combat operations, one headquarters, MDVSS is allocated on a basis of one per 60,000 personnel of any Service supported and one per 300 MWDs.

Capabilities

3-30. The headquarters, MDVSS provides—

- Mission command of subordinate units.
- Unit administration and supply functions.
- Unit movement plans.
- Mission analysis and task-organized teams.
- Senior veterinary intellectual capital and coordination or liaison experience for operations characterized predominately by stability tasks, foreign humanitarian assistance. or in support of defense support to civil authorities activities to establish or re-establish animal agricultural and public health infrastructure, assist in re-establishing small farms to large commercial fish, swine, poultry, ruminant animal production enterprises, coordinate with SOF and civil affairs units and/ or personnel, facilitate support to foreign humanitarian assistance, and liaison with other governmental agencies, such as the United States Agency for International Development, as well as with nongovernmental organizations.
- Host nation public health official coordination.
- Epidemiologic surveillance of endemic zoonotic and foreign animal disease.
- Maintenance personnel who will augment the maintenance capability of the unit that performs field maintenance on the unit's organic vehicles and power equipment.

3-31. Individuals of this organization can assist in the coordinated defense of the unit's area or installation. This unit does not perform field maintenance on any organic equipment to include communications security equipment.

Functions

3-32. The functions of the headquarters, MDVSS include mission command of subordinate units; unit administration, and supply functions; unit movement planning; intellectual capital and coordination/liaison experience for stability tasks and in support of defense support to civil authorities; and liaison with foreign government officials.

Employment

3-33. The MDVSS headquarters is deployed in the AO to provide mission command for any combination of three subordinate teams being deployed. The MDVSS headquarters may be centrally located to subordinate team operations or collocated with a higher medical headquarters, such as MEDCOM (DS), MEDBDE (SPT), or MMB. This headquarters supports the Joint forces by being the sole provider of veterinary support.

3-34. The headquarters, MDVSS may be assigned with planning cells for civil-military operations centers at BCTs, civil affairs units, or provincial reconstruction teams when directed to support stability tasks.

Note: The MDVSS headquarters coordinates and functions well in conjunction with PVNTMED units.

Mobility

3-35. This unit requires 60 percent mobility of its TOE equipment to be transported in a single lift using organic vehicles.

FOOD PROCUREMENT AND LABORATORY TEAM

3-36. The food procurement and laboratory team provides the specialized equipment and personnel to perform a variety of procedures necessary for ensuring food protection.

Mission

3-37. The mission of the food procurement and laboratory team (TOE 08516RB00) (Figure 3-1 on page 3-4) is to provide field confirmatory microbiological and presumptive chemical analysis of food and bottled water and to provide further assurance of food protection. In order to provide field confirmatory food and bottled water microbiological and presumptive chemical laboratory analysis, a controlled environment is required to minimize contamination of specimens and samples and ensure proper operation of equipment. The food procurement and laboratory team provides expertise for conducting commercial audits of food production facilities. The food procurement and laboratory team provides the trained expertise to use the organic Joint Biological Agent Identification and Diagnostic System. The food procurement and laboratory team provide manpower and equipment to support stability tasks, foreign humanitarian assistance and defense support to civil authorities in areas requiring a higher degree of expertise in food inspection, food diagnostics, and infrastructure re-establishment particularly with respect to food facilities, distribution, and sanitation.

Assignment

3-38. The food procurement and laboratory team is assigned to a MDVSS. This team may be directly assigned to a MEDCOM (DS), MEDBDE (SPT), or MMB.

Dependencies

3-39. The food procurement and laboratory team dependencies are the same as those described for the headquarters, MDVSS, as stated in paragraph 3-27 on page 3-6, with the exception of reachback for veterinary Role 4 medical care for MWDs.

Basis of Allocation

3-40. For contingency and major combat operations this team is allocated based on one food procurement and laboratory team per 60,000 personnel from any Service supported for field confirmatory microbiological and presumptive chemical laboratory testing analysis of food and bottled water.

Capabilities

3-41. The food procurement and laboratory team provides—

- Field confirmatory microbiological and presumptive chemical food and bottled water laboratory diagnostics in the AO.
- Commercial and military establishment audits to include assessment of potential military construction sites for food production and storage in the AO.
- Food defense vulnerability and food and water risk assessment.
- Surveillance inspection of CBRN contamination of Class I subsistence.
- Manpower and equipment to support stability tasks including civil affairs, foreign humanitarian assistance, and SOF.

- Modularity and flexibility to disperse a food procurement team and a Level I and II food diagnostics laboratory to separate locations.
- Trained expertise for the organic Joint Biological Agent Identification and Diagnostic System.

3-42. Individuals of this organization can assist in the coordinated defense of the unit's area or installation.

3-43. This unit does not perform field maintenance on any organic equipment to include communications-security equipment.

Functions

3-44. The functions of the food procurement and laboratory team include providing Levels I and II microbiological and chemical testing of food; conducting commercial audits of food production facilities; performing Joint Biological Agent Identification and Diagnostic System testing for suspect CBRN agents; and providing support for the conduct of stability tasks and defense support to civilian authorities activities in areas requiring a higher degree of expertise in food inspection, food diagnostics, and infrastructure re-establishment particularly with respect to food facilities, distribution, and sanitation.

Employment

3-45. The food procurement and laboratory team as stated in paragraph 3-41 provides a field laboratory capability in support of food protection. It is normally aligned with units/activities providing Class I support. These units/activities may include aerial/sea ports of debarkation; Class I supply points, ration breakdown points, ration receipt points, or ration distribution points anywhere within the operational area. The food procurement and laboratory team can be employed as two separate teams: one field confirmatory microbiological and presumptive food and bottled water diagnostics laboratory team and one food procurement team. In operations characterized by a preponderance of stability tasks, this team could be aligned with civil-military operations centers, civil affairs units, or with task-organized provincial reconstruction teams when directed. The food procurement and laboratory team may also be aligned with medical laboratories for Joint Biological Agent Identification and Diagnostic System testing. The food procurement and laboratory team supports Joint forces in execution of the DHA mission for veterinary services.

Note. The MDVSS headquarters coordinates and functions well in conjunction with PVNTMED units.

Mobility

3-46. This unit requires 100 percent mobility of its TOE equipment to be transported in a single lift using organic vehicles.

VETERINARY MEDICINE AND SURGICAL TEAM

3-47. The veterinary medicine and surgical team is the element that provides health care to military work dogs and other government-owned animals.

Mission

3-48. The veterinary medicine and surgical team (TOE 08516RC00) provides veterinary Role 1 through Role 3 canine health care capabilities to sustain military and contractor working dog health and minimize theater evacuations. The veterinary Role 3 hospital team provides referral level, clinical veterinary medical consultative expertise and referral hospitalization to increase veterinary clinical expertise for in-theater treatment and provides recovery or evacuation coordination capability. As a theater matures, veterinary medical capabilities under the direction of the clinical medicine veterinarian (AOC 64F) provides expanded capabilities in support of stability tasks within his AO with a focus on infrastructure rebuilding of animal health care and institutional veterinary training programs, ranging from university hospitals to local veterinary technician training, and accomplishing critical tasks in animal agricultural-based economies.

Assignment

3-49. The veterinary medicine and surgical team is assigned to the MDVSS. The veterinary medicine and surgical team may also be assigned directly to a MEDCOM (DS), MEDBDE (SPT), or MMB.

Dependencies

3-50. The veterinary medicine and surgical team is dependent upon the following:

- Appropriate elements of the theater for religious, legal, AHS support, finance, and personnel and administrative services.
- Sustainment vehicle and generator maintenance support from higher headquarters, consolidated motor pools, or sister units.
- Transportation services when single-lift requirements exceed unit capability, vehicle recovery operations, and administrative services.
- Medical maintenance support from the supporting medical logistics company for veterinary medical equipment.
- Reachback capability for veterinary Role 4 medical care of MWDs.

3-51. When attached or assigned to U.S. Navy, U.S. Air Force, or U.S. Marine Corps units, the veterinary medicine and surgical team support requirements and dependencies on that Service are same as stated in paragraph 3-50 for Army units.

Basis of Allocation

3-52. For contingency and major combat operations, one veterinary medicine and surgical team is allocated for veterinary Role 1 to veterinary Role 2, one per 50 military working dogs/contract working dogs and can provide veterinary Role 3 care for a catchment population of up to 300 working dogs provided five veterinary service support teams are deployed in support. The veterinary medicine and surgical team is also allocated one per major animal agricultural or veterinary structure rebuilding mission within the AO.

Capabilities

3-53. The veterinary medicine and surgical team provides—

- Veterinary Role 1 and veterinary Role 2 canine health care.
- Veterinary Role 3 hospitalization, major medical and surgical care, and consultation services. In order to perform surgical procedures, a controlled environment with a stable temperature to minimize contamination of the patient, and to ensure proper operation of equipment is required.
- Coordination for theater evacuation and preparation of patients for evacuation to veterinary Role 4 medical care facilities.
- Support to stability tasks relating to infrastructure rebuilding of the animal health care and institutional veterinary training programs.

3-54. Individuals of this organization can assist in the coordinated defense of the unit's AO or installation. This unit does not perform field maintenance on any organic equipment to include communications-security equipment.

Functions

3-55. The veterinary medicine and surgical team function is to provide the capability to conduct animal medical care operations throughout the theater. It can provide veterinary Role 1 and veterinary Role 2 medical care to units deployed within the AO. Military working dogs requiring care which exceeds the capability of the theater veterinary Role 3 hospital facility are stabilized and prepared for evacuation out of the theater to the supporting veterinary Role 4 facilities in CONUS or other safe haven. The veterinary medicine and surgical team also provides the expertise to assist in missions involving veterinary infrastructure rebuilding of the animal health care and institutional veterinary training programs.

Employment

3-56. The veterinary medicine and surgical team will be employed in the AO. It normally establishes a centrally located veterinary hospital in proximity to the supported animal population. It is normally established along normal ground and air evacuation routes or main supply routes. This team may also be aligned with military police and/or engineer units supporting large populations of military working dogs anywhere within the theater. The veterinary medicine and surgical team is normally employed as a single element but can provide individual augmentation to deployed VSSTs veterinary service support teams, if required. The veterinary medicine and surgical team may also be aligned with civil-military operations centers at BCTs, with civil affairs units, or with task-organized provincial reconstruction teams when directed. This team supports Joint forces in execution of the Army's role as the sole provider of veterinary services.

Mobility

3-57. This unit requires 50 percent mobility of its TOE equipment to be transported in a single lift using organic vehicles.

VETERINARY SERVICE SUPPORT TEAMS

3-58. Veterinary service support teams (TOE 08516RD00) are required to support initial entry capability to provide veterinary Roles 1 and 2 medical and/or resuscitative surgical care to military and contractor working dogs in support of initial theater food inspection requirements.

Mission

3-59. The VSSTs provide additional food protection, quality assurance, and sanitation support, field confirmatory microbiological and presumptive chemical food and bottled water laboratory diagnostics, conduct food protection audits of commercial food establishments and sanitation inspection of military facilities. This includes the inspection of potential military construction sites for food production and storage. The teams conduct food vulnerability assessments, food and water risk assessments, and maintain capability to provide surveillance inspection of CBRN contamination of Class I subsistence. The VSSTs provide manpower and equipment to support the accomplishment of stability tasks to include civil affairs and foreign humanitarian assistance and to support SOF. In addition to the veterinary Role 1 and veterinary Role 2 animal treatment teams, each VSST provides the modularity and flexibility to disperse food inspection teams to two locations to maximize food protection support throughout the AO.

Assignment

3-60. The VSSTs are normally assigned to an MDVSS. These teams may also be assigned directly to a MEDCOM (DS), MEDBDE (SPT), or MMB.

Dependencies

3-61. The VSSTs are dependent upon—

- Appropriate elements of the theater for religious, legal, AHS support, finance, and personnel and administrative services.
- Sustainment vehicle and generator maintenance support from higher headquarters, consolidated motor pools, or sister units.
- Transportation services when single lift requirements exceed unit capability, vehicle recovery operations, and administrative services.
- Medical maintenance support from the supporting medical logistics company for veterinary medical equipment.
- Reachback capability for field confirmatory for chemical, theater validation for microbiological (AML), and definitive (CONUS) food and bottled water microbiological and chemical analysis for veterinary Role 3 (medicine and surgical team) and veterinary Role 4 medical care (CONUS) and for MWDs.

3-62. When attached or assigned to U.S. Navy, U.S. Air Force, or U. S. Marine Corps units, the VSSTs requirements and dependencies on that Service are the same as stated in paragraph 3-61 for Army units.

Basis of Allocation

3-63. For contingency and major combat operations, one VSST is allocated per 10,000 personnel of any Service supported; one per 50 MWDs supported; and one per major agricultural or veterinary infrastructure rebuilding mission within the theater; and one per evacuation control center during noncombatant evacuation operations.

Capabilities

3-64. The VSSTs provide—

- Early entry capability to provide veterinary medical and/or resuscitative/surgical care up to 50 military and/or contractor working dogs and initial theater food inspection requirements for 10,000 personnel. In order to perform surgical procedures, a controlled environment with a stable temperature to minimize contamination of the patient and ensure proper operation of equipment is required.
- Food protection and food inspection support for up to 10,000 personnel. In order to provide field confirmatory microbiological and presumptive chemical laboratory analysis of food and bottled water, a controlled environment is required to minimize contamination of specimens and samples and ensure proper operation of equipment.
- Field confirmatory microbiological/presumptive chemical food and bottled water laboratory diagnostics in the AO.
- Food protection audits of commercial food establishments and sanitation inspections of military food facilities to include assessment of potential military construction sites for food production or storage in the AO.
- Installation food vulnerability and food and water risk assessments in the AO.
- Surveillance inspection of CBRN contamination of Class I subsistence in the AO.
- Manpower and equipment to support the accomplishment of stability tasks to include civil affairs and foreign humanitarian assistance tasks and support to SOF.
- Modularity and flexibility to disperse two food inspection teams to separate locations to maximize food protection support throughout the AO.

3-65. Individuals of this organization can assist in the coordinated defense of the unit's area or installation. This unit does not perform field maintenance on any organic equipment to include communications-security equipment.

Functions

3-66. The VSSTs functions include providing food protection and sanitation support, field confirmatory microbiological/presumptive chemical food and bottled water laboratory diagnostics, and veterinary Role 1 and Role 2 animal medical care to early entry and follow-on forces. Within the food protection mission, the VSSTs conduct food protection audits of commercial and sanitary inspection of facilities to include providing assessment and consultation on potential military construction sites for food production and/or storage facilities within the AO. The VSSTs perform surveillance inspections of potentially contaminated subsistence for CBRN warfare agent contamination and perform food vulnerability assessments and food and water risk assessments within the AO.

Employment

3-67. There are five VSSTs assigned to the MDVSS to provide veterinary support to multiple sites throughout the AO. This support is required not only during early entry operations but also for follow-on forces as the theater matures. The VSSTs provide veterinary Role 1 and veterinary Role 2 animal medical care, as well as food inspection protection. A VSST may be aligned with its primary customers or those units/activities providing Class I or military and/or contractor working dog support at aerial/sea ports of

debarkation and military police and/or engineer units supporting MWDs populations anywhere within the theater. The VSSTs may also be aligned with EAB or BCT Class I supply points, ration breakdown points, ration receipt points, or ration distribution points dispersed throughout the theater AO. Each VSST can be subdivided into three teams: one veterinary Role 1 and veterinary Role 2 animal health care team and two food inspection teams. The VSSTs may also be aligned with civil-military operations centers at BCTs, with civil affairs units, or with task-organized provincial reconstruction teams when directed. The VSST may support stability tasks, foreign humanitarian assistance tasks and SOF. These teams support the Joint forces in execution of the DOD DHA mission function for veterinary services. The U.S. Army is the sole provider of veterinary assets to the DOD.

Note: The VSSTs coordinate and function well in conjunction with PVNTMED units.

Mobility

3-68. This unit requires 67 percent mobility of its TOE equipment to be transported in a single lift using organic vehicles.

SECTION III — VETERINARY SERVICE STAFF POSITIONS

3-69. Veterinary Services staff personnel are assigned to—

- Combatant commands.
- Joint task forces.
- Army commands.
- Army Service component commands.
- Direct reporting units.
- Medical command (deployment support).
- Medical brigade (support).
- Medical battalion (multifunctional) (this unit has a senior veterinary noncommissioned officer assigned).
- Area medical laboratory.
- Special Forces groups (airborne).
- Civil affairs commands, brigades, and teams and detachments in the public health, governmental, and civil affairs area with direct support and general support missions.

3-70. Veterinary services staff personnel may also be assigned to joint task forces, United Nations peacekeeping operations, and emergency management agencies for stability tasks and in support of defense support to civil authorities missions or other mission command organizations and/or sister Services. When it is determined a veterinary services staff officer is necessary, this officer should be assigned to the task force medical organization and be included in the initial planning and deployment.

DUTIES OF THE VETERINARY STAFF OFFICER

3-71. The veterinary staff officer's duties include the following:

- Advises the commander on—
  - All veterinary matters.
  - Foreign animal disease that may affect redeployment of military equipment back to the U.S. (coordinates with United States Department of Agriculture and Animal and Plant Health Inspection Service, as appropriate).
  - Food defense issues based on the food vulnerability assessments of the food distribution system.
- Coordinates veterinary activities with the command surgeon.
- Exercises staff supervision over the veterinary support provided to the command, joint task force, or other agencies.

- Prioritizes requirements based on mission, enemy, terrain and weather, troops and support available, time available, and civil considerations and recommends employment of veterinary detachments and team personnel.
- Establishes policies and procedures to—
  - Ensure food protection and quality assurance.
  - Establish an approved food sources list according to AR 40-657/NAVSUP 4355.4H/MCO P10110.31H.
  - Ensure the roles of veterinary medical care and treatment regimens of military and contractor working dogs meet professional standards.
  - Establish procedures for veterinary care and treatment for other government-owned animals and, when authorized, privately owned and indigenous animals.
  - Assist the operational commander in determining eligibility for care in a U.S. veterinary facility. Refer to Appendix A for additional information.
  - Ensure compliance with U.S. food export and/or import laws and the food laws and regulations of the host nation or other foreign countries and existing multinational forces agreements and standards.
  - Ensure that training priorities for veterinary personnel are accomplished.
  - Formulate and establish food recall procedures for all hazardous subsistence items according to AR 40-660/DLAR 4155.26/NAVSUPINST 10110.8C/AFR 161-42/MCO 10110.38C.
  - Establish coordination and reporting procedures for food protection issues.
  - Establish priorities for the treatment and care of military and contractor working dogs and other government-owned animals and the inspection of subsistence during redeployment operations.
- Establishes and maintains liaison with veterinarians of higher and subordinate headquarters, those of multinational or host-nation forces, and the host-nation Minister of Agriculture or a specific office or governmental agency involved in veterinary services.
- Prepares or consolidates, evaluates, and forwards statistical and historical data and other required veterinary reports.
- Provides guidance on decontamination procedures for U.S.-owned equipment being retrograded to CONUS and multinational partners to prevent transmission of animal diseases.
- Conducts staff visits and inspections of veterinary facilities, activities, and units.
- Investigates claims concerning injury or death of indigenous animals resulting from military operations.

VETERINARY SUPPORT IN THE FIELD

3-72. Veterinary support is a FHP function that is required to support unified land operations. The medical detachment (veterinary service support) units provide veterinary support on an area basis.

MILITARY WORKING DOG UNITS

3-73. Department of Defense units may have veterinary service personnel attached to provide care for the unit's MWDs. These Soldiers are responsible for providing emergency veterinary care (veterinary Role 1 medical care) and DNBI prevention measures for their assigned MWDs. They also assist in the evacuation of MWD casualties to the nearest veterinary Role 2 or veterinary Role 3 medical facilities. Veterinary service personnel may be deployed with organic U.S. Air Force MWD units into an AO.

AREA MEDICAL LABORATORY

3-74. Veterinary service personnel may be assigned individually or as a complete laboratory section to the AML. These Soldiers may provide analysis of food samples and animal specimens submitted by field veterinary units organic to the AO, depending on the personnel assigned to the laboratory. They—

- Detect and diagnose diseases transmissible from animals to humans.
- Provide histopathological and limited laboratory diagnostic support for military and contractor working dogs.
- Detect CBRN and/or directed-energy exposure in animals.
- Provide microbiological and chemical testing for food safety, food defense, and quality assurance.

SPECIAL OPERATIONS FORCES

3-75. Veterinary service personnel are assigned and/or attached to SOF units. These Soldiers may work with indigenous military assets and multinational and foreign governmental agencies. They may assist in planning and executing population and resource control, civic action, and other security and development programs, and stability tasks. During military and paramilitary operations, veterinary personnel may assist in planning and executing civic action, foreign humanitarian assistance, and other programs designed to expand the government's legitimacy within contested areas. Veterinary personnel may also provide estimates and data on the resources essential to build an effective infrastructure for civil health and agricultural administration and operations.

CIVIL AFFAIRS UNITS

3-76. Veterinary personnel are assigned or attached at various command levels in civil affairs units. Their duties include—

- Assessing available infrastructure to support combat forces.
- Supporting and coordinating foreign humanitarian assistance to include disaster relief in coordination with other DOD elements, other U.S. Government agencies, foreign and host nation authorities, and nongovernmental organizations.
- Assisting in the planning and coordination of noncombatant evacuation operations in the areas of food supply and privately owned animal evacuation.
- Assisting in coordinating the use of local host nation resources such as providing for the maintenance of veterinary care facilities. Providing and conducting public health, veterinary PVNTMED, and civil defense operations in conjunction with local agencies.

UNITED STATES NAVY MARINE MAMMAL SYSTEMS

3-77. Veterinary personnel are assigned to and deploy as organic members of U.S. Navy Marine Mammal Systems explosive ordnance disposal units. These personnel provide veterinary Role 1 through veterinary Role 3 medical care to military working dolphins and sea lions that are assigned to mine-detection, port security, and recovery operations. This veterinary support generally reports through the U.S. Navy explosive ordnance disposal chain of command and functions independent of other Army veterinary service units in the AO. Coordination between Marine Mammal Systems veterinary personnel and other veterinary units is useful as they may be able to support and augment each other's capabilities. Veterinary Role 4 medical care for Marine Mammal Systems animals is provided by the U.S. Navy Space and Naval Warfare Systems Command.

3-78. Marine Mammal Systems veterinary personnel provide for the—

- Direct supervision of U.S. Navy marine mammal transport and deployment operations.
- Supervision of food safety, hygiene, and storage for Marine Mammals Systems animal rations (frozen fish).
- Detection, diagnoses, and treatment of diseases and injuries of deployed Marine Mammals System animals.
- Direction and coordination of evacuation of Marine Mammals Systems animals, as needed.

AREA VETERINARY SUPPORT

3-79. Area veterinary support is the primary method of providing veterinary support in the AO. The extent of support is contingent upon resources, time, and the types and numbers of units to be supported. Additionally, veterinary personnel can be placed in direct support of approved establishments designated for local procurement. Area veterinary units also conduct vigorous veterinary PVNTMED programs to identify and control those diseases that can be transmitted from animals to man. Area veterinary medical support to government-owned and indigenous animals can vary from expedient treatment with limited animal medical services to full medical and surgical care and hospitalization.

SECTION IV — VETERINARY ROLES OF MEDICAL CARE

3-80. The roles of veterinary medical care for government-owned animals are discussed in a similar fashion as the roles of medical care are used to describe the successive and increasing capabilities to provide care to our injured and wounded Soldiers in the operational environment. The major difference is there are very few organic veterinary assets in the BCT. The majority of veterinary assets in the theater are assigned to EAB veterinary units and must be projected forward to provide care in the BCT AO.

VETERINARY ROLE 1 MEDICAL CARE

3-81. This role of veterinary medical care is provided by an animal care specialist (MOS 68T) assisted in his duties by the MWD, equestrian, livestock, and marine mammal handlers who provides immediate first aid for his animal in the event of injury with or without a veterinarian (AOC 64A) present.

ANIMAL HANDLER

3-82. Nonveterinary personnel, such as MWD, equestrian, livestock, and/or marine mammal handlers perform limited lifesaving and first aid procedures until an animal care specialist or a veterinarian is available.

ANIMAL CARE SPECIALIST

3-83. Animal care specialists are organic to Army Engineer, military police, Ranger, U.S. Navy, and MDVSS units. The animal care specialist supervises or provides the care, management, and treatment with a primary responsibility for the prevention and control of diseases transmitted from animal to man and comprehensive care for government-owned animals. They also supervise the sanitary conditions for animals.

CAPABILITIES

3-84. Veterinary Role 1 medical care includes—

- Providing routine daily care for animals in veterinary treatment, or research and development facilities or field units.
- Obtaining medical history from handlers and measuring and recording animal vital signs.
- Performing physical examinations to detect obvious abnormalities and report findings to the veterinarian.
- Positioning and restraining animals for examination and treatment.
- Calculating doses and administering oral and topical medications as directed by the veterinarian or established protocol approved by a veterinarian.
- Maintaining sanitary conditions for all components of the veterinary treatment area (to include operating room and equipment).
- Assisting the veterinarian in surgical procedures and performing euthanasia when instructed by veterinarian. In the event a veterinarian is not present, an animal care specialist is trained to perform lifesaving measures to stabilize the patient for transport and/or evacuation and further care by a veterinarian. Lifesaving measures include maintaining the airway, restoring the airway by invasive means, if appropriate, controlling bleeding, (through the use of tourniquets, if appropriate), initiating intravenous fluids and medicines, preventing and controlling shock, and splinting or immobilizing fractures.

- Cleaning, debriding, and suturing superficial wounds.
- Collecting, preserving, and preparing blood, urine, feces, skin scraping, and postmortem specimens for shipment and evaluation.
- Performing routine diagnostic laboratory tests such as fecal smears, urinalysis, blood counts and chemistries, and recording laboratory test result.
- Coordinating and stabilizing MWDs, horses, livestock, and marine mammals for evacuation to a veterinary field unit or treatment facility. Performing frequent monitoring of vital signs and collecting fluids (blood, urine, saliva, and feces) for further evaluation.
- Conducting minor sick call by animal care specialist under the indirect supervision of a veterinarian (such as using telemedicine or preauthorized protocol).
- Preventing DNBI (such as heat and/or cold injuries, bloat, arthropod/reptile bites or stings, vomiting/diarrhea, and the like).

3-85. Veterinary Role 1 medical care is provided by the animal care specialist and veterinarian assigned individually to various U.S. Army, U.S. Air Force, U.S. Marine Corps, or U.S. Navy field units or veterinary service support teams. Either the animal care specialist or veterinarian will respond to an emergency in a MWD or a contractor-owned animal, equestrian, livestock, or marine mammal. Depending on the type of emergency, the animal care specialist or veterinarian will evaluate the traumatized or ill animal to provide stabilization with basic first aid equipment or medications so that the patient can withstand further evacuation and treatment at a deployed veterinary Role 2 VSSTs, veterinary Role 3 medical care facility established by the veterinary medicine and surgical team, or veterinary Role 4 medical care at a CONUS-based Army veterinary hospital. An animal handler can be instructed to perform basic emergency aid procedures and prepare the animal for transport/evacuation to a higher role of veterinary medical care in the event the animal care specialist or veterinarian cannot provide veterinary Role 1 medical care at the point of injury.

VETERINARY ROLE 2 MEDICAL CARE

3-86. Veterinary Role 2 medical care is provided by deployed VSST veterinarian assisted by animal care specialist from the MDVSS and includes veterinarian-directed resuscitation and stabilization and may include advanced trauma management, emergency medical procedures, and limited forward emergency resuscitative surgery for dogs, horses, livestock, and Navy marine mammals. The VSST provides veterinary Role 2 support for up to 50 military or contractor working dogs per VSST. There are five VSSTs in an MDVSS.

3-87. Veterinary Role 2 medical care includes—

- Basic veterinary laboratory (microscopic examination, packed cell volume, serum total protein, and urinalysis).
- Limited veterinary pharmacy.
- Limited temporary military or contractor working dog holding facilities for basic medical disease treatment.
- Sick call.
- Routine preventive care.
- Nonemergent surgical care.
- General anesthesia for emergency medical procedures (such as bloat).
- Ultrasound.
- Limited care for large animals under certain conditions of government interest during stability and defense support to civil authorities tasks.
- Endemic zoonotic and foreign animal disease epidemiology surveillance and control by examination of local farm animals in the area, captured wildlife, and stray animals.

3-88. Patients are treated and returned to duty or are stabilized for transport/evacuation to a higher veterinary role of medical care.

Note. There are no kennels at veterinary Role 2. The MWD handler is expected to stay with his dog. Each MWD handler has a crate for his dog. Dogs can either sleep or rest in their crates or on the ground with the handle present. The horse rider, livestock caretaker, or marine mammal handler is also expected to stay with his particular animal.

VETERINARY ROLE 3 MEDICAL CARE

3-89. This role of veterinary medical care is provided by the veterinary medicine and surgical team which consists of a clinical specialty veterinarian (AOC 64F00) and three animal care specialists. The veterinary medicine and surgical team was designed to care for dogs only. No veterinary Role 3 capability is available in theater for horses, livestock, or Navy marine mammals.

3-90. Veterinary Role 3 medical care requires advanced clinical capabilities which include veterinary diagnostic, therapeutic, and surgical procedures. The veterinary medicine and surgical team provides veterinary Role 3 care for a catchment population of up to 300 military/contract working dogs, provided five VSST are deployed in support to provide veterinary Role 1 and veterinary Role 2 care. There is one veterinary medicine and surgical team per medical detachment (veterinary service support).

3-91. Veterinary Role 3 medical care capabilities include—

- Patient case consultation and acceptance of referrals.
- Advanced canine veterinary medical and/or surgical care.
- Veterinary laboratory capabilities (complete blood count, chemistry, and urinalysis).
- Robust veterinary pharmacy.
- Diagnostic imaging (radiographs and ultrasound).
- Definitive and restorative military and contractor working dog dental care to include endodontic procedures.
- Theater wide patient tracking of military working dogs to include evacuation.
- Training for veterinarians and animal care specialists.
- Development of theater policies for care of government-owned animals to include evacuation policy.
- Treatment, return to duty, or hospitalization of military working dogs for continued care or stabilization of military working dogs for transport/evacuation to veterinary Role 4 medical care.

3-92. The veterinary medicine and surgical team is staffed and equipped to hospitalize up to five MWDs for up to 72 hours.

VETERINARY ROLE 4 MEDICAL CARE

3-93. Veterinary Role 4 medical care is found in the CONUS at the Department of Defense Military Working Dog Veterinary Service. Veterinary Role 4 medical care expands the capabilities available at veterinary Roles 1 through veterinary Role 3 and provides additional specialized veterinary medical and surgical care, rehabilitative therapy, and convalescent capability.

SECTION V — VETERINARY SERVICE SUPPORT FOR SUBSISTENCE

3-94. In emerging concepts for Army public health support, the levels of veterinary support are being characterized in a similar fashion as the levels of PVNTMED support discussed in Chapter 2, Section V; however, some differences exist (see Table 3-1 on pages 3-19 and 3-20). The majority of veterinary assets are EAB resources which provide support on an area basis throughout the AO.

LEVELS OF VETERINARY SUPPORT FOR FOOD SAFETY AND DEFENSE

3-95. The levels of veterinary support refer mainly to the capability to perform microbiological and chemical testing to support food surveillance activities and the identification of food contaminants. The four levels of CBRN testing (presumptive identification, field confirmatory, theater validation, and definitive identification) are discussed in ATP 3-11.37/MCWP 3-37.4/NTTP 3-11.29/AFTTP 3-2.44 and ATP 4-02.84/MCRP 4-11.1C/NTRP 4-02.23/AFMAN 44-156_IP.

Note. These levels of veterinary support are different from the veterinary roles of care, which refer to medical treatment for MWDs and other government-owned animals.

Table 3-1. Comparison of veterinary and preventive medicine levels of support

Levels	*Veterinary*	*Preventive medicine*
I	**Company** • No veterinary trained specialists at this level. • Food handlers, in the normal course of their duties, do not prepare or serve any suspect food items. • Food handlers report suspect food items to Level II food inspectors. • As necessary, Level II food inspectors collect samples of reported suspect food items.	**Individual, leader, and unit** • No preventive medicine trained specialists at this level. • Soldiers, leaders, commanders, and unit field sanitation team plan, implement, and enforce preventive medicine and personal protective measures. • Food service sanitation and hygiene inspected and standards enforced.
II	**Brigade combat team** • No organic veterinary food inspectors. • Food protection support provided by deployed echelons above brigade veterinary resources. • Capable of performing microbiological and chemical testing of food items collected at Levels I and II (field confirmatory for microbiological and presumptive identification for chemical).	**Organic preventive medical personnel and brigade preventive medicine staff support** • Operational preventive medicine personnel are organic to brigade combat teams, military police battalions (internment/resettlement), and some special operations forces and other conventional force units. Operational preventive medicine resources interact with the supported population and are equipped to conduct health surveillance and control activities. • Staff preventive medicine personnel are assigned to nonmedical units and headquarters to plan for and coordinate preventive medicine activities.
III	**Area support** • Medical detachments (veterinary service support) provide area support for food protection support to include quality and sanitation inspections; installation food vulnerability assessments; audits of commercial food establishments to identify approved food sources for Class A rations; and sanitation and inspections of military food facilities. • Collect samples for field confirmatory microbiological and presumptive chemical analysis of food items collected at echelons above brigade and commercial food sources. • Field confirmatory and theater validation microbiological and chemical testing is performed by the area medical laboratory and/or by reachback to Level V veterinary support.	**Preventive medicine detachments and echelons above brigade preventive medicine support** • Preventive medicine detachments and preventive medicine staff in medical headquarters plan, monitor, and implement preventive medicine programs. • Preventive medicine detachments provide direct support to units without organic preventive medicine assets and general support to units with organic preventive medicine assets. These detachments have additional capabilities not found in Level II preventive medicine support.

Table 3-1. Comparison of veterinary and preventive medicine levels of support (Continued)

Levels	*Veterinary*	*Preventive medicine*
IV	**Theater of operations** • Veterinary staff support provided at the theater level. • Level IV microbiological and chemical testing (theater validation) is performed by the area medical laboratory and/or by reachback to Level V support.	**Army-level preventive medicine staff support** • Area medical laboratory provides Level IV (theater validation) testing capability.
V	**Strategic/generating force** • The Department of Defense Food Analysis and Diagnostic Laboratory and the research laboratories of the United States Army Public Health Center (Provisional) provide definitive testing of food samples and veterinary specimens collected in the theater. (Refer to United State Army Public Health Center (Provisional) Technical Guide 361 for additional information.	**Preventive medicine reachback support** • Definitive analysis and support is provided by the research laboratories of the United States Army Public Health Center (Provisional).

SUBSISTENCE STOCK

3-96. When a new AO is being established, units bring their subsistence into the new theater as part of the prescribed unit basic load. Operational rations include, but are not limited to, meals, ready-to-eat; unitized group rations-A; unitized group rations-heat and serve; and medical diet field feeding supplements. Meals, ready-to-eat and unitized group rations-heat and serve will be consumed in the theater during the early stages of conflict. Unitized group rations-A (including perishable and semiperishable items) will be introduced into the AO when refrigerated transport and storage assets are available. Enhancements to the operational rations (bread, fruit, and milk—usually in ultrahigh temperature form) are recommended for meals, ready-to-eat and required for unitized group rations and must be from approved sources. For definitive information on the types of rations used to support the AO, see ATP 4-41 and NATICK PAM 30-25.

3-97. The medical diet field feeding supplement, when used in combination with the unitized group ration, provides medically unique food components to prepare modified diets for consumption by patients in medical treatment facilities. The supplement is designed to simplify and streamline the ordering process of medically unique food items. The supplement is not a stocked item; it is ordered and purchased on an as needed basis.

3-98. Meals, ready-to-eat may be consumed as the sole source of subsistence for twenty one days (see AR 30-22). After 21 days, they must be served with authorized enhancements, as identified in DA Pam 30-22, or alternate rations will be served.

3-99. In an established AO, other subsistence besides operational rations may be available from such sources as the military exchange system; dining facility and/or prime vendor; morale, welfare, and recreation activities; and the American Red Cross.

SUBSISTENCE SUPPORT TO THE THEATER

3-100. Veterinary support will also be required for U.S. Air Force, U.S. Marine Corps, U.S. Coast Guard, U.S. Navy general support and direct support supply and service (sustainment) units. The assurance of food protection is essential to the health of the command. The sanitary inspection and food screening at places of procurement, production, and storage, and in conveyances is an integral part of assuring food protection, defense, and quality assurance. Recommendations on the disposition of food supplies are performed by veterinary units to ensure only wholesome and safe food is consumed. Veterinary units are also responsible for determining the disposition of CBRN-contaminated rations. (Refer to ATP 4-02.7/MCRP 4-11.1F/NTTP 4-02.7/AFTTP 3-42.3 for additional information on the destruction and/or decontamination of subsistence.)

Veterinary support requirements are based on the mission and the size of the force supported. Medical detachments (veterinary service support) are found in support of a theater sustainment command and other Services' support units that receive, store, and distribute subsistence. These general support units generally provide support from fixed facilities located near ports of embarkation and debarkation. Additional food protection support is provided to subsistence platoons, support companies, supply companies, and support battalions. The requisitioning and distribution of subsistence is discussed in ATP 4-41. Veterinary units are found in support of those EAB sustainment units that receive, store, and distribute subsistence. For a discussion of the Army subsistence requisition and supply system in a deployed environment, refer to ATP 4-41.

TESTING, SCREENING, AND COLLECTING FOOD SAMPLES IN THE FIELD

3-101. Currently presumptive for chemical and field confirmatory for microbiological testing for food-borne pathogens and biological warfare agents can be done at the deployed unit level. Suspect food samples, or those which have a pathogen or biological agent detected during the screening process, are sent to the AML, DOD Food Analysis and Diagnostic Laboratory or to other U.S. Army Public Health Center (Provisional) laboratories for field confirmatory, theater validation, and/or definitive levels of identification testing. Collecting food samples for laboratory analysis can be accomplished during procurement, receipt, or surveillance of food items. Either veterinary or PVNTMED personnel may collect food samples from food procurement establishments or dining facilities. Food samples will be split so that a portion of the original sample is preserved until the field testing is completed. For definitive information on how samples are prepared for shipment to the supporting laboratory, see ATP 4-02.7/MCRP 4-11.1F/NTTP 4-02.7/AFTTP 3-42.3 and the applicable food laboratory sample guide. Samples must be properly labeled, packaged, and shipped to ensure they arrive in a condition acceptable for analysis. Perishable samples should be maintained at a temperature of 1º Celsius (C) to 4ºC during transport. Containers must be approved by the International Air Transportation Association and must contain sufficient material to absorb the entire contents in the event of a leak. The technical escort asset should transport food samples suspected of containing biological or chemical warfare agents. A documented chain of custody using DA Form 4137 (Evidence/Property Custody Document) must accompany all samples suspected of being intentionally contaminated or containing pathogens. These samples will not be split prior to arrival at the first receiving laboratory. This will prevent an accidental contamination of the samples and ensure that valid samples arrive at the destination laboratory.

FOOD PROTECTION

3-102. All planners must integrate risk management for food and water into the mission planning, preparation, and execution of all operations. They must answer the questions about what needs to be done to ensure our food and water is secure, protected, and safe for consumption. The veterinary staff officer and AHS planner should identify all food protection issues as they develop the AHS annexes to operation orders. Make risk decisions at the appropriate levels in the chain of command. The responsibility for food protection must be assigned and or identified by tactical standard operating procedures. Commanders are ultimately responsible for food protection.

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Chapter 4

Combat and Operational Stress Control

Control of stress is often the decisive difference between victory and defeat across the range of military operations. Uncontrolled combat and operational stress may cause erratic or harmful behaviors, may impair mission performance, may result in failure, and may defeat COSC preventive measures. The COSC preventive measures are aimed at minimizing maladaptive stress reactions while promoting adaptive stress reactions, such as loyalty, selflessness, and acts of bravery.

Many stressors in a combat situation are due to deliberate enemy actions aimed at killing, wounding, or demoralizing our Soldiers and our multinational partners. Other stressors are due to the operational environment. Some of these stressors can be avoided or counteracted by command actions. Still other stressors are due to our own calculated choice, accepted in order to exert greater stress on the enemy. Sound leadership works to keep stressors within tolerable limits and prepares the troops mentally and physically to endure them. Some of the most potent stressors can be due to personal and/or organizational problems in the unit or on the home front. These, too, must be identified and, when possible, corrected or controlled. Unit needs assessments can help BH providers to identify specific stressors in a unit and develop interventions to help unit personnel learn coping skills.

SECTION I — OVERVIEW OF COMBAT AND OPERATIONAL STRESS CONTROL

4-1. Combat and operational stress control is defined as programs developed and actions taken by military leadership to prevent, identify, and manage adverse COSRs in units. This program optimizes mission performance; conserves the fighting strength; and prevents or minimizes adverse effects of COSR on Soldiers and their physical, psychological, intellectual, and social health. Its goal is to return Soldiers to duty expeditiously. According to DODD 6490.02E, COSC activities include routine screening of individuals when recruited; continued surveillance throughout military service, especially before, during, and after deployment; continual assessment and consultation with medical and other personnel from garrison to the battlefield; and the early identification of mild traumatic brain injury. Soldiers who are temporarily impaired or incapacitated with stress-related conditions are diagnosed as experiencing BH disorders. Combat and operational stress control promotes Soldier and unit readiness by—

- Enhancing adaptive stress reactions.
- Preventing maladaptive stress reactions.
- Assisting Soldiers with—
  - Controlling COSRs.
  - Managing behavioral disorders.
- Teaching warrior resiliency skills.

Note. The word control is used with combat and operational stress, rather than the word management, to emphasize the active steps that leaders, supporting BH personnel, and individual Soldiers must take to keep stress within an acceptable range.

SECTION II — COMBAT AND OPERATIONAL STRESS

4-2. Combat and operational stress control is the commander's responsibility at all levels. The key concern for combat commanders is to maximize the return-to-duty rate of Soldiers who are temporarily impaired or incapacitated with stress-related conditions or diagnosed behavioral disorders. (Refer to FM 6-22.5 for further information.)

INTERVENTION AND CONTROL OF THE COMBAT AND OPERATIONAL STRESS THREAT

4-3. The commander is assisted with his responsibility for COSC by his staff, unit leaders, unit chaplain, and organic medical personnel. The commander may also receive assistance from organic BH personnel at brigade and from the medical detachment (COSC) BH personnel.

STRESS CONTROL

4-4. Combat stress includes all the physiological and emotional stresses encountered as a direct result of the dangers and mission demands of combat. The purpose of COSC is to promote Soldier and unit readiness by—

- Enhancing adaptive stress reactions.
- Preventing maladaptive stress reactions.
- Assisting Soldiers with controlling COSRs. Combat and operational stress reaction is defined as the physical, emotional, cognitive, or behavioral reactions, adverse consequences, or psychological injuries of Soldiers who have been exposed to stressful or traumatic events in combat or military operations. Combat and operational stress reactions vary in severity as a function of operational conditions, such as intensity, duration, frequency of combat exposure, rules of engagement, leadership, effective communications, unit morale, unit cohesion, and perceived importance of the mission. Combat and operational stress reactions do not represent mental health disorders or medically diagnosable conditions and concerns. (Refer to ATP 4-02.5 for additional information.) Posttraumatic stress disorder is not equivalent to or another name for combat and operational stress reaction.
- Assisting Soldiers with behavioral disorders.

COMBAT AND OPERATIONAL STRESS THREAT

4-5. Many stressors in a combat situation are due to deliberate enemy actions aimed at killing, wounding, or demoralizing our Soldiers and our multinational partners. Other stressors are due to the natural environment, such as intense heat or cold, humidity, or poor air quality. Still others are due to leaders' own choices (for example, decisions about unit strength, maneuver, the time of the attack, and plans for AHS and logistical support). Sound leadership works to keep operational stressors within tolerable limits and prepares troops mentally and physically to endure them. However, in some cases, excessive stress can affect both leaders' and Soldiers' decisionmaking and judgment, resulting in missed opportunities, or worse, failure to complete the mission. Finally, some of the most potent stressors are interpersonal in nature and can be due to conflict in the unit or on the home front. Extreme reactions to such stressors may involve harm to self or to others. These stressors must be identified and, when possible, corrected or controlled. See FM 4-02 for additional information on the general and health threat.

EFFECT OF STRESS

4-6. Focused stress is vital to survival and mission accomplishment. However, stress that is too intense or prolonged results in COSRs that impair Soldiers' abilities to function effectively. Some stressors contribute to misconduct that requires disciplinary action and may take the Soldier from duty for legal action and possible incarceration. In a broader context stress may cause battle and nonbattle injuries through inattention, clumsiness, and reckless behavior. These resultant injuries can include equipment losses and friendly fire incidents. Stress may increase disease rates by disrupting hygiene and protective measures and impairing the

body's immune defenses. Stress may progress to BH disorders or suicidal and/or homicidal behaviors. Excessive stress in combat contributes to lapses in operational and tactical judgment and to missed opportunities that could increase the numbers of Soldiers injured over time.

MODEL FOR COMBAT AND OPERATIONAL STRESS CONTROL INTERVENTIONS

4-7. Combat and operational stress control assessments are performed across the range of military operations. Combat and operational stress control assessments are performed at unit and individual level. They consider the range of variables according to a model, which recognizes that biological, psychological, and social factors influence each other. The combat and operational stress assessment reviews the interaction systematically to a depth appropriate to the need. The assessment identifies which variables can be modified to improve coping or outcome. Based on these assessments COSC personnel recommend courses of action to the commander. They identify and initiate COSC interventions to improve unit effectiveness and Soldier efficiency and well-being.

4-8. Figure 4-1 depicts a conceptual model of stress, its mitigating and aggravating factors, and its potential outcomes on Soldiers and Families. This model can be helpful when designing COSC interventions to improve short-term and long-term outcomes.

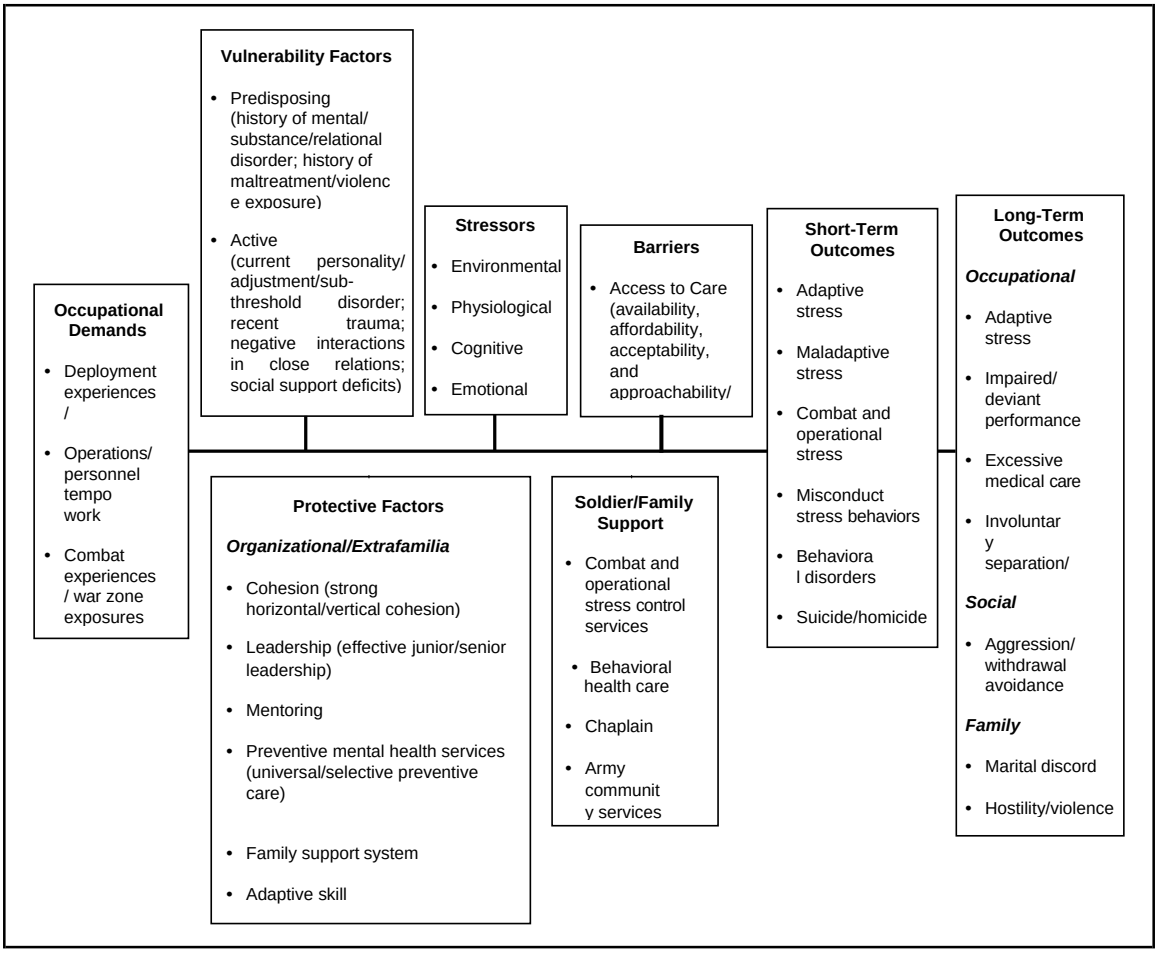

Figure 4-1. Model of stress and its potential Soldier and Family outcomes

MENTAL AND PHYSICAL STRESSORS

4-9. A rough distinction between a mental and physical stressor can be made as a—

- Mental stressor is one in which the brain receives information about a given threat or demand, but this information results in only indirect physical impact on the body. Instead, its primary effect is to place demands on and evoke reactions from the perceptual, cognitive and/or emotional systems of the brain (such as information overload, perceived lack of control, or grief-producing losses).
- Physical stressor has a direct, potentially harmful effect on the body. These stressors may be external environmental conditions (such as temperature) or the internal physiologic demands required by or placed upon the human body (such as the need for hydration or an immune response to a viral infection).

TYPES OF MENTAL AND PHYSICAL STRESSORS

4-10. Figure 4-2 provides examples for the two types of physical stressors (environmental and physiological) and the two types of mental stressors (cognitive and emotional). Also, as recognized in the COSC intervention model (Figure 4-1 on page 4-3) physical stressors cause mental stressors when they result in discomfort, distraction, and threat of harm, as well as when they directly impair brain functions. Mental stressors can lead to adaptive or maladaptive stress behaviors that decrease or increase with exposure to physical stressors.

Physical stressors	Mental stressors
Environmental Heat, cold, wetness, dust Vibration, noise, blast Noxious odors (fumes, poisons, chemicals) Directed-energy weapons/devices Ionizing radiation Infectious agents Physical work Poor visibility (bright lights, darkness, haze) Difficult or arduous terrain High altitude	**Cognitive** Information (too much or too little) Sensory overload or deprivation Ambiguity, uncertainty, unpredictability Time pressure or waiting Difficult decision (rules of engagement) Organizational dynamics and changes Hard choices versus no choice Recognition of impaired functioning Working beyond skill level Previous failures
Physiological Sleep deprivation Dehydration Malnutrition Poor hygiene Muscular and aerobic fatigue Overuse or underuse of muscles Impaired immune system Illness or injury Sexual frustration Substance use (smoking, caffeine, alcohol) Obesity Poor physical condition	**Emotional** Being new in unit, isolated, lonely Fear and anxiety-producing threats (of death, injury, failure, or loss) Grief-producing losses (bereavement) Resentment, anger, and rage-producing frustration and guilt Inactivity producing boredom Conflicting/divided motives and loyalties Spiritual confrontation or temptation causing loss of faith Interpersonal conflict (unit, buddy) Home-front worries, homesickness Loss of privacy Victimization/harassment Exposure to combat/dead bodies Having to kill

Figure 4-2. Examples of combat and operational stressors

STRESS BEHAVIORS IN COMBAT AND OTHER OPERATIONS

4-11. Combat and operational stress behavior is the generic term that is used for all of the combat and operational stress behaviors. It covers the range of reactions, from adaptive to maladaptive.

ADAPTIVE STRESS REACTIONS

4-12. Stressors, when combined with effective leadership and good peer relationships, may lead to adaptive stress reactions which enhance individual and unit performance. Examples of adaptive stress reactions include—

- Strong personal trust, loyalty, and cohesiveness (called horizontal bonding), which develops among peers in a small military unit.
- Personal trust, loyalty, and cohesiveness that develop between leaders and subordinates (called vertical bonding).
- Esprit de corps, which can be defined as a feeling of identification and membership in the larger, enduring unit with its history and ideas. This may include the unit (such as battalion or BCT) the branch (such as infantry, artillery, or military police) and beyond the branch to the U. S. Army level.
- Unit cohesion is the binding force that keeps Soldiers together and performing the mission in spite of danger and death. Cohesion is a result of Soldiers knowing and trusting their peers and leaders and understanding their dependency on one another. It is achieved through personal bonding and a strong sense of responsibility toward the unit and its members. The ultimate adaptive stress reactions are acts of extreme courage and almost unbelievable strength. They may even involve deliberate self-sacrifice.

MALADAPTIVE STRESS REACTIONS

4-13. Combat and operational stress reaction and misconduct stress behaviors comprise the maladaptive stress reactions.

COMBAT AND OPERATIONAL STRESS REACTION

4-14. The Army uses the DOD-approved term combat and operational stress reaction in official medical reports. This term can be applied to any stress reaction in the military unit environment. Many reactions look like symptoms of mental illness (such as panic, extreme anxiety, depression, or hallucinations), but they are only transient reactions to the traumatic stress of combat and the cumulative stresses of military operations. Some individuals may have behavioral disorders that existed prior to deployment or disorders that first present during deployment and need BH intervention beyond the interventions for COSRs.

MISCONDUCT STRESS BEHAVIORS

4-15. Examples of misconduct stress behaviors are listed in Figure 4-3 on page 4-6. Misconduct stress behaviors are most likely to occur in poorly trained undisciplined Soldiers. Soldiers who are normally professional and heroic, however, may also under extreme combat stress engage in misconduct.

4-16. Generally, misconduct stress behaviors—

- Range from minor breaches of unit orders or regulations to serious violations of the Uniform Code of Military Justice and the Law of Land Warfare. (For a discussion of the medical aspects of the Law of Land Warfare, refer to FM 4-02 and FM 27-10.)
- May also become a major problem for highly cohesive and proud units. Such units may come to consider themselves entitled to special privileges and, as a result, some members may relieve tension unlawfully when they stand-down from their military operations. They may lapse into illegal revenge when a unit member is lost in combat. Stress control measures and sound leadership can prevent such misconduct stress behaviors, but once serious misconduct has occurred, Soldiers must be punished to prevent further erosion of discipline. Combat stress, even with heroic combat performance, cannot justify criminal misconduct.

OVERLAPPING STRESS BEHAVIORS

4-17. The distinctions among adaptive stress reactions, misconduct stress behaviors, and COSRs are not always clear. Indeed, the three categories of combat and operational stress behaviors may overlap. Soldiers with COSRs may show misconduct stress behaviors and vice versa. Soldiers with adaptive stress reactions may also suffer from COSRs.

4-18. Figure 4-3 provides a listing of typical adaptive and maladaptive stress reactions.

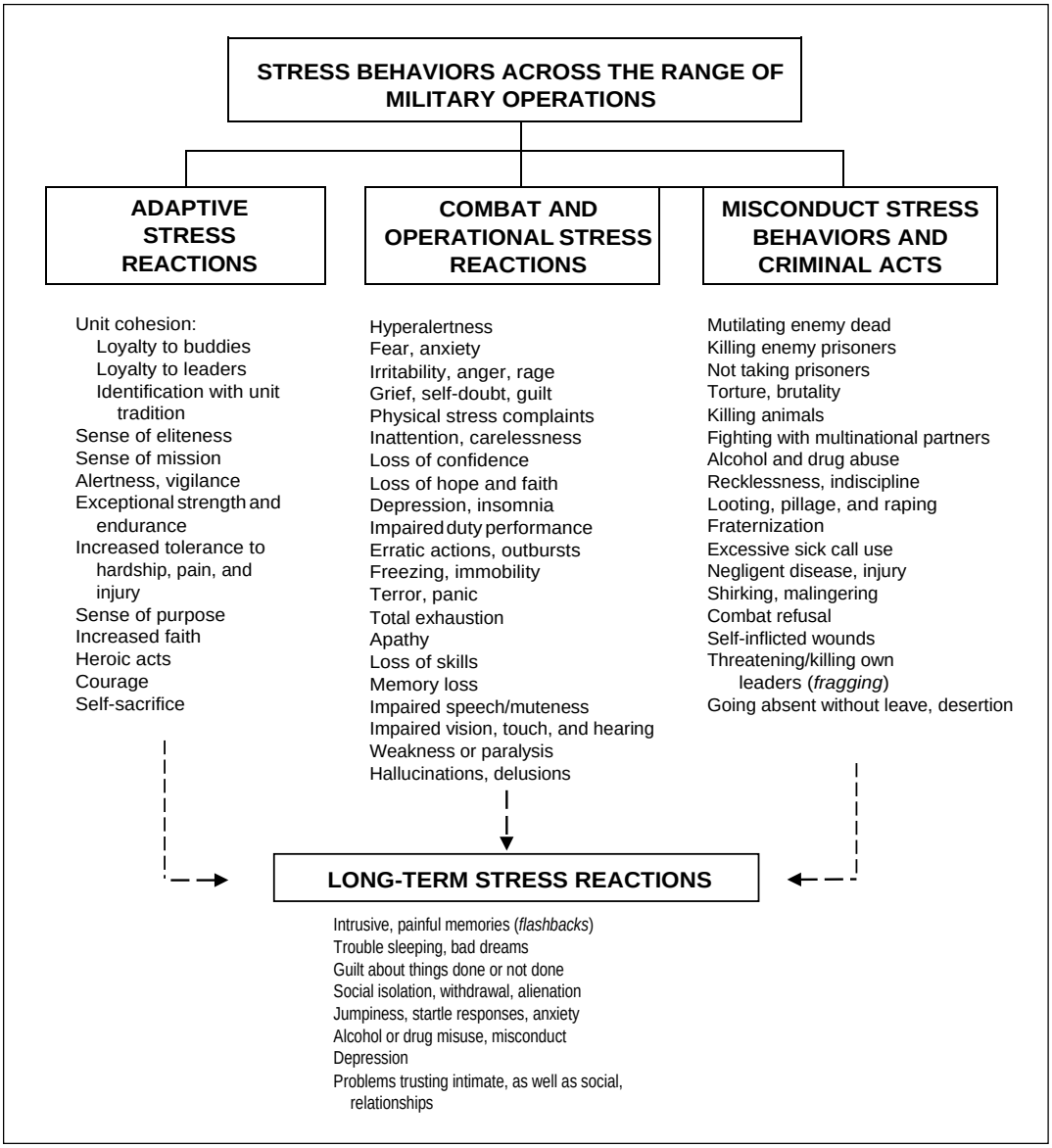

Figure 4-3. Stress behaviors across the range of military operations

4-19. It is common for stress reactions to persist or arise long after exposure to distressing events. When there is impairment in social and/or occupational functioning, a clinical assessment is warranted. Combat and operational stress control is important to sustain Army strength over the long-term and reduce the cost to society, the DOD, our Soldiers, and their Families.

SECTION III — PRINCIPLES AND SUBFUNCTIONS OF COMBAT AND OPERATIONAL STRESS CONTROL

4-20. Soldier and unit readiness is best achieved through an active, prevention-focused orientation that is embodied in the principles of COSC. These principles apply to all COSC interventions or activities throughout the theater and are followed by medical personnel in all BH and/or COSC elements. Their application may differ based on a particular role of care and other factors pertaining to the mission, enemy, terrain and weather, troops and support available, time available, and civil considerations.

COMBAT AND OPERATIONAL STRESS CONTROL INTERVENTIONS

4-21. Preventive interventions seek to reduce the occurrence or severity of COSRs and behavioral disorders, thereby sustaining Soldier and unit readiness. These interventions are tailored to the needs of the supported units and elements. There are four categories of preventive interventions that include—

- Universal interventions targeted to the general population or an assigned AO.
- Selective interventions targeted to a unit or Soldier whose risk is higher than average.
- Indicated interventions targeted to Soldiers with COSRs or indications of a potential behavioral disorder and to units that show signs their mission effectiveness is being affected by combat and operational stressors.
- Treatment interventions targeted to treat and follow-up on Soldiers with behavioral disorders to prevent their loss from duty.

4-22. Preventive interventions are used as soon as possible after identifying life- or function-threatening medical, surgical, or psychiatric conditions and provide those patients with required emergency treatment.

COMMUNICATIONS

4-23. To maximize prevention, COSC personnel must maintain a high degree of involvement with Soldiers and leaders of supported units. Regular visits to the battalion level are essential to maintain appropriate accessibility. The COSC personnel must always be attuned to Soldiers around them and not rely on Soldiers to come to them. This means that when time permits, COSC personnel need to start conversations with as many supported Soldiers as possible.

4-24. Communication is the delivery system of COSC services and therefore is essential. Use all available means to communicate and coordinate with supported units, subordinate teams, and higher headquarters to ensure delivery of effective and timely COSC and BH services.

COMBAT AND OPERATIONAL STRESS CONTROL MANAGEMENT PRINCIPLES

4-25. The COSC management principles are expressed in the memory aid—brevity, immediacy, contact, expectancy, proximity, and simplicity (BICEPS). These principles apply to all COSC interventions or activities throughout the theater and are adhered to by COSC personnel in all BH and COSC elements. These principles may be applied differently based on a particular role of care and other factors pertaining to mission, enemy, terrain and weather, troops and support available, time available, and civil considerations.

BREVITY, IMMEDIACY, CONTACT, EXPECTANCY, PROXIMITY, AND SIMPLICITY

4-26. Using the BICEPS principles is extremely important in the management of Soldiers with COSRs and/or behavioral disorders.

Brevity

4-27. Initial rest and replenishment at COSC facilities located in close proximity to the Soldier's unit should last no more than 1 to 3 days (U.S. Marine Corps and U.S. Navy is 3 to 4 days). Those requiring further treatment are moved to the next role of care. Since many require no further treatment, military commanders expect their Soldiers to rapidly return to duty.

Immediacy

4-28. It is essential that COSC measures be initiated as soon as possible when operations permit. Intervention is provided as soon as symptoms appear.

Contact

4-29. The Soldier must be encouraged to continue to think of himself as a Soldier, rather than a patient or a sick person. The chain of command remains directly involved in the Soldier's recovery and return to duty. The COSC team coordinates with the unit's leaders to learn whether the overstressed individual was a good performer prior to the COSR. Whenever possible, representatives of the unit or messages from the unit tell the Soldier that he is needed and wanted back. The COSC team coordinates any special advice on how to assure quick reintegration when the Soldier returns to his unit with his unit leaders. Medical and chaplain personnel may assist in this process if needed.

Expectancy

4-30. The individual is explicitly told that he is reacting normally to extreme stress and is expected to recover and return to full duty in a few hours or days. A military leader is extremely effective in this area of treatment. Of all the things said to a Soldier suffering from a COSR, the words of his small-unit leader have the greatest impact due to the positive bonding process that occurs. A simple statement from the small-unit leader to the Soldier that he is reacting normally to COSR and is expected back soon will have a positive impact. Small-unit leaders should tell Soldiers that their comrades need and expect them to return. When they do return, the unit treats them as every other Soldier and expects them to perform well.

Proximity

4-31. Soldiers requiring observation or care beyond the unit level are evacuated to facilities in close proximity to, but separate from the medical or surgical patients at the battalion aid station or medical company nearest the Soldiers' unit. It is best to send Soldiers who cannot continue their mission and require more extensive intervention to a facility other than a hospital, unless no other alternative is possible. Combat and operational stress reactions are often more effectively managed in areas close to the Soldier's parent unit. On the noncontiguous battlefield characterized by rapid, frequent maneuver and continuous operations, COSC personnel must be innovative and flexible in designing interventions which maximize and maintain the Soldier's connection to his parent unit.

Note. Soldiers who are considered to be in a nonpatient status cannot be housed within the perimeter of a medical unit or facility. To house combat Soldiers within the perimeter of the medical facility, could jeopardize the protected status of the facility afforded by the Geneva Convention—Convention (I) for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field. Refer to FM 27-10 for information on Geneva Conventions. All personnel considered in a nonpatient status must be housed in supporting sustainment units in close proximity to the medical facilities.

Simplicity

4-32. The principle of simplicity indicates the need to use brief and straightforward methods to restore physical well-being and self-confidence. The actions used for controlling COSRs (commonly referred to as the 5 R's) involve the following actions:

- Reassurance of normality.
- Rest (respite from combat or break from the work).

- Replenish bodily needs (such as thermal comfort, water, food, hygiene, and sleep).
- Restore confidence with purposeful activities and contact with his unit.
- Return to duty and reunite Soldier with his unit.

Nonpatient Status

4-33. To prevent Soldiers with COSR from adopting the patient role, the following guidelines should be followed:

- Keep the Soldier in uniform and hold him responsible for maintaining Soldier standards.
- Keep the Soldier separate from seriously ill or injured patients.
- Avoid giving the Soldier medications unless essential to manage sleep.
- Do not evacuate or hospitalize the Soldier unless absolutely necessary.
- Do not diagnose the Soldier prematurely.
- Transport the Soldier via general-purpose vehicles and not ambulances, when at all possible.

Note. Soldiers who are considered to be in a nonpatient status, if captured by the enemy may not receive the protections afforded by the Geneva Convention—Convention (I) for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field. These personnel would be considered as prisoners of war under the Convention (III) Relative to the Treatment of Prisoners of War. Refer to FM 27-10 for information on Geneva Conventions.

SECTION IV — COMBAT AND OPERATIONAL STRESS CONTROL INTERVENTIONS AND ACTIVITIES

4-34. Combat and operational stress control interventions and activities are organized into nine functions. These functions cover all of the BH care from preventive through clinical intervention.

UNIT NEEDS ASSESSMENT

4-35. A unit needs assessment is a valuable tool for BH personnel to use in identifying and assessing the needs of deployed combat units and to provide recommendations to commanders on actions required.

PROCESS

4-36. The unit needs assessment is a systematic process for identifying the COSC needs of units. The unit needs assessment allows COSC personnel to identify priorities for interventions and activities and for allocating resources. The unit needs assessment is not a clinical screening to identify individuals who have or are at risk for BH disorders problems, but rather evaluates the needs of the Soldier population and leads to more effective preventive COSC activities and early interventions. The unit needs assessment allows COSC personnel to—

- Identify and describe specific areas of COSC need.
- Discover factors contributing to the needs.
- Provide an assessment of the BH training needs of Soldiers, leaders, unit ministry team, and medical personnel within the unit.
- Develop plans to meet or improve the COSC needs of Soldiers and units through prevention and early intervention activities.

Scope

4-37. Unit needs assessments can be conducted at various command levels from small to large units. The COSC personnel at each command level should conduct unit needs assessments for their supported units. A unit needs assessment for a larger unit headquarters can include the composite findings and recommendations of one or more unit needs assessments completed at subordinate levels. For example, a brigade unit needs assessment may include the results of several subordinate battalion unit needs assessments (consolidated

for confidentiality). Generally, unit needs assessments are not conducted below the company level, though exceptional circumstances may dictate a platoon or lower unit needs assessment to be completed.

Conduct of Unit Needs Assessments

4-38. When conducting unit needs assessments, BH personnel should—

- Gain commander approval and support prior to conducting the unit needs assessment.
- Protect anonymity and ensure confidentiality of Soldiers and commanders which may include the protection of the unit's identity from higher headquarters.
- Provide the commander with an unbiased assessment.
- Consider the social, political, and organizational factors of the environment.
- Ensure that information sources represent the entire unit.
- Select an assessment method that is consistent with the operational situation.
- Limit over generalizing the findings from one unit to another or from one time or situation to another.
- Recognize that unit needs assessments provide population-level assessments of COSC needs, not clinical screening tools to identify individuals who may benefit from COSC interventions.
- Distinguish between what respondents report they need and what interventions are required.
- Ensure the unit needs assessment is planned and coordinated at a level commensurate with the complexity of the assessment and/or situation before starting.

FOCUS AND METHODS OF DETERMINING UNIT NEEDS ASSESSMENT

4-39. To effectively develop a unit needs assessment, BH personnel should be familiar with the unit, its recent activities (such as engaged in preparation for combat operations, actual participation in combat operations, or supporting stability tasks), length of deployment, and other factors discussed below.

Areas of Focus for a Unit Needs Assessment

4-40. A unit needs assessment involves the systematic assessment of numerous areas of Soldier and unit functioning. A typical unit needs assessment includes, but is not limited to, the following areas:

- Major stressors impacting the unit.
- Level of unit cohesion.
- Well-being of unit Soldiers.
- Soldier—
  - Concern about home-front issues.
  - Knowledge and skill for controlling combat and operational stress.
  - Ideas for addressing COSC needs.
  - Knowledge of accessing COSC resources.
- Barriers and stigma that prevent Soldiers from accessing COSC services.
- Training needs of Soldiers, leaders, unit ministry team, and medical personnel on topics of COSC importance (such as buddy aid, suicide awareness, or suicide prevention).

Methods of Unit Needs Assessments

+ 4-41. The unit needs assessment takes advantage of all available information. Various methods can be used to assess general unit needs and to identify issues that differ among subgroups (for example, sex, rank, or race and/or ethnicity). The use of multiple assessment methods is recommended. These methods may include—

- Interviewing Soldiers to hear their perceptions and concerns. Information gathered during the casual conversation, although informal, may afford valuable anecdotal information (as well as developing trust and familiarity).
- Reviewing policy documents (standard operating procedures).
- Interviewing key unit personnel (chain of command, chaplain, and medical personnel).

- Conducting structured group interviews (focus groups or unit survey interviews).
- Administering standardized surveys and questionnaires (paper or Web-based).
- Monitoring trend indicators (such as high rates of BH referrals, sick call, misconduct, Soldier suicide, sexual assault, fratricide, or disciplinary actions).
- Using multiple methods for gathering information when possible to ensure different viewpoints are considered.

Planning Considerations for Unit Needs Assessment

4-42. The unit needs assessment varies in complexity and formality depending on the purpose of the assessment and the needs of the supported unit commander. Many factors determine the complexity and formality of a unit needs assessment, which in turn influences its feasibility.

Complexity

4-43. Complexity equates to the requirements and cost to complete a unit needs assessment. Complexity is influenced by factors such as the—

- Size and number of units to be assessed.
- Geographic dispersion of the units and time constraints.

Formality

4-44. Formality equates to the degree that scientific principles and methods are employed in the conduct of the unit needs assessment. An example of a unit needs assessment with low formality is one where the assessing team uses nonstructured group and individual interviews and perhaps brief questionnaires they have developed. The information is obtained from key individuals and a convenience sample of troops. This method may be sufficient to quickly identify problems and make recommendations to resolve them. A unit needs assessment with high formality is one that uses professionally validated questionnaires and structured focus group interviews according to standardized protocols. The data is collected from a scientifically selected sample of the larger population. The data is analyzed by standard analysis programs, so that statistically selected samples of valid comparisons can be made with other similarly sampled units in other geographical locations and across time. The operational stress assessment team expertise and assistance may be necessary for some unit needs assessment instruments and methods. In general, increasing formality increases the complexity of the unit needs assessment. The unit needs assessment requires a higher level of formality as the need for objective data and scientific precision increases (such as when results from multiple units are to be merged or compared with other unit needs assessments).

Feasibility

4-45. Feasibility is the ability to accomplish a unit needs assessment with available resources. In developing a particular unit needs assessment, trade-offs are made to achieve an acceptable level of data quality (formality) for an affordable cost (complexity).

UNIT NEEDS ASSESSMENT PROCESS

4-46. All unit needs assessments are conducted following a three phase plan—preassessment, assessment, and postassessment.

Preassessment

4-47. Preassessment is an initial phase to obtain command support, determine target issues, and select appropriate methods to use.

Assessment

4-48. Assessment is the phase for gathering, integrating, and analyzing information to identify the COSC needs of the unit.

Postassessment

4-49. The principal task of the postassessment phase is to determine the courses of action to present to the commander which address the identified COSC needs. These findings are then linked to a plan of action.

WHEN TO CONDUCT UNIT NEEDS ASSESSMENTS

4-50. Unit needs assessments may be conducted at various times throughout the deployment cycle. A unit needs assessment may be conducted prior to initiation of COSC interventions and activities while COSC personnel and units establish their support relationships. The unit needs assessment may be done at the request of the supported commander or after a serious traumatic events and significant unit transitions to—

- Assess the effectiveness of COSC interventions and activities that are in the process of being conducted or that have been completed.
- Monitor trend indicators.
- Collect unit information for COSC planning.

4-51. Unit needs assessments should be conducted during all types of deployments across the range of military operations.

CONSULTATION AND EDUCATION

4-52. Combat and operational stress control consultation is defined as the transmission of information through an interactive relationship between the consultant and consultees. Education is used here in a broader sense in that it is the transmission of information by any means.

GENERAL PRINCIPLES

4-53. During the consultation and education process, the consultant learns about the consultees and their needs and tailors the interactions accordingly. Examples of education include distributing flyers, video and radio broadcasts, and news articles. Examples of consultation include COSC advice, coaching, training, and planning assistance.

4-54. The consultation and education function support the other COSC functions.

Consultants

4-55. The term BH consultant is used in the general sense to describe any person performing COSC consultation or education. In addition to those theater or subordinate commander COSC consultants, all BH and/or COSC personnel may serve as consultants at their level of command. Familiarization training with other BH disciplines enriches the ability to serve as a consultant.

Consultees

4-56. Depending on the units in the area of support, broad types or categories of personnel may be consultees. These personnel are involved in the recognition and control of stress as a result of their position or duty assignments. Consultation and education consultees may include—

- Command or unit surgeon and his staff.
- Staff chaplain and unit ministry team.
- Senior commander and the senior noncommissioned officer of a battalion in a BCT, and division or corps headquarters.
- Staff officers and noncommissioned officers, including the personnel officer, intelligence staff officer, operations staff officer, and the staff judge advocate.
- Medical personnel such as PVNTMED teams that have missions that often complement the COSC mission.
- Company grade leaders, especially company commanders, executive officers, first sergeants, platoon leaders, platoon sergeants, company noncommissioned officers, and Soldiers that are trained to be peer mentors.

Soldier Peer Mentors

4-57. Soldiers selected by their commanders may be trained to provide COSC help-in-place assistance and/or COSC information to peers. They may also serve as a point of contact between fellow Soldiers and the COSC and unit ministry teams. Selected Soldier-peer mentors with additional training could assist commanders with conducting COSC training in mission risk assessments. For additional information on COSC help-in-place refer to ATP 4-02.5.

FUNDAMENTALS OF CONSULTATION AND EDUCATION

4-58. Consultation and education are ongoing processes that are performed across the deployment cycle and unified land operations. They may be provided in response to a specific request by command or recommendation of COSC personnel. Consultation and education may be provided during routine scheduled meetings such as a commander's weekly update or a leader professional development class.

4-59. Effective consultation is accomplished by the consultant's active outreach. Consultation is best conducted through recurring face-to-face contact, preferably at the consultee's location. Telephone and radio may be used to setup initial meetings and provide follow-up consultation. Consultation may be conducted one-on-one or in small groups where interaction is feasible. When necessary and feasible, audio or video teleconference may suffice. Active outreach supports the functions of COSC triage, traumatic event management (TEM), and transition management.

4-60. Successful consultation depends on the consultant's credibility and the trust and familiarity established with consultees. In addition to a sound professional knowledge base and clinical skills, the consultant must have military bearing and knowledge of a professional Soldier. Rapport is enhanced by the demonstration of the consultant's genuine interest in the consultee and the unit. There are some situations when consultation and education are more effectively provided by COSC officers, noncommissioned officers, or enlisted personnel.

CONSULTATION, EDUCATION, AND PLANNING

4-61. Behavioral health personnel follow a six step process for most consultations. The six steps of the consultation process are to—

- Initiate the process by introducing the consultant and his capabilities to key leadership and get approval to continue.
- Assess the needs of consultees and formulate ways to address them.
- Present courses of action to the consultees and define goals and feasibility of alternative actions.
- Implement approved courses of action.
- Evaluate outcomes or progress.
- Plan follow-up actions.

4-62. Consultation and education encompasses a broad range of topics, extending from prevention to treatment. The process of consultation and education assists the consultee with anticipation, identification, and control of stressors (environmental, physiological, cognitive, and emotional) and stress reactions (adaptive and maladaptive stress reactions). The following list of COSC functions, resources, and their availability provides examples of consultation and education topics:

- Operational risk factors.
- Individual risk factors.
- Stress moderators.
- Unit cohesion, esprit de corps, and morale.
- Traumatic event management.
- Barriers to care and overcoming stigma.
- Operations planning.
- Integration of new personnel to unit.
- Trust in equipment and supporting units.

- Tough realistic training.
- Home-front stressors.
- Indicators of unit stress level.
- Combat and operational stress reactions and/or behaviors.
- Command referral processes.
- Scapegoating behaviors.
- Rumor control.
- Physical needs (such as sleep, nutrition, and hygiene).
- Social and emotional needs (such as morale, welfare, and recreation push package).
- Communication with home.
- Reintegration of Soldiers into unit.
- Alcohol and substance abuse.
- Procedures for COSC triage.
- Care provider stress (such as compassion fatigue, vicarious trauma, moral dilemma).
- Leadership.
- Fear management.
- Rest and relaxation considerations.

4-63. From theater staff-level down to the mental health sections, BH personnel are involved in the consultation and planning process for COSC support. Their support may be either through providing situational updates, developing running estimates, or being directly involved and assisting with the development of the FHP plan.

TRANSITION MANAGEMENT AND SUPPORT IN THE DEPLOYMENT CYCLE

4-64. Transition and phases of a deployment cycle may have different and sometimes unique stressors. These stressors may be subjects for consultation and education. Needs assessment may be necessary to redistribute COSC assets and change the means for delivering COSC support.

4-65. The COSC personnel may conduct transition (change of command) workshops, especially after relief of commanders. These workshops are normally requested by the incoming commander. The purpose of these workshops is to—

- Facilitate staff discussion of what the staff sees as the unit's and staff's strong points and the areas needing more work.
- Provide the new commander the opportunity to discuss his leadership style and his expectations and set priorities for the staff.

PREDEPLOYMENT SUPPORT

4-66. Medical support in predeployment is mainly the responsibility of medical center and/or Medical Department activity personnel or of a United States Army Reserve mobilization site augmentation unit (which has no BH personnel assigned). Brigade combat team BH personnel are involved with their units' Soldiers who are being treated for behavioral disorders and with general COSC prevention of the unit members and Families. The COSC units that are not deploying may be tasked to support predeployment

COSC activities and interventions. Combat and operational stress control screening of individuals during predeployment may include—

- Secondary BH screening for Soldiers who are referred by primary care providers that were flagged positive on DD Form 2795.
- Health screening of medical and BH records.
- Fitness for duty evaluations according to AR 40-501.
- Evaluations and recommendations to leadership about Soldiers who are fit for duty overall, but should not be deployed at this phase of the operation for BH reasons.

4-67. Other predeployment functions may be provided on request. These functions may include—

- Briefings, consultations, and education on deployment cycle stressors and how to cope and on specific stressors that Soldiers may encounter in the AO.
- Unit needs assessments at the request of commanders.

MIDTOUR REST AND RECUPERATION OR EMERGENCY LEAVE

4-68. Leaders must be aware and alert for Soldiers who exhibit a need for COSC screening prior to midtour rest and recuperation leaves. Other Soldiers may only require some education briefings and handout cards on handling their transition from a hostile AO to rest and recuperation environments. In some cases, prior to emergency leave, some screening for domestic violence risk may also be necessary in any potential high-risk Soldier. This COSC screening is done to ensure the safety of the Soldier and of others. One protocol has unit commanders referring those Soldiers that have requested leave for the purpose of addressing marital, legal, or other highly charged difficulties at home to the BH officer. The BH officer explores the situation and the Soldier's reactions to it and checks for history with the rear detachment. If the BH officer finds the Soldier to be at high risk, the commander can deny his leave request. Another option is to escort the Soldier to home base. At home base, he is kept by his unit's rear detachment until a meeting is held under safe conditions with the Soldier, BH personnel, Family Advocacy Program personnel, his Family, and the others involved in the difficulty. At this meeting the situation is defused or resolved before the Soldier is permitted to leave the rear detachment area.

REDEPLOYMENT

4-69. For Soldiers, redeployment is the process of receiving orders to redeploy, embarking towards the demobilization site, or deploying to another out-of-the-theater mission. Screening of these individual Soldiers may be a requirement and may have established criteria that should be used to ensure appropriate screening is conducted. The theater or specific units may require that all primary care providers who perform the screening interview for the postdeployment health assessment have a designated BH consultant. Available COSC and/or BH personnel provide secondary one-on-one BH screening for Soldiers who are referred by primary care providers because they were flagged positive on DD Form 2795. Some Soldiers may require brief treatment or referral as a result of the screening.

END OF TOUR STRESS MANAGEMENT

4-70. End of tour stress management is essential to reduce behavioral problems with Soldiers returning to their home station and/or Families. This also promotes Soldiers seeking help early when problems occur. Behavioral health and/or COSC personnel consult with the command on activities during redeployment and for post-redeployment. Issues may include—

- Common behavioral issues and potential misconduct may result when Soldiers are relieved of the stress and the focus of dangerous missions and while transitioning to and preparing to go home.
- Memorial services for Soldiers who died during the deployment.
- Recognition of outstanding performance and the equitable awarding of decorations.

- Closure ceremonies.
- Homecoming and/or reunion education briefings and training period covered extends from predeployment through to this point in redeployment. The end of tour debriefing should be conducted while the unit is still in the theater or at an intermediate staging base. For each phase of the operation, the participants review significant events and the problems or stressors that bothered the group (including critical events, if any). Equally important is that the group recalls what went well, how problems and stressors were overcome, and what positive memories and feelings they have from the deployment.

FACILITATORS

4-71. The COSC or unit ministry team facilitators should be invited to advise the leader and sit in if there are likely to be many negative memories and feelings that have disrupted or threatened unit cohesion. The facilitator should advise leaders and troops on the importance of sustaining unit identity and contact with teammates beyond postdeployment and in the future.

POSTDEPLOYMENT

4-72. Postdeployment covers that period of time from embarking from theater and through returning to work after block leave, including participation in scheduled postdeployment activities. As with predeployment, AHS support in postdeployment is mainly the responsibility of the installation MTF, often augmented by a U.S. Army Reserve mobilization site augmentation unit. Brigade combat team COSC and/or BH personnel and COSC units that are themselves demobilizing as their units are deactivating will have limited involvement with the BH and COSC needs of fellow Soldiers. These personnel continue to provide, as needed, consultation to the command and to key personnel of the unit that they were assigned or attached. They consult with the installation MTF about BH and coordinate COSC needs that should be met. The COSC units that were not deployed may be tasked to support postdeployment COSC activities and interventions. The COSC personnel who are not demobilizing provide reintegration education. Screening of individuals and secondary screenings continue in postdeployment and are recorded on a DD Form 2796. Each primary screener should have a designated BH consultant from the medical center or Medical Department activity. Secondary screening and treatment of referrals are provided by the installation MTF. Research with a BCT returning from a combat or stability operations deployment indicated that a secondary postdeployment screening from 90 to 120 days after returning from the theater may be necessary. This seems to be the time when persistent or delayed symptoms, problems, and perhaps impairment may require intervention. All Soldiers should be advised about follow-up BH support resources. Soldiers who are leaving active service should also be informed about deployment-related entitlements and benefits.

READINESS PHASE OF THE DEPLOYMENT CYCLE

4-73. Brigade combat team mental health sections and medical detachments (COSC) of the active Army and Reserve Component must use their training opportunities to the fullest. During these training exercises, they should provide COSC consultation, education, and training to supported units the same as they would in an actual deployment. Mental health section personnel should perform many of their critical mission functions and should not just simulate them. The management of real COSRs occurs in the field, garrison, and/or home-station settings, as well as during deployments. Triage and emergency stabilization may be required. Restoration may be appropriate in some field exercises. Even reconditioning can sometimes be provided as a multiday course at active Army installations where COSC units are stationed. Further, TEM and transition management are potential major roles for organic mental health sections and medical detachments (COSC) in peacetime. The Reserve Component, as well as active Army medical detachments (COSC) have been used extensively to respond to traumatic events and to assist units that are within the ARFORGEN process.

TRAUMATIC EVENT MANAGEMENT

4-74. Traumatic event management blends other COSC functions to create a flexible set of interventions specifically focused on stress management for units and Soldiers following a potentially traumatizing event.

Like the other functions, COSC providers must tailor COSC and TEM support to the needs of the unit and Soldier.

4-75. An event is considered potentially traumatic when it causes individuals or groups to experience intense feelings of terror, horror, helplessness, and/or hopelessness. Guilt, anger, sadness, and dislocation of world view or faith are potential emotional and/or cognitive responses to potentially traumatizing events. Studies of Soldiers in Operations Enduring Freedom and Iraqi Freedom have shown a correlation between exposure to combat experiences and BH disorders, most particularly acute stress disorder and posttraumatic stress disorder. The following events should be monitored as potentially traumatizing events for Soldiers and units:

- Heavy or continuous combat operations.
- Death of unit members due to enemy or friendly fire.
- Accidents.
- Serious injury.
- Suicide and/or homicide.
- Environmental devastation and/or human suffering.
- Significant home-front issues.
- Operations resulting in the death of civilians or combatants.

SCOPE OF TRAUMATIC EVENTS MANAGEMENT

4-76. Traumatic events management is discussed as it applies to military units and personnel to support readiness. Traumatic events management can be adapted to nonmilitary groups or individuals brought together by a potentially traumatizing event. Traumatic events debriefing should be conceptualized as an ongoing process and not an acute intervention. For military units and personnel, TEM is active in all phases of the deployment cycle and across the range of military operations.

TRAUMATIC EVENTS MANAGEMENT FUNCTION

4-77. Successful TEM relies on a solid foundation of other COSC functions activities such as unit needs assessment that may require the COSC provider to—

- Establish a credible working relationship with supported unit leadership.
- Understand the unit's needs via previously conducted unit needs assessments.

4-78. In the absence of preexisting relationships and unit needs assessment, COSC providers should secure command support and recommend a unit needs assessment as the first step in TEM. Subsequent unit needs assessments will clarify unit responses to other TEM interventions and to ongoing unit needs.

UNIT NEEDS ASSESSMENTS

4-79. When conducting a unit needs assessment after a potentially traumatizing event the COSC providers need to take under consideration the following:

- Ensure a timely arrival that does not disrupt unit operations but facilitates the unit needs assessment. They should not interrupt or intrude on the people who are attending to the acute crisis when arriving at the unit, unless asked. Presence without intruding will gain trust, information, and points of contact.
- Understanding that the unit needs assessment may be limited by the urgency of the unit's return to action, the difficulty of data collection, and having limited resources. Sufficient knowledge must be gained to tailor the interventions to the unit before initiating them. It is better to defer the intervention to the next opportunity if the unit must return to action immediately after replenishment and/or before necessary data is collected.
- Know that the unit needs assessment is a unit-level assessment and does not substitute for individual-level screenings or COSC triage.

CONSULTATION AND EDUCATION

4-80. The COSC provider should conduct unit leader consultation and education activities prior to a potentially traumatic event. Consultation and education topics should include—

- Impact of potentially traumatic event on unit and Soldier readiness.
- Common potentially traumatic events for units and Soldiers.
- Overview and components of TEM.
- Normal responses to potentially traumatic events.
- Triggers to refer Soldiers for BH evaluation.
- Development of standard operating procedures for responding to potentially traumatic events when they occur.

4-81. Preemptive consultation and education prepare unit leaders to institute TEM interventions following a potentially traumatic event. The 5 R's (see paragraph 4-32 on page 4-8 and 4-9) are a good model to build on. In acute TEM interventions, leaders should consider interventions that target—

- Safety, security, and survival.
- Food, hydration, clothing, and shelter.
- Sleep.
- Medication (replace medications destroyed or lost).
- Orientation of unit and Soldiers to developing situation.
- Restoration of communication with unit, Families, friends, and community.
- Location should be at a secure site that provides protection from ongoing threats and environmental hazards.

4-82. Consultation and education to Soldiers should emphasize normalizing the common reactions to trauma, improving their coping skills, enhancing self-care, facilitating recognition of significant problems, and increasing knowledge of and access to COSC services. Potentially traumatic event unit needs assessments guide further consultation and education efforts. Combat and operational stress control providers should be aware that leaders may not have experienced a potentially traumatic event in person, but have experienced the potentially traumatic event through their Soldiers and may require support.

COMBAT AND OPERATIONAL STRESS CONTROL TRIAGE

4-83. The COSC provider should be prepared to provide COSC triage in the aftermath of the potentially traumatic event. Consultation and education are important to ensure appropriate and timely referrals for triage are accomplished. The COSC provider can offer the following guidelines in referral of Soldiers for COSC triage:

- Persistent or worsening traumatic stress reactions (such as dissociation, panic, autonomic arousal, and cognitive impairment).
- Significant functional impairments (such as role and/or work relationships).
- Dangerousness (suicidal or violent ideation, plan, and/or intent).
- Severe psychiatric comorbidity (such as psychotic spectrum disorder, substance use disorder, or abuse).
- Maladaptive coping strategies (such as pattern of impulsivity or social withdrawal under stress).
- New or evolving psychosocial stressors.
- Poor social support.
- Failure to respond to acute supportive interventions.
- Exacerbation of preexisting psychiatric conditions.
- Soldier request for assessment.

4-84. For an in-depth discussion of the COSC triage process, stabilization, and BH treatment, refer to ATP 4-02.5.

STABILIZATION

4-85. The COSC provider should be prepared to provide or coordinate stabilization services following a potentially traumatic event. Potentially traumatic event coordination with medical unit personnel promotes safe management.

SOLDIER RESTORATION

4-86. The measures below are applicable to Soldiers with COSR following a potentially traumatic event. The COSC provider should be familiar with the 5 R's and with BICEPS. In keeping with restorative efforts, the COSC provider focuses on the following measures through leadership consultation, Soldier education, and/or direct management:

- Minimizing exposure of Soldiers with COSR to further potentially traumatic events.
- Reducing physiological arousal.
- Mobilizing support for those who are most distressed.
- Providing information and fostering communication and education.
- Using effective risk communication techniques.
- Providing assurance and reassurance.
- Mitigating fear and anxiety.
- Encouraging sleep hygiene.
- Reestablishing routines.
- Promoting exercise and nutrition.
- Encouraging self-paced emotional ventilation.
- Discouraging use of alcohol and other substances.

BEHAVIORAL HEALTH TREATMENT

4-87. Given the correlation between potentially traumatic events and development of traumatic stress disorders, the COSC provider must be familiar with the best current practices for evaluation and treatment. The Department of Veterans Affairs and DOD Clinical Practice Guidelines offer clinicians evidence-based assessment and treatment algorithms for acute stress disorder, posttraumatic stress disorder, and many other BH disorders.

4-88. In accordance with the Department of Veterans Affairs and DOD Clinical Practice Guidelines for posttraumatic stress disorder, COSC providers should—

- Consider alternative methods to psychological debriefings for individuals affected by potentially traumatic events.
- Avoid psychological debriefing as a means to reduce acute posttraumatic distress (acute stress reaction or acute stress disorder) or to slow progression to posttraumatic stress disorder.
- Understand there is insufficient evidence to recommend for or against conducting structured group debriefings.
- Be aware that compulsory repetition of traumatic experiences in a group may be counterproductive.
- Consider group debriefings with preexisting groups (such as teams, units, medical treatment teams, coworkers, or Family members) may assist with group cohesion, morale, and other important variables that have not been demonstrated empirically.
- Emphasize that group participation must be voluntary.

4-89. For an in depth discussion of BH treatment and differential diagnosis, refer to ATP 4-02.5.

LEADER-LED AFTER ACTION DEBRIEFING

4-90. A leader-led after action debriefing is led by a platoon, squad, or team leader and is not normally conducted above platoon level. The leader-led after action debriefing should be conducted after all missions

especially when the maneuvers did not go according to plan. A leader-led after action debriefing may even be sufficient for potentially traumatic events involving injury or death. For the leader to conduct a psychological debriefing, his personnel should have received previous psychological debriefings; and normally provide peer support and validation for showing and talking about their emotional reactions during and after the debriefing. The best time to conduct this debriefing is as soon as is feasible after the team, squad, or platoon has returned to a relatively safe place, members have replenished bodily needs, and they are no longer in a high state of arousal. Usually a well conducted leader-led after action debriefing is the best option to manage potentially traumatic events during a mission. The exception to this type of debriefing is when the event evoked reactions that seriously threaten unit cohesion and/or have a high likelihood of arousing disruptive behavior and emotions. In these situations, the leader should ask himself the following:

- Should I conduct the debriefing?
- Should a trained facilitator be present?
- Should a request for COSC TEM support be submitted for his team, squad, or platoon?

CONDUCTING A LEADER-LED AFTER ACTION DEBRIEFING

4-91. These debriefings require the leader to extend the lessons-learned orientation of the standard after action review. He uses the event reconstruction approach or has the individuals present their own roles and perceptions of the event, whichever best fits the situation and time available. When individuals express or show emotions, the leader and the teammates recognize and normalize them; they agree to talk about them later, and support the distressed Soldier through personal interactions. The group then returns to determining the facts. Lessons-learned discussion is deferred until all the facts are laid out. The leader may provide education about controlling likely reactions or referral information at the end, depending on his knowledge and experience.

4-92. When a potentially traumatic event is likely to create individual or collective guilt, distrust, or anger, the unit leader should be encouraged to request COSC assistance. Either a COSC or a unit ministry team person trained in TEM sits in with the leader-led debriefing as a familiar and trusted friend of the unit. The COSC or unit ministry team facilitator helps the unit and/or team leader rehearse and mentors the leaders on the debriefing process. During the psychological debriefing, the facilitator can ask questions of the group to clarify the facts and steer the process away from divisive anger, blaming, and scapegoating toward a positive, cohesion-restoring outcome. This method is halfway between a simple leader-led after action debriefing and a psychological debriefing and is referred to as a facilitated leader-led after action debriefing. The leader conducting the debriefing must be attentive to identify individuals needing COSC follow-up.

4-93. Leaders in positions above platoon level also have a role in leader-led after action debriefing. Company commanders and first sergeants may conduct leader-led after action debriefing with their subordinate leaders. Battalion commanders and higher may conduct leader-led after action debriefings with their staff after distressing actions and may include subordinate leaders when time allows bringing them together.

COOL DOWN MEETINGS

4-94. A cool down meeting is referred to as an immediate, short meeting when a team or larger unit and/or group return from the battlefield or other missions. These cool down meetings are held after heavy and intense battles with the enemy or when a shift in the mission has occurred which is highly arousing and/or distressing. This is especially important after critical events. The cool down meeting is an informal event and occurs before the participants fully replenish their bodily needs and precedes any other activities including more COSC interventions or return to the mission.

4-95. Personnel who coordinate and wait for the return of the unit that has been in a heavy intense battle, include leaders or supporting officers or noncommissioned officers from the command, unit ministry team, and COSC providers. (In defense support to civil authorities the same personnel identified above or other trained personnel from governmental or nongovernmental organizations may be waiting on the return of the unit after a potentially traumatic event. These personnel may be present at the cool down meeting.)

4-96. Components of a cool down meeting may include—

- Assembling all of the unit personnel at a safe and relatively comfortable location for a brief period of time (about 15 minutes).
- Receiving or sharing nonstimulating beverages and convenient food (comfort foods, if available).
- Providing personnel the opportunity to talk among themselves.
- Giving recognition and praise for the difficult mission they have completed.
- Providing information to unit personnel on where and how they will rest and replenish.
- Previewing the immediate agenda for the unit on what will happen after the cool down meeting including plans for further debriefing and/or other available stress control or morale and welfare intervention.
- Providing announcements pertaining to further preparations and expected time of return to the mission.

4-97. Combat and operational stress control personnel may have a role in cool down meetings. In consultation and education, COSC consultants emphasize the value of cool down meetings and the simplicity of the components, which are easily neglected in crisis situations. When feasible, they unobtrusively attend the cool down meeting, showing presence while learning of the event, getting familiar with the key people, and observing anyone showing signs of distress, and being available to them. If requested, they may give a very brief introduction and review of normal stress reactions that unit personnel may have in the next few hours.

RECONSTITUTION SUPPORT

4-98. The purpose of reconstitution support is to allow the commander to develop a plan to enable him to increase the unit's combat effectiveness and to assess the COSC requirements for unit reconstitution.

UNIT RECONSTITUTION SUPPORT

4-99. Unit reconstitution support consists of extraordinary actions that commanders plan and implement to restore units to a desired level of combat effectiveness commensurate with mission requirements and available resources. Besides normal support actions, reconstitution may include—

- Removing the unit from combat.
- Assisting the unit with external assets.
- Reestablishing the chain of command.
- Training the unit for future operations.
- Reestablishing unit cohesion.

4-100. When tasked as part of a reconstitution task force, COSC personnel are responsible for providing units with Soldier restoration, performing the COSC function of the unit needs assessment, and providing consultation and education, as required. They provide triage, stabilization, Soldier restorations, and short time-constrained COSC treatment, when needed. Reconstitution is a time-constrained process, but Soldier restoration may be provided at the reconstitution site if several days are available. The focus of consultation and education efforts include—

- Rebuilding unit cohesion.
- Integrating new Soldiers or groups of Soldiers into the unit.
- Facilitating assumptions of command by replacement leaders.
- Facilitating the building of Soldiers' confidence in their leaders and themselves.
- Mentoring unit leaders in the leader-led after action debriefing process.
- Advising on COSC aspects of bereavement memorial services and communication with the Family support group and unit Families. Combat and operational stress control personnel also facilitate leader-led after action debriefings and lead or serve as observers in TEMs interventions.

RECONSTITUTION PROCESS

4-101. Reconstitution of units transcends normal day-to-day sustainment actions. Reconstitution is a total process. Its major elements are reorganization and assessment, in that order. All COSC personnel should be thoroughly familiar with Army doctrine on reconstitution.

Reorganization

4-102. Unit reorganization primarily involves a shifting of internal resources and is accomplished as either immediate or deliberate reorganization. The commander of the attrited unit decides to reorganize when required and may consider the following:

- Immediate reorganization is the quick and usually temporary restoring of degraded units to minimum levels of effectiveness. Normally, the commander implements immediate reorganization at his combat location or as close to that site as possible to meet near-term needs. The COSC personnel provide consultation with key points of contact in the unit (leaders, unit ministry teams, and combat medics), usually by radio and/or telephone.
- Deliberate reorganization is done to restore a unit to the specified degree of combat effectiveness. Usually, more time and resources are available further to the rear. Procedures are similar to immediate reorganization except that some personnel and weapons system replacement resources may be available, equipment repair is more intensive, and more extensive cross-leveling is possible. When used in reorganization, cross-leveling involves the movement of personnel and/or equipment between units to achieve equalization. The process is accomplished while maintaining or restoring the combat effectiveness of the units involved.
- The role of COSC personnel in deliberate reorganization may require a COSC team to deploy to the reorganization site. They assess the stressors and COSRs and advise the commanders on supportive actions, (such as those for the reorganization of small unit-level elements) and assist the command with transitions and integration of new replacements.

Assessment Phases

4-103. Assessment measures a unit's capability to perform its mission. It occurs in two phases. The unit commander conducts the first phase. He continually assesses his unit before, during, and after operations. If he determines it is no longer mission-capable even after reorganization, he notifies his commander. The higher headquarters either changes the mission of the unit to match its degraded capability or removes it from combat. External elements may also have to assess the unit after it disengages. This is the second phase. These elements do a more thorough evaluation to determine reconstitution needs. They also consider the resources available.

4-104. The second phase of assessment begins with an initial survey by a team sent by the higher headquarters. This team determines the status and needs of the attrited and exhausted unit as it moves to the reconstitution site. Some of the key issues in estimating the COSC needs of the unit include the—

- Percentage and nature of casualties.
- Duration of operations and environmental exposure.
- Status of hydration, nutrition, and sleep.
- Loss and current effectiveness of leaders.
- Attitudes, perceptions, and level of confidence of unit survivors.
- Traumatic events experienced and traumatic event management.

4-105. The COSC consultants at every level of command must provide consultation to all command surgeons on the importance of including BH and/or COSC personnel in all reconstitution operations. The initial evaluation team should include a COSC consultant. Task-organized COSC teams normally deploy to the unit during the second phase to provide a unit needs assessment, consultation, and other COSC activities and interventions. A unit needs assessment with high formality may be requested by the higher headquarters for decisionmaking purposes. These assessments are feasible for selected units, with prior coordination, as much of the logistical complexity is reduced by the orchestrated planning at higher command echelons.

Reconstitution Task Forces

4-106. The reconstitution task force guides each element of the arriving units into its designated areas and provides for the immediate needs of the survivors. This should include personal gear and equipment to replace lost or damaged items, food services, personnel services, maintenance teams, and medical teams to provide sick call services while organic medical personnel rest. Replacement personnel are sent to the reconstitution site. The COSC personnel assist with their assimilation into the reconstituted unit.

Reconstitution Resource Requirements for Combat and Operational Stress Control Personnel

4-107. Factors which influence the resource requirements for COSC in reconstitution (deliberate reorganization) include the size of the unit, number of subunits which have suffered heavy casualties, the extent of emotional trauma, and time available. A guideline is provided in Table 4-1 for COSC personnel requirements. This staffing should not overly rely on organic COSC staff that will be in need of rest.

Table 4-1. Reconstitution operations guideline for combat and operational stress control personnel requirements

Size of unit	*Personnel required*
Company	2 to 4
Battalion/Squadron	6 to 12
Brigade Combat Team	12 to 30

COMBAT AND OPERATIONAL STRESS CONTROL TRIAGE AND STABILIZATION

4-108. Combat and operational stress control triage is the process of sorting Soldiers with COSRs and/or behavioral disorders based upon where they can best be managed. For an in-depth discussion of this function refer to ATP 4-02.5.

4-109. The COSC stabilization function provides initial management of Soldiers with severe COSRs or behavioral disorders. Their safety is ensured and they are evaluated for return-to-duty potential or prepared for further treatment or medical evacuation. Refer to ATP 4-02.5 for a discussion of this function.

SOLDIER RESTORATION

4-110. Soldier restoration is normally a 24- to 72-hour (1- to 3-day) program in which Soldiers with COSR receive treatment. Soldier restoration is accomplished using the principles of BICEPS and the 5 R's. The 5 R's are tailored to the needs of the Soldier. Refer to ATP 4-02.5 for additional information on the 5 R's.

SOLDIER RESTORATION PROGRAM

4-111. The Soldier restoration program is conducted as close to the Soldier's unit as possible. Soldier restoration can be conducted by medical units and/or elements throughout the theater with the assistance of organic and/or augmenting COSC personnel. The medical detachment (COSC) is staffed and equipped to establish Soldier restoration programs. Soldier restoration may also be accomplished at a combat support hospital or other hospitalization facility. The fundamentals of Soldier restoration remain the same but implementation may differ in the duration of Soldier restoration and the specialized skill and knowledge of the available providers. There are three subcategories of Soldier restoration (referred to as lines of Soldier restoration) based on location and available resources that are discussed below. For information on the5 R's refer to ATP 4-02.5.

SOLDIER RESTORATION PROCESS

4-112. The process of Soldier restoration involves several steps that include screening, assessment, intervention, reintegration and/or coordination, and movement of Soldiers. A discussion of each of the steps in the process is provided below.

Screening

4-113. Adequate medical screening and treatment as necessary must be done before the Soldier begins the Soldier restoration program. Minor medical conditions can be treated during routine sick call. Soldiers entering a Soldier restoration program should be only those hold cases that require continuous medical and/or BH evaluation and observation for 24 hours or more. The criteria for hold cases are discussed in ATP 4-02.5. Tending to and restoring physiological status (such as sleep and hydration) is a priority. Some Soldiers who need Soldier restoration will also have a behavioral disorder. Treatment for the behavioral disorder may continue or be initiated during the Soldier restoration process.

Assessment and Intervention

4-114. Initial assessment and subsequent COSC interventions depend upon the severity of the COSRs and to what extent the reactions interfere with the Soldier's ability to function. More thorough interviews are conducted only after the Soldier's physiological status has been restored.

Reintegration

4-115. Coordination is required to assist Soldiers with reintegration back into their units. Soldiers are reassessed regularly. When a Soldier experiencing COSR begins to improve, the COSC interventions shift toward the reintegration of the Soldier back into his unit. The COSC personnel must work with the COSC consultant of their area or other resources to assist with this reintegration.

Movement

4-116. Movement of Soldiers from one line of Soldier restoration to another that has greater capabilities or security may be required. When movement of these Soldiers is required, vehicles used to transport them should be nonmedical vehicles, if possible, and these Soldiers should be accompanied by escorts from their unit. If nonmedical unit members are not available to perform escort duties, medical augmentation may be required.

PRINCIPLES AND PROCEDURES OF SOLDIER RESTORATION

4-117. Initial Soldier restoration begins as close to the Soldier's unit as possible, normally near an MTF where the Soldier can get a reprieve from extreme stress, but at the same time, can be close to his unit. Normally, Soldier restoration facilities are established in the sustainment area near or adjacent to the medical company (brigade support) (Role 2 MTF). Soldier restoration is not feasible at locations that are consistently under artillery, air, or direct-fire attack, but ideally are still within the sound of the artillery or other reminders of combat. If there is potential for attack; there must be cover and defensive positions. The location should not be one from which a move is likely within 24 hours. If there is a significant possibility of a move, only those cases that can participate actively in the move with minimal supervision should be managed at this location. The specific site of the Soldier restoration facility should be adjacent to the medical company's area and be out of the immediate (close) sight of the medical triage and treatment areas.

Note. Soldiers who are considered to be in a nonpatient status cannot be housed within the perimeter of a medical unit and/or facility. To house combat Soldiers within the perimeter of the medical facility, could jeopardize the protected status of the facility under the Geneva Conventions—Convention (I) for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field. Refer to FM 27-10 for information on Geneva Conventions. All personnel considered in a nonpatient status must be housed in supporting sustainment units in close proximity to medical facilities.

Reassurance

4-118. Immediate reassurance is given to the Soldier with COSR beginning with the COSC triage process. The Soldiers should be told that they are temporarily joining the unit, not as patients, but as Soldiers who need a few days to recover from COSR. Emphasize that COSR is a normal response to extremely abnormal conditions. Rapid recovery is also normal and return to duty is expected. Reassure the Soldiers about safety and what to do in the event of an attack or march order. Lastly, orient the Soldiers to the Soldier restoration program.

Structured Military Environment

4-119. An emphasis should be placed on maintaining a highly structured military unit environment and schedule of activities in order to keep the Soldier from adopting a patient role. Assign the Soldier to a squad under supervision of a specific squad leader. The squad leader may be a COSC unit/mental health section member or a member of a brigade support battalion subordinate unit. The squad leader may also be one of the Soldiers there for Soldier restoration, if his condition allows. The newly arrived Soldier is assigned to a tent that has been designated and/or erected for the Soldier restoration program. Soldiers with more dramatic COSR or BH symptoms should be temporarily quartered separately from other Soldiers receiving Soldier restoration. In remaining consistent with the principle of treating Soldiers with COSR as Soldiers instead of patients, the Soldier restoration facilities should not display the Geneva Emblem (red cross on a white background) as displayed on an MTF. See FM 27-10 for information on the Geneva Conventions.

Support the Soldier's Military Identity

4-120. Maintain appropriate rank distinctions, titles, and military courtesies within the confines of the tactical situation. Expect the Soldier to maintain military bearing and personal appearance. They should be in duty uniform. Conduct basic Soldiering skills classes or activities. Do not take personal possessions away from the Soldier. This includes weapons, unless there is significant concern for the Soldier's or other's safety. If the Soldier arrives with a weapon, standard operating procedures of the AO will guide whether or not the weapon is to be secured for the Soldier. Also, encourage the unit to maintain contact with its Soldier.

Replenishment

4-121. Get the Soldier under shelter and cool down if overheated, warmed up if cold, and dried off if wet. If available, providing warm beverages and/or soup will also assist with restoring body temperature. Replenish hydration with palatable beverages and meals, when available. Unless the Soldier is totally exhausted, institute some personal hygiene. If the Soldier needs uniforms or equipment, coordinate with the Soldier's unit for replacement items. Medical companies and battalion aid stations do not stock items of clothing and equipment for patients. Restorative sleep should be as normal as possible. Soldiers are typically able to fall asleep when reassured of safety and do not routinely require medication to induce sleep. They should be informed that they may awaken with vivid and frightening dreams and be instructed on quick relaxation techniques to go back to sleep. If those measures are insufficient, one-time medication with a sedative or hypnotic may be considered, coordinated, and prescribed by a physician or physician assistant from the supporting medical company. The duration of sleep should also begin the process of restoring a reasonable sleep and wake cycle that is consistent with the Soldier's duties in his unit.

Restore Confidence

4-122. Restoring a Soldier's confidence may include—

- Providing regularly scheduled formations to keep Soldiers informed of daily activities and the tactical situation, including information about their unit, when available.
- Providing therapeutic occupations that are based on the Soldier's current functional ability. The occupational therapist (or COSC team members under the guidance of the occupational therapist) selects therapeutic occupations that support the Soldier's military identity and enhances the Soldier's sense of competence. Therapeutic occupations may include activities of daily living (such as physical fitness or uniform maintenance); educational activities (selected common and collective Soldier task training or life skills training); work and/or productive activities (militarily

relevant tasks such as vehicle maintenance or site maintenance); leisure and recreational activities (enjoyable, relaxing activities, games, and sports); social participatory activities (cooperative and/or competitive sports, games, ceremonies, or celebrations). Therapeutic occupations provide the Soldier with a challenge but afford successful performance that shows the Soldier that he is still capable and competent. This realization plays the dominant role in restoring the Soldier's sense of confidence, functional capacity, and ability to return to duty.

- Training and teaching Soldiers on methods for managing excessive stress.
- Facilitating factual review of precipitating event that has caused the Soldier's COSR through talking (ventilating) and coaching. Combat and operational stress control personnel facilitate these discussions. They help Soldiers restore perspective with questions and coaching. The factual review (debriefing) is often best done individually unless several Soldiers experienced the same event.

LINES OF SOLDIER RESTORATION

4-123. Soldier restoration (first line) is provided by medical personnel either organic to the medical company (area support) or the medical company (brigade support battalion) and augmented by personnel from the medical detachment (COSC). Higher lines of restoration are located in the EAB.

First-Line Soldier Restoration

4-124. First-line Soldier restoration is usually provided at the medical company (brigade support battalion). It is provided by COSC personnel organic to the Role 2 MTF usually assisted by COSC personnel from the supporting medical detachment (COSC). Because of the high mobility of the medical company (brigade support battalion), Soldier restoration will often be a 24- to 72-hour process. First-line Soldier restoration also may occur in relative secure locations in EAB. First-line Soldier restoration in EAB is provided by the medical company (area support) within its assigned AO. It is provided by COSC personnel organic to the medical company and/or from the supporting medical detachment (COSC) personnel. The medical company (area support) will be relatively less likely to move on short notice so Soldier restoration up to 72 hours should be feasible. Support provided for Soldier restoration is a responsibility of the mental health section of supporting medical companies. Tasking for support of Soldier restoration programs is accomplished through the command surgeon.

Second-Line Soldier Restoration in a Soldier Restoration Center

4-125. Each of the first-line Soldier restoration locations listed above should be backed up by a second-line Soldier restoration capability at a location that is less likely to have to move on short notice and has more COSC capabilities. Soldier restoration centers may be located near the medical company (area support) or with a medical detachment (COSC). They can be located in proximity of a medical company (brigade support) when it is at a stable base camp. The Soldier restoration center may receive hold cases that are transferred from the first-line medical companies, as well as Soldiers from nearby units. Second-line Soldier restoration has more equipment and a greater range of COSC expertise and Role 2 MTFs will require augmentation of COSC resources. This permits a 72-hour holding capacity for a stable well-organized Soldier restoration center and may provide full stabilization.

Third-Line Soldier Restoration

4-126. In some scenarios, units with Soldiers in need of Soldier restoration may be significantly closer to a combat support hospital or other hospitalization facility than to a medical company (area support) or medical detachment (COSC). On order, a Soldier restoration program may be conducted by the combat support hospital or other hospitalization facility, which may also be augmented with personnel from a medical detachment (COSC). In such cases, a Soldier restoration program may be conducted by the hospital staff with augmentation. Soldier restoration near a hospital complex must be kept clearly separate from patient wards and other medical facilities. It may be done in a minimal care ward, when augmented with the medical detachment (minimal care), or in separate tents.

Return to Duty of Recovered Combat and Operational Stress Reaction Soldiers

4-127. Most COSR symptoms do not necessarily improve completely while the prospect of combat continues. The Soldiers should be given the positive expectation that they will return to duty. Every possible effort should be made to return Soldiers to their original unit. The return to duty of Soldiers following Soldier restoration depends on how near the Soldier's unit is, the availably of a means of transportation, and the tactical situation. Ideally, their units are contacted to send someone to get the Soldier or he may be returned to his unit by way of supporting logistical vehicles. Behavioral health personnel coordinate directly with the unit to which the Soldier is returning and/or with COSC personnel, other medical personnel, or the unit ministry team supporting the unit's AO. These contacts can consult with the leaders of the Soldier's unit and facilitate the Soldier's acceptance back into his unit.

Documentation

4-128. Soldiers receiving Soldier restoration interventions must be tracked from the initial contact until they are returned to their unit. A record must be maintained of interventions and activities provided during Soldier restoration, as well as the Soldier's response. A notation of the dates, any pertinent medical data, and providing unit is entered in the Soldier's medical record. An administrative summary of Soldier restoration services may be developed, stored, and disposed of as directed by the Soldier restoration center standard operating procedures. If the Soldier received BH treatment, documentation should be maintained as delineated in AR 40-66. A statistical record is maintained and sent to higher medical headquarters according to standard operating procedures.

BEHAVIORAL HEALTH TREATMENT

4-129. Patients with identified behavioral disorders receive ongoing evaluation, treatment, and follow-up to sustain them. This function implies a therapist-patient relationship, clinical documentation, and adherence to clinical standards of care. Refer to ATP 4-02.5 for information on BH treatment.

SOLDIER RECONDITIONING

4-130. Reconditioning is an intensive program of work therapy, military activities, physical training, and psychotherapy. Reconditioning programs are conducted up to seven days (or more) in EAB.

4-131. Reconditioning programs are intensive efforts to restore those Soldiers triaged as a refer case, but who still have good potential for return to duty. Referral to reconditioning can be from Role 2 MTFs, Soldier restoration program or from the combat support hospital or other hospitalization facility. Reconditioning includes the rehabilitation of Soldiers with behavioral disorders, such as substance abuse and/or dependency. Reconditioning programs are conducted by COSC personnel and Soldiers usually participate for up to 7 days. Soldier participation may be extended by a case-by-case exception to theater evacuation policy. Reconditioning is conducted only in a theater where there are adequate COSC elements and supplies. When COSC resources are needed for other functions, any ongoing reconditioning program reduces its scope of services or closes. Reconditioning is provided at first-, second-, or third-line centers determined by location and available resources.

PROVIDERS

4-132. Conducting reconditioning programs is a mission of the medical detachment (COSC).

FUNDAMENTALS AND PROCEDURES OF RECONDITIONING

4-133. Reconditioning may be considered an extension of Soldier restoration. Reconditioning is similar to Soldier restoration, but with potentially longer stays, treatment strategies focus on preventing atrophy of skills and assisting Soldiers in regaining skills needed for duty. Reconditioning makes more use of BH treatment modalities.

Structured Military Environment to Sustain the Soldier's Identity as a Soldier

4-134. Like Soldier restoration and reconditioning emphasize a highly structured military unit environment and schedule of activities in order to keep the Soldier from adopting a patient role. Maintaining a military environment is even more critical when in close proximity to hospitals or other MTF elements.

Replenishment of Physiologic Status and Confidence

4-135. Reconditioning initially emphasizes physical replenishment and hygiene, but later shifts the emphasis to more closely match the conditions that the Soldier should expect when returned to duty. In order to restore confidence in the Soldier, unit formations are held on a regularly scheduled basis and include the Soldiers receiving reconditioning.

OCCUPATIONAL THERAPY

4-136. Therapeutic occupations may include—

- Activities of daily living (for example, hygiene, physical fitness, and uniform maintenance) and educational activities (such as, common and collective Soldier task training and life skills training).
- Militarily relevant work details according to the current functional level and MOS code and/or duties of the Soldier.
- Leisure and recreational activities (such as, enjoyable, relaxing activities, including cooperative physical and mental activities and basic relaxation techniques).
- Social participatory activities (for example, games and ceremonies).
- Group training in relaxation techniques.
- Ventilation and coaching where COSC personnel encourage discussion about stressors and their impact on mental well-being. This technique helps the Soldier to restore personal perspective with questions and coaching. Individual counseling and therapy may improve the Soldier's functions as well.

4-137. When reclassification recommendations are considered, an adjacent sustainment unit may be able to provide a job that will match the Soldier's abilities. This provides an opportunity to demonstrate the Soldier's abilities and to build confidence. The reconditioning personnel may recommend to the personnel staff officer that the Soldier be reclassified to another MOS.

FIRST-LINE RECONDITIONING PROGRAM

4-138. First-line reconditioning programs in EAB are staffed by task-organized COSC elements from the medical detachment (COSC). The first-line reconditioning center is usually located in close proximity to a combat support hospital or other hospitalization facility but must maintain its separate, nonhospital identity. It should not be situated within the hospital perimeter, among the hospital wards, or near the sustainment areas, triage area, or helicopter pad. Within an AO, the preferred option is to have one or two reconditioning centers placed such as to allow easy access from Soldier restoration centers. The reconditioning center is dependent on the hospital for support. The reconditioning center works with the supporting hospital by sending work parties of Soldiers in the program to assist in food preparation and delivery and cleanup chores. These Soldiers may also be used for assisting with work details throughout the hospital, but must be under direct supervision of either hospital or BH personnel. The reconditioning center uses the supporting hospital's medical records section to maintain the permanent case records. Cases in the reconditioning center are counted as patients in the reconditioning center on the daily hospital census. The cases are not counted as occupied beds when reporting the hospital bed occupancy. Upon disposition from the reconditioning center, whether for return to duty, retraining for other duty, or evacuation, the reconditioning center prepares the chart for further evacuation or writes the discharge summary and closes the hospital's chart.

4-139. Some reconditioning cases will be able to return to hazardous duty. However, many of the Soldiers who need reconditioning will be unable to return to their original unit, due to combat operations or the nature of their symptoms. Soldiers who undergo a 4- to 7-day Soldier restoration program in EAB should not be crossed off the BCTs personnel rolls. Continuing contact with the unit increases return to duty rates.

For Soldiers who recover but are no longer on the BCTs rolls, every feasible effort should be made to return them to their original units. The BH personnel and the medical detachment (COSC) teams that are attached to reinforce the BCT should maintain frequent contact with the reconditioning centers that supports the BCT. Coordination efforts with supporting personnel and other sustainment units should facilitate return of recovered Soldiers to their original units. If recovered Soldiers cannot be returned to their previous small unit, consider forming them into cohesive pairs or small groups which can be reassigned to a new unit together. The standard theater evacuation policy is seven days, but some Soldiers with good potential for return to duty may need a few more days at the reconditioning center. An exception to the theater evacuation policy may be required.

EXTENDING THE EVACUATION POLICY

4-140. If a needs assessment indicates that a longer period of time (more than seven days) will achieve a Soldiers' return to duty, the theater COSC consultant can request permission to extend the theater evacuation policy (up to 14 days). He submits the request for authority through the MEDBDE (SPT) to the corps headquarters. The reconditioning program, because of its austerity, is not a significant logistical burden to the corps headquarters. Soldiers in the reconditioning program perform useful work details and perimeter defense. Further, the increase in return to duty is important in operations characterized by stability tasks, where reducing personnel attrition becomes an important factor. Reconditioning cases that do not recover sufficiently to return to some duty within the designated evacuation period are evacuated.

SECOND-LINE RECONDITIONING

4-141. Second-line reconditioning is conducted in the theater but away from active combat operations. This center could be at a combat support hospital or other hospitalization facility, a fixed MTF, or a medical detachment (COSC) element. The second line reconditioning center continues to emphasize physical fitness, Soldier skills, work details, and individual and group counseling and psychotherapy. Depending upon human resources policy, cases may be retrained for sustainment duties at EAB level. As soon as the recovering Soldiers are ready, the retraining site can shift to on-the-job training at a nearby sustainment unit, if appropriate.

THIRD-LINE RECONDITIONING

4-142. Third-line reconditioning is for Soldiers with COSRs and/or behavioral disorders who did not improve sufficiently at lower lines of reconditioning, but may still have return to duty potential. These Soldiers are transferred to a reconditioning program at a regional medical center, home station Medical Department activity, or Warrior transition unit. These reconditioning centers, like the others, must maintain a military atmosphere and provide opportunities to engage in occupational therapy. Some Soldiers may also require retraining for MOS reclassification.

SECTION V — UNIT MINISTRY TEAM SUPPORT

4-143. The unit ministry team, which is embedded within units down to battalion level, provides immediate support to leaders in fulfilling their COSC responsibilities. Unit ministry teams serve as a primary referral agency to BH resources.

ROLE OF THE UNIT MINISTRY TEAM

4-144. The unit ministry teams also assist in training leaders to recognize combat and operational stress signs and symptoms and to identify Soldiers in need of support.

RELIGIOUS SUPPORT FOR COMBAT AND OPERATIONAL STRESS CONTROL SERVICES AND ACTIVITIES

4-145. Soldiers' inner resources are generally rooted in their religious and spiritual values. In combat, Soldiers often show more interest in their religious beliefs. When religious and spiritual values are challenged

by the chaos of combat, Soldiers may lose connection with the inner resources that have sustained them. The unit ministry team is the primary resource available to Soldiers experiencing such dilemmas and is a valuable resource in assisting them as they seek to refocus their spiritual values.

4-146. The unit ministry team provides preventive, immediate, and restorative spiritual and emotional support and care to Soldiers experiencing COSRs.

PREVENTIVE RELIGIOUS SUPPORT FOR COMBAT AND OPERATIONAL STRESS REACTION

4-147. The unit ministry team assists in preventing COSRs and misconduct stress behaviors through spiritual fitness training. Ministry of presence with Soldiers, assigned Army civilians, and contractors is critical. The unit ministry teams provide a stabilizing influence on personnel and assist them in strengthening and regaining personally held spiritual values. Preventative activities include—

- Worship opportunities.
- Private and group prayer opportunities.
- Religious literature and materials.
- Scripture readings.
- Sacraments and ordinances.
- Assistance to personnel and Families prior to deployment, emphasizing Family strengths.

IMMEDIATE RELIGIOUS SUPPORT FOR COMBAT AND OPERATIONAL STRESS REACTION

4-148. The unit ministry team assists commanders in the identification of personnel experiencing negative reactions to combat and operational stress, COSRs, and misconduct stress behaviors. The unit ministry team works closely with the unit's leaders and medical personnel to care for COSR cases through religious support and comfort. Immediate religious support activities may include—

- Administration of religious rites, sacraments, and ordinances, as appropriate.
- Worship opportunities.
- Pastoral care and counseling (to include confidential communication).
- Memorial ceremonies and services.

RESTORATIVE RELIGIOUS SUPPORT FOR COMBAT AND OPERATIONAL STRESS CONTROL

4-149. Following an operation, a unit may require reconstitution. Surviving Soldiers may need to rebuild emotional, psychological, and spiritual strength. Depending upon the spiritual, emotional, and physical condition of the unit's Soldiers, the organic unit ministry team may need augmentation from higher echelons or other units. Restorative religious support activities may include—

- Worship, sacraments, rites, and ordinances.
- Memorial ceremonies and services.
- Religious education (to include religious literature and materials).
- Grief facilitation and counseling.
- Reinforcement of the Soldiers' faith and hope.
- Opportunities for Soldiers to talk about combat experiences and to integrate those experiences into their lives.

SECTION VI — MENTAL HEALTH SECTIONS

4-150. Mental health sections are located in medical companies assigned to BCTs and the MMB. In the BCT, mental health sections are assigned to the medical company (brigade support) of the brigade support battalion. At EAB, the mental health sections are assigned to the medical company (area support) of the MMB.

FUNCTIONS AND RESPONSIBILITIES OF MENTAL HEALTH SECTIONS

4-151. All mental health sections regardless of their organizational assignment are tasked with providing COSC services and support for their supported units. In all of these units, COSC is accomplished through vigorous prevention, consultation, training, educational, and Soldier restoration programs. These programs are designed to provide BH expertise to unit leaders and Soldiers where they serve and sustain their mission focus and effectiveness under heavy and prolonged stress. The mental health sections identify Soldiers with COSRs who need to be provided rest and/or Soldier restoration within or near their unit area for rapid return to duty. These programs are designed to maximize the return-to-duty rate of Soldiers who are either temporarily impaired, have a diagnosed behavioral disorder, or have stress-related conditions. Also the prevention of posttraumatic stress disorders is an important objective for BCT and EAB units. The BH officer (either a clinical psychologist or social work officer) and a BH specialist are especially concerned with assisting and training of—

- Small-unit leaders.
- Unit ministry teams and staff chaplains.
- Battalion medical platoon personnel.
- Patient-holding squad and treatment squad personnel of the medical company.

RESPONSIBILITIES

4-152. The mental health section has a primary responsibility for assisting commanders with COSC by implementing the brigade combat mental fitness program. Also, the mental health section serves as a consultant to the commander, staff, and others involved with providing prevention and intervention services to unit Soldiers and their Families. The mental health section has staff responsibilities for assisting the brigade surgeon with establishing brigade policy and guidance for the prevention, diagnosis, treatment, management, and return to duty of stress-related casualties. This is accomplished under the guidance and in close coordination with maneuver battalions and medical company (brigade support battalion) physicians.

SUBFUNCTIONS

4-153. The function of all mental health sections is to support the nine COSC subfunctions except Soldier reconditioning.

UTILIZATION AT HOME STATION

4-154. In garrison, BH personnel assigned to brigade and EAB units continue to perform the same staff and outreach functions with supported units as they do in a field environment. An increase in the BH treatment functions may be possible as a result of consolidating BH care providers. The BH providers make available their consultation skills and clinical expertise to the Soldiers of supported units and their Family readiness groups. Clinical care of Family members and of Soldiers that require longer-term care beyond crisis intervention, brief treatment, and medication follow-up is the responsibility of the Medical Department activity or medical center. The mental health section personnel should focus their clinical work primarily on Soldiers with problems amenable to brief treatment.

4-155. The mental health sections should strive to reduce referrals for BH treatment by working closely with unit leaders and chaplains to control organizational stress and rapidly identify and intervene with those Soldiers having BH disorders.

4-156. When the medical company or battalion deploys on training exercises, assigned BH personnel deploy with them to provide COSC training and support. In addition, they train to improve their own technical and tactical skills.

EMPLOYMENT AND DEPLOYMENT OF MENTAL HEALTH SECTIONS

4-157. The involvement of a mental health section with supported units during field and other training exercises is important. It permits BH personnel to gain a familiarity with type of units supported, how they conduct operations, their mission, and the likely stressors associated with a particular type of unit. It also allows them to interact and become familiar with unit personnel and to gain some level of trust through their interactions. Combat and operational stress control personnel should be active participants in all training exercises. Unit predeployment training must be planned when the unit is alerted for its deployment but scheduled after cross-leveling and filling of all positions is completed. Training of BH personnel includes—

- Ensuring their active participation in the normal training cycle of the BCT to which assigned.
- Training the BH officers and specialists in all COSC subfunctions that support their unit.
- Working with the supported units on a frequent basis so BH personnel may gain a familiarity with the unit's personnel, capabilities, and possible stressors associated with its mission.
- Providing predeployment train-up to include refresher and operation-specific training before deployment.

SECTION VII — MEDICAL DETACHMENT, COMBAT AND OPERATIONAL STRESS CONTROL

4-158. The medical detachment (COSC) is an echelons above brigade organization that provides BH expertise in direct support of BCT requirements or on an area basis to the EAB. The functions of the individual elements are discussed in paragraphs 4-190 to 4-192 on page 4-36.

MEDICAL DETACHMENT (COMBAT AND OPERATIONAL STRESS CONTROL)

4-159. The medical detachment (COSC) is structured to have a main support element and a forward support section. Each element will be discussed below.

MISSION

4-160. The mission of the medical detachment (COSC) (TOE 08460R000) is to provide COSC prevention and treatment services in direct support of BCT and EAB units, and on an area basis to a joint or multinational force as directed.

ASSIGNMENT

4-161. This detachment is assigned to an MMB (TOE 08485R000).

DEPENDENCIES

4-162. This unit is dependent upon the following:

- Appropriate elements of the theater for religious, legal, AHS support, finance, and personnel and administrative services.
- The headquarters and headquarters detachment MMB, (TOE 08485R000) or elements of the Army Service component command for medical administration, field feeding, logistical support, AHS support, coordination for return to duty of recovered COSR Soldiers and field maintenance for equipment.

EMPLOYMENT

4-163. This detachment is employed in the supporting BCTs and EAB units. The medical detachment (COSC) provides mission command for the main support section and the forward support section when it deploys as a complete detachment. The medical detachment (COSC) has the capability to deploy a forward

support section supporting EAB formations as required. The supported unit provides mission command for the forward support section. Both support sections have the capability to break down into six 3-man teams.

BASIS OF ALLOCATION

4-164. One medical detachment (COSC) is required per 39,000 Army population supported in theater. Minimum of one.

CAPABILITIES

4-165. This unit's capabilities include—

- Planning and staff advice to mission command headquarters regarding the stressors affecting the troops, mental readiness, and morale and cohesion.
- Preventive consultation and stress education support to leaders, chaplains, and medical personnel.
- Neuropsychiatric care, triage, and stabilization.
- Assistance to nonmedical units with rest category COSR casualties and the return to duty of recovered COSR Soldiers.
- Holding/restoration capability for 50 Soldiers for up to 3 days.
- Reconstitution to supported units.
- Debriefings after critical events and after action reports.

MOBILITY

4-166. See paragraphs 4-175 and 4-184 for mobility requirements.

MEDICAL DETACHMENT (COMBAT AND OPERATIONAL STRESS CONTROL) (MAIN SUPPORT ELEMENT)

4-167. The flexibility for providing COSC support at different locations enhances this unit's effectiveness and timeliness.

MISSION

4-168. The mission of the medical detachment (COSC) (main support element) (TOE 08463RA00) is to provide direct support COSC prevention and treatment services for BCT, EAB, and joint or multinational forces on an area basis.

ASSIGNMENT

4-169. The medical detachment (COSC) (main support element) is assigned to a medical detachment (COSC) (TOE 08460R000).

DEPENDENCIES

4-170. This unit is dependent upon the following:

- Appropriate elements of the theater for religious, legal, AHS support, finance, and personnel and administrative services.
- The units to which its sections, teams, and task-organized elements are attached for field feeding, water distribution, AHS support, biomedical maintenance, and logistic support and maintenance.
- Medical battalion (multifunctional) (TOE 08485R000) for logistical support to include water, cots, and field feeding.

EMPLOYMENT

4-171. The medical detachment (COSC) provides mission command for the main support section and the forward support section when it deploys as a complete detachment. The medical detachment (COSC) has the capability to deploy a forward support section in support of division and/or corps as required. The forward support section will require mission command to be provided by the supported medical detachment, (COSC). Both support sections (main and forward) have the capability to break down into six 3-man teams.

BASIS OF ALLOCATION

4-172. The medical detachment (COSC) (main support element) is allocated based on one per medical detachment, COSC (TOE 08460R000).

CAPABILITIES

4-173. This unit's capabilities include—

- Planning and staff advice to mission command headquarters regarding the stressors affecting the troops, mental readiness, and morale and cohesion.
- Preventive consultation and stress education support to leaders, chaplains, and medical personnel.
- Neuropsychiatric care, triage, and stabilization.
- Assistance to nonmedical units with rest category COSR casualties and the return to duty of recovered COSR Soldiers.
- Holding/restoration capability of 50 Soldiers for up to 3 days.
- Reconstitution to supported units.
- Debriefings after critical events, after action reports, case evaluation, and neuropsychiatric triage and stabilization.
- The maintenance personnel will augment the maintenance capability of the unit that performs field maintenance on the unit's organic vehicles and power equipment.
- This unit does not perform field maintenance on any organic equipment to include communications security equipment.

4-174. Individuals of this organization, except the chaplain can assist in the coordinated defense of the unit's AO.

MOBILITY

4-175. This unit requires 100 percent of its organic personnel and equipment be transported in a single lift using its authorized organic vehicles.

MEDICAL DETACHMENT (COMBAT AND OPERATIONAL STRESS CONTROL) (FORWARD SUPPORT ELEMENT)

4-176. The flexibility for providing COSC support at different locations enhances this unit's effectiveness and timeliness.

MISSION

4-177. The medical detachment (COSC) (forward support element) (TOE 08463GB00) is to provide prevention and limited fitness activity support to maneuver brigades and area support to units in the BCT AO.

ASSIGNMENT

4-178. The medical detachment (COSC) (forward support element) is assigned to a medical detachment (COSC) (TOE 08460R000).

DEPENDENCIES

4-179. This unit is dependent upon the following:

- Appropriate elements of the theater Army for laundry, bath services and clothing exchange for unit personnel and stress casualty caseload, mortuary affairs, and the security of enemy prisoners of war and U.S. military prisoner patients. The medical detachment (COSC) (forward support element) will require additional logistical, legal, finance, maintenance, personnel and administrative services support.
- The units to which its section, teams, and task organized elements are attached for field feeding, water distribution, AHS support to include medical maintenance, logistic support, and maintenance.
- Medical battalion (multifunctional) (TOE 08485R000) for logistical support to include water, cots, and field feeding.

EMPLOYMENT

4-180. The forward support section performs prevention and limited fitness activity support to maneuver brigades and area support to units in the BCT AO. The medical detachment (COSC) provides mission command for the main support section and the forward support section when it deploys as a complete detachment. The medical detachment (COSC) has the capability to deploy a forward support section in support of EAB units as required. The forward support section will require mission command to be provided by the supported unit. Both support sections (main and forward) have the capability to break down into six 3-man teams.

BASIS OF ALLOCATION

4-181. The medical detachment (COSC) (forward support element) is allocated based on one per medical detachment (COSC) (TOE 08460R000).

CAPABILITIES

4-182. This unit's capabilities include—

- Providing preventive consultation and stress education support to leaders, chaplains, and medical personnel.
- Neuropsychiatric care, triage, and stabilization.
- Assistance to nonmedical units with rest category COSR casualties and the return to duty of recovered COSR Soldiers.
- Reconstitution to supported units.
- Debriefings after critical events, after action reports, case evaluation, and neuropsychiatric triage and stabilization.
- Quantities designate the minimum mission essential wartime requirement for personnel and equipment.

4-183. Individuals of this organization can assist in the coordinated defense of the unit's AO.

MOBILITY

4-184. This unit requires 100 percent mobility of its TOE equipment to be transported in a single lift using organic vehicles.

FUNCTIONS

4-185. Medical detachment (COSC) (Forward Support Element) functions are described in the following paragraphs.

Detachment Headquarters

4-186. The detachment headquarters provides advice, planning, and coordination for COSC to include employment and coordination of COSC assets. This element also provides unit-level personnel, supply, patient administration, and vehicle maintenance.

Main Support Section

4-187. The main support section provides flexible, modular, task-organized COSC support in a variety of modularized teams. The 18-person BH team is comprised of up to six 3-person subteams which perform prevention and limited fitness activity support.

Forward Support Section

4-188. The forward support section provides flexible, modular, task-organized COSC support in a variety of modularized teams.

Chapter 5
Preventive Dentistry

This chapter superseded by ATP 4-02.19.

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Chapter 6

Area Medical Laboratory

This chapter explains the important role of the medical laboratory services and their relationship with FHP. The AML is the Army's specialized theater laboratory that can provide field confirmatory and theater validation laboratory support. Its primary role is to provide theater validation analytical laboratory support for environmental (air, water, and soil), epidemiological, food and water security, infectious disease, and CBRN samples. Its focus is the total health environment of the theater, not individual patient care.

SECTION I — AREA MEDICAL LABORATORY SERVICES

6-1. The AML is a Level IV preventive medicine asset that focuses on rapid health-hazard identification and assessment within the AO.

OPERATIONAL

6-2. These operational hazards include CBRN threat agents, endemic diseases, and other health threats associated with occupational and environmental health hazards. The AML's capabilities include the identification and confirmatory analytical laboratory testing and health hazard assessment of suspect CBRN agents, endemic diseases, and OEH hazards. It focuses on the total health environment of the theater, not individual patient care. The AML equipment and platform facilitates studies in pest identification, the efficacy of pesticides, frequency of infectious agents, monitoring immune response, transmission of zoonotic diseases, and identification of suspect CBRN samples/specimens in theater. Its personnel also function as consultants to hospital clinical laboratory services within the theater. The AML commander may task-organize teams and employ them forward to troubleshoot a particular problem.

CLINICAL

6-3. All Role 2 MTFs provide basic clinical laboratory services within the theater. They perform basic procedures in hematology, urinalysis, microbiology, and serology. Role 2 MTFs receive, maintain, and transfuse blood products.

6-4. The clinical laboratory in the combat support hospital performs procedures in biochemistry, hematology, urinalysis, microbiology, and serology in support of clinical activities. The combat support hospital also provides blood-banking services.

SECTION II — AREA MEDICAL LABORATORY SUPPORT

6-5. The AML was created under the Medical Reengineering Initiative and replaced the theater Army medical laboratory. The AML's focus is on rapid health-hazard identification and assessment within an AO. These operational health hazards include CBRN threat agents, endemic diseases, and other health threats associated with OEH hazards. The AML commander can tailor its deployable assets to meet specific operational objectives.

6-6. The AML's modular design permits task-organization of AML personnel for limited functional capabilities without the deployment of the entire organization. Modules consist of functional increments that provide the necessary array of analytical, diagnostic, and investigative capabilities tailored for a specified mission or contingency operation.

6-7. The AML is capable of incrementally deploying its functional modules as the operational requirement for laboratory support increases. These characteristics enhance the total AHS mission and better support split-based operations and rapid force projection without significantly degrading the capabilities of the parent unit.

6-8. The unit may send one or more of the three operational sections forward and that module can operate with local support. However, each section cannot be split to operate at more than one location due to the lack of critical equipment redundancy. The sections can be tailored to accomplish specific missions, if required. The AML may operate with its forward elements located in separate areas; however, mission command should remain with the headquarters section due to the unique support needs of the AML.

6-9. Although the AML is the most sophisticated environmental medical laboratory in theater, it cannot accomplish all tests and procedures required in theater. Using reachback, the AML coordinates with nondeployable (fixed facility) organizations and laboratories for confirmatory tests that exceed its capabilities and for definitive laboratory analysis.

6-10. The AML is strategically and operationally deployable. Organic vehicles are limited to those required for daily administrative, operational, and logistical functions, as well as for movement of tailored, force projection teams to support OEH hazard assessments and investigative efforts.

6-11. The AML is normally deployed to a theater to provide field confirmatory and theater validation medical laboratory support to Army and other DOD units (as directed) on an area basis.

SECTION III — AREA MEDICAL LABORATORY

MISSION

6-12. The mission of the AML (TOE 08668R000) is to identify and evaluate health hazards in the AO through unique field confirmatory and theater validation medical laboratory analyses and rapid health hazard assessments of CBRN, endemic disease, OEH threats.

ASSIGNMENT

6-13. The AML is assigned to a headquarters and headquarters company, MEDCOM (DS) (TOE 08640G000) or headquarters and headquarters company, MEDBDE (SPT) (TOE 08420G000) and may be further attached to other deployed medical units as needed.

DEPENDENCIES

6-14. This unit is dependent upon appropriate elements within the theater for religious, legal, AHS support, finance, field feeding, and personnel and administrative services.

6-15. This unit requires maintenance support on organic equipment, to include communications security equipment.

BASIS OF ALLOCATION

6-16. One unit is required to support unified land operations.

CAPABILITIES

6-17. This unit's capabilities include—

- Analytical, investigative and consultative capabilities to identify CBRN threat agents in medical specimens and other samples from the AO.
- Analytical, investigative, and consultative capabilities to assist in the identification of OEH hazards and endemic diseases.

- Special environmental control and containment to evaluate medical specimens for the presence of highly infectious or hazardous agents of operational concern.
- Data and data analysis to support medical analysis and operational decisions.
- Medical laboratory analysis to support the diagnosis of zoonotic and significant animal diseases that impact on military operations.
- Tailorable force projections to support war and other operations.
- Deployed modular sections or sectional teams will normally be deployed in the corps area where they will interface with PVNTMED teams, veterinary teams, medical units, Biological Integrated Detection System teams, and CBRN company elements.
- This unit does not perform field maintenance on organic equipment to include communications security equipment. One wheeled vehicle mechanic (91B) is assigned to augment the maintenance capability of the unit that performs field maintenance on the unit's organic equipment.

6-18. Individuals of this organization can assist in the coordinated defense of the unit's area or installation.

FUNCTIONS

6-19. The area medical laboratory functions are described in the paragraphs that follow.

HEADQUARTERS SECTION

6-20. This section is staffed to—

- Provide mission command networks and systems to include coordinating for secure and nonsecure capabilities.
- Provide mission command capabilities, automation, and computer analysis support requirements for the laboratory to facilitate split-based operations and administrative and logistical support for the unit.
- Conduct staff planning activities and oversee the development and implementation of unit plans and orders.
- Coordinate with supporting intelligence organizations to receive and disseminate information relating to threat identification functions of the laboratory.
- Perform unit administration activities.
- Plan for and execute unit movements.
- Identify unit training requirements and plan for and conduct unit training activities.
- Determine and submit requisitions for Class VIII supplies and equipment, as well as general supply requirements.
- Identify requirements and supervise the use of contractual services for operator maintenance of all organic medical equipment.

ENDEMIC DISEASE SECTION

6-21. The endemic disease section provides analytical, investigative, and consultative services on endemic diseases. This section is staffed to—

- Identify the endemic diseases that pose a potential threat to deployed forces (or other populations at risk) in the AO.
- Conduct diagnostics, identification, and consultation on treatment and description of the natural history and transmission of infectious diseases.
- Conduct and direct the performance of microbiological procedures and investigate the characteristics of microorganisms.
- Provide risk assessment and advice on health hazards and disease trends.
- Determine the status of conditions that influence the health of personnel in an AO.

- Plan, implement, supervise, and consult in the field of veterinary pathology and perform ante-and postmortem examination of animal tissues to diagnose zoonotic and other diseases of military importance.
- Plan, direct, and conduct medical entomological studies and provide consultation and recommendations on control of pests and disease vectors.
- Conduct insecticide resistance testing on arthropods to ensure adequacy of control measures employed.

OCCUPATIONAL AND ENVIRONMENTAL HEALTH SECTION

6-22. The OEH section monitors and evaluates OEH hazards to deployed forces and provides medical assessment and consultation on associated hazards. This section is staffed to—

- Conduct and direct the performance of chemical analysis and investigative protocols to determine OEH hazards.
- Provide consultation in areas related to chemical analysis and data interpretation.
- Perform scientific work using sanitary/environmental engineering principles and practices to protect the health of deployed forces and the environment. Make recommendations to preserve and enhance health and environmental conditions, including air, water, noise reduction, liquid and solid waste disposal, and industrial hygiene.
- Plan, implement, supervise, direct, and conduct various microbiological diagnostic procedures to diagnose zoonotic and animal diseases of military concern.
- Determine the status of conditions influencing the health of military personnel in an AO.
- Provide risk assessment and advice on health hazards and occupational disease trends.
- Formulate and recommend measures for health improvement as they relate to the performance of military duties in the operational environment.
- Perform analysis and investigations related to health physics, laser, microwave, directed energy, and ionizing and nonionizing radiation associated with military operations.
- Supervise and perform chemical analysis on OEH hazard specimens/samples in the AO.
- Conduct PVNTMED inspections, surveys, and laboratory procedures relative to OEH.
- Assess, prepare, evaluate, and analyze food samples to determine food hygiene, and safety and defense.

CHEMICAL, BIOLOGICAL, RADIOLOGICAL, AND NUCLEAR SECTION

6-23. The CBRN section provides analytical, investigative, and consultative services to assist in the identification of CBRN threat agents in medical specimens and other samples. This section is staffed to—

- Provide analytical, investigative, and consultative services to assist in the identification of CBRN threat agents in medical specimens and other samples.
- Perform field confirmatory and theater validation analytical laboratory testing and identification of suspected CBRN threat agents.
- Conduct microbiological procedures and investigate microorganisms and their products (toxins) as a directed threat or weapon.
- Conduct chemical analysis and investigative protocols to identify and evaluate chemical warfare agents.
- Perform scientific work related to health physics, laser, microwave, directed energy, and ionizing and nonionizing radiation biology that may be used as a weapons system.
- Perform elementary and advanced examinations of medical specimens and environmental samples to aid in determining the CBRN threat directed against personnel or operations.
- Perform analysis of radiologically contaminated samples.

EMPLOYMENT

6-24. This theater asset may be deployed incrementally or as an entire unit. The MEDCOM (DS) or MEDBDE (SPT) provides mission command networks and systems and support to forward assigned sections of the AML or to the entire unit when deployed. When operating in a split-base mode, the stay-behind headquarters element remains in CONUS or at EAB and conducts associated laboratory analysis, consultation, and referral of specimens to non-AML organizations, as appropriate.

6-25. The AML integrates its functional capabilities with other AMEDD and non-AMEDD assets to enhance the identification of health threat agents; provides accurate identification of suspect samples/specimens; and performs health hazard assessments across unified land operations.

6-26. When operating in a split-base mode, the stay-behind headquarters element remains in CONUS or at EAB and conducts associated laboratory analysis, consultation, and referral of specimens to non-AML organizations, as appropriate.

MOBILITY

6-27. This unit requires 10 percent of its TOE equipment to be transported in a single lift using its authorized organic vehicles.

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Appendix A

Determination of Eligibility for Care of Military Working Dogs and Other Government-Owned Animals

During interagency and multinational operations conducted in a deployed environment, issues may arise in determining which working dogs and other animals can be treated in U.S. Army established veterinary treatment facilities. Additionally, the extent of care to be provided may also need to be clarified. A determination of eligibility and whether reimbursement for services is required is made at the highest level possible and in conjunction with the supporting staff judge advocate, in accordance with applicable law and DOD policy. Additionally, Department of State and other military staff sections (such as the assistant chief of staff, civil affairs) may also need to be involved in the determination process. Each operation is unique and the authorization for care is based on the appropriate U.S. and international law, DODD and DODI, ARs, ADPs, ADRPs, ATPs, and standard operating procedures. Other factors impacting on the determination of eligibility are command guidance, practical humanitarian and ethical considerations, availability of U.S. veterinary assets (in relationship to the threat faced by the force), and the potential training opportunities for veterinary personnel. The sample format provided in this appendix is just one approach to delineate and disseminate this information to veterinary personnel and may not be all-inclusive based on specific scenarios.

DOCUMENTATION

A-1. Eligibility for veterinary care is based upon ownership of the animal. All DOD-owned animals will always be authorized comprehensive care, to include evacuation to Veterinary Role 4 facilities in CONUS. Basic documents required for determining eligibility include relevant DODD and DODI; international standardization agreements; acquisition and cross-servicing agreements; orders from higher headquarters; interagency agreements (memorandums of understanding and memorandums of agreement); and appropriate multinational force or international agency guidance for the specific operation. When working dogs and/or other animals are provided by a contractor, the terms of the statement of work, public works services contract, or other contract instrument should delineate what, if any, veterinary care is to be provided and whether these services are reimbursable to the military service providing the care. A copy of the relevant sections of the contract should be on file with the servicing veterinary unit to delineate specific medical services to be rendered. Additionally, for contract animals a point of contact for the contracting company and a point of contact for the administration of the contract should be maintained.

DISSEMINATION OF ELIGIBILITY FOR CARE INFORMATION

A-2. It is essential that guidance regarding eligibility for veterinary care is disseminated and understood by the chain of command and all civilians and military members of the deployed force. The veterinary commander must be able to articulate the basic concepts for veterinary care eligibility determinations. This means that he will need to condense them into simple, easily understood instructions, and widely disseminate them through electronic means or other media (such as pocket-sized cards).

Note. This matrix and the authorities listed for providing treatment are for example purposes only and should not be used as the basis for providing or denying veterinary care for any category of animal.

A-3. Table A-1 provides a sample of an eligibility for care matrix for treatment in a U.S. Army veterinary treatment facility.

Table A-1. Sample eligibility for veterinary medical care support matrix

ELIGIBILITY FOR VETERINARY MEDICAL CARE SUPPORT MATRIX (DATE) (THIS DOCUMENT IS SUBJECT TO FURTHER VERIFICATION AND/OR MODIFICATION)				
Category	***Veterinary care***	***U.S. Army medical evacuation***	***Strategic evacuation (TRANSCOM)***	***Information/authority***
DOD working dogs	Yes	Yes	Yes	DODD 5200.31E, DODD 6400.04E.
Allied military working dogs	Yes	Yes	Yes	The following nations have acquisition and cross-servicing agreements and ISAs with the U.S. which are administered by (*combatant command*): *List nations.*
Coalition military working dogs	Yes	Yes	Yes	The following nations have acquisition and cross-servicing agreements and ISAs with the U.S. which are administered by (*combatant command*): *List nations.*
U.S. Government working dogs (non-DOD)	Yes[3]	Yes	Yes	DODD 6400.04E and MOU/MOA.
U.S. Embassy working dogs	Yes	Yes	No	DODD 6400.04E and MOU/MOA.
Government-owned animals POC: Ms. XXX (XXX) XXX-XXXX ADMIN: Mr. XXX DSN XXX-XXXX	Yes[3]	Yes	Yes	DODD 6400.04E and MOU/MOA.
Contractor-owned working dogs POC: XXX (company name classified) POC: Ms. XXX (XXX) XXX-XXXX ADMIN: Mr. XXX DSN XXX-XXXX	Yes[3]	Yes	No	Per Mr. XXX, CWDs belonging to this contractor are entitled to comprehensive veterinary care within the area of operations. The terms of the contract and the name of the contracting company are classified. Contact Mr. XXX, DSN XXX-XXXX, if additional information is required.
Contractor #1 CDWs Tuff Dogs Company POC Mr. XXX (XXX) XXX-XXXX ADMIN: Mr. YYY DSN XXX-XXXX	Yes[1, 2] No	Yes	No	Contractor did not contract for the provision of medical care by military veterinary treatment facility. Contractor stated in writing that they contracted with the host nation veterinary infrastructure for the required care.

Table A-1. Sample eligibility for veterinary medical care support matrix (continued)

Category	*Veterinary care*	*U.S. Army medical evacuation*	*Strategic evacuation (TRANSCOM)*	*Information/authority*
Contractor #2 CWDs Horses and Mules POC: Mr. XXX (company name classified) POC: Ms. XXX (XXX) XXX-XXXX ADMIN: Mr. XXX DSN XXX-XXXX	Yes[3]	Yes No	Yes No	Per Mr. XXX, CWDs belonging to Contractor #2 are entitled to comprehensive veterinary care within the area of operations. The terms of the contract and the name of the contracting company are classified. Contact Mr. XXX, DSN XXX-XXXX, if additional information is required.
Contractor #5 Mr. YYY CWDs ABC Contract Dogs POC: Ms. YYY (XXX) XXX-XXXX ADMIN: Mr. XXX DSN XXX-XXXX		Yes	No	Per Mr. XXX, Mr. YYY is entitled to comprehensive veterinary care without reimbursement within the area of operations. The terms of the contract and the name of the contracting company are classified. Contact Mr. XXX, DSN XXX-XXXX, if additional information is required.
Personal pets of eligible personnel (such as US Embassy employees)	Yes[3]	No	No	Only if space is available and appropriate veterinary services/care are available in the operational setting. AR 40-400. Contact Mr. XXX, DSN XXX-XXXX, if additional information is required.
Military working dog injured as a result of military operations	Yes	Yes	No	U.S. and international law (FM 27-10) and status of forces agreements. If the U.S. military injures a host nation's military working dog the U.S. is responsible for providing immediate care. For additional legal considerations, coordinate with Mr. XXX, DSN XXX-XXXX and LTC YYY, supporting staff judge advocate, DSN XXX-XXXX.
Other animals injured as a result of military operations	Contact legal	Contact legal	No	U.S. and international law (FM 27-10) and status of forces agreements. If the U.S. military injures a host nation privately owned animal (such as in an automobile accident involving a military vehicle).

Notes:

[1] Emergency veterinary care only. Emergency care is that care required to save life, limb, or eyesight.
[2] Care provided is limited to contractual agreement. Reimbursement for care is required.
[3] Reimbursable.

Legend:

ADMIN	administrator
AR	Army regulation
CWD	contractor working dog
DOD	Department of Defense
DODD	Department of Defense Directive
DSN	Defense Switched Network
ISA	international standardization agreement
MOA	memorandum of agreement
MOU	memorandum of understanding
POC	point of contact
TRANSCOM	United States Transportation Command

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Glossary

This ATP is not the proponent publication for any terms.

SECTION I – ACRONYMS AND ABBREVIATIONS

ABCA	American, British, Canadian, Australian, and New Zealand (Armies)
ADP	Army doctrine publication
ADRP	Army doctrine reference publication
AFI	Air Force instruction
AFPMB	Armed Forces Pest Management Board
AHS	Army Health System
AMEDD	Army Medical Department
AMedP	Allied medical publication
AML	area medical laboratory
AMovP	Allied movement publication
AO	area of operations
AOC	area of concentration
AR	Army regulation
ARFORGEN	Army Force Generation
ATP	Army techniques publication
ATTP	Army tactics, techniques, and procedures
BCT	brigade combat team
BH	behavioral health
BICEPS	brevity, immediacy, contact, expectancy, proximity, and simplicity
C	Celsius
CBRN	chemical, biological, radiological, and nuclear
CONUS	continental United States
COSC	combat and operational stress control
COSR	combat and operational stress reaction
DA	Department of the Army
DA Pam	Department of the Army pamphlet
DHA	Defense Health Agency
DNBI	disease and nonbattle injury
DOD	Department of Defense
DODD	Department of Defense directive
DODI	Department of Defense instructions
EAB	echelons above brigade
FHP	force health protection
FM	field manual
HRCoE	Health Readiness Center of Excellence
MDVSS	medical detachment (veterinary service support)

MEDBDE (SPT)	medical brigade (support)
MEDCOM (DS)	medical command (deployment support)
MMB	medical battalion (multifunctional)
MOS	military occupational specialty
MTF	medical treatment facility
MWD	military working dog
NATO	North Atlantic Treaty Organization
OCONUS	outside the continental United States
OEH	occupational and environmental health
PVNTMED	preventive medicine
SOF	special operations forces
STANAG	standardization agreement
TB MED	technical bulletin (medical)
TC	training circular
TDA	table of distribution and allowances
TEM	traumatic event management
TG	technical guide
TOE	table of organization and equipment
TM	technical manual
U.S.	United States
USAMEDDC&S	United States Army Medical Department Center and School
VSST	veterinary service support team

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