An Approach to Monitoring the Quality and Effectiveness of Military Service Combat and Operational Stress Control (COSC) Programs

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Background

In accordance with Department of Defense Instruction (DoDI) 6490.05, each of the military Services develops and implements their own Combat and Operational Stress Control (COSC) programs. These programs aim to:

- Prevent, identify, and manage Combat and Operational Stress Reactions (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
- Return the unit or Service member to duty

Each of the different Services' COSC programs focus on one or more of the following activities:

- 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 (disaster mental health)
- Individual and unit management of COSRs

Per Defense Health Agency (DHA) Decision Memorandum (dated September 02, 2016), the Psychological Health Center of Excellence (PHCoE) is tasked with oversight of COSC policy execution and programs for all Military Services which includes:

- Developing and standardizing required COSC data collection metrics
- Annually monitoring the quality and effectiveness of Services' COSC programs to identify evidence-based programs

These objectives are particularly challenging as the Services independently develop and implement their own COSC programs with little standardization across the Services.

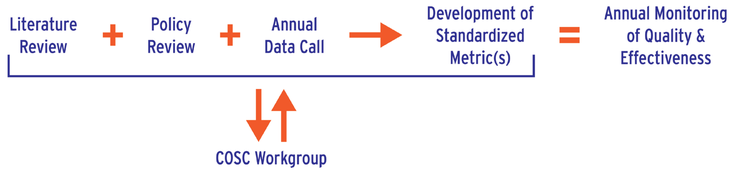
Objectives

1. Describe a plan for developing standardized metrics to monitor the quality and effectiveness of Services' COSC programs
2. Describe initial results of the data call, policy review, and literature review
3. Identify the similarities and differences between the Services' COSC programs

Methods

The model describes PHCoE's strategic plan to fulfill the tasks assigned by DHA within a five year timeframe. Three components are currently being implemented that together, along with feedback from a COSC Workgroup (comprised of representatives from four Services), will inform the development of a standardized metric(s). This metric(s) will then be used for annual monitoring of the quality and effectiveness of Services' COSC programs.

Model for Developing Standardized Metrics & Monitoring the Quality & Effectiveness of COSC Programs



Methods (continued)

Model Components

Quarterly COSC Workgroup
Build collaboration, coordination, and communication among Army, Navy, Air Force, Marine Corps, Reserves, National Guard, and PHCoE.

Literature Review
Identify and obtain published peer-reviewed literature on programs, trainings, activities, and interventions targeting the prevention, identification, and management of stress reactions among military personnel (or civilian counterparts exposed to operational or acute occupation-related stress). Searched the following databases: PILOTS (Published International Literature on Traumatic Stress) via ProQuest, ProQuest Military Database, PsychINFO, and PubMed, as well as 13 websites.

Policy Review
Review COSC program policy documentation to determine gaps/alignment with the DoDI 6490.05. Developed a policy review tool[1] and methodology to analyze documents provided by the four Services.

Data Call
Obtain information about the components of each Service's COSC program) to identify similarities/differences. Each of the four Services was asked to provide detailed information on: all services/activities being implemented in their COSC program, specific COSC prevention training activities for psychological health providers, role of embedded behavioral/ mental health providers in COSC program, and role of COSC-trained providers in screening for traumatic brain injury.

Results

Quarterly COSC Workgroup

To date, a total of three workgroup meetings have been conducted. These meetings have increased communication and sharing of information between the Services, and resulted in the current development of a shared workspace (via Max.gov) to facilitate sharing of COSC-related documents. These meetings have also served as a forum for PHCoE to: discuss current and upcoming tasks, solicit feedback from Services, and provide preliminary results of tasks to the Services.

Literature Review

Over 300 abstracts were identified and over 200 hundred articles were obtained in the following topic areas: evidence-based prevention/intervention programs targeting combat, operational, and deployment-related stress (n=45); effectiveness of COSC-related interventions/programs (n=190); mediators/ moderators of combat and operational stress (n=128); and best practices/clinical guidelines relevant to combat and operational stress (n=31). A report summarizing this literature is currently in development.

Policy Review

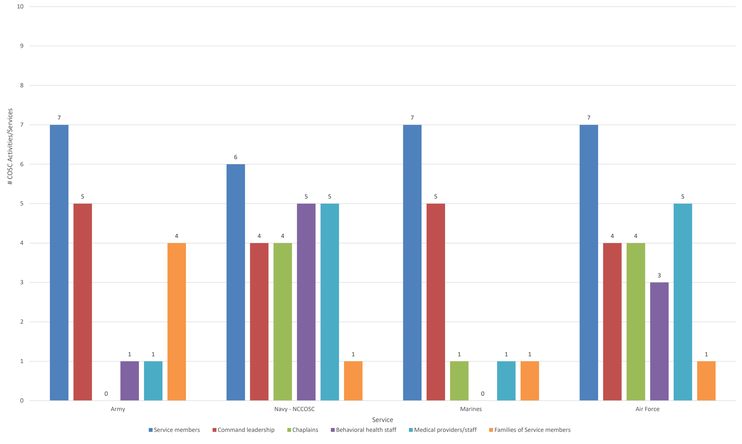
A total of 13 policies from the four Services were reviewed. Each policy was rated on 35 different criteria based on the DoDI requirements. Preliminary results indicated that across all Service's documentation the majority (83-94%) of these criteria were met. The most common criteria not met in the policies were in the areas of: coordination of COSC policies/programs with the Chairman of the Joint Chief of Staff (CJCS), and interoperability of COSC functions across all Services.

Data Call

Analysis of data received from the four Services indicated both similarities and differences in their COSC programs (see Table 1 & Figure 1).

Similarities / Differences Between Services COSC Programs

Figure 1. Number of COSC Services/Activities Targeting Specific Populations by Service*



* A single service/activity may target more than one population

Table 1. COSC Activities Implemented by Embedded Behavioral/Mental Health Providers by Service

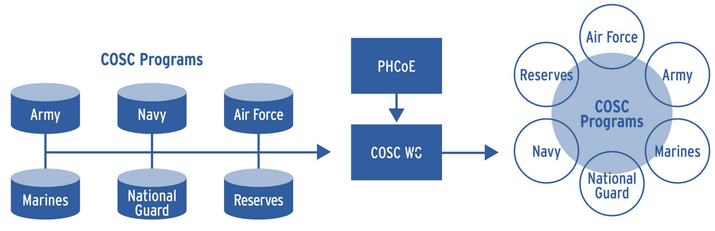
COSC Activity*	Army	Navy-NCCOSC	Marines	Air Force**
Walkabouts	✓	✓	✓	
Command Consultation	✓	✓	✓	
Education	✓	✓	✓	
Training	✓	✓	✓	

*Some services include additional COSC activities. Army: early intervention; Navy NCCOSC: direct clinical care, coordination of services, administrative tasks, activities enhancing cultural and operational competence, psychological surveillance, performance optimization counseling, unit-level crisis intervention; Marines: One-on-one clinical counseling
**Air Force does not utilize embedded behavioral/mental health providers in their COSC program

Conclusions /Next Steps

Each Service's approach to the COSC mission reflects its unique culture and placement of the mission within the Service's organizational structure. These programs primarily function as separate silos (see Figure 2). PHCoE's work with the COSC workgroup aims to breakdown these silos and increase the overlap between the Service's COSC programs. Future plans involve continuing to identify opportunities for standardization and information sharing across Services. Activities include: development of standardized metric, annual data call, and quarterly workgroup meetings.

Figure 2. Transition of Services' COSC Programs from Independent Silos to Shared COSC Mission



[1] The policy review tool was based on a tool developed in 2013 to analyze previous versions of COSC policies for the COSC workgroup under contract # W81XWH-08-D-0024-0019.

Poster presented at MHSRS in Aug, 2018. For more information, please contact Ilene.f.Klein.ctr@mail.mil.