COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

This Instruction implements Air Force Policy Directive (AFPD) 44-1, Medical Operations. It establishes the requirement and guidance for Disaster Mental Health Response (DMHR) teams at all active duty Air Force (AF) installations, integrating resources and efforts of the Air Force Reserve (AFR) and Air National Guard (ANG). It interfaces with DoD Directive 6490.5, *Combat Stress Control (CSC) Programs*; DoDI 6490.05, *Maintenance of Psychological Health and Contingency Operations, Psychological Health in Military Operations*; DoD Instruction 6200.03, *Public Health Emergency Management Within the Department of Defense*; and AFI 44-172, *Mental Health*. This AFI may be supplemented at any level, but all supplements must be routed to AFMSA/SG3OQ for coordination prior to certification and approval. Refer recommended changes and questions about this publication to the Office of Primary Responsibility (OPR) using the AF Form 847, *Recommendation for Change of Publication*; route AF Form 847s from the field through the appropriate functional chain of command. The authorities to waiver wing/unit level requirements in this publication are identified with a Tier number following the compliance statement. See AFI 33-360, *Publications and Forms Management*, Table 1.1 for a description of the authorities associated with the Tier numbers. Submit requests for waivers through the chain of command to the appropriate Tier waiver approval authority, or alternately, to the Publication OPR for non-tiered compliance items. Ensure that all records created as a result of processes prescribed in this publication are maintained in accordance with Air Force Manual (AFMAN) 33-363, *Management of Records*, and disposed of in accordance with Air Force Records Disposition Schedule (RDS) located at **https://www.my.af.mil/afrims/afrims/afrims/rims.cfm**.

SUMMARY OF CHANGES

This publication has been revised and must be completely reviewed. Name has changed from Traumatic Stress Response to Disaster Mental Health Response and Combat and Operational Stress control to incorporate DoDI 6490.05, *Maintenance of Psychological Health and Contingency Operations, Psychological Health in Military Operations*; and DoDI 6200.03, *Public Health Emergency Management Within the Department of Defense.* The name change encompasses both the natural disaster and operational environments with the goal of emphasizing the role of psychological first aid. Major changes include: Tiers were added for waiver authority for Wing Level or below requirements. Combat Stress Control (CSC) and Combat Operations Stress Control (COSC) training requirements were incorporated to bring into compliance with DoDI 6490.05.   Training attachments were expanded to include all areas required by DoDI 6490.05 for training all levels of Air Force personnel on COSC principles.

Chapter 1

PROGRAM OVERVIEW

1.1. Purpose. Most individuals respond to challenging life events without significant negative consequences. Nonetheless, while in garrison and in traditional battle roles, Airmen may encounter several types of incidents putting them at risk for the full spectrum of stress reactions ranging from minor stress reactions to more severe symptoms of Posttraumatic Stress Disorder. Disaster Mental Health (DMH) and Combat and Operational Stress Control (COSC) are two methods to proactively respond to these incidents and minimize the likelihood of longstanding or debilitating stress reactions.

1.1.1. Disaster Mental Health (DMH) is the coordinated response typically at permanent in-garrison locations, initiated by unit leaders in which the DMH team provides psychological first aid to individuals and groups who may have or who have had direct exposure to an all-hazard incident. An all-hazard incident is any incident, natural or manmade, serious enough to warrant action to protect the life, property, health, and safety of military members, dependents, and civilians at risk, and minimize any disruptions of installation operations.

1.1.2. COSC utilizes many of the same psychological first aid principles as does DMH but addresses prevention and management of *battle related stress* before, during, and after deployment. The various presentations of combat related stress are termed *Combat and Operational Stress Reactions* (COSR) and when they occur are typically normal and/or an expected reaction to battle. In their milder and more common forms, COSRs do not represent diagnosable mental health conditions.

1.2. While the majority of individuals who are exposed to an all-hazard incident or battle most will not experience long-term adverse effects, though all have the potential to experience stress reactions. If stress reactions are noted following an all-hazard event or battle, most reactions are typically mild and of short duration. DMH and COSC preventive services can mitigate these symptoms and help prevent potential long term problems such as Posttraumatic Stress Disorder (PTSD).

Chapter 2

DISASTER MENTAL HEALTH

2.1. Purpose.

2.1.1. DMH Teams foster resilience in those who are, or may be exposed to all-hazard incidents or operational stress environments. This is accomplished through preparatory education for those likely to experience significant, or high stress events/experiences and stressors, through ongoing education, intervention, screening, psychological first aid, and referrals as needed for those exposed.

2.1.2. Other requests for consultation. Commanders and other leaders may approach the DMH team chief or team members for consultation and advice for many matters outside the scope of an all-hazards incident, i.e. for losses such as a death of a unit member away from the workplace. Although not DMH, this response may include members of the DMH team (e.g. the RST for grief issues and memorial services). See AFI 44-172, for requirements when consultations or when contacts become clinical in nature.

2.2. Roles and Responsibilities.

2.2.1. **Installation/Wing Commander (At installations with a military treatment facility (MTF)) shall:**

2.2.1.1. Ensure establishment of a DMH Team. (T-0)

2.2.1.2. Appoint licensed Mental Health providers as primary and alternate DMH Team Chief.

2.2.1.3. Identify DMH Team Chief to Command Post and ensures effective notifications and activation process for DMH events. (T-0)

2.2.1.4. Ensure formal agreements are secured for provision of personnel and/or resources if outside resources (other installations, Guard, Reserve, non-military) are present and required for program effectiveness. (T-0)

2.2.1.5. Ensure the DMH team is included as a member of the Emergency Family Assistance Control Center (E-FACC) in disaster response, in order to identify populations needing intervention and community needs that can be met by DMH resources. (T-0)

2.2.1.6. Ensure host bases arrange for geographically separated units (GSUs) to have access to DMH teams and are available to respond by coordinating with other bases or MAJCOM. (T-0)

2.2.1.7. Ensure Command Post has a process in place to notify the DMH team chief when aware of an all-hazard incident as part of base notification protocol. (T-0)

2.2.1.8. Ensure unit commanders consult with the DMH Team regarding pre-exposure training, long and short term interventions, unit assessments and other prevention for all-hazard incidents or operational stress reactions. (T-0)

2.2.2. **DMH Team Chief shall:**

2.2.2.1. Integrate DMH team preparedness and response plans with other installation response plans and the Medical Contingency Response Plan (MCRP). For Joint Bases the DMH team chief will coordinate with lead service for any DMH issues. Coordinating with the Public Health Emergency Management officer, the DMH team should integrate efforts into the overall public health emergency preparedness and response. (T-0)

2.2.2.2. Coordinate with both Airman and Family Readiness Center, Religious Support Team (RST) (and other agencies as appropriate) to deliver DMH services to base community members at installations impacted by all-hazard incidents. (T-0)

2.2.2.3. Maintain a listing of local resources in the community. Establishes or modifies necessary Memoranda of Agreement (MOA) with local mental health support agencies to ensure coordinated delivery of services in the aftermath of an all-hazards incident. Coordinate MOA's through base Judge Advocate (JA) as needed and appropriate. (T-0)

2.2.2.4. Participate in Installation Emergency Management Working Groups to develop appropriate scenarios for DMH response and annually participates in installation emergency management exercises. Should others occur, DMH will participate with base/civilian agencies, such as Security Forces, Wing Safety and American Red Cross, in any other exercises involving all-hazard scenarios. (T-0)

2.2.2.5. Complete documentation on all command consultation, exercises and real-world responses and maintains these and other after action reports in a DMH binder.

2.2.2.6. Ensure DMH training of principles and services are completed IAW DoDI 6200.03, to include annual training for installation and unit leadership. (T-0)

2.2.2.6.1. Establish ongoing training and exercise requirements for primary, alternate, and augmentee DMH team members to maintain proficiency and function effectively as a team. (T-0)

2.2.2.6.2. Ensure all DMH team members and augmentees receive the training material contained in Attachment 2 maintaining records of training for each attendee in DMH binder. (T-0)

2.2.2.6.3. Establish and maintain a monitoring plan for DMH team members surveying members' psychological health for signs of secondary trauma, burnout, and vicarious traumatization in prolonged DMH situations. (T-0)

2.2.2.6.4. Coordinate effective team response with downtime for each team member to minimize potential adverse reactions in team members. (T-0)

2.2.3. ARC and ANG units will develop and utilize resources under their control to support DMH. Maintain partnership with the regular component where proximity allows. (T-0)

2.3. DMH Program.

2.3.1. Provides services for individuals who either directly witnessed or were involved in an all-hazard incident. (T-0)

2.3.2. Establishes standard operating procedures that include, at a minimum, team composition, an assessment of local resources, high-vulnerability groups, a survey of local

organizations with personnel trained in emergency response, a response plan for team activation, and a plan for conducting DMH needs assessment and surveillance during and after an all-hazard incident. (T-0)

2.3.3. Coordinates efforts with the Public Health Emergency Officer and integrates efforts of the DMH team into the overall public health emergency preparedness and response. (T-0)

2.4. DMH Team.

2.4.1. DMH team membership is multidisciplinary and will include at a minimum:

2.4.1.1. A licensed Mental Health provider serves as the DMH team chief.

2.4.1.2. Mental health personnel (Psychiatrists, psychologists, social workers, mental health nurses, MH technicians and/or a licensed provider who is trained in acute mental health intervention). (T-0)

2.4.1.3. Religious Support Team (RST). (Chaplain and chaplain assistant).

2.4.1.4. Airman and Family Readiness Center (AFRC). Community Readiness Consultant (CRC). (T-0)

2.4.1.5. Alternate members for each role. Alternates' training requirements to be determined IAW paragraph 2.2.5.6.1. If qualified ARC and ANG personnel are available, DMH team chief should consider their membership when forming DMH teams on active duty installations. (T-0)

2.4.1.6. Representatives from certain career fields involved in all-hazards responses (e.g. Security Forces, Civil Engineers) may also serve as either permanent or ad hoc DMH members at the discretion of the DMH chief and proposed member's leadership IAW DoDI 6490.05 and DoDI 6200.03. (T-0)

2.5. DMH Services.

2.5.1. All individuals directly involved in all-hazard incident or combat and operational stress should be provided the opportunity to access DMH services IAW DoDI 6490.05 and DoDI 6200.03. (T-0)

2.5.2. Participation in interventions is voluntary, though unit leaders may arrange for affected personnel to receive education.

2.5.3. DMH services may include Pre-Exposure Preparation, education, screening and referral. Medical or mental health record documentation is not required for DMH team services, since they are not medical services. However, after action reports for intervention/education with groups (date, squadron, number in attendance, incident/training) should be annotated for continuity in DMH binder IAW DoDI 6200.03.

2.5.4. Following an all-hazard incident, individuals can seek up to four one-on-one meetings with any member of the DMH team IAW DoDI 6200.03. Should non-beneficiaries seek educational visits with the team's mental health providers, they should be referred to the resources of their specific employee assistance program or applicable medical plan. (T-0)

2.5.4.1. One-on-one meetings are for the purpose of education and consultation, not for medical assessment or treatment. Since interventions are educational and focused on the incident they are not documented.   If an individual begins to discuss topics outside the

incident they need to be reminded of the guidelines of DMH and their options for formal treatment (e.g. installation Mental Health Clinic).

2.5.5. Personnel Reliability Program (PRP) status members exposed to potentially traumatic experiences in battle or as a result of an all-hazards incident are entitled to DMH services. As long as those services are psycho-educational, there is no need for reporting it as a clinical visit. However, if services elevate to treatment, the provider will need to comply with DoDI 5210.42-R, *Nuclear Weapon Personnel Reliability Program, AFMAN* 10-3902 and any local guidance on PRP. Regardless of whether DMH services are psycho-educational or treatment, any Potentially Disqualifying Information (PDI) discovered must be passed to the CMA as soon as possible. It is also prudent to remind any PRP members receiving DMH services that they have a duty to notify their supervisor or certifying official of any factors that could have an adverse impact on their performance, reliability, or safety while performing PRP duties. (T-0)

2.5.5.1. Prior to sessions, members will be informed that regulations requiring notification of Potentially Disqualifying Information or risk still apply, especially for individuals on PRP, with security clearances, on flying status or other special duties. (T-0)

2.5.6. For Mental Health providers such as operational psychologists or "embedded" mental health providers who may serve in dual or multiple relationship roles (DMH Lead, consultant to command, treatment provider) may exist, explanation of the role of DMH during all-hazard incident responses will help clarify responsibilities and eliminate confusion.

2.5.6.1. DMH as an educational/consultative intervention is not formal mental health treatment. This difference must be communicated to DMH recipients and leadership when responding to all-hazards incidents. In the course of DMH education, if an individual needs to be directed to mental health treatment, MH providers will follow AF guidance for quality and documentation IAW AFI 44-119, *Medical Quality Operations* and AFI 44-172.

2.6. Other Consultative Roles.

2.6.1. Air or Ground Incidents That Involve Loss of Life or Major Injury**.** The DMH team leader is a consultant to the on-scene commander and assists in determining whether there is a need for DMH support. If the commander requests service, the scope of those services should be outlined by the commander in consultation with the DMH team leader IAW DoDI 6200.03 and DoDI 6490.05.

2.6.2. Hostage Negotiation Consultation. Members of the DMH team may serve in a consultation role to the on-scene commander, Security Forces hostage negotiation team or civilian counterparts consistent with their level of training. Unless the DMH team member has specific training in hostage negotiation, their role will be limited to consultation on DMH or other mental health issues consistent with their training. (T-0)

2.6.3. Search and Rescue Activities. Individuals participating in search and rescue activities, including professional personnel (e.g., forensic pathologists and mortuary personnel) should have the opportunity to receive DMH services IAW DoDI 6200.03 and DoDI 6490.05.

2.6.4. Services provided will vary depending on the nature of the incident and the needs of the personnel involved. (T-0)

2.7. DMH Team Training.

2.7.1. Minimum training topics include: prevention, outreach, screening, triage, psychological first aid, education and referral services for individuals and groups, command consultation, ethical issues, needs assessments and surveillance, burnout and secondary trauma.

2.7.2. All team members, regardless of duty location or length of tenure on the team, will train at least quarterly and train and exercise as a team.

2.7.3. Training is focused on preparation of the team to respond to realistic all-hazards incidents that could activate DMH.

2.8. Pre-Exposure Preparation (PEP).

2.8.1. DMH Teams are available to provide preventive, Pre-Exposure Preparation (PEP) to individuals, units and communities who expect to encounter All-Hazard Incidents. (T-0)

2.8.2. PEP's purpose is to build resilience and skills to understand and minimize typical stress reactions under abnormal circumstances. The DMH team chief should cooperatively plan PEP training with leaders of units expecting battle exposure or exposure to all-hazards incidents when both agree the training is warranted. PEP training should be tailored to specific unit requirements and expected exposures and should not duplicate existing training. Mental Health providers can access additional PEP resources at the following Readiness Skills Verification site (**https://kx2.afms.mil/kj/kx7/MentalHealthRSVP/Pages/training-resources.aspx**). (T-0)

Chapter 3

COMBAT AND OPERATIONAL STRESS CONTROL (COSC).

3.1. Purpose. Where PEP and DMH seek to prevent or minimize responses to stressors prior to any type of potentially traumatic exposure such as an all-hazards incident, COSC seeks to prevent and manage stress reactions through increased psychological resilience and skill building both prior to and after exposure in a wartime environment.

3.2. COSC Principles.

3.2.1. In a deployed setting, the COSC can operate in different capacities or under different leadership (e.g., when local OPCON is an Army or Navy function). MH providers may work in a COSC clinic or a MH clinic that has a COSC Team supporting the installation or region where potentially traumatic incidents occur. No matter the setting, the principles for psychological interventions for the prevention of combat and operational stress reactions are the same: support of our first-responders and those impacted by combat or operational stress.

3.2.2. COSC, in concert with other prevention efforts, intervenes to mitigate the risk of potential longer-term physical and psychological consequences of combat and other military operations.

3.2.3. COSC or a similar low stigma term shall be used to reduce the risk that these services are confused with clinical treatment or traditional mental health care. (T-0)

3.3. Roles.

3.3.1. Commanders of the Combatant Commands. Designates a Mental Health professional as the COSC consultant to each Command Surgeon and Combatant Commander as needed.

3.3.2. Mental Health Personnel. Will provide COSC services and complete training standards IAW DoDI 6490.05 (encl 2. c. and g.). (T-0)

3.3.3. Non-Mental Health Medical Personnel. Will be familiar with the general principles of COSC management, and will be trained on the identification of stress related conditions, psychological first aid and the management of COSR. (T-0)

3.3.4. RSTs. Similar to their role in DMH, RSTs are a core component when supporting COSC in responding to a traumatic event in the deployed setting. In addition to their religious/spiritual roles in the battle environment, their training will also include familiarity with the general principles of COSC management, the identification of stress related conditions, psychological first aid and the management of COSR. (T-0)

3.3.5. Leadership. Commissioned and Noncommissioned Officers alike will complete training in the identification of COSR in themselves and others, psychological first aid, resilience and importance of consulting with COSC personnel for support, referral resources and when to utilize them. (T-0)

3.3.6. Line Personnel. Will complete training in COSR, resilience, psychological first aid and referral resources and when to utilize them. (T-0)

3.4. COSC Program.

3.4.1. COSC programs seek to prevent or minimize adverse effects of COSR through primary, secondary, and tertiary prevention efforts, to include:

3.4.1.1. COSC Personnel consult with line commanders regarding surveillance and prevention, identification, and management of COSR in units and individuals before, during and after deployments. (T-0)

3.4.1.2. COSC Personnel will be familiar with and use Module A2 from the Department of Veterans Affairs/Department of Defense (VA/DoD) Clinical Practice Guideline (CPG) for the Management of Post-Traumatic Stress to manage COSR (see **http://www.healthquality.va.gov/ptsd**/). (T-0)

3.4.1.3. COSC Personnel will complete assessments and interventions regarding the effects of potentially traumatic events in squadrons as requested by commanders or recommended by providers as trends are noticed within units. (T-0)

3.4.2. COSC personnel will record numbers of incidents and individuals with COSR separately; checking with servicing department for the format currently established (e.g., COSC Workload and Activity Reporting System (WARS)). Absent any other guidance, tracking and monitoring is to be completed IAW DoDI 6490.05. (T-0)

3.5. COSC Training Requirements.

3.5.1. All AF Personnel will complete required pre-deployment training IAW DoDI 6490.05 and AFI 10-403, *Deployment Planning and Execution.* (T-0)

3.5.1.1. All MH Personnel will complete required pre-deployment training and subsequent COSC training topics outlined in DoDI 6490.05. (T-0)

3.5.2. It is the responsibility of the Wing/installation commander to assure the pre and post deployment training of deploying personnel and with the assistance of subordinate installation resources (e.g. Community Action Information Board/Integrated Delivery System) to ensure that COSC principles are supported across the deployment cycle. (T-0)

3.5.3. Airman Pre-/post-Deployment Training (APPDT) is a standardized and mandatory set of briefings developed by AFMSA/SG3OQ for both pre- and post-deployment IAW AFI 10-403, Chapter 8 and DoDI 6490.05, *Maintenance of Psychological Health and Contingency Operations Maintenance of Psychological Health in Military Operations*. For units that deploy frequently and for shorter durations, AFI 10-403 allows exceptions based on these factors. (T-0)

3.5.4. For the highest risk career fields with regular exposure to life threatening situations or casualties, individuals may have the opportunity to attend a Deployment Transition Center to facilitate reintegration and long term resilience. AF/A1S is the point of contact regarding the DTC. Local units may also request a tailored reintegration program through local support agencies IAW DoDI 6490.05. (T-0)

Chapter 4

REDEPLOYMENT

4.1. Redeployment. Mental Health staff in collaboration with CAIB/IDS agencies will provide reintegration education and support to redeployed members, families and units IAW AFI 10-403.

THOMAS W. TRAVIS
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Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

References

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DoDI 5210.42, Nuclear Weapon Personnel Reliability Program, July 16, 2012

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AFI 10-2501, Air Force Emergency Management (EM) Program Planning and Operations, 10 May 2013

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TRAINING REFERENCES

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Prescribed Forms

None

Adopted Forms

AF Form 847, *Recommendation for Change of Publication*

Abbreviations and Acronyms

AFRC—Air Force Reserve Command

ANG—Air National Guard

BHOP—Behavioral Health Optimization Program

CBRNE—Chemical, Biological, Radiological and High-Yield Explosive

CMA—Competent Medical Authority

COSC—Combat and Operational Stress Control

COSR—Combat and Operational Stress Reaction

CPG—Clinical Practice Guideline

DMH—Disaster Mental Health

E-FACC—Emergency Family Assistance Control Center

GSU—Geographically Separated Unit

IDS—Integrated Delivery System

MAJCOM—Major Command

MCRP—Medical Contingency Response Plan

MH—Mental Health

MTF—Medical Treatment Facility

NIMH—National Institute of Mental Health

PEP—Pre-Exposure Preparation

PRP—Personnel Reliability Program

DMH—Disaster mental Health

VA—Veterans Affairs

Terms

All hazard incident—Any incident, natural or manmade, that warrants action to protect the life, property, health, and safety of military members, dependents, and civilians at risk, and minimize any disruptions of installation operations.

Combat Operation Stress Control— Program developed to prevent, identify, and manage adverse COSRs in individuals/units; enhance mission performance; increase individual and unit resilience; conserve fighting strength; prevent or minimize adverse effects of combat stress on members' physical, psychological, behavioral, and social health; and to return the unit or Service member to duty.

Combat Operation Stress Control consultant— A mental health professional with training and expertise in COSC management who consults with Commanders about matters related to combat stress such as unit cohesion, unit morale, resilience, leadership, effective communication, and perceived mission importance.

Combat Operation Stress Control personnel— Active and Reserve Component mental health professionals and technicians, Chaplains or other personnel including medical who are trained in COSC principles, including combat and operational stress first aid and application of principles to enhance combat effectiveness. Senior experience COSC personnel serve as advisors to line commanders on leadership, communication, unit cohesion, morale, and training factors that prevent or minimize COSRs.

Combat Operation Stress Reaction—The physical, emotional, cognitive, or behavioral reactions, adverse consequences, or psychological injuries of Service members who have been exposed to stressful or traumatic events in combat or military operations. COSRs vary in severity as a function of operational conditions, such as intensity, duration, frequency of combat exposure, rules of engagement, leadership, effective communication, unit morale, unit cohesion, and perceived importance of the mission, etc. COSRs do not represent mental health disorders or medically diagnosable conditions and concerns. Post-traumatic stress disorder is not equivalent to or another name for COSR.

Deployment Transition Center (DTC)—The DTC provides centralized training through a graduated transition home, small group discussion, individual resiliency skills, coping mechanisms and a support system to fellow Airmen.

Disaster Mental Health Teams— Designated teams that provide pre-exposure preparation training, consultation to unit commanders and leaders, screening, psychological first aid, education and referral services to individuals and groups who may have or who have had direct exposure to an all-hazard incident.

Pre-Exposure Preparation—An educational approach seeking to prepare individuals to deal with stress reactions expected when exposed to traumatic events emphasizing the typical and normal stress responses and basic techniques in stress management.

Attachment 2

TRAINING OUTLINE FOR DISASTER MENTAL HEALTH (DMH) TEAM MEMBERS

A2.1. The content listed below is not an all-inclusive list of all training topics, and/or resources, but offered as a team resource. Team members are encouraged to review the *Field Manual for Mental Health and Human Services Workers in Major Disaster*, the *Post Deployment Guides for Emergency and Disaster Response Workers* and *Supervisors of Deployed Personnel*, *Mental Health and Mass Violence Evidence-Based Early Psychological Intervention for Victims/Survivors of Mass Violence* and the Army Field Manual *Combat and Operational Stress Control* (listed in references).

A2.2. DMH team chiefs are responsible for ensuring team members train on the following topics: Pre-Exposure Preparation, Ethnic and Cultural Issues, Screening and Triage of Individuals, Principles of Early Interventions/Psychological First Aid, Referral in response to all-hazard incident, Vicarious Trauma (Taking Care of the Care-Takers), Management of COSRs. All DMH training components listed must be accomplished annually. To ensure that all areas are covered; training should occur and be documented at least quarterly.

A2.3. PRE-EXPOSURE PREPARATION.

A2.3.1. PEP education is the primary preventive function of DMH teams. Community education regarding the functions of the DMH teams and PEP should be accomplished on a regular basis through briefings and articles in base publications. Education regarding the services of the DMH teams should not wait until a response is anticipated or needed. PEP training should be offered to all individuals for whom exposure to an all-hazard incident is anticipated and should cover at a minimum stress and stress reactions, methods of coping with stress and how to avoid ineffective coping.

A2.4. ETHNIC AND CULTURAL ISSUES.

A2.4.1. Training for DMH/COSC team members in ethnic and cultural competence facilitates awareness and improves the effectiveness of response whether at home station or deployed. The death of a loved one, community trauma and mass victimization are interwoven with cultural overlays. Understanding customs, traditions, rituals, family structure, gender roles, and social bonds assist the team members with designing an effective response to an all-hazards incident.

A2.5. SCREENING AND TRIAGE OF INDIVIDUALS.

A2.5.1. Assessment checklists can assist in the identification and documentation of needs in those exposed. One such checklist is the Screening and Assessment Checklist from *the Mental Health Response to Mass Violence and Terrorism*, Chapter II (in References).

A2.5.1.1. Trauma and loss exposure.

A2.5.1.2. Presence of risk and resiliency factors.

A2.5.1.3. Current psychological distress.

A2.5.1.4. Prior coping with major stressors.

A2.5.1.5. Availability of social support.

A2.5.1.6. Current pressing concerns.

A2.5.2. The flow charts in attachment 3 provide an overview of the Department of Veterans Affairs/ Department of Defense (VA/DoD) Clinical Practice Guideline (CPG) on Management of Traumatic Stress. DMH team members can use this CPG to screen and refer individuals who have been exposed to an all-hazard incident. The first flow chart depicts a core module that can be used to screen any individual who has been exposed to a potentially traumatic event. The remaining charts provide guidance on management of individuals with acute stress reactions, combat and operational stress reactions, and those who are referred to primary care or MH for further assessment.

A2.5.3. Medical and MH providers are encouraged to review the entire VA/DoD CPG for the Management of Post-Traumatic Stress (see References in Attachment 1).

A2.6. PRINCIPLES OF EARLY INTERVENTIONS/PSYCHOLOGICAL FIRST AID.

A2.6.1. Early intervention policies should be based on empirically defensible and evidence-based practices. As mental health staff and COSC members you have an ethical duty to discourage team members and Airman from using of ineffective or unsafe techniques, i.e., excessive alcohol use, blaming, breakdown in communication and risk taking behaviors.

A2.6.2. *Basic Needs*.

A2.6.2.1. The DMH Team in consultation with commands must recognize and prioritizethe individual's needs after traumatic events to include: survival, safety, security, food, shelter, health (physical and mental health, triage for emergency care) and communication (family, friends etc.). Exposed individuals will need information about available services which will vary depending on environment and location.

A2.6.3. *Elements of Psychological First Aid.*

A2.6.3.1. Protect individuals from further harm.

A2.6.3.2. Reduce physiological arousal.

A2.6.3.3. Provide support for those in acute distress.

A2.6.3.4. Keep support systems together and facilitate reunions.

A2.6.3.5. Keep communication open and consistent across the continuum of care.

A2.6.4. *Assessment and Surveillance of Population Needs*.

A2.6.4.1. Assessment and surveillance in an all-hazards incident or during military operations identifies the current needs of individuals, groups, a population and/or institution or system. The assessment is not a clinical screening. Once enough information is gathered, trends and needed resources can be determined to support the broader population. If there is enough information to indicate a need in a specific unit, the team leader should take these services to them through command consultation.

A2.6.4.2. If a disaster response is prolonged, long term efforts will include ongoing surveillance and reassessment of population needs, the effectiveness of the programs, services and supports implemented.

A2.6.5. *Resilience and Recovery*.

A2.6.5.1. Individuals generally rely on and effectively utilize the resilience skills they bring to the 'fight'. These same skills are the ones they will most effectively utilize to respond to operational stress and all hazards incidents. The DMH team promotes existing skills and also teaches new skills when possible to increase overall resilience in the face of stressors.

A2.6.6. *Command Consultation and Education*.

A2.6.6.1. DMH/COSC team members are consultants providing education on responses to battle or other all hazards incidents for commanders and other leaders, first responders and other exposed individuals appropriate to each role.

A2.6.7. *Tenets for Consultation and Education*.

A2.6.7.1. Consultation and education is an ongoing process and occurs whether in-garrison or deployed. Consultation may be provided at a specific request of command, at the recommendation of the DMH Team Leader, or by mutual arrangement, and the topic of consultation can center on a unit member, the leader or the unit.

A2.6.7.2. The consultative process is improved when the consultant reaches out in active outreach to commanders. It is best conducted face-to-face; building the relationship prior to a specific need being identified.

A2.6.7.3. Successful consultation depends on gaining trust and credibility when the consultant displays knowledge of services/organizations and good military bearing and an interest in the wellbeing of the organization.

A2.6.7.4. Sample 6-step consultation process.

A2.6.7.4.1. Making the introduction.

A2.6.7.4.2. Asking commander's goals/needs: assess/formulate ways to address them.

A2.6.7.4.3. Presenting a plan of action: include goals and alternative actions.

A2.6.7.4.4. Implementing approved plan of action.

A2.6.7.4.5. Evaluating progress and outcomes.

A2.6.7.4.6. Planning follow-up actions, if needed.

A2.7. REFERRAL IN RESPONSE TO ALL-HAZARD INCIDENT.

A2.7.1. Whether in garrison or deployed, DMH team members must have a thorough working knowledge of base and local community resources. Individuals under stress benefit from receiving simple, concrete information and easy to understand written guidance on available referral sources (i.e. pamphlets, handouts). This written information serves as a quick reference for the individual.

A2.8. VICARIOUS TRAUMA (TAKING CARE OF THE CARE-TAKERS).

A2.8.1. Even if not directly exposed to battle or all-hazards events, caretakers may experience vicarious trauma from the cumulative exposure of hearing the traumatic histories of others. Particularly vulnerable to vicarious trauma are those with personal trauma histories; newer, less experienced providers; and those who exhibit higher levels of empathy.

A2.8.2. The team leader or the senior mental health provider must consider stress management/prevention for DMH team members and other associated helping professionals tailoring them to the needs of the agencies and situation.

A2.8.3. As relief workers transition from the high operational environment back to normal operations after an incident they should be aware of expected responses and what to do in the case of unexpected symptoms and responses.

A2.9. MANAGEMENT OF COSRs.

A2.9.1. Combat and Operational Stress Reactions (COSR) are not synonymous with a diagnosis of PTSD and should be managed differently. COSR represents the broad physical, mental and emotional signs that frequently result from exposure to combat or operational environments. By definition, COSR does not typically meet the clinical threshold for a diagnosis and most people with symptoms will recover successfully with the appropriate attention and time.

A2.9.2. Some risk factors that will likely impact COSR may include the length of exposure to combat or operational stress, exhaustion due to cumulative effects of one or more of the following, lack of sleep, extreme physical stress, poor sanitary conditions, limited caloric intake, dehydration and extreme environmental conditions; severity of combat or operational stress experienced; history of previous trauma; mental health history; substance abuse; lack or social support or unit cohesion.

A2.10. MANAGEMENT OF POST TRAUMATIC STRESS DISORDER.

A2.10.1. Reference **http://www.healthquality.va.gov/ptsd**/ for full clinical practice guide including: Initial Evaluation and Triage, Acute Stress Reaction/Disorder-Prevention of PTSD, Management of Stress Reactions, and Assessment and Diagnosis of PTSD modules/flow charts.