



Department of Defense INSTRUCTION

NUMBER 6490.05

November 22, 2011

Incorporating Change 1, Effective October 2, 2013

USD(P&R)

SUBJECT: Maintenance of Psychological Health in Military Operations

- References:**
- (a) DoD Directive 5124.02, "Under Secretary of Defense for Personnel and Readiness (USD(P&R))," June 23, 2008
 - (b) DoD Directive 6490.5, "Combat Stress Control (CSC) Programs," February 23, 1999 (hereby cancelled)
 - (c) DoD Instruction 6490.03, "Deployment Health," August 11, 2006
 - (d) Chapter 47, sections 801-940 of title 10, United States Code (also known as "The Uniform Code of Military Justice")
 - (e) DoD 8910.1-M, "Department of Defense Procedures for Management of Information Requirements," June 30, 1998
 - (f) DoD Instruction 5025.01, "DoD Directives Program," September 26, 2012, as amended

1. **PURPOSE.** In accordance with the authority in Reference (a), this Instruction:

- a. Renames and reissues Reference (b) as a DoD Instruction.
- b. Establishes policy and assigns responsibilities in accordance with References (c), (d), and (e) for developing combat and operational stress control (COSC) programs within the Military Departments, the Combatant Commands, and joint Service operations.
- c. Establishes requirements for activities that support psychological health in military operations and the early detection and management of combat and operational stress reactions (COSR) in order to preserve mission effectiveness and warfighting capabilities and mitigate the adverse physical and psychological consequences of exposure to severe stress.

2. **APPLICABILITY.** This Instruction applies to OSD, the Military Departments, the Office of the Chairman of the Joint Chiefs of Staff (CJCS) and the Joint Staff, the Combatant Commands, the Office of the Inspector General of the Department of Defense, the Defense Agencies, the DoD Field Activities, and all other organizational entities within the DoD.

3. DEFINITIONS. See Glossary.

4. POLICY. It is DoD policy that:

a. The Military Departments shall implement COSC policies and programs to enhance readiness, contribute to combat effectiveness, enhance the physical and mental health of military personnel, and prevent or minimize adverse effects associated with combat and operational stress.

b. The Military Departments' leadership shall foster an environment and climate of prevention and protection to enhance operational performance and mitigate the potential physical and psychological consequences of combat exposure and other military operational stress and shall require that:

(1) Combat stress prevention and protection principles be addressed in senior enlisted, officer, and general/flag grade professional military education and training programs.

(2) COSC consultants and healthcare professionals are provided to support leadership.

5. RESPONSIBILITIES. See Enclosure 1.

6. PROCEDURES. See Enclosure 2.

7. RELEASABILITY. UNLIMITED. This Instruction is approved for public release and is available on the Internet from the DoD Issuances Website at <http://www.dtic.mil/whs/directives>.

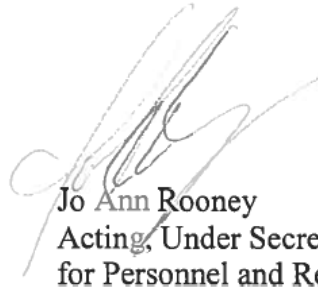
8. SUMMARY OF CHANGE 1. The changes to this issuance are administrative and update organizational titles, references, plain language, and the effective date for accuracy.

9. EFFECTIVE DATE. This Instruction:

a. Is effective November 22, 2011.

b. Must be reissued, cancelled, or certified current within 5 years of its publication to be considered current in accordance with DoD Instruction 5025.01 (Reference (f)).

c. Will expire effective November 22, 2021 and be removed from the DoD Issuances Website if it hasn't been reissued or cancelled in accordance with Reference (f).



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Acting, Under Secretary of Defense
for Personnel and Readiness

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ENCLOSURE 1

RESPONSIBILITIES

1. ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS (ASD(HA)). The ASD(HA), under the authority, direction, and control of the Under Secretary of Defense for Personnel and Readiness (USD(P&R)), shall ensure DoD compliance with this Instruction.

2. DIRECTOR, DEFENSE HEALTH AGENCY (DHA). The Director, DHA, under the authority, direction, and control of the Under Secretary of Defense for Personnel and Readiness, through the ASD(HA), shall:

a. Annually monitor the quality and effectiveness of Military Service COSC programs, in coordination with Military Service quality assurance monitors, in an effort to identify evidence-based COSC programs for dissemination and use by the Military Services as applicable.

b. Develop and standardize required COSC data collection metrics.

c. Promote COSC initiatives that prepare Service members for military operations, support them during periods of transition, enhance psychological resilience, and reduce stigma associated with seeking mental health assistance.

d. Ensure that Military Service psychological health consultants meet as needed to develop, coordinate, and oversee implementation of COSC programs.

3. ASSISTANT SECRETARY OF DEFENSE FOR RESERVE AFFAIRS (ASD(RA)). The ASD(RA), under the authority, direction, and control of the USD(P&R), shall ensure that policies for the Reserve Components (including the National Guard) and Joint COSC Program are consistent with the policies established for Active Components.

4. SECRETARIES OF THE MILITARY DEPARTMENTS. The Secretaries of the Military Departments shall:

a. Ensure that their senior Military Service commanders comply with this Instruction.

b. Develop comprehensive COSC policies and programs for Military Service-specific operations from garrison to the battlefield that:

(1) Establish standardized COSC policies.

(2) Enhance psychological health, to include strength building strategies and application of psychological principles in mission performance, and address prevention and management of stress before deployment and stress reactions during and after deployment.

- c. Coordinate COSC policies and programs with the CJCS, the other Military Department Secretaries, the ASD(RA), the Director, DHA, and the ASD(HA).
 - d. Ensure assignment of appropriately trained personnel to provide COSC services.
 - e. Annually monitor, review, and evaluate COSC policy and training curricula using appropriate program evaluation procedures. Make recommendations for policy and program improvements to the ASD(HA) and Director, DHA, when appropriate.
 - f. In coordination with the CJCS, oversee Combatant Command and Military Service COSC Program implementation both during combat operations and during military operations other than war.
 - g. Assign mental health professionals to serve as consultants to the Combatant Commanders as needed, based on contemporary or anticipated operational tempo and demands.
5. CJCS. The CJCS shall monitor the execution of the policies in this Instruction during all operations.
6. COMMANDERS OF THE COMBATANT COMMANDS. The Commanders of the Combatant Commands shall:
- a. Ensure that the policies of this Instruction are executed during all operations.
 - b. Designate a mental health professional with training and demonstrated expertise in COSC principles and management to serve as the COSC consultant to each Command Surgeon and Combatant Commander, as needed.
 - c. Apprise the Joint Staff Surgeon regarding the availability of COSC resources.

ENCLOSURE 2

PROCEDURES

1. CORE PRINCIPLES OF COMBAT AND OPERATIONAL STRESS CONTROL

a. To support the development and maintenance of an environment and climate of prevention and protection, psychological interventions for combat and operational stress reactions shall be implemented by first-responders on the same parity with physical injuries in order to mitigate the risk of potential longer-term physical and psychological consequences of combat and other military operations.

b. Policies developed for the implementation of psychological first-response intervention for combat-related reactions shall identify the required services and programs as “psychological first aid,” or an equivalent stigma reducing term, to mitigate risk that this assistance be viewed as either clinical treatment or traditional mental health care and follow up.

c. Military Service COSC policy shall emphasize the importance of psychological first aid as the first step in preventing complications arising from combat and operational stress.

2. COSC-SPECIFIC AND MILITARY EDUCATION PROGRAMS

a. The required Military Departments’ leadership education or training program curricula as appropriate shall incorporate the DoD principles of risk mitigation for combat stress prevention and protection.

b. All mental health, medical, and line personnel and the Chaplain Corps shall be trained in role-appropriate COSC principles. The amount, content, and type of training shall be appropriate to the rank and responsibility of the Service member or associated civilian personnel.

c. Training of COSC personnel shall include the ability to consult with units/individuals on psychological principles that enhance combat effectiveness and to evaluate, identify, and differentiate combat stress reactions from diagnosable mental health conditions and concerns. Interventions shall be appropriate to the qualifications and credentials of the COSC team member and tailored to the organizational and individual context. Only licensed, privileged providers will be trained to diagnose and treat mental health conditions.

d. In addition to assessment and intervention with individuals, training of Military Departments’ leadership and COSC personnel shall include a focus on organizational assessment and intervention regarding the effects of traumatic events on the unit as a whole.

e. Senior enlisted Service members shall be trained in COSC principles including identification of COSRs, resilience, and psychological first aid.

f. Leaders shall be trained to recognize the indicators of COSR in themselves and their unit(s) that may require consultation with COSC personnel.

g. Training standards for mental healthcare personnel providing COSC services shall include experiential learning of universal, selective and indicated prevention, and COSR intervention approaches. At a minimum, mental healthcare providers shall also be trained in command consultation, psychological first aid, management of COSRs, and all related regulations pertinent to the COSC mission. In addition, COSC functions should be consistent and interoperable across the Military Services. Cross-Service differences in COSC practice shall be included in training for sister Service personnel performing COSC functions for other Military Services.

h. All other non-mental health medical personnel shall be familiar with the general principles of COSC management. Non-mental health medical personnel shall also be trained in identification of stress-related conditions, psychological first aid, resilience-building, and management of COSR.

3. LEADERSHIP. Leaders (officer and non-commissioned officer) at all levels shall:

a. Understand COSC policy and management strategies and integrate COSC plans in strategic and operational planning, both in wargaming and on the battlefield.

b. Develop strategies related to leadership, communication, unit cohesion, resilience, and morale to mitigate impact of COSR.

c. Take action to ensure personnel seeking or requiring mental health services are afforded access without stigma or other barriers to seeking such care.

4. COSC DELIVERY MODEL

a. Military Departments' COSC programs shall consist of curricula, training, and exercise requirements for joint and Military Services-specific operations that focus on using psychological principles that enhance combat effectiveness and prevention and management of COSR in settings from garrison to the battlefield. This shall include a variety of command consultation activities. In addition to psychological first aid, the training shall address leadership training, communication with Service members, peer support activities, unit morale and cohesion, operational risk management, unit assessment of functioning, health risk communication, individual psychosocial stressors, preventive stress management, trauma management, referral resources, and psychological first aid, before, during, and after deployment.

b. As unit enlisted personnel are most likely to seek out COSC team members who are themselves among the enlisted grades, Service members experiencing a combat stress reaction shall be managed within the unit or as close to the Service member's unit as possible.

c. COSC personnel shall be fully trained in:

(1) Preventive stress management techniques, unit risk factor assessment, operational risk management, command consultation, and application of principles to enhance combat effectiveness.

(2) The prevention, identification, and management of combat and operational stress reactions and other mental health conditions, including severe psychiatric disorders, as applicable. Enlisted specialists and administrative support COSC team members will be trained on mental health conditions, but they are not qualified to diagnose or treat those conditions.

d. COSC personnel shall coordinate delivery of psychological first aid programs with available mental health clinical assets assigned to military units or with deployed medical assets.

e. When possible, COSC team members shall forward deploy to conduct COSC operations in coordination with deployed mental health clinical assets.

f. When possible, only evidence-based universal, selective, and indicated prevention, and management approaches shall be applied to prevent and treat COSRs and other mental health conditions in garrison and theater. If evidence is unavailable, the Military Services shall conduct program evaluations to ensure the effectiveness of the ongoing programs or undertake efforts to transition to evidence-based programs.

g. The use of algorithms for assessing and managing behavioral health problems following a traumatic event in the deployed setting shall be incorporated into the Military Departments' COSC delivery system and continuously revised based on the best available clinical practice guidelines or recommendations of Blue Ribbon panels of cross-Service experts.

5. SURVEILLANCE AND MONITORING

a. Surveillance of mental health problems and workload measures shall be conducted for ongoing monitoring and future planning. As combat stress reactions are not clinical disorders but instead are consequences associated with either prolonged exposure to high-demand environments or exposure to single or repeated intense or traumatic events, rates of COSR shall be monitored by COSC personnel as a discrete, separate category from neuropsychiatric and disease and non-battle injury rates.

b. COSC unit personnel shall engage in first-hand surveillance activities through: consultation with commanders about surveillance and prevention; identification, and management of COSR in units or individuals; identification of at-risk populations by assessing unit morale, cohesion, and stress levels; evaluation of combat units on a periodic basis or after exceptionally stressful events; and, by the provision of consultation to commanders about end-of-tour and transition training and briefings. Wherever possible, COSC personnel shall use standardized measures to assess the status of units and individuals.

GLOSSARY

PART I. ABBREVIATIONS AND ACRONYMS

ASD(HA)	Assistant Secretary of Defense for Health Affairs
ASD(RA)	Assistant Secretary of Defense for Reserve Affairs
CJCS	Chairman of the Joint Chiefs of Staff
COSC	combat and operational stress control
COSR	combat and operational stress reactions
DHA	Defense Health Agency
USD(P&R)	Under Secretary of Defense for Personnel and Readiness

PART II. DEFINITIONS

Unless otherwise noted, these terms and their definitions are for the purposes of this Instruction.

COSC. Programs developed and actions taken by military leadership to prevent, identify, and manage adverse COSRs in 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. In accordance with Reference (c), COSC activities include continual assessment and consultation to line, medical, and other personnel from garrison to the battlefield regarding physiologic, psychological, and organizational stressors; personnel training about combat stress; traumatic event management; and individual and unit management of COSRs.

COSC consultant. A mental health professional with training and expertise in COSC management who consults with the Combatant Command Surgeon and the Combatant Commander about matters related to combat stress such as unit cohesion, unit morale, resilience, leadership, effective communication, and perceived mission importance. Completion of grade-appropriate professional Military Service or Joint Staff education is recommended prior to appointment as COSC consultant.

COSC personnel. Active and Reserve Component mental health professionals or other personnel including enlisted specialists and administrative support personnel who are trained in COSC principles, including combat and operational stress first aid and application of principles to enhance combat effectiveness. Senior experienced COSC personnel serve as advisors to line commanders on leadership, communication, unit cohesion, morale, and training factors that prevent or minimize COSRs.

COSR. 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.

Prevention of COSRs

indicated prevention. Interventions targeted to Service members with COSR or indications of a potential mental health disorder, and to units that show signs that their mission effectiveness is being affected by combat or operational stressors.

selective prevention. Interventions targeted to a unit or Service member whose risk is higher than average.

universal prevention. Interventions targeted to the general population or area of responsibility.

treatment. Interventions targeted to treat and follow up Service members with mental health disorders to prevent their loss from duty.