UNITED STATES SPECIAL OPERATIONS COMMAND

7701 Tampa Point Boulevard

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USSOCOM DIRECTIVE

Number 40-6 **11 September 2023**

Medical Services

COMPREHENSIVE STRATEGY FOR SPECIAL OPERATIONS FORCES WARFIGHTER BRAIN HEALTH

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1. Purpose. Commander (CDR) USSOCOM published the Comprehensive Strategy for SOF Warfighter Brain Health Policy in 2019, emphasizing the need to monitor and treat Traumatic Brain Injury (TBI) within its ranks. Historically, performance optimization and resiliency has focused on efforts within the physical, psychological, spiritual, and family domains with less emphasis on optimizing brain health. As USSOCOM adjusts to a new strategic era, enhancement and reinforcement of the cognitive domain will align with the command's three top overarching priorities-People, Win, and Transform – to strengthen our force and families, succeed for the nation, and modernize for the future. This Directive:

a. Aligns medical and operational resources to ensure superior cognitive performance and brain health of SOF.

b. Establishes policies, procedures, and responsibilities for implementing the USSOCOM Comprehensive Strategy for SOF Warfighter Brain Health.

c. This directive is intended to meet the requirements in accordance with (IAW) references (i), (j), and (p).

2. Applicability.

a. Headquarters (HQ), USSOCOM.

b. U.S. Army Special Operations Command, includes associated National Guard/Reserve Forces.

c. U.S. Air Force Special Operations Command, includes associated Reserve Forces.

d. Naval Special Warfare Command, includes associated Reserve Forces.

e. U.S. Marine Corps Forces Special Operations Command.

f. Joint Special Operations Command (JSOC).

g. Special Operations Command Africa.

h. Special Operations Command Central.

i. Special Operations Command Europe.

j. Special Operations Command Korea.

k. Special Operations Command North.

l. Special Operations Command Pacific.

m. Special Operations Command South.

3. References. (See Glossary Section II).

4. Background.

a. DOD defines Warfighter Brain Health as the physical, psychological, and cognitive status that affects a Warfighter's capacity to function adaptively in any environment affecting readiness and operational capabilities. In the past, brain health has centered on TBI, particularly mild TBI (mTBI), among the military community.

b. TBI, often referred to as a concussion, is a signature injury of our military's conflicts and has significantly increased in incidence since 9/11. More than 80% of TBI exposure accounted for within DOD reporting have been characterized as mTBI. These injuries can result from acute or repetitive impact, blast exposure, and acceleration or deceleration forces. Even though these injuries may be classified as mild, early diagnosis and treatment is essential, for optimal outcomes. The effects of mTBI/TBI are myriad including the following symptoms, but are not limited to, changes in mood, headaches, dizziness, fatigue, difficulty sleeping, and degraded cognitive performance.

c. DOD has established guidelines and thresholds for occupational BOP to prevent negative physical (pulmonary, audio logical) and potential neurocognitive effects. Exposure to BOP can result in acute symptoms, such as headaches, dizziness, and reduced reaction time when individuals are exposed to BOP above 4 pounds per square inch (PSI). In addition to the potential long-term effects of repetitive sub-concussive blast exposure and blunt force, the effects of directed energy and other environmental hazards on brain health are unknown.

d. Anomalous Health Incidents (AHI) is an emerging health and readiness concern, and is a priority for the DOD, the Defense Health Agency (DHA), and USSOCOM. Existing DOD guidelines and clinical tools for the initial triage and management of mTBI should be utilized in the acute and post-acute phases of suspected AHI. Exposure to directed energy has been proposed as a possible cause for AHI though an exact etiology is unknown. Environmental hazards and exposure to directed energy must be assessed in garrison, training, and forward deployed settings.

e. Our pursuit of superior lethality must be matched by a commitment to understanding, preventing, diagnosing, and treating brain injuries in adherence to the SOF truth that, "Humans are more important than hardware." This directive is intended to monitor and support Special Operators and other identified at-risk attached/assigned personnel throughout their careers in terms of their exposures (including blasts), TBI histories, and cognitive/mental health status.

5. Discussion. The USSOCOM Warfighter Brain Health Program represents a robust community of interest comprised of the USSOCOM Surgeon's Office, Preservation of the Force and Family (POTFF), SOF Acquisition, Technology, and Logistics (SOF AT&L), Science and Technology (S&T), and Warrior Care Program – Care Coalition. While the Command Surgeon's office is primarily responsible for overseeing USSOCOM Warfighter Brain Health efforts, long lasting benefits and change are only possible in collaboration with USSOCOM directorates and DOD, academic, and commercial partners.

The intent is to ensure the brain health and superior cognitive performance of the SOF Service Member; proactively sustain and extend the lifecycle of our Forces and ensure optimal healthcare of our warfighters during and after service. There are 4 Lines of Effort (LOE) established to achieve goals of the USSOCOM Brain Health Program. The Monitor LOE establishes a cognitive monitoring program using standardized Neurocognitive Assessment Tools (NCAT), comprehensive brain injury histories, and blast exposure monitoring. The Enhance LOE focuses on enhancing and optimizing cognitive abilities through biofeedback and cognitive and mental skills training. The Advance LOE focuses on developing innovative partnerships with DOD, civilian, industry, medical and academic institutions to support research on long-term brain health and quality of life for SOF Warfighters. The Connect LOE focuses on identifying gaps in communication across the enterprise by linking wounded, ill, or injured SOF Warfighters and their families with appropriate government, private or community-based programs to address their needs. **LOE:**

a. **Monitor.** *Monitor brain health and cognitive performance to keep Warfighters lethal longer.*

(1) **Objectives.** Collect data and document symptoms and exposures to blasts/overpressure, blunt force/impact, projectiles, directed energy, chemical and biological toxins, as well as other environmental hazards. Establish career longitudinal monitoring while collecting data to define repeated low-level blast exposure thresholds to mitigate injuries. Synchronize all efforts to implement protection measures of SOF cognitive performance.

(2) **Office of Primary Responsibility (OPR).** USSOCOM Office of the Command Surgeon (SOCS-SG).

b. **Enhance.** *Optimize cognitive capacity, agility, and resilience.*

(1) **Objectives.** Implement evidence-based enhancement strategies/training, track performance, provide feedback to SOF Warfighters, and develop objective cognitive performance measures.

(2) **OPR.** USSOCOM POTFF – Refer to USSOCOM Directive (D) 10-12, *USSOCOM Preservation of Force and Family,* 07 January 2023.

c. **Advance.** *Leverage innovation in (S&T) to further cognitive function and protection.*

(1) **Objectives.** Communicate requirements with DOD, academia, and industry partners, develop solutions for SOF personnel gains in the brain health area of interest, and establish sound transition paths for implementation. Utilize collected data to reduce risk for blast and impact injuries, identify and distribute best practices, field, and sustain material that protect cognition over the course of an operator's career.

(2) **OPR.** USSOCOM SOF AT&L.

d. **Connect.** Support *USSOCOM SOF Wounded, Ill, and Injured Warfighters and their families' lifetime advocacy after life-altering trauma or illness, enhancing their quality of life; Strengthening SOF readiness through increased connection between Service Members and medical resources.*

(1) **Objectives.** Locate appropriate treatment programs, government, or private/community-based, to address the needs of the SOF Warfighter. Develop partnerships with government (Department of Veterans Affairs) and private organizations to gain access to treatment programs specializing in the treatment of TBI with additional comorbidities (Post – Traumatic Stress Disorder, chronic migraine, chronic pain, Obstructive Sleep Apnea, etc.)

(2) **OPR.** USSOCOM Warrior Care-Care Coalition.

6. Responsibilities.

a. **CDRUSSOCOM shall:**

(1) Direct subordinate activities to implement a Service driven Brain Health program in compliance with DODI 6490.13., and any other applicable policies and guidance supplied by the DOD and the Joint Staff.

(2) Monitor the implementation of this policy and related DOD, Joint Chiefs of Staff (JCS), Combatant Commands, and Service policies, directives and instructions.

(3) Ensure resources required to implement Brain Health program by assigned forces are available. This may include the provision of, or advocacy for, those resources.

b. **USSOCOM Chief of Staff shall:**

(1) Issue applicable guidance and assign adequate resources to ensure the provisions of this instruction are fully implemented, and that no recipient of Major Force Program -11 funding is exempt from these requirements.

c. **USSOCOM SOCS-SG shall:**

(1) Serve as principal advisor to CDRUSSCOM and the SOF enterprise on all matters pertaining to SOF Warfighter Brain Health, the implementation of this directive, and DOD guidance under the same name.

(2) Chair and charter the SPARTAN WG. This WG will include, at a minimum, representatives from USSOCOM POTFF, SOF AT&L, and Service Component representation.

(3) Serve as the LOE 1 lead.

d. **USSOCOM POTFF Enterprise shall:**

(1) Comply with this directive by integrating cognitive domain efforts found in USSOCOM D 10-12 (Cognitive Domain).

(2) Provide Human Performance Data Management System (HPDMS) integrated technical support to facilitate collaboration and further USSOCOM Brain Health LOEs.

(3) Participate as a member of the SPARTAN WG.

(4) Serve as the LOE 2 Lead.

e. **USSOCOM SOF AT&L and S&T shall:**

(1) Update directives/standard operating procedures and acquisition strategies to ensure compliance and/or fulfillment of LOE 3.

(2) Participate as a member of the SPARTAN WG.

(3) Serve as the LOE 3 lead.

f. **USSOCOM Inspector General's Office shall:** Provide independent professional services (audits assistance, inspections, and/or investigations) which aid USSOCOM leadership in improving accountability, efficiency, readiness, and mission effectiveness.

g. **Subordinate Command shall:**

(1) Assigned a representative to the SPARTAN WG.

(2) Identify and support requirements.

(3) Oversee the development and implementation of programs to meet identified needs.

(4) Ensure all assigned personnel complete NCAT testing, as well as all SOF Warfighters and other assigned/attached personnel deemed high risk complete a CASH as outlined in this directive.

(5) Ensure personnel deemed to be at risk of blast exposure, wear a Blast Exposure Monitoring (BEM) approved device as outlined in this directive.

(6) Upload NCAT data to the Automated Neuropsychological Assessment Metrics (ANAM) system consistently within 10 days of completion.

(7) Provide education for TBI awareness, recognition (signs/symptoms), and reporting for all subordinate leaders and service members.

(8) Ensure medical personnel are aware and knowledgeable of program requirements, as well as trained and proficient in the evaluation of Potential Concussive Events (PCE) using approved tools outlined in PCE Clinical Practice Guidelines (CPG).

(9) Ensure all personnel who experience PCE, blast exposure, etc., in conjunction with treatment execute an ANAM evaluation as soon as possible following exposure.

(10) Submit TBI reports through USSOCOM. TBI reports for those SOF-affiliate elements and personnel supporting SOF assigned units will be submitted based upon their respective command relationships reference (r).

7. Requirements.

a. **Neurocognitive Baseline Testing. All SOF Warfighters will undergo a computerized NCAT. NCAT assessments will be administered as followed:**

(1) The USSOCOM designated NCAT is the ANAM, Version 4, Military Expanded Battery, until such time evolving science, technology capabilities, and medical best practices inform a change in policy.

(2) Testing will be administered after completion of Assessment & Selection (A&S) at the start of SOF qualification training. Units will test SOF qualified Warfighters without a documented NCAT.

(3) SOF Warfighters will be non-deployable until a baseline NCAT is recorded. DODI 6490.13 requires an ANAM within 12 months before deployment for all personnel. (See Appendix A)

(4) Testing will be completed at least every 3 years after initial baseline testing and following a PCE IAW reference (h).

(5) NCATs will be used to screen for cognitive changes as part of a comprehensive evaluation and will not be used as a standalone diagnostic tool.

b. **CASH. All New and Mid-career SOF Warfighters** (See Appendix B) **will undergo a CASH. CASHs will be administered as followed:**

(1) CASH is a monitoring and data collection tool used to capture longitudinal data and document brain injuries and various brain exposures. These exposures include, but are not limited to, environmental, impact, and blast. The CASH utilizes evidenced-based outcome measures and tools to collect subjective history. This standardized data collection platform will be updated periodically over the SOF Warfighter's career to provide monitoring of brain injuries and exposures, until such documentation is automated.

(2) For the purpose of this directive, SOF Warfighters are defined as personnel who have undergone A&S, and who have received specialized qualification training for assignment to a unit within USSOCOM. Inclusion of at-risk SOF enablers and DOD civilians may be considered based on unit policy or at the CDR's discretion.

(3) A baseline CASH will be administered within 12 months of completion of qualification courses, and all mid-career (6-15 year) SOF Warfighters will complete a baseline within 3 years once resources become available. CASHs are optional for SOF Warfighters with more than 16 years of service and will be conducted as time and resources allow. CASH will be updated every 5 years while assigned to USSOCOM.

(4) All CASH encounters must be administered by HQ USSOCOM, CASH Administrators. The USSOCOM CASH Assessment Team will be centrally located at HQ USSOCOM, Tampa, FL. CASH encounters will be completed in person or virtually by approved individuals only.

(5) CASH data will be entered and maintained in HPDMS. Completed CASH data can be uploaded into the Electronic Health Record (EHR) via Health Artifact and Image Management Solution for medical referrals, treatment, or documentation.

c. **Blast Exposure Monitoring. The Blast Exposure Monitoring effort will capture and quantify BOP exposure via the use of BEM Devices.** (See Appendix C)

(1) BEM will increase USSOCOM understanding of current blast exposure levels in dynamic environments and mitigate sources of unnecessary exposure to the individual SOF Warfighter without degrading the quality of training or combat.

(2) USSOCOM identified personnel shall wear a USSOCOM sponsored BEM system, once available, during situations where exposure may occur. Examples of blast include, but are not limited to: explosive breaching, mine detonation, mortars, artillery firing, grenades (including flashbangs), and shoulder-fired munitions.

(3) USSOCOM personnel with blast exposure that exceeds 4 PSI will be evaluated by medical personnel at the earliest possible opportunity.

(4) Failure of a BEM system to reveal moderate or severe blast exposure will not be used to rule out TBI due to blast exposure or impact. Any personnel who report symptoms of TBI after blast exposure or impact will be evaluated by medical personnel IAW DODI 6490.11

(5) Cumulative data from blast exposure monitoring devices will be downloaded at a minimum once per month for longitudinal exposure tracking and placed in a designated database, once established, for longitudinal exposure tracking. Until a database is established, units will store data locally if possible.

(6) USSOCOM Range Firing Limitations. USSOCOM directs the following limitations for shoulder-fired munitions for all SOF personnel as described below. While very prescriptive in nature, these limitations have been put in place to reduce the hazards from overpressure and noise. These munitions require special precautions during training therefore, to reduce these hazards, firers must observe the firing limitations shown in the table below. (See Appendix D)

d. **AHIs. Units will report all suspected incidents of AHI through operational and medical channels.**

(1) Subordinate commands are responsible for tracking and reporting suspected AHI incidents. Theater Special Operations Commands, Component Commands, JSOC, and HQ USSOCOM will maintain a running log of all suspected SOF AHI reports, associated medical treatment, and any substantial impacts to force readiness.

(2) Subordinate commands shall provide maximum awareness of the AHI threat to all assigned personnel and family members, and provide the most robust threat mitigations available and fiscally supportable by the command.

(3) The current evaluation and treatment model for AHI includes use of the Military Acute Concussion Evaluation 2, and Progressive Return to Activity following Acute Concussion/mTBI tools. USSOCOM will continue to monitor research and community best practices with regard to AHI evaluation and treatment to determine future policy changes.

e. **SPARTAN WG.** (See Appendix E)

(1) This Working Group shall assist the Deputy CDRUSSOCOM, and the executive steering committee (ESC), to address capability gaps, requirements generation, force modernization, research, development, test, and evaluation and acquisition interests within the domains outlined in this directive.

(a) The primary mission of the SPARTAN WG is to synchronize and monitor efforts, requirements, and capability gaps across the SOF Enterprise and external agencies. The SPARTAN WG will advise the ESC, with recommendations to address policy, requirements, and/or capabilities gaps within the guidelines of the Joint Capability Integration Development System/Special Operations Forces Capability Integration Development System processes. It shall also provide inputs into the planning, programming, and budgeting execution process.

(b) The secondary mission of the SPARTAN WG is to draft, staff, and publish documents necessary to identify and pursue solutions facing the force and provide subject matter expert assessment and feedback of associated products, proposals, and activities.

(c) Utilize results from research to advise the Command of evolving science, and technological capabilities, and medical best practices to inform a change in policy or practice.

(d) Foster relationships with (but not limited to); USSOCOM staff sections, USSOCOM Biomedical Research and Advisory Group, USSOCOM Human Performance Enterprise, DOD TBI Center of Excellence (TBICoE), DHA, Joint Program Committees, National Institute of Health, Uniformed Services University, National Intrepid Center of Excellence, and the Defense Research Project Agency.

(2) SPARTAN WG will address at a minimum the following.

(a) Basis of procurement and issue a plan for fielding of blast exposure monitoring device.

(b) Mechanism to record/store computer based NCAT, CASH, and blast exposure data, and a method for adding CASH data into Service Member's EHR.

(c) Identify knowledge gaps for action by USSOCOM Brain Health Community of Interest stakeholders.

(3) SPARTAN WG will inform the TBICoE and the Joint Trauma System (JTS) on significant data collection and analysis outcomes. SPARTAN WG will coordinate with JTS for a USSOCOM Functional Combatant Command specific CPG, if deemed necessary.

(4) SPARTAN WG will identify recommendations for blast protections and present to the Board of Command Surgeons for formalization as a requirement.

8. Proponent. The proponent for this directive is the Command Surgeon (SOCS-SG). Suggested improvements should be forwarded to HQ USSOCOM, ATTN: SOCS-SG, 7701 Tampa Point Blvd., MacDill AFB, FL 33621-5323.

(SOCS-SG)

FOR THE COMMANDER:

OFFICIAL:

MILTON J. SANDS III
Rear Admiral, U.S. Navy
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APPENDIX A

DEPARTMENT OF DEFENSE INSTRUCTION (DODI) 6490.13 ENCLOSURE 3

ENCLOSURE 3

SERVICE-LEVEL PROGRAM ADMINISTRATION

Service-level program will provide written guidance that is current, contains task-level requirements, and standardizes implementation to accomplish or address, at a minimum, these core elements:

a. Scope of testing as it pertains to the DoD Neurocognitive Assessment Program across the development cycle, specifically at pre-deployment, post-injury, and post-deployment.

(1) Pre-Deployment

(a) Perform a pre-deployment baseline neurocognitive assessment within the 12 months before deployment using the designated DoD neurocognitive assessment instrument.

(b) DoD civilian employees will receive a baseline neurocognitive assessment in the same manner as Service members, to the extent practical and consistent with Directive-type Memorandum-17-004 (Reference (i)).

(2) Post-injury

(a) Perform a neurocognitive assessment following a diagnosed concussion or mild traumatic brain injury in accordance with the DCoE clinical practice recommendation, found on the MHS website at https://health.mil./TBIresrouces.

(b) Compare post-injury neurocognitive assessments to Service member baseline neurocognitive assessments, when available, to inform return-to-duty decisions by medical providers. To request baseline neurocognitive assessments during deployment, medical provider will call or e-mail the Neurocognitive Assessment Branch (MHS Lead Service) helpdesk at (855) 630-7849 or DSN 471-9242 or usarmy.jbsa.medcom.mbx.otsg--anam-baselines@mail.mil.

(c) Compare post-injury evaluations on Service members without baseline neurocognitive assessments to pre-deployment relevant norms.

(3) Post-deployment

(a) Upon return from deployment, those Service members who respond affirmatively to the traumatic brain injury risk assessment questions on the Post Deployment Health Assessment contained in DoDI 6490.03 (Reference (j)) will be referred for further clinical evaluation that may include the administration of a neurocognitive assessment. All referred Service members will be tracked as appropriate.

(b) Appropriate quality assurance, testing environment, and quality control activities established by the MHS Lead Service.

(c) Preventive maintenance on hardware used in neurocognitive assessment testing as established by the MHS Lead Service.

APPENDIX B

SPECIAL OPERATIONS FORCES (SOF) WARFIGHTER SPECIALTY CODES COMPREHENSIVE ASSESSMENT AND SYMPTOM HISTORY (CASH) SPECIFIC

Special Operations Specialty Codes

Air Force Special Operations Command	
Officers	**Enlisted**
11SX – Special Operations Pilot	1A1X1 – Flight Engineer
11UX – Remotely Piloted Aircraft (RPA) Pilot	1A2X1 – Aircraft Loadmaster
12SX – Special Operations Navigator/Combat Systems Operations	1A3X1 – Airborne Mission Systems
12UX – RPA Pilot	1A9X1 – Special Missions Aviation
J15WX – Special Operations Weather Officer	1U0X1 – RPA Sensor Operator
18SX – RPA Pilot	1Z1X1 – Pararescue
19ZXX – Special Warfare Officer	1Z2X1 – Combat Control
	1Z3X1 – Tactical Air Control Party
	1Z4X1 – Special Reconnaissance

U.S. Army Special Operations Command	
Officers	**Enlisted**
11A – Ranger Officer	11X (V) – Ranger
15A/B (K4) – Special Operations Pilot	15T- Helicopter Repairer (UH-60)
152C (K4) – WO Pilot (OH-6)	15U – Helicopter Repair (CH-47)
153E (K4) – WO Pilot (MH-60)	18B – Special Forces Weapons SGT
154E (K4) – WO Pilot (MH-47)	18C – Special Forces Engineer SGT
18A – Special Forces Officer	18D – Special Forces Medical SGT
180A – Special Forces Warrant Officer	18E – Special Forces Communication SGT
37A – Psychological Operations Officer	18F – Special Forces Intelligence SGT
38B – Civil Affairs Officer	18Z – Special Forces Senior SGT
	37F – Psychological Operations
	38B Civil Affairs

U.S. Naval Special Warfare Command	
Officers	**Enlisted**
113X – SEAL Officer	026A – SEAL
715X – SEAL Warrant Officer	026A – SEAL Delivery Team Operator
717X – SWCC Warrant Officer	052A – Special Warfare Combatant Craft Crewman (SWCC)
114X – EOD/DIV/SAL/EOM Officer	091A – Special Operations Medic (SO-TM)
716X – Ordnance Chief Warrant Officer	092A – Special Operations Combat Medic (SOCOM)
	M02A – Basic EOD Technician
	M03A – Senior EOD Technician
	M04A – Master EOD Technician
	M05A – EOD Exploitation Specialist
	M06A – Ordnance Diver
	MMDV – Master Diver
	M1DV/ M2DV – Diver First/Second Class

U.S. Marine Corps Forces Special Operations Command	
Officers	**Enlisted**
0370 – Special Operations Officer	0372 – Critical Skills Ops (CSO)
	8247 – Special Amphibious Reconnaissance Corpsman (SARC)
	8403 – Special Operations Independent Duty Corpsman (SOIDC)

APPENDIX C

COMMON WEAPON SYSTEMS ASSOCIATED WITH BLAST OVERPRESSURE (BOP) EXPOSURE (NON-EXHAUSTIVE)

Category of Weapons System	Weapon Systems
Breaching Explosives	Door: Net Explosive Weight (NEW) of 0.23 lbs Trinitrotoluene (TNT), slider - 0.30 lbs TNT
	Wall: NEW of 10.0 lbs – 14.0 lbs
Shoulder Fired	M3, Multi-role Anti-armor Anti-personnel Weapon System (MAAWS)
	M136, Light Anti-Tank Weapon (AT4)
	M72, Light Anti-Armor Weapon (LAW)
0.50 Caliber	M107, Sniper rifle
	M2A1, Machine gun
	MK 15, Sniper rifle
	GAU 21, Machine gun
Indirect Fires	Howitzers (all platforms) – 105mm, 155mm
	Mortars (all platforms) - 120mm, 81mm, 60mm

APPENDIX D

U.S. SPECIAL OPERATIONS COMMAND (USSOCOM) RANGE FIRING LIMITATIONS

MUNITION	ASSOCIATED MATERIAL	MAXIMUM NUMBER OF ROUNDS THAT MAY BE FIRED IN A 24-HOUR PERIOD		
M141 BDM	TM 9-1340-228-10	Prone		1
		Sitting		0
		Kneeling		3
		Standing		6
M136 AT4	TM 9-1315-886-12	Prone		0
		Sitting		1
		Kneeling		3
		Standing		3
M136A1 AT4CS	TM 9-1315-255-13	Outdoor (with single ear protection)	Prone	70
			Sitting	0
			Kneeling	14
			Standing	28
		Indoor (with combat earplugs)	Prone	0
			Sitting	0
			Kneeling	0
			Standing	1
M3/M3A1 (Carl Gustav)	TM 9-1015-262-10	Outdoor (with single ear protection)	Prone	TBD
			Sitting	TBD
			Kneeling	TBD
			Standing	TBD
		Indoor (with combat earplugs)	Prone	TBD
			Sitting	TBD
			Kneeling	TBD
			Standing	TBD
M72A2/A3	TM 9-1340-214-10	4 (for Soldier firing the munition and personnel within 20 meters of the launcher, given that properly fitted, approved earplugs are worn)		
M72A7	TB 9-1340-230-13			
Note. Shoulder-launched munitions TMs and this manual explain four firing positions: standing, kneeling, sitting, and prone. Although shoulder-launched munitions can be fired from the four positions, the sitting and prone positions increase the chances that blast/overpressure will injure the firer. Soldiers should be trained on assuming the four firing positions, but only live fire from the standing and kneeling positions.				

APPENDIX E

SOF PROTECTION, ASSESSMENT, REHABILITATION, AND TREATMENT OF NEUROHEALTH (SPARTAN) WORKING GROUP (WG) CHARTER

UNITED STATES SPECIAL OPERATIONS COMMAND
OFFICE OF THE DEPUTY COMMANDER
7701 TAMPA POINT BLVD.
MACDILL AIR FORCE BASE, FLORIDA 33621-5323

JAN 13 2020

MEMORANDUM FOR SEE DISTRIBUTION

SUBJECT: Charter for Special Operations Forces Protection, Assessment, Rehabilitation, and Treatment of Neurohealth Working Group

1. Name: This constituent of U.S. Special Operations (USSOCOM) is officially named the Special Operations Forces Protection, Assessment, Rehabilitation, and Treatment of Neurohealth (SPARTAN) working group (WG). The formation and mandate of this WG is dictated by USSOCOM Policy Memorandum 19-01; "Comprehensive Strategy for Special Operations Forces Warfighter Brain Health" (PM 19-01).

2. Objective: Purpose of this WG is to execute the directives of PM 19-01. This WG will assist the USSOCOM Deputy Commander (DCDR) and the executive steering committee (ESC), in order to address capability gaps, requirements generation, force modernization, Research, Development, Test, and Evaluation and acquisition interests within the domains outlined in PM 19-01. WG and ESC will keep the USSOCOM DCDR well-informed for his role on the Comprehensive Strategy for Warfighter Brain Health Executive Committee.

a. The primary mission of the SPARTAN WG is to synchronize and monitor efforts, requirements, and capability gaps across the Special Operations Forces (SOF) Enterprise and external agencies. The SPARTAN WG will advise the ESC, chaired by the USSOCOM DCDR, with recommendations to address policy, requirements, and/or capability gaps within the guidelines of the Joint Capability Integration Development System/Special Operations Forces Capability Integration Development System processes. It shall also provide inputs into the Planning, Programming, and Budgeting Execution process.

b. The secondary mission of the SPARTAN WG is to draft, staff, and publish documents necessary to identify and pursue solutions facing the force and provide subject matter expert (SME) assessment and feedback of associated products, proposals, and activities.

c. The SPARTAN WG is not considered a research managing body. However, it can and will use the results from research to advise the Command of evolving science, technology capabilities, and medical best practices to inform a change in policy. This necessitates a close relationship with current bodies such as, but not limited to: USSOCOM staff sections, Defense and Veterans Brain Injury Center (DVBIC), USSOCOM Biomedical Research and Advisory Group, USSOCOM Human Performance Enterprise, Defense Health Agency, Joint Program Committees, National

SOF PROTECTION, ASSESSMENT, REHABILITATION, AND TREATMENT OF NEUROHEALTH (SPARTAN) WORKING GROUP (WG) CHARTER (Cont.)

SODC
SUBJECT: Charter for Special Operations Forces Protection, Assessment, Rehabilitation, and Treatment of Neurohealth Working Group

Institute of Health, Uniformed Services University, National Intrepid Center of Excellence, and the Defense Research Projects Agency.

3. Executive Steering Committee Membership: The ESC operates under the authority and direction of the USSOCOM DCDR and consist of the following individuals.

a. USSOCOM DCDR or delegated representative

b. USSOCOM Command Surgeon

c. USSOCOM Director, Preservation of the Force and Family (POTFF)

d. USSOCOM Director, Science and Technology (S&T)

e. USSOCOM Deputy J8

f. USSOCOM Program Executive Office, SOF Warrior (PEO-SW)

g. As directed by USSOCOM DCDR

4. SPARTAN WG Membership:

a. Classification of Members. The SPARTAN WG comprises three types of members: core, representative, and consultant.

(1) Core (voting) members are permanent, identified by organization, represent their respective organization, and vote on their behalf with respect to matters within the scope of the SPARTAN WG Charter. Core organizations are responsible for appointing personnel to these positions. Additional Core (voting) members can only be added/removed by direction of the ESC.

(2) Representative (non-voting) members are permanent and advise the SPARTAN WG on behalf of their represented organization.

(3) Consultant (non-voting) members speak and advise the WG of their professional opinions and recommendations based on their SME and are not intended to represent the view of an organization. Consultant membership is based on a directive of the ESC or the assessment, selection, and vote of the core body.

b. IAW PM 19-01, USSOCOM Command Surgeon's designated representative will chair the WG, and organize the ESC meetings. The WG chairperson will vote in the event of a tie. The chairperson will act as arbiter of decisions in response to directions from and/or recommendations to the ESC. The Chairperson will:

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SOF PROTECTION, ASSESSMENT, REHABILITATION, AND TREATMENT OF NEUROHEALTH (SPARTAN) WORKING GROUP (WG) CHARTER (Cont.)

(1) Supervise activities of the WG and preside over meetings

(2) Prepare meeting agendas

(3) Facilitate, preserve order, promote impartiality, and defend the motion rights of all WG members during committee meetings and/or communications

(4) Resolve all assembly tie votes, through casting a tie breaking vote

(5) Speak for appropriate representation for the WG to ESC and other Boards, Committees, and Advisory Groups

(6) Draft and staff all meeting minutes or other documents as needed

(7) Appoint sub-committee chairs and members as applicable

(8) Synchronize and communicate the actions of committees and subcommittees

c. The following will appoint one core (voting) member:

(1) U.S. Army Special Operations Command

(2) Marine Forces Special Operation Command

(3) Air Force Special Operations Command

(4) Naval Special Warfare Command

(5) Joint Special Operations Command

d. The following will appoint a representative (non-voting) member:

(1) USSOCOM Office of POTFF

(2) USSOCOM Acquisitions Technology & Logistics, S&T

(3) USSOCOM (PEO-SW)

(4) USSOCOM J8

(5) USSOCOM Command Surgeon

(6) USSOCOM DVBIC Clinical Educator

SOF PROTECTION, ASSESSMENT, REHABILITATION, AND TREATMENT OF NEUROHEALTH (SPARTAN) WORKING GROUP (WG) CHARTER (Cont.)

(7) USSOCOM DVBIC Clinical Researcher

(8) USSOCOM Comprehensive Assessment and Symptom History SME

e. It is the responsibility of each member, regardless of core or representative status, to communicate the actions of the WG with their organization and advocate their constituents' specific requirements to the WG. It is the responsibility of the respective organization to select an interim member, of equal status and qualifications, to represent them at scheduled SPARTAN WG assemblies if the primary cannot be present.

5. WG Quorum and Voting Procedures:

a. Core Member Quorum. The Chairperson and 3 of the 5 voting members (or designated representative) must be present for a scheduled WG meeting to occur.

b. Voting Procedures. Casting of ballots can be done via electronic means, paper ballots or through verbal means. The end results will be made public to the assembly as soon as the voting and counting is completed. Members are authorized to abstain from votes and will be recorded as such.

c. For a vote to pass, a majority must be reached. A majority is defined as greater than 50%. If a voting member abstains, that organization is not included in the calculation of the majority (i.e. denominator is reduced). In the event of a tie, the Chairperson will cast one vote.

d. In all matters that are put forth for a decision to the ESC, any organization that may have non-concurred with the recommendation, the Chairperson will ensure that the dissenting views of that organization are presented to the ESC during the decision making process.

6. WG Meeting Minutes and Records: Every official meeting of the SPARTAN WG will have minutes recorded and those minutes will be published and distributed to the WG members within 3 weeks of the assembly. All minutes must include attendees, old business covered, new business established, and business items resolved. Voting will be recorded with results. The Chairperson must approve and sign the minutes before final distribution. The finalized minutes must be historically archived and electronically stored on the USSOCOM portal.

7. Sub-SPARTAN WG Committees:

a. SPARTAN WG has, with the approval of the ESC, the authority to establish sub-committees to further the directives of PM 19-01. ESC will approve sub-committee leads and primary tasks.

SOF PROTECTION, ASSESSMENT, REHABILITATION, AND TREATMENT OF NEUROHEALTH (SPARTAN) WORKING GROUP (WG) CHARTER (Cont.)

SODC
SUBJECT: Charter for Special Operations Forces Protection, Assessment, Rehabilitation, and Treatment of Neurohealth Working Group

b. Sub-committee leads will have the responsibility to report to the SPARTAN WG as a representative (non-voting) member.

c. SPARTAN WG has the authority to dissolve sub-committees if all issues are closed. If there are outstanding minor issues, these tasks will become tasks of the SPARTAN WG until complete and/or redirected.

8. Authority: With the exception of order by the Commander of USSOCOM, amendment authority of the SPARTAN WG mission, charter, and bylaws will ultimately rest with the ESC. SPARTAN WG can be dissolved in its entirety by direct order of the DCDR. The WG will then be given 180 days, after the order, to meet and resolve any unfinished business; however, no new business will be considered or acted upon.

9. Point of Contact: For questions, please contact the USSOCOM Surgeon's office at (813) 826-4797.

TIM SZYMANSKI
Vice Admiral, U.S. Navy
Deputy Commander

DISTRIBUTION:
A, B, C, D

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GLOSSARY

SECTION I--ABBREVIATIONS AND ACRONYMS

A&S	Assessment & Selection
AHI	Anomalous Health Incidents
ANAM	Automated Neuropsychological Assessment Metrics
ASD	Assistant Secretary of Defense
BEM	Blast Exposure Monitoring
BOP	Blast Overpressure
CASH	Comprehensive Assessment and Symptom History
CDR	Commander
CPG	Clinical Practice Guidelines
D	Directive
DHA	Defense Health Agency
DOD	Department of Defense
DODD	Department of Defense Directive
DODI	Department of Defense Instruction
ESC	Executive Steering Committee
EHR	Electronic Health Record
HQ	Headquarters
HPDMS	Human Performance Data Management System
IAW	In Accordance With
JCS	Joint Chiefs of Staff
JTS	Joint Trauma System
JSOC	Joint Special Operations Command
LOE	Lines of Effort
mTBI	Mild Traumatic Brain Injury
NCAT	Neurocognitive Assessment Tool
OPR	Office of Primary Responsibility
PCE	Potential Concussive Event
POTFF	Preservation of the Force and Family
PSI	per square inch
SECDEF	Secretary of Defense
SOF	Special Operations Forces
S&T	Science and Technology
SOCS-SG	Office of the Command Surgeon
SOF AT&L	Special Operation Forces Acquisition, Technology & Logistics
SPARTAN	SOF Protection, Assessment, Rehabilitation, and Treatment of Neuro-health
TBI	Traumatic Brain Injury
TBICoE	Traumatic Brain Injury Center of Excellence
USD	Under Secretary of Defense
USSCOM	U.S. Special Operations Command
WG	Working Group

SECTION II—DEFINITIONS

***NOTE*:** Unless otherwise noted, these terms and their definitions are for the purpose of this directive only.

Automated Neuropsychological Assessment Metrics (ANAM). DOD program of record for assessments of cognitive functions including attention, concentration, reaction time, memory, processing speed, and decision-making. It may be used serially to assess changes in cognitive ability over time.

Comprehensive Assessment of Symptom History (CASH). Comprehensive history-taking interview and series of brief questionnaires, administered by trained personnel, to obtain exposure history and subjective symptoms.

Neurocognitive Assessment. A standardized cognitive and behavioral evaluation using validated and normed testing performed in a formal environment. Testing uses specifically designated tasks to measure cognitive function known to be linked to a particular brain structure or pathway. Aspects of cognitive functioning that are assessed typically include intellectual functioning, attention, new-learning or memory, intelligence, processing speed, and executive functioning.

Traumatic Brain Injury. A traumatically induced structural injury or physiological disruption of brain function as a result of an external force that is indicated by new onset or worsening of at least one of these clinical signs immediately following the event:

- Any alteration in mental status (e.g., confusion, disorientation, slowed thinking).
- Any loss of memory for events immediately before or after the injury.
- Any period of loss of or a decreased level of consciousness, observed or self-reported.
- Vestibular symptoms to include dizziness and blurred vision.

SOF Warfighter. For the purpose of this directive, SOF Warfighters are defined as personnel who have undergone A&S and who have received specialized qualification training for assignment to a unit within USSOCOM. Inclusion of at-risk SOF enablers and DOD civilians may be considered based on unit policy. See Appendix B for specific career fields which require a CASH.

SECTION III--REFERENCES

a. Assistant Secretary of Defense (ASD) Memorandum, *Traumatic Brain Injury: Updated Definition and Reporting*, April 6, 2015.

b. DHA Memorandum, *Guidance for Evaluation of Anomalous Health Incidents*, August 11, 2021.

c. Deputy ASD Memorandum, *Designation of the JTS as a Defense Center of Excellence*, June 19, 2013.

d. Deputy Secretary of Defense (SECDEF) document, *DOD Warfighter Brain Health Initiative: Strategy and Action Plan*, 2021.

e. DODD 5124.02, *Under Secretary of Defense for Personnel and Readiness (USD(P&R))*, June 23, 2008.

f. DODD 6025.21E, *Medical Research for Prevention, Mitigation, and Treatment of Blast Injuries*, October 15, 2018.

g. DODI 6040.47, *Joint Trauma System (JTS)*, April 5, 2018, as amended.

h. DODI 6490.11, *DOD Policy Guidance for Management of Mild Traumatic Brain Injury/Concussion in the Deployed Setting*, October 1, 2021, as amended.

i. DODI 6490.13, *Comprehensive Policy on Traumatic Brain Injury-Related Neurocognitive Assessments by the Military Services*, March 31, 2017, as amended.

j. HR 2810, Section 734, FY18 National Defense Authorization Act.

k. Joint Publication 4-02, *Joint Health Services*, and September 28, 2018, as amended.

l. Joint Requirements Oversight Council Memorandum 003-22, *Initial Capability Document for Warfighter Brain Health*, January 19, 2022.

m. JTS Clinical Practice Guideline, 2018.

n. Public Law 111-383, Section 722, *Comprehensive policy on consistent neurological cognitive assessments of members of the armed forces before and after deployment*, January 7, 2011.

o. Technical Manual 3-23.25 (FM 3-23.25), *Shoulder-Launched Munitions*, December 14, 2010, as amended.

p. SECDEF Memorandum, *Comprehensive Strategy and Action Plan for Warfighter Brain Health*, October 1, 2018.

SECTION III—REFERENCES (Cont.)

q. Under SECDEF (USD) Document, *Report to Armed Services Committees Section 734 of the National Defense Authorization Act for Fiscal Year 2018 (Public Law 115-91)*, *Longitudinal Medical Study on Blast Pressure Exposure of Members of the Armed Forces Initial Report*, April 11, 2019.

r. USD Memorandum, *Directive-type Memorandum 17-004, DOD Expeditionary Civilian Workforce*, February 8, 2021, as amended.