
MEDICAL SUPPORT TO DETAINEE OPERATIONS

November 2007

Headquarters, Department of the Army

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MEDICAL SUPPORT TO DETAINEE OPERATIONS

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Preface

This field manual interim (FMI) establishes guidelines for medical support to detainee operations (DO) as part of the Army Health System (AHS) in the theater. It discusses command structure and staff operations necessary to provide medical support to detainees.

This FMI is designed for use by commanders and their staffs in the planning and execution of providing medical support to detainees. Field Manual Interim 4-02.46 is not a stand-alone manual and must be used in combination with other publications. These publications are noted throughout the manual and a consolidated listing is provided in the references.

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

Users of this publication are encouraged to submit comments and recommendations to improve the publication. Comments should include the page, paragraph, and lines of the text where the change is recommended and a rationale for the recommended change. The proponent for this publication is the United States (US) Army Medical Department Center and School (USAMEDDC&S). Comments and recommendations should be forwarded directly to the **Commander, USAMEDDC&S, ATTN: MCCS-FCD-L, 1400 East Grayson Street, Fort Sam Houston, Texas 78234-5052** or send electronic suggestions to e-mail address: medicaldoctrine@amedd.army.mil.

Unless this publication states otherwise, masculine nouns and pronouns do not refer exclusively to men.

Use of trade or brand names in this publication is for illustrative purposes only and does not imply endorsement by the Department of Defense (DOD).

The Army Medical Department (AMEDD) is in a transitional phase with terminology. This publication uses the most current terminology; however, other Field Manual (FM) 4-02-series and FM 8-series may use older terminology. Changes in terminology are a result of adopting the terminology currently used in joint and/or North Atlantic Treaty Organization (NATO) and American, British, Canadian, and Australian Armies publication arenas. Therefore, the following terms are synonymous—

- Medical logistics (MEDLOG) is now the Army term but health service logistics and combat health logistics were previously used.
- Roles of care is now the Army term but echelons of care and levels of care were previously used.

Chapter 1

Overview of Medical Support to Detainee Operations

It is DOD policy that the US military services will comply with the principles, spirit, and intent of the international law of war, both customary and codified, to include the Geneva Conventions. As such, captured or detained personnel shall be accorded an appropriate legal status under international law and conventions. Personnel in US custody shall receive health care consistent with the standard of health care that applies for US military personnel in the same geographic area. For additional information refer to Department of Defense Directives (DODDs) 2310.01E, 2311.01E, Army Regulation (AR) 40-400, AR 190-8, FM 3-19.40, FMs 4-02- and 8-10-series, and FM 27-10.

SECTION I — DETAINEE STATUS DEFINED

1-1. It is essential for all health care personnel involved in the care of personnel in US custody to understand that the differences between categories of captured, retained, or detained personnel should not affect health care treatment.

ENEMY COMBATANT

1-2. The term *enemy combatants* is used for personnel engaged in hostilities against the US or its multinational partners during an armed conflict. This term includes both *lawful combatants* who are engaging in hostilities on behalf of a party to the conflict and *unlawful combatants*, such as spies, saboteurs, or civilians who are engaging in or supporting, hostilities against the US or multinational partners on behalf of a party to the conflict or on behalf of another party such as a terrorist organization. For purposes of the war on terrorism, the term *enemy combatant* means an individual who was part of or supporting terrorist forces that are engaging in hostilities against the US or multinational partners.

- *Lawful enemy combatants* include enemy prisoners of war (EPW) who are members of the regular armed forces of a State party to the conflict; militia, volunteer corps, and organized resistance movements belonging to a State party to the conflict, which are under responsible command. These individuals wear a fixed distinctive sign recognizable at a distance, carry their arms openly, and abide by the laws of war. Members of regular armed forces who profess allegiance to a government or an authority not recognized by the detaining power are also referred to as enemy combatants. They are entitled to EPW status upon capture and are entitled to *combatant immunity* for their lawful pre-capture warlike acts. They may be prosecuted, however, for violations of the law of war. If so prosecuted, they still retain their status as prisoners of war (POW).
- An *unlawful enemy combatant* is a person who is not entitled to treatment either as a peaceful civilian or as an EPW by reason of the fact that the person has engaged in hostile conduct without meeting the qualifications established by Article 4 of the Geneva Convention Relative to the Treatment of Prisoners of War, 12 August 1949 (GPW). Unlawful enemy combatants may include spies, saboteurs, or civilians who are participating in hostilities or who otherwise engage in unauthorized attacks or other combatant acts. Unlawful enemy combatants are not entitled to EPW status and may be prosecuted under the domestic law of the captor. This may include those individuals or entities designated according to references *Comprehensive List of*

Terrorist Groups Identified Under Executive Order and *Terrorist Groups Identified Under Executive Order*, as identified in applicable Executive Orders approved by the Secretary of Defense (SECDEF).

RETAINED PERSONNEL

1-3. Enemy personnel who are within any of the categories below are eligible to be certified as retained personnel (RP). See paragraph 1-19 for additional information.

- Health care personnel exclusively engaged in the—
 - Search for, collection, transport, or treatment of the wounded or sick.
 - Prevention of disease.
 - Staff administration of medical units and establishments exclusively.
- Chaplains attached to enemy armed forces.
- Staff of national Red Cross societies and other voluntary aid societies duly recognized and authorized by their governments. The staff of such societies must be subject to military laws and regulations.

CIVILIAN INTERNEES

1-4. A civilian internee is a person that is interned during armed conflict or occupation for security reasons or for protection or because he has committed an offense against the detaining power. This term is used to refer to persons interned and protected in accordance with the Geneva Convention Relative to the Protection of Civilian Persons in Time of War, 12 August 1949 (GC).

OTHER DETAINEES

1-5. Persons in the custody of the US Armed Forces that have not been classified as an EPW (Article 4, GPW), a RP (Article 33, GPW), or civilian internee (Article 78, GC), shall be treated as an EPW until a legal status is ascertained by competent authority.

1-6. It is possible that other detainees may be designated additional classifications according to the policies promulgated by The President or the DOD. Such additional classifications do not impact the planning and execution of DOs governed by this publication. Instead, these additional classifications impact issues such as possible criminal charges for engaging in unprivileged military activities.

SECTION II — LAW OF LAND WARFARE AND THE GENEVA CONVENTIONS

LAW OF LAND WARFARE

1-7. The conduct of armed hostilities on land and sea is regulated by the Law of Land Warfare. This body of law is inspired by the desire to diminish the evils of war by—

- Protecting both combatants and noncombatants from unnecessary suffering.
- Safeguarding certain fundamental human rights of persons that fall into the hands of the enemy, particularly POWs, the wounded and sick, and civilians.
- Facilitating the restoration of peace.

1-8. The Law of Land Warfare places limits on the exercise of a belligerent's power in the interest of furthering that desire (diminishing the evils of war) and it requires that belligerents—

- Refrain from employing any kind or degree of violence that is not actually necessary for military purposes.
- Conduct hostilities with regard for the principles of humanity.

SOURCES OF THE LAW OF LAND WARFARE

1-9. The Law of Land Warfare is derived from two principal sources—

- Lawmaking treaties or conventions (such as The Hague and Geneva Conventions).
- Custom (practices which by common consent and long-established uniform adherence have taken on the force of law).

1-10. Under the US Constitution, treaties constitute part of the Supreme Law of the Land and, thus, must be observed by both military and civilian personnel. The unwritten or customary Law of Land Warfare is also part of the US law. It is binding upon the US, citizens of the US, and other persons serving this country. For additional information on the Law of Land Warfare, refer to Department of the Army Pamphlet (DA Pam) 27-1 and FM 27-10.

GENEVA CONVENTIONS

1-11. The US is a party to numerous conventions and treaties pertinent to warfare on land. Collectively, these treaties are often referred to as The Hague and Geneva Conventions. Whereas The Hague Conventions concern the methods and means of warfare, the Geneva Conventions concern the victims of war or armed conflict. The Geneva Conventions are four separate international treaties, signed in 1949. The Conventions are very detailed and contain many provisions, which are tied directly to the medical mission. These Conventions are entitled—

- Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field (GWS).
- Geneva Convention for the Amelioration of the Condition of Wounded, Sick, and Shipwrecked Members of Armed Forces at Sea.
- Geneva Convention Relative to the Treatment of Prisoners of War.
- Geneva Convention Relative to the Protection of Civilian Persons in Time of War.

PROTECTION OF THE SICK AND WOUNDED

1-12. The essential and dominant idea of the GWS is that the Soldier who has been wounded or is sick, and for that reason is out of the fight, is from that moment protected.

Protection and Care

1-13. Article 12 of the GWS imposes several specific obligations regarding the protection and care of the wounded and sick.

- The first paragraph of Article 12, GWS, states “Members of the armed forces and other persons mentioned in the following Article, who are wounded or sick, shall be respected and protected in all circumstances.”
 - The word *respect* means “to spare, not to attack,” and *protect* means “to come to someone’s defense, to lend help and support.” These words make it unlawful to attack, kill, ill-treat, or in any way harm a fallen and unarmed enemy soldier. At the same time, these words impose an obligation to come to his aid and give him such care as his condition requires.
 - This obligation is applicable in all circumstances. The wounded and sick are to be respected just as much when they have fallen into the hands of the enemy as when they are with their own army or in no man’s land, as well as when they have fallen into the hands of the enemy.
 - Combatants, as well as noncombatants, are required to respect the wounded. The obligation also applies to civilians; Article 18, GWS, specifically states: “The civilian population shall respect those wounded and sick, and in particular abstain from offering them violence.”
 - The GWS does not define what “wounded or sick” means, nor has there ever been any definition of the degree of severity of a wound or a sickness entitling the wounded or sick combatant to respect. Any definition would necessarily be restrictive in character and

would thereby open the door to misinterpretation and abuse. The meaning of the words “wounded and sick” is thus a matter of common sense and good faith. It is the act of falling or lying down of arms because of a wound or sickness that constitutes a claim to protection. Only the soldier who is himself seeking to kill may be killed.

- The benefits afforded the wounded and sick extend not only to members of the armed forces, but to other categories of persons as well, classes of whom are specified in Article 13, GWS. Even though a wounded person is not in one of the categories enumerated in the Article, we must still respect and protect that person. There is a universal principle which says that any wounded or sick person is entitled to respect and humane treatment and the care that his condition requires. Wounded and sick civilians have the benefit of the safeguards of the GC.
- The second paragraph of Article 12, GWS, provides that the wounded and sick “...shall be treated humanely and cared for by the party to the conflict in whose power they may be, without any adverse distinction founded on sex, race, nationality, religion, political opinions, or other similar criteria...”
 - All adverse distinctions are prohibited. Nothing can justify a belligerent in making any adverse distinction between wounded or sick that require his attention, whether they be friend or foe. Both are on equal footing in the matter of their claims to protection, respect, and care. The foregoing is not intended to prohibit concessions, particularly with respect to food, clothing, and shelter, which take into account the different national habits and backgrounds of the wounded and sick.
 - The wounded and sick shall not be made the subjects of biological, scientific, or medical experiments of any kind that are not justified on medical grounds and dictated by a desire to improve their condition.
 - The wounded and sick shall not willfully be left without medical assistance nor shall conditions exposing them to contagion or infection be created.
 - The only reasons that can justify priority in the order of treatment are reasons of *medical urgency*.
 - Article 12, GWS, provides that if we must abandon wounded or sick, we have a moral obligation to, “as far as military considerations permit,” leave medical supplies and personnel to assist in their care. This provision is in no way bound up with the absolute obligation imposed by paragraph 2 of Article 12 to care for the wounded. A belligerent can never refuse to care for enemy wounded on the pretext that his adversary has abandoned them without medical personnel and equipment.

Enemy Wounded and Sick

1-14. The protections accorded the wounded and sick apply to friend and foe alike without distinction. Certain provisions of the GWS, however, specifically concern enemy wounded and sick. There are also provisions in the GPW which, because they apply to POWs generally, also apply to enemy wounded or sick.

- Article 14 of the GWS states that persons who are wounded and then captured have the status of POWs. However, that wounded soldier is also a person who needs treatment. Therefore, a wounded soldier who falls into the hands of an enemy who is a Party to the GWS and the GPW, such as the US, will enjoy protection under both Conventions until his recovery.
- Article 16 of the GWS requires the recording and forwarding of information regarding enemy wounded, sick, or dead. See AR 190-8 for disposition of an EPW after hospital care.
- When intelligence indicates that large numbers of EPWs may result from an operation, medical units may require reinforcement to support the anticipated additional EPW patient workload. Procedures for estimating the medical workload involved in the treatment and care of EPW patients are described in FM 8-55.

Search for and Collection of Casualties

1-15. Article 15 of the GWS imposes a duty on combatants to search for and collect the dead, wounded, and sick as soon as circumstances permit. It is left to the tactical commander to judge what is possible and to decide to commit his medical personnel to this effort. If circumstances permit, an armistice or suspension of fire should be arranged to permit this effort.

Assistance for the Civilian Population

1-16. Article 18, GWS, addresses the civilian population. It allows a belligerent to ask civilians to collect and care for wounded or sick of whatever nationality. This provision does not relieve the military authorities of their responsibility to give both physical and moral care to the wounded and sick. The GWS also reminds the civilian population that they must respect the wounded and sick, and in particular, must not injure them.

Enemy Civilian Wounded and Sick

1-17. Certain provisions of the GC are relevant to the medical mission.

- Article 16 of the GC provides that enemy civilians who are “wounded and sick, as well as the infirm, and expectant mothers shall be the object of particular protection and respect.” The Article also requires that, “as far as military considerations allow, each Party to the conflict shall *facilitate* the steps taken to search for the killed and wounded (civilians), to assist...other persons exposed to grave danger, and to protect them against pillage and ill-treatment (emphasis added).”
 - The “protection and respect” to which wounded and sick enemy civilians are entitled is the same as that accorded to wounded and sick enemy military personnel.
 - While Article 15 of the GWS requires Parties to a conflict to search for and collect the dead, wounded, and sick members of the armed forces, Article 16 of the GC states that the Parties must “facilitate the steps taken” in regard to civilians. This recognizes the fact that saving civilians is the responsibility of the civilian authorities rather than of the military. The military is not required to provide injured civilians with health care in a combat zone (CZ). However, if we start providing treatment, we are bound by the provisions of the GWS. Provisions for treating civilians (enemy or friendly) will be addressed in division, corps, and theater regulations.
- In occupied territories, the Occupying Power must accord the inhabitants numerous protections as required by the GC. The provisions relevant to medical care include the—
 - Requirement to bring in medical supplies for the population if the resources of the occupied territory are inadequate.
 - Prohibition on requisitioning medical supplies unless the requirements of the civilian population have been taken into account.
 - Duty of ensuring and maintaining, with the cooperation of national and local authorities, the medical and hospital establishments and services, public health, and hygiene in the occupied territory.
 - Prohibition on requisitioning civilian hospitals on other than a temporary basis and then only in cases of urgent necessity for the care of military wounded and sick and after suitable arrangements have been made for the civilian patients.
 - Requirement to provide adequate medical treatment to detained persons.
 - Requirement to provide adequate health care in internment camps.

PROTECTION AND IDENTIFICATION OF MEDICAL PERSONNEL

1-18. Article 24 of the GWS provides special protection for “Medical personnel *exclusively engaged* in the search for, or the collection, transport or treatment of the wounded or sick, or in the prevention of disease, staff exclusively engaged in the administration of medical units and establishments...(emphasis added).”

Article 25 provides limited protection for “Members of the armed forces specially trained for employment, should the need arise, as hospital orderlies, nurses or auxiliary stretcher-bearers, in the search for or the collection, transport or treatment of the wounded and sick...*if they are carrying out these duties at the time when they come into contact with the enemy or fall into his hands* (emphasis added).”

1-19. There are two separate and distinct forms of protection.

- The first is protection from intentional attack if medical personnel are identifiable as such by an enemy in a combat environment. Normally this is facilitated by medical personnel wearing an armband bearing the distinctive emblem (a Red Cross or Red Crescent on a white background), or by their employment in a medical unit, establishment, or vehicle (including medical aircraft and hospital ships) that displays the distinctive emblem. Persons protected by Article 25 may wear an armband bearing a miniature distinctive emblem only while executing medical duties.
- The second protection provided by the GWS pertains to health care personnel who fall into the hands of the enemy. Article 24 personnel are entitled to RP status. They are not deemed to be POWs, but otherwise benefit from the protections of the GPW. They are authorized to carry out medical duties only, and as stated in Article 28, “shall be retained only in so far as the state of health...and the number of prisoners of war require.” Article 25 personnel are POWs, but shall be employed to perform medical duties in so far as the need arises. They may be required to perform other duties or labor, and may be held until a general repatriation of POWs is accomplished upon the cessation of hostilities.

1977 PROTOCOLS TO THE GENEVA CONVENTIONS

1-20. Additional Protocols to the Geneva Conventions have been ratified by some of our allies and potential adversaries. The US representative to the diplomatic conference signed these amendments, but they have not been officially ratified by our government.

MEDICAL REPATRIATION

1-21. The Geneva Conventions provide for the repatriation of—

- Retained medical personnel once they are no longer needed to provide medical care to members of their own forces (Article 28 and 30, GWS).
- Seriously wounded and sick POWs.

1-22. Parties to the conflict are bound to send back to their own country, regardless of number or rank, seriously wounded and seriously sick POWs, after having cared for them until they are fit to travel. No sick or injured POW may be repatriated against his will during hostilities (Article 109, GPW).

1-23. The following shall be directly repatriated (Article 110, GPW):

- Incurably wounded and sick whose mental or physical fitness seem to have been gravely diminished.
- Wounded and sick who, according to medical opinion, are not likely to recover within one year, whose condition requires treatment, and whose mental or physical fitness seems to have been gravely diminished.
- Wounded and sick who have recovered, but whose mental or physical fitness seems to have been gravely and permanently diminished.

1-24. The following may be accommodated in a neutral country (Article 110, GPW):

- Wounded and sick whose recovery may be expected within one year of the date of the wound or the beginning of the illness, if treatment in a neutral country might increase prospects of a more certain and speedy recovery.
- Prisoners of war whose mental or physical health, according to medical opinion, is seriously threatened by continued captivity.

1-25. The conditions which POWs accommodated in a neutral country must fulfill in order to permit their repatriation will be fixed, and will likewise their status, by agreement between the Powers concerned. In

general, POWs who have been accommodated in a neutral country and who belong to the following categories, should be repatriated:

- Those whose state of health has deteriorated so as to fulfill the conditions laid down for direct repatriation.
- Those whose mental or physical powers remain, even after treatment, considerably impaired.

1-26. Upon the outbreak of hostilities, Mixed Medical Commissions will be appointed to examine sick and wounded POWs and to make all appropriate decisions regarding them (Article 112, GPW). However, POWs, who in the opinion of the medical authorities of the Detaining Power, are manifestly seriously injured or seriously sick, may be repatriated without having been examined by a Mixed Medical Commission.

1-27. Submit and track compassionate release candidates (elderly detainees 65 years or older, complex or chronic medical problems, terminal or end-stage conditions, problems that cannot be treated within the theater medical system, and problems that require constant supervision or that restrict movement and/or personal care) to avoid inappropriate transfers or on-going difficulty within the facility. Compassionate release requests must be submitted to the higher command governing DO via secret internet protocol router network (SIPRNET). All requests must be cleared through military intelligence (MI) and higher headquarters (HQ) before the request is submitted to the commander, detainee operations (CDO). Refer to Figure 1-1 for a sample compassionate release request.

**DEPARTMENT OF THE ARMY
XXX COMBAT SUPPORT HOSPITAL
APO XXXXX**

XXXX-XX-XX-XX

19 February 2005

MEMORANDUM THRU Detainee Operations Medical Director

MEMORANDUM FOR Commander, Detainee Operations

SUBJECT: Detainee's Name Here (internment serial number [ISN] # 123456)

1. The above mentioned detainee is a 71-year-old male currently detained at the XXX Theater Internment Facility. In addition to his advanced age, he has high blood pressure, recurrent chest pain, chronic dizziness, anxiety, and arthritis. He is on multiple medications to control these problems, but continues to come to sick call for problems related to dizziness, arthritis, and disorientation. He cannot walk around the compound without becoming short of breath, having chest pain, and becoming dizzy. As a result, he has an increased likelihood of having a fall resulting in hip fracture or a significant cardiac event (such as heart attack or even sudden death). If he survives after a fall or heart attack, he would most likely require long-term hospitalization or outpatient medical care. Therefore, I petition for the accelerated review of his case and consideration for compassionate release.

2. If this detainee receives approval for a medical release, our civil-military operations (CMO) liaison can assist and contact his family in order to arrange transfer to their custody, as required.

3. Point of contact for this memorandum is the undersigned at (123) 456-7890.

JOHN C. BROWN
Colonel, MC
Commanding

Military Intelligence CONCUR/NONCONCUR
Staff Judge Advocate CONCUR/NONCONCUR

The release of internee 123456 is APPROVED/DISAPPROVED

SAMUEL S. SMITH
Brigadier General, USA
Commander, Detainee Operations

Figure 1-1. Sample compassionate release request

SECTION III — ETHICAL CONSIDERATIONS FOR THE MEDICAL TREATMENT OF DETAINEES**RESPONSIBILITIES OF HEALTH CARE PERSONNEL**

1-28. Health care personnel are well trained in and guided by the ethics of their professional calling. This training and ethical principles, coupled with the requirements of international law as it pertains to the treatment of EPWs, detainees, and civilians during conflict, will ensure the ethical treatment of all sick and wounded personnel. Refer to Appendix A for additional information on the medical code of conduct in detainee operations.

1-29. Health care personnel (particularly physicians) perform their duties consistent with the following principles: health care personnel—

- Have a duty in all matters affecting the physical and behavioral health (BH) of detainees to perform, encourage, and support, directly and indirectly, actions to uphold the humane treatment of detainees. See Appendix B for additional information on detainee BH care. They must ensure that no individual in the custody or under the physical control of the DOD, regardless of nationality or physical location, shall be subject to cruel, inhuman, or degrading treatment or punishment, according to and as defined in US law.
- Charged with the medical care of detainees have a duty to protect detainees' physical and behavioral health and provide appropriate treatment for disease. To the extent practicable, treatment of detainees should be guided by professional judgments and standards similar to those applied to personnel of the US Armed Forces.
- Will not be involved in any professional provider-patient treatment relationship with detainees the purpose of which is not solely to evaluate, protect, or improve their physical and behavioral health.
- Whether or not in a professional provider-patient treatment relationship, will not apply their knowledge and skills in a manner that is not in consonance with applicable law or the standards set forth in DODD 2310.01E.
- Will not certify or participate in the certification of, the fitness of detainees for any form of treatment or punishment that is not in consonance with applicable law or participate in any way in the administration of any such treatment or punishment.
- Will not participate in any procedure for applying physical restraints to the person of a detainee unless such a procedure is determined to be necessary for the protection of the physical or behavioral health or the safety of the detainee or necessary for the protection of other detainees or those treating, guarding, or otherwise interacting with them. Such restraints, if used, shall be applied in a safe and professional manner.

1-30. Health care personnel engaged in a professional provider-patient treatment relationship with detainees will not participate in detainee-related activities for purposes other than health care. Such health care personnel will not actively solicit information from detainees for other than medical purposes. Health care personnel engaged in nontreatment activities (such as forensic psychology, behavioral science consultation [BSC], forensic pathology, or similar disciplines) will not engage in any professional provider-patient treatment relationship with detainees (except in emergency circumstances in which no other health care providers can respond adequately to save life or prevent permanent impairment).

- During the initial screening of detainees any preexisting medical conditions, wounds, fractures, and bruises should be noted. Documentation of these injuries/conditions provides a baseline for each detainee which facilitates the identification of injuries which may have occurred in the theater internment facility (TIF).
- Detainees who report for routine sick call should be visually examined to determine if any unusual or suspicious injuries are apparent. If present, the health care provider should determine from the detainee how the injuries occurred. Any injuries which cannot be explained or for

which the detainee is providing evasive responses should be noted in the medical record and reported to the chain of command, technical medical channels, and US Army Criminal Investigation Command (USACIDC).

- Health care personnel may enter the holding areas of the facility for a variety of reasons. These can include, but are not limited to, conducting sanitary inspections, providing emergency medical treatment (EMT), and dispensing medications. When in the holding areas of the facility, health care personnel must be observant. Should they observe anything suspicious which might indicate that detainees are being mistreated, they should report these suspicions immediately to the chain of command. Should they observe a detainee being mistreated, they should take immediate action to stop the abuse and then report the incident.

1-31. Detained personnel must have access to the same standard of medical care as the US and multinational forces to include respect for their dignity and privacy. In general, the security of detainees' medical records and confidentiality of medical information will be managed the same way as for the US and multinational forces. During DO, the patient administrator (PAD), the Criminal Investigation Division (CID), the International Committee of the Red Cross (ICRC), and medical chain of command can have access to detainee medical records besides the treating health care personnel.

1-32. Health care personnel shall safeguard patient confidences and privacy within the constraints of the law. Under US and international law and applicable medical practice standards, there is no absolute confidentiality of medical information for any person. Detainees shall not be given cause to have incorrect expectations of privacy or confidentiality regarding their medical records and communications. However, whenever patient-specific medical information concerning detainees is disclosed for purposes other than treatment, health care personnel shall record the details of such disclosure, including the specific information disclosed, the person to whom it was disclosed, the purpose of the disclosure, and the name of the medical unit commander (or other designated senior medical officer) approving the disclosure. Similar to legal standards applicable to US citizens, permissible purposes include preventing harm to any person, maintaining public health and order in TIFs, and any lawful law enforcement, intelligence, or national security-related activity.

1-33. In any case in which the medical unit commander (or other designated senior medical officer) suspects that the medical information to be disclosed may be misused, he should seek a senior command determination that the use of the information will be consistent with the applicable standards.

1-34. The information disclosed to a physician during the course of the relationship between physician and patient is confidential to the greatest possible degree. The patient should feel free to make a full disclosure of information to the physician in order that the physician may most effectively provide needed services. The patient should be able to make this disclosure with the knowledge that the physician will respect the confidential nature of the communication. The physician should not reveal confidential communications or information without the express consent of the patient, unless required to do so by law. The obligation to safeguard patient confidences is subject to certain exceptions, which are ethically and legally justified because of overriding social considerations. Where a patient threatens to inflict serious bodily harm to another person or to himself and there is a reasonable probability that the patient may carry out the threat, the physician should take reasonable precautions for the protection of the intended victim, including notification of law enforcement authorities.

1-35. Patient consent for the release of medical records is not required. The medical treatment facility (MTF) commander or commander's designee, usually the PAD, determines what information is appropriate for release. Only that specific medical information or medical record required to satisfy the terms of a legitimate request will be authorized for disclosure.

1-36. Because the chain of command is ultimately responsible for the care and treatment of detainees, the internment facility chain of command requires some medical information. For example, detainees suspected of having infectious diseases such as tuberculosis (TB) should be separated from other detainees. Guards and other personnel who come into contact with such patients should be informed about their health risks and how to mitigate those risks.

1-37. Releasable medical information on internees includes that which is necessary to supervise the general state of health, nutrition, and cleanliness of internees and to detect contagious diseases. Such information should be used to provide health care; to ensure health and safety of internees, Soldiers, employees, or others at the facility; and to ensure the administration and maintenance of the safety, security, and good order of the facility.

1-38. For additional information on medical ethics refer to the *Textbooks of Military Medicine: Military Medical Ethics, Volumes I and II*, and *The Emergency War Surgery Handbook*. Both of these publications are available electronically at: <http://www.bordeninstitute.army.mil/>.

PROHIBITED ACTS

1-39. The GPW describes acts that are prohibited under the Conventions and specifies that all detainees will receive humane treatment.

- Prohibited acts include killing, torture, medical/scientific experimentation, physical mutilation, removal of tissues/organs for transplantation, and causing serious injury, pain, and suffering.
 - Torture can take many guises in wartime situations. Historically, it has been used to extract tactical information from an uncooperative EPW. However, it has also been applied for the sake of punishment and/or to inflict pain and suffering. Regardless of the rationale, the torture of EPWs is prohibited. Health care personnel, who administer drugs to facilitate interrogation or advise interrogators on the ability of an individual to withstand torture, can be considered complicit in that torture.
 - Under current DOD policy, health care personnel cannot certify a detainee for torture but they can provide consultation to interrogators so long as they are not also detainee treatment providers.
 - Medical care will be provided with the consent of the detainee. To the extent practicable, standards and procedures for obtaining consent will be consistent with those applicable to consent from other patients. Standard exceptions for lifesaving emergency medical care provided to a patient incapable of providing consent or for care necessary to protect public health, such as to prevent the spread of communicable diseases, will apply.
 - The Detaining Power is prohibited from conducting medical and scientific experimentation on detained personnel. This prohibition arose from the experiences in World War II. Since the prisoner is in the custody of the Detaining Power, any consent to the experiment is suspect as the prisoner may feel coerced to provide consent. This prohibition does not extend to the introduction of new treatment regimens and/or pharmaceuticals when there is a substantiated medical necessity and withholding the treatment would be detrimental to the health of the detainee.
 - Due to the nature of warfare, numerous combatants/noncombatants will sustain injuries that require amputation of the unsalvageable limb to save life. Amputation which is based on a medical necessity and conforms to existing standards of health care is not considered physical mutilation and therefore not prohibited. Refer to paragraph 3-81 pertaining to documenting serious injuries and paragraph 3-85 pertaining to medical photography.
 - With advances in medical science, transplantation of organs in peacetime has become an accepted method of treatment for certain conditions. However, during wartime with the exception of blood and skin grafts, transplantation of organs is prohibited. Although the recipient's health benefits from the transplant, the donor's health status does not. As with the discussion of consent for medical experimentation, the consent of a donor in custody of the Detaining Power is suspect as he may feel coerced into providing consent by his status. Additionally, the transplantation of organs/tissue from cadavers is also prohibited as the practice could lead to allegations that donors were permitted to die in order to harvest their organs. Protocol I, which supplements the GWS for the protection of war victims, permit the exception of blood and skin grafts but provides stringent controls. Tissues obtained must be used for medical purposes, not research or experimentation. The tissue donor must voluntarily consent to the procedure and records must be maintained.

- One ethical issue may confront surgeons on the battlefield that does not have a clear answer. Protocol I reiterates the right of an individual to refuse to undergo a surgical procedure, even if that procedure would be lifesaving and falls within existing medical standards. A surgeon may feel that he is not ethically bound by a refusal in the case of a minor or of an individual whose judgment is impaired by injury or illness. Documenting the issue, whether it is the patient's refusal (in writing if at all possible) or the surgeon's decision is an essential step in ensuring that allegations of abuse are not forthcoming.

ASSISTANCE PROVIDED TO INTERROGATION TEAMS

1-40. Under the provisions of the Geneva Conventions, health care personnel are prohibited from engaging in acts that are considered harmful to the enemy. Therefore, health care personnel providing direct patient care for detainees will not provide assistance to detainee interrogation teams. However, health care personnel must also consider the welfare of their patients. If a detainee has a medical condition which could deteriorate during interrogation and result in a health crisis for the detainee, the health care provider should inform the interrogation team of existing medical limitations. For example, a detainee who is a diabetic may have dietary restrictions and requirements, as well as a need to take medications on a scheduled basis.

1-41. Health care personnel charged with any form of assistance with the interrogation process, to include interpretation, of medical records and information will not be involved in any aspect of detainee health care. Health care providers charged with the care of detainees should not engage in any activities that jeopardize their protected status under the Geneva Conventions. Health care providers charged with the care of detainees should not be actively involved in interrogation, advise interrogators how to conduct interrogations, or interpret individual medical records/medical data for the purposes of interrogation or intelligence gathering. Health care providers who are asked to perform duties they feel are unethical should ask to be recused. Requests for recusal should first go to the health care provider's commander and chain of command. If the chain of command is unable to resolve the situation, providers should engage the technical chain by contacting the detainee operations medical director (DOMD) or command surgeon. If these avenues are unfruitful, health care providers may contact their specialty consultants or the Inspector General (IG).

1-42. As a matter of personnel management policy, except as provided in this paragraph, health care personnel's support of DO is limited only to providing services in a professional provider-patient treatment relationship in approved clinical settings, conducting disease prevention and other approved public health activities, advising proper command authorities regarding the health status of detainees, and providing direct support for these activities. Health care personnel will not be used to supervise, conduct, or direct interrogations. Health care personnel assigned as, or providing direct support to, behavioral science consultation teams (BSCT), consistent with Armed Forces Medical Examiner personnel, are the only authorized exceptions to this paragraph. The Assistant Secretary of Defense for Health Affairs (ASD[HA]), or designee, must approve any other exceptions to this paragraph. Behavioral science consultants—

- Are authorized to make psychological assessments of the character, personality, social interactions, and other behavioral characteristics of detainees, including interrogation subjects and, based on such assessments, advise authorized personnel performing lawful interrogations and other lawful DO, including intelligence activities and law enforcement. They employ their professional training not in a provider-patient relationship, but in relation to a person who is the subject of a lawful governmental inquiry, assessment, investigation, interrogation, adjudication, or other proper action. Requirements in this instruction applicable to behavioral science consultants are also applicable to other health care personnel providing direct support to behavioral science consultants.
- May provide advice concerning interrogations of detainees when the interrogations are fully in consonance with applicable law and properly issued interrogation instructions are available.
- May observe, but shall not conduct or direct, interrogations.

- May provide training in listening and communications techniques as well as skills needed to interpret results of studies and assessments concerning safe and effective interrogation methods and potential effects of cultural and ethnic characteristics of subjects of interrogation.
- May advise command authorities on the detention facility environment, organization and functions, ways to improve DO, and compliance with applicable standards concerning DO.
- May advise command authorities responsible for determinations of release, continued detention of detainees, or assessments concerning the likelihood that a detainee will, if released, engage in terrorist, illegal, combatant, or similar activities against the interests of the US.
- Will not support interrogations that are not conducted according to applicable law.
- Will not use or facilitate directly or indirectly the use of physical or behavioral health information regarding any detainee in a manner that would result in inhumane treatment or not be in consonance with applicable law.
- Ensure that detainees do not obtain the mistaken impression that health care personnel engaged in clinical care of detainees are also assisting in interrogations. Behavioral science consultants will not allow themselves to be identified to detainees as health care providers. Behavioral science consultants will not provide medical care for staff or detainees (except in emergency circumstances in which no other health care providers can respond adequately to save life or prevent permanent impairment).
- Will not provide training in first aid, sanitation, or other health matters. Absent compelling circumstances requiring an exception to the rule, health care personnel will not within a three-year period serve in the same location both in a clinical function position and as a behavioral science consultant.
- Will not provide medical screening (which is a health care function) to detainees nor act as medical monitors during interrogation.
- May consult at any time with the psychology or other applicable specialty consultants designated by The Surgeon General concerned for this purpose regarding the roles and responsibilities of behavioral science consultants and procedures for reporting instances of suspected noncompliance with standards applicable to DO.
- As a matter of professional personnel management, physicians are not ordinarily assigned duties as behavioral science consultants, but may be so assigned, with the approval of the ASD(HA) in circumstances when qualified psychologists are unable or unavailable to meet critical mission needs.

1-43. A psychologist, who is the behavioral science consultant, is assigned to DO. This person assists interrogators and the detention staff with interrogations and the management of detainees within the facility and is not assigned a mission of patient care. The medical treatment team should not consult with the BSCT on issues of treatment. Behavioral science consultation team members will not have access to medical records or any information about a detainee's medical treatment except as needed to maintain safe, legal, and ethical interrogations. For example, it may be helpful to advise the BSCT that a detainee has diabetes and should not be provided certain types of food during interrogation. The BSCT will not provide treatment, except in emergency, and will inform the medical treatment staff of any medical issues needing attention.

REPORTING OF SUSPECTED ABUSE AND/OR TORTURE

1-44. Any health care personnel who in the course of a treatment relationship or in any other way observes or suspects a possible violation of applicable standards, including those prescribed in ASD(HA) Policy Memorandum 05-006, and DODD 2310.01E for the protection of detainees will report those circumstances to the chain of command. Health care personnel who believe such a report has not been acted upon properly should also report the circumstances to the medical program leadership, including the DOMD or military department specialty consultant. Officials in the medical program leadership may inform the joint staff surgeon or the command surgeon concerned, who then may seek senior command review of the circumstances presented. Other reporting mechanisms, such as the IG, CID, or staff judge advocate (SJA), may also be used.

1-45. Health care personnel involved in clinical practice activities will make a written record of all reports of suspected or alleged violations in a reportable incident log maintained by the medical unit commander or other designated senior medical officer.

INVESTIGATION

1-46. While all medical staff members are responsible for immediately identifying and reporting potential and actual cases of abuse or assault to CID and to the applicable MTF commander and higher HQ, no further investigation is warranted beyond that necessary to render appropriate treatment, except in the case of rape or sexual assault, where health care personnel will collect and process rape kits, as set forth below. It is the role of CID and/or the military police (MPs) to investigate the allegation and collect evidence such as photographs.

DOCUMENTATION

1-47. For the purposes of this policy, a medical examination is a physical examination that evaluates and documents medical injury and/or trauma and reviews a detainee's overall health. The examination includes the documentation of findings and may include photographs or radiographs as needed for patient care purposes only.

Procedures

1-48. When physical, sexual, or emotional abuse is alleged or suspected, the health care provider is required to report the situation immediately to the MPs and the supporting CID.

1-49. A thorough medical examination will be performed by a licensed independent health care provider in all cases of suspected physical or sexual abuse. If the patient is a female of childbearing age, a pregnancy test will be performed. In cases of suspected rape or sexual assault, health care personnel will comply with the standard procedures applied to US personnel for the collection, preservation, and processing of a "rape kit" evidence.

1-50. All detainees alleging sexual abuse will be tested for sexually transmitted diseases (STDs), such as chlamydia, gonorrhea, syphilis, and human immunodeficiency virus (HIV).

1-51. The medical report of the medical examination will read "alleged" or "suspected" abuse and the detainee will be identified as the victim where indicated.

1-52. Cases of alleged sexual assault will follow procedures specified in the theater sexual assault policy.

1-53. Once required medical care has been rendered, the detainee will be released to the MPs or the CID, who will return the detainee to an appropriate location.

1-54. Subsequent investigation of the alleged abuse, including identifying the perpetrator, is the responsibility of the MPs and CID.

1-55. The MTF commander where a report of suspected or alleged detainee abuse originates will ensure that a serious incident report (SIR) is submitted to its higher HQ, documenting each incident of alleged or suspected abuse or assault. Abuse can involve physical harm, financial exploitation, emotional or verbal abuse, neglect (including self-neglect), or abandonment. Abuse is by definition improper. Inflicting physical harm against an active combatant is not abuse since causing harm to an enemy is by custom and treaty considered a proper use of force.

Categories of Abuse

1-56. Physical Abuse: Slapping, hitting, bruising, beating, or any other intentional act that causes someone physical pain, injury, or suffering. The use of painful physical restraints or the use of restraints for purely punitive action rather than safety reasons may be considered abuse.

1-57. Emotional Abuse: Threatening, humiliating, and causing emotional pain, distress, or anguish. Emotional abuse can be verbal or nonverbal; it includes insults and threats of harm.

1-58. Sexual Abuse: Any sexual activity to which the individual does not consent or is incapable of consenting. Any sexual activity between detainees and internment facility personnel is without question abusive because it cannot be truly “consensual.” Nonconsensual sexual activity includes everything from exhibitionism to inappropriate touching to sexual intercourse.

Tenets of Abuse Prevention

1-59. The four “Ps” of abuse prevention are:

- Priorities—Has a command philosophy that places honor and dignity at the top of priorities be established.
- Policies—It is not good enough to tell everyone to do the right thing...put it in writing.
- Procedures—Have systems in place that by nature reduce the potential for abuse.
- Practices—Continuous exercise of a professional demeanor and conduct is required.

1-60. When dealing with detainees, Soldiers need to use their common sense and exercise good judgment. Remember that if—

- It looks wrong, then it probably is.
- It is something that would enrage you if you saw a family member or another Soldier being subjected to, then it is probably wrong.
- You are confused and you do not know if it is right or wrong seek help and guidance.

RESPECT AND DIGNITY

1-61. Medical providers will treat all detainees with dignity and respect. They will be especially protected against violence, insults, public curiosity, bodily injury, reprisal, sexual attack, or any form of indecent assault. Thus, detainees will be examined in an environment appropriate for the preservation of individual dignity and safety. Graduated levels of privacy will be used, appropriate to the type of examination. The detainee will be asked only to expose as much body surface as medically necessary for a complete examination. Every effort will be made to provide an examiner of the same gender as the detainee.

RESPECT FOR PRIVACY

1-62. To the extent possible, informed consent will be obtained through an interpreter before performing an examination of sensitive areas, such as the genital region or the female breast region. The MTF commander responsible for providing health care to a detainee may authorize such examinations without consent where the safety of the detainee and/or staff may be at risk. All attempts will be made to minimize body exposure to the level medically appropriate for a thorough evaluation of the region at issue. This will be done by giving the patient proper gowns and clothing and by conducting the examinations behind curtains or walls and away from public view.

1-63. In order to ensure safety of detainees and medical staff, detainees will be examined in the presence of designated security personnel. The medical staff will maximize the use of same-gender medical examiners and security support. Examiners will position patients to minimize any exposure of private regions of detainees to nonmedical personnel, consistent with security requirements.

BODY CAVITY SEARCHES

1-64. Cavity examinations and searches may conflict with the customs of some detainees. Therefore, intake and routine medical examinations will not include body cavity exams or inguinal (hernia) exams. Body cavity examinations may be performed for valid medical reasons with the verbal consent of the patient. Body cavity searches may only be performed when there is a reasonable belief that the detainee is concealing an item that could present a security risk and must be authorized by the first general officer in

the chain of command. To the extent possible, body cavity examinations or searches will be conducted by trained personnel of the same gender and with the utmost respect for the detainee's dignity and privacy.

CONTRABAND

1-65. For the safety of the detainee population, the security personnel, internment/holding facility staff, and the medical staff, any contraband found on a detainee during the course of a medical examination will be turned over to appropriate security personnel.

INFORMED REFUSAL

DETAINEE

1-66. Detainees may refuse routine examinations or parts of physical examinations. Competent detainees that do not consent, will be informed that this refusal may alter the type of detention environment in which they live, particularly if there is a suspicion that they harbor potential communicable diseases. The MTF commander responsible for providing health care to the detainee may authorize examination or treatment in the absence of consent if it is deemed necessary to preserve the life, limb, or eyesight of the detainee or to preserve the health or safety of other detainees or any other persons.

1-67. Involuntary treatment or intervention in an internment facility must be preceded by a thorough medical and BH evaluation of the detainee and counseling concerning the risks of refusing consent. Such treatment or intervention shall be carried out in a medically appropriate manner, under standards similar to those applied to personnel of the US Armed Forces.

1-68. Detention facility procedures for dealing with cases in which involuntary treatment may be necessary to prevent death or serious harm shall be developed with consideration of procedures established by Title 28, Code of Federal Regulations, Part 549.

MENTAL COMPETENCY FOR INFORMED REFUSAL

1-69. On occasion, severely impaired detainees will require medical examination. Unconscious or psychotic individuals, under customary rules, may be examined without expressed verbal consent. Health care personnel will use a two-person verification rule when dealing with impaired detainees. In order to deem a detainee *impaired* and unable to give informed consent, two members of the medical staff must agree that the detainee is, in fact, impaired and this is to be documented clearly on the examination report. Preferably, one of the two individuals assessing competency will possess BH expertise.

Chapter 2

Health Care Personnel Roles and Functions

Health care personnel provide all detainee health care to include inprocessing, periodic, and outprocessing screening examinations, all routine and emergency outpatient care, all dental and BH care, all inpatient care including critical care, all detainee medical transfers, and public health. Refer to Appendix C for additional information on medical inprocessing screening tools. Detainee health care personnel will not provide or share detainee medical information with Joint Interrogation and Debriefing Center intelligence or interrogator personnel. This prohibition applies to all agencies conducting interrogations. Medical record information may be shared with the CDO who has a responsibility for the welfare of all detainees. Detainee health care personnel will not provide detainee security and custody or control under any circumstances for even brief instances; nor will there ever be the perception that health care personnel provide such functions (such as they will not carry handcuffs or flex cuffs). Health care personnel when operating within a detainee collection point (DCP), detainee holding area (DHA), or internment facility are under operational control (OPCON) of the MP unit operating the DCP, DHA, or internment facility.

SECTION I — ROLES AND FUNCTIONS

HEALTH CARE PERSONNEL

DETAINEE OPERATIONS MEDICAL DIRECTOR

2-1. The Army Service component commander's (ASCC) senior Army medical officer appoints a DOMD to oversee and guide all elements of health care delivery to detainees within the theater. This ensures that a comprehensive assessment of critical mission tasks is continuous, facilitates the rapid identification of deficiencies, and enhances the timely resolution of health care delivery issues.

2-2. The DOMD is responsible for—

- Advising the CDO on the health of the detainee population.
- Providing guidance, in conjunction with the SJA, on the ethical and legal aspects of providing health care to detainees.
- Recommending task organization of medical resources to satisfy mission requirements.
- Recommending policies concerning medical support to DO.
- Developing, coordinating, and synchronizing health consultation services for detainees.
- Evaluating and interpreting medical statistical data.
- Recommending policies and determining requirements and priorities for medical logistics (MEDLOG) operations in support of detainee health care. This includes blood and blood products, medical supply/resupply, formulary development, medical equipment, medical equipment maintenance and repair services, optometric support, and fabrication of single- and multivision optical lens, and spectacle fabrication and repair.
- Recommending medical evacuation policies and procedures and monitoring medical evacuation support to detainees.

- Recommending policies, protocols, and procedures pertaining to medical and dental treatment of detainees. These policies, protocols, and procedures will provide the same standard of care provided to US Forces in the same geographical area.
- Ensuring medical records are maintained on each detainee as prescribed by AR 40-66 and AR 40-400.
- Ensuring monthly weigh-ins are conducted and reported as required by regulation and international law.
- Planning for and implementing preventive medicine (PVNTMED) operations and facilitating health risk communications (to include PVNTMED programs and initiating PVNTMED measures [PMM] to counter the health threat). Refer to Appendix D for additional information on PVNTMED inspection checklist.
- Planning for medical support to the detainee population. See Appendix E for additional information on the planning checklist for medical support to detainee operations.

TECHNICAL SUPERVISION

TECHNICAL SUPERVISION DEFINED

2-3. Technical supervision is the authority, less than command, over certain clearly delineated technical functions performed by units not in the chain of command. Technical supervision is governed by policies and procedures that are established by regulation and restricted to prescribing detailed and specific technical guidance to control the performance of those functions.

TECHNICAL SUPERVISION OF DETAINEE MEDICAL OPERATIONS

2-4. The DOMD is designated by the ASCC to exercise technical supervision of the medical aspects of DO conducted throughout the joint operational area (JOA). Technical supervision is exercised across units of assignment and levels of command and affects all health care personnel and units engaged in delivery of health care to detainee populations (Figure 2-1). Technical supervision encompasses—

- All medical services provided at DCPs and DHAs to include limited medical screening, EMT, PMM (hygiene and sanitation), and medical evacuation of seriously injured or ill detainees through medical channels.

Note. For those detainees evacuated through medical channels, the echelon commander or supporting MP commander must provide guards/escorts as health care personnel cannot perform guard functions.

- Medical services provided in the TIF include—
 - Initial medical examinations.
 - Medical treatment (routine care, sick call, emergency services, hospitalization, and medical consultation and specialty care requirements).
 - Medical evacuation.
 - Preventive medicine (to include medical surveillance, occupational and environmental health [OEH] surveillance, hygiene and sanitation standards and practices, pest management activities, water potability inspections, and dining facility/services hygiene and food preparation practices).
 - Dental services.
 - Veterinary service support (to include food safety, veterinary PVNTMED, animal health care, and oversight of animal welfare, as required).
 - Neuropsychiatric (NP) treatment and stress prevention (as required) and BH support.

- Medical logistics (to include medical supplies, pharmaceuticals, medical equipment and medical equipment maintenance and repair, blood management, and optical lens fabrication.)
- Medical laboratory services for the clinical diagnosis of infectious diseases.
- All medical services provided in US military MTFs that are not part of established internment facilities. This can include EMT provided at battalion aid stations (BASs) and Role 2 MTFs (medical companies), forward resuscitative surgery provided at forward surgical teams (FSTs) to stabilize the detainee for further evacuation and hospitalization, and contract public health services
- All medical administrative matters such as the establishment and maintenance of medical records, documentation of preexisting injuries (to include medical photography, if deemed appropriate), restrictions on activities based on medical conditions (similar to medical profiles), and documentation required for legal purposes (such as monthly height and weight records).
- Procedural guides/standing operating procedures (SOPs) for reporting suspected detainee abuse are developed and disseminated and health care personnel are trained on procedures and ethical considerations.
- Procedural guides/SOPs are developed that standardize credentialing of health care providers, define the scope of practice of health care personnel, and establish scope of practice and supervision of retained health care personnel.
- Standards of health care throughout internment facilities within the JOA are established, inspected, and enforced (the standards used are the same as the standard of health care provided to US Forces in the same geographical area).
- Procedures for identifying, reporting, and resolving of medical ethics and other legal issues are established and disseminated.
- Procedures are established for ensuring medical proficiencies/competencies, and providing required training to resolve deficiencies. Programs of instruction are developed to ensure all health care personnel engaged in health care delivery to detainees will have appropriate orientation/training in culture, language (and/or language support), social, and religious beliefs of the detainee population. Refer to Appendix F for additional information on a sample mission essential task list with collective tasks.

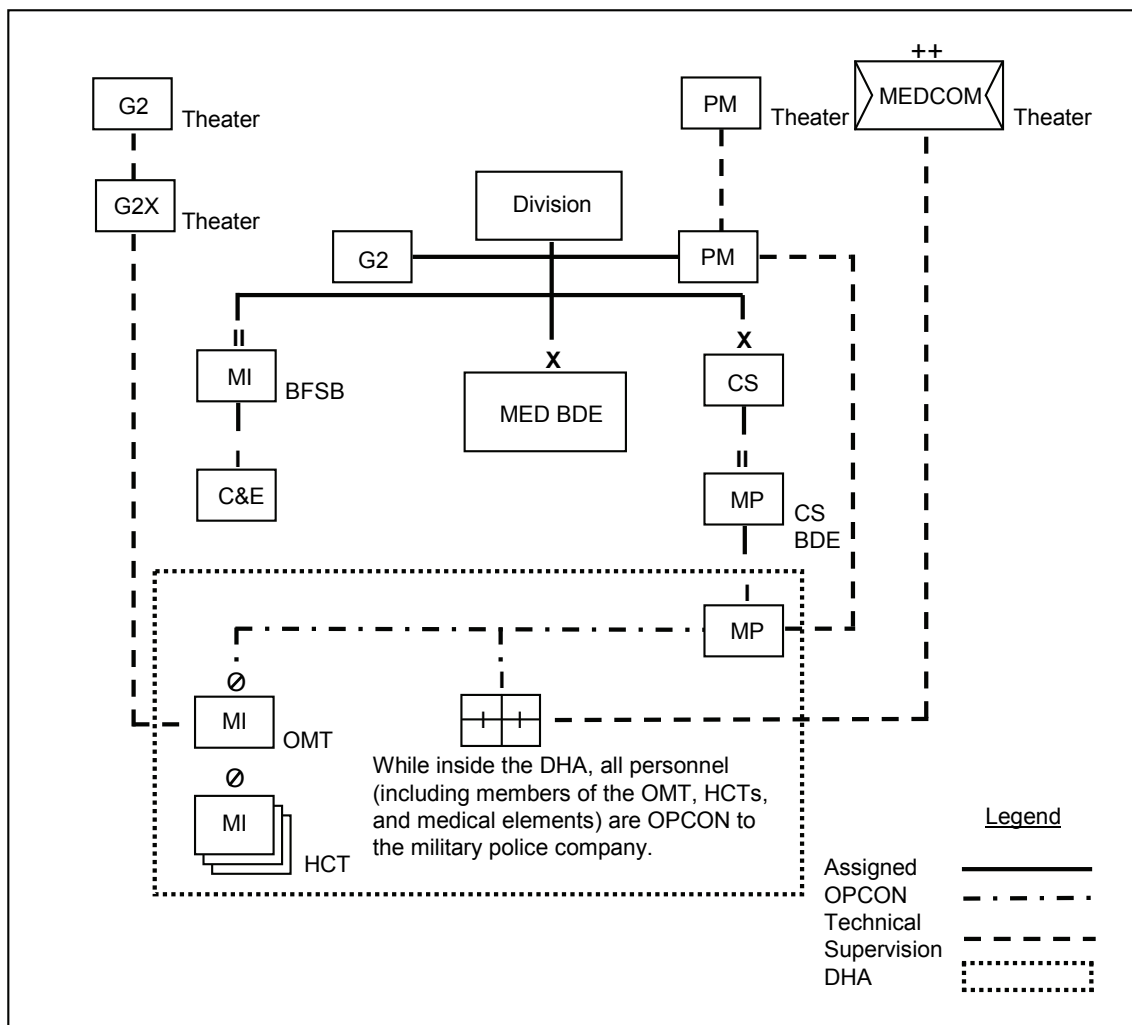


Figure 2-1. Technical supervision

HEALTH CARE PERSONNEL ORGANIC TO MILITARY POLICE UNITS

2-5. The internment/resettlement (I/R) battalion has organic health care personnel to provide a limited Role 1 medical care capability and PVNTMED services within the internment facility. When a DOMD has been designated within the JOA, these health care personnel are under the technical supervision of the DOMD. The TIF health care personnel inprocess detainees and provide the initial medical examination. They provide routine sick call services and EMT and coordinate with the supporting medical units for Role 2 and above care. They maintain medical records to include the monthly weight register. When the supporting medical unit is collocated with the TIF, their scope of practice, schedule, and duty assignments are coordinated through the supporting medical unit.

HEALTH CARE PERSONNEL ORGANIC TO MANEUVER UNITS

2-6. Health care personnel organic to maneuver units may be required to provide EMT, area medical support, and medical evacuation (if required) at the point of capture and to temporary concentrations of detainees at DCPs and DHAs. In early-entry operations, the senior medical officer (brigade surgeon) will serve as the DOMD until follow-on forces are deployed and a DOMD is designated for the JOA.

RELATIONSHIPS

COMMANDER, DETAINEE OPERATIONS

2-7. The operational commander shall designate the commander of the senior MP HQ as the CDO with OPCON of forces conducting DO. While the CDO exercises OPCON of all forces conducting DO, technical supervision of medical assets remains in the medical channels to ensure medical guidelines and standards are met.

JOINT INTERROGATION AND DEBRIEFING CENTER

2-8. The CDO is the approval authority for any detainee to be interrogated during an inpatient hospitalization. Before making this decision the DOMD will be notified and the supporting SJA will provide legal review for consideration by the CDO.

SECURITY PERSONNEL

2-9. Designated security personnel are solely responsible for detainee security, custody, and control. At no time, when outside of the internment facility, will a detainee be without a designated security person as overwatch.

Note. Designated security personnel are normally MP personnel but may be other military occupational specialty (MOS) or area of concentration (AOC) Soldiers. Medical MOS/AOC personnel will not serve as security personnel.

2-10. Security personnel do not provide health care to detainees. However, guard personnel may administer first aid (self-aid/buddy aid) or enhanced first aid (combat lifesaver [CLS]) in an emergency situation until health care personnel arrive.

THEATER INTERNMENT FACILITY

2-11. Key organizational elements in the TIF may be task organized and include a joint security group, a joint interrogation group, a detainee hospital, a joint logistics group, and a joint internment operations group. Special and personal staff considerations may include a joint visitor's bureau, a chaplain, the IG, the SJA, public affairs office (PAO), a surgeon, a forensic psychologist, a forensic psychiatrist, a medical plans and operations officer, an environmental health officer, and a provost marshal (PM) and/or security forces.

SECTION II — NONGOVERNMENTAL ORGANIZATIONS

INTERNATIONAL ORGANIZATIONS

2-12. International organizations (IOs) may request access to and/or information about detainees at any phase of the operation. All requests for access or information should flow via the established chain of command to the Office of the SECDEF (OSD).

2-13. There are three principal types of civilian organizations. They are—

- International organizations. These are established by intergovernmental agreements and operate at the international level (such as various United Nations [UN] organizations).
- Nongovernmental organizations (NGOs). These are voluntary organizations that are not funded by governments. They are primarily nonprofit organizations that are independent of governments, IOs, or commercial interest. They are legally different from UN agencies and other IOs in that they write their own charters and missions. Nongovernmental organizations are increasingly numerous and sophisticated and can involve hundreds of people in any potential conflict. They generally remain strongly independent from political control in order to preserve

their effectiveness. In many cases, their impartiality has been of great benefit, forming the only available means of rebuilding relations when political dialog has broken down. They are often highly professional in their field, extremely well motivated, and prepared to take physical risk in appalling conditions. They may fall into the two following categories:

- Mandated. A mandated NGO has been officially recognized by the lead IO in a crisis and is authorized to work in the affected area.
- Nonmandated. A nonmandated NGO has no official recognition or authorization and, therefore, works as a private concern. These organizations could be subcontracted by IOs or a mandated NGO. In other cases, they obtain funds from private enterprises and donors.
- International humanitarian organizations. These are impartial, neutral, and independent organizations whose mandate is to assist and protect victims of conflict. This group includes organizations such as the ICRC and the Red Crescent Societies. They carefully guard their neutrality and do not desire to be associated with or dependent upon the military for fear of losing their special status in the international community that allows them to fulfill their mission. Per DOD policy, generally the ICRC is the only international humanitarian organizations authorized conditional access to detainees.

2-14. Media attention concerning detainees will likely be substantial. Commanders and staffs should anticipate such attention and ensure that supporting PAO develops procedures, in advance, for dealing with media requests for visits and information. Photographing, filming, and videotaping of detainees is strictly controlled by DOD policy and ARs. The OSD is the sole release authority for photographs of detainees. Advance public affairs plans for events such as detainee movement for transfer and/or release is prepared and coordinated, with both the transferring and receiving geographic combatant commands (GCCs).

2-15. Requests for access to detainees by other government agencies (such as the Drug Enforcement Agency [DEA]) outside the DOD are common. All of these requests should flow through the chain of command to the appropriate approval authority. For various reasons, such visits may occur with little advance notice. Established procedures will assist units in verifying visit approval and coordinating the actual conduct of the visit.

INTERNATIONAL COMMITTEE OF THE RED CROSS

2-16. The ICRC is an independent agency whose activities include observing and reporting on conditions in wartime detention camps and facilities. During visits, it attempts to register all prisoners, inspect facilities, and conduct private interviews with detainees to discuss any problems concerning detainee treatment or conditions; it also provides a means for detainees to contact their families. While the ICRC has no enforcing authority and its reports are confidential, any public revelation regarding standards of detainee treatment can have a substantial effect on international opinion.

2-17. The ICRC seeks to handle problems at the lowest level possible. When a team conducts an inspection, it provides a briefing and sometimes a report to the local commander. Discrepancies and issues are presented to the detaining authorities and follow-up visits are made to monitor compliance with recommendations. The commander may not implement the recommendations based on either resource constraints or his interpretation of applicable law. These constraints can make complete implementation of ICRC recommendations either difficult or inappropriate. If recommendations are not implemented, the ICRC may address the issue with higher authorities. The ICRC does not expect to receive, nor does the DOD have a policy of providing, a written response to ICRC reports. However, DOD elements do attempt to implement as many of the recommendations as practicable, given security and resource constraints.

2-18. The ICRC should serve as an early warning indicator of possible abuse. Commanders should be alert to ICRC observations in their reports and take corrective actions as appropriate.

HEALTH CARE PERSONNEL CONTACT WITH NONGOVERNMENTAL ORGANIZATIONS

2-19. Health care personnel engaged in detainee health care will have no contact with NGOs without direct authorization from their chain of command.

2-20. The PAO is the staff officer responsible for understanding and fulfilling the information needs of the Soldier, the Army community, and the public. A PAO is located at division, corps, and theater levels.

2-21. The medical task force supporting DO will designate a staff officer (normally the personnel staff officer, US Army [S1]) to serve as the PAO. The medical task force PAO is the primary point of contact for the PAO supporting the CDO and coordinates and facilitates media efforts within the health care facility.

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Chapter 3

Medical Guidelines for Detainee Operations

Providing health care to a detainee population presents some unique challenges for health care personnel. Normally, detainees cannot be evacuated out of their national boundaries and must be escorted and guarded everywhere they go including the latrine and showers. Detainees are not military recruits and therefore do not normally have the advantages of being physically fit and having protective equipment (body armor). This results in detainees having more serious injuries than seen in allied and multinational forces. There may also be a secondary gain for a detainee in feigning illness and he can do so without negative repercussions.

SECTION I — GENERAL CONSIDERATIONS

CULTURAL CONSIDERATIONS

3-1. All personnel participating in multinational operations normally receive, as part of their predeployment activities an orientation, to the culture, languages, and religious beliefs prevalent in the area of operations (AO). Health care personnel must ensure they understand the medical considerations presented by these beliefs. Cultural or religious norms may affect a detainee's compliance with a prescribed medical regimen, may prohibit the use of blood and blood products, or may restrict the use of certain food products, thereby affecting the detainee's nutritional status.

GENERAL INTERACTION

3-2. Be sensitive to male-female interactions. Use a female provider and nurse for a female detainee whenever possible. This allows the health care personnel to respect the detainee's cultural and religious beliefs, as well as protect against potential allegations of physical or sexual misconduct. Male detainees will usually allow female providers to examine them, although some staunch believers may refuse even minimal physical contact. However, the detainee may simply be hesitant if the complaint requires observation and examination of the genitals. Usually an explanation of the examination and an acknowledgment of the detainee's modesty will suffice. The detainee will then allow the examination to proceed. If the detainee continues to refuse, explanation of the ramifications of no examination and documentation of his refusal and its consequences is essential. Each health care provider must determine whether they will subsequently prescribe treatment even if a detainee refuses an examination.

MODESTY

3-3. Always keep modesty in mind when examining a detainee and allow for privacy whenever possible. This is especially important in the case of examination of a "sensitive" body area. The use of curtains, draping, and positioning are helpful in protecting a detainee's modesty. Modesty must be balanced against guard force security and detainee and medical staff safety. Refer to paragraphs 1-62 and 1-63 for additional information.

RELIGIOUS REQUIREMENTS

3-4. Religious requirements can interfere with health care (such as fasting and prayer times). For example, Muslims take time to pray up to six times daily and for longer periods on Fridays. Health care

personnel must not interrupt prayer unless it is a medical requirement for immediate examination. If a detainee is truly ill, he will usually disregard prayer time in favor of examination whenever it is available. As in the US, there are many different preferences for following one's religious beliefs. Whether or not a detainee observes fasting requirements on a regular basis is an individual decision. Some fast regularly and others fast only on chief religious holidays. Make contingency plans for handling medication distribution and meals for a detainee observing a fast and anticipate delays during prayer times.

MEDICATIONS

3-5. In many countries/cultures, people can easily purchase medications from a pharmacy without a prescription and the individual normally takes those medications however he desires. This leads to requests for inappropriate medication prescribing, as well as the common mentality of using a pill or cream to treat all problems. This also results in detainees refusing medications whenever they feel that the condition is sufficiently treated or at any other random time of their choosing.

3-6. When captured, detainees will often bring their medications with them and they will expect to take those medications in their normal way. For the individual's safety, medications will be confiscated at the time of capture and will be placed in a bag and identified with the detainees name and capture tag number. Individual detainees will not normally retain medications on their person with the exception of emergency inhalers (or other emergency medicines), creams, or lotions as specified by command policy.

SECONDARY GAIN

3-7. Always be aware of secondary gain issues. To avoid secondary gain, make every effort to practice field medicine within the facility as much as possible. Detainees will try to obtain treatment at the hospital facility and will repeatedly ask for it. They will also feel important when requiring transport in an ambulance. This may occur because of the impression of better care, favorable environmental conditions (depending upon the temperature and time of year), the possibility of better food, or most importantly, the opportunity to gain intelligence about the facility, its personnel, and its operations.

3-8. Detainees may attempt to thwart interrogations by manipulating the medical system. Medical treatment will never be given nor denied in relation to interrogations. Health care will never be offered as incentive for participating nor denied for nonparticipation in the interrogation process. The medical staff must be vigilant of manipulation attempts by both the detainees and interrogators with regard to treatment requests and interrogations.

HEALTH CARE AND DRAMATICS

3-9. Health care in the facility can become the day's entertainment. Usually care through the wire elicits a crowd of interested or bored detainees who feel that they have something to contribute to the care of their friends. For privacy issues, as well as detainee and provider safety, it is important to insist that only the detainee come forward and that all the others remain a safe distance behind. Some detainees will markedly overplay their symptoms or appear helpless. "Blanket litters," in which a detainee is carried forward in a blanket due to the "inability" to walk or "severe" illness, are commonplace and should not influence the provider's examination or diagnosis. Having the detainee stand or sit upright and actively participate in the examination helps the provider determine the true nature and extent of the illness. Avoid rewarding dramatics whenever possible. Be concerned and compassionate, but not a pushover.

FAVORITISM

3-10. Do not play favorites and avoid making promises that you cannot keep. Perception is paramount in many cultures. The perception of special treatment of some detainees in favor of others can lead to unrest and feelings of inequality amongst the detainees, which can interfere with the trust relationship that must sustain the health care provider's interactions. A promise is essentially a contract and the provider damages his credibility if promises are not kept or if the detainee expectations are not met, within reason. (See paragraph 3-18 below for additional information on trust.)

LINGUIST REQUIREMENTS

MEDICAL CONSIDERATIONS

3-11. Linguists are a major priority. Obtaining an accurate medical history is paramount to detainee care, both for documentation issues and for treatment plans. Use a trained linguist whenever possible. Even better is a medical translator who knows the specific medical terminology that providers commonly use. Most times, trained linguists are in high demand and are hard to acquire.

3-12. When using linguists, talk to the detainee, not to the linguist. Speak in brief, short sentences. Speak only about medical issues and not reasons for capture or social, religious, or political issues.

3-13. For additional information on linguist support refer to Appendix G.

RETAINED/DETAINED PERSONNEL

3-14. If a professional linguist is not available, use medical detainees (physicians, nurses, dentists, and veterinarians) first if at all possible and then detainees with good English skills. Develop a good working relationship with the translator because the success of your mission depends upon a good medical history.

DEFINITION OF TERMS

3-15. Make sure that your definition of a term matches what the detainee really means. Do not assume that you know what they mean. Ask questions in different ways to obtain a full and accurate medical history. Many times, the detainees will complain of symptoms or problems that may sound foreign to US providers. Some common examples are: “colon infection” (generally means heartburn or chronic diarrhea); “allergies in the blood” (means anything from seasonal allergies to rashes and itching); “fluenza” (refers to the common cold); “low blood” (suggests anemia); “no sleep” (usually means poor or interrupted sleep); “I have psychology” (refers to any psychological disorder); and “blisters” on the feet (are usually warts). Having a good translator who knows your train of thought can really go a long way in determining what the detainee’s real problem is especially since some descriptions are very similar.

3-16. The linguist must give you the exact translation of an interaction, not his “cleaned-up” version. At times, the detainee will speak for several minutes and the translation will be a short sentence. This is a very frustrating situation and commonly occurs with detainee translators as well as with linguists. Detainees like to take off on multiple tangents when giving a history. Repeatedly encourage your translator, whether a detainee or employed, to tell you exactly what the detainee is saying. Questions about a coughing condition may result in a story about how the detainee has knee pain during prayer times. It can be very frustrating to wait patiently and listen to the detainee and translator talk for minutes and then receive a “yes” or “no” answer. In many cultures it is common for a person to try to protect one’s friends and neighbors from embarrassment and from trouble; detainees are no exception. The translator may try to save you and the detainee from embarrassment related to the area of the body that is causing trouble or in reference to off-color comments that the detainee may be making without your knowledge of the language. Some detainees will say hateful things which are translated as innocuous statements or which are not translated at all. If you get the feeling that something is not right, push the issue and ask for an accurate translation. This sort of behavior by the detainee and translator can result in impatience and frustration on the part of the provider, who must always remember that the translator thinks he is doing the right thing.

DIALECTS

3-17. Different regional beliefs, dialects, and customs will affect detainee interactions and communication. As with any large nation, people from different geographic regions can speak and sound differently from the other parts of the nation. Because of the subtle differences in dialect, voice inflection, or other vocal characteristics, translators can experience difficulty understanding a detainee who fundamentally speaks the same language. Many times, finding a translator with experience in different languages or dialects can be very difficult. Know which of your translators speak other dialects or languages; ask for them and use

them for these more difficult situations. It is also common to encounter a detainee from another country who may not speak the predominant language at all. This can significantly impact the delivery of health care and force the provider to rely on other communication means.

TRUST

3-18. Constantly emphasize trust between the health care personnel and the detainees. Always reinforce that you are not there to poison the detainees, make them sick, or hurt them in any way. This refers to medical treatments, immunizations, and medications (both oral and injected). Many detainees may refuse the optional immunization because they believe it might be harmful to them, despite strong educational programs developed by providers and provided by fellow detainees and others, to include common language handouts. Refer to Appendix H for more information on immunizations. Signs in the local language, or in different dialects (if required), and in English are useful and may help alleviate some reservations that the detainees have. Caring and compassion go a long way to bolster the medical relationship with the detainees. Also, enlist the help of the detainee leaders to reassure their fellow detainees of your actions and intentions. Never make promises. Always say “I’ll try,” “I will look into it,” or “We will see.” Even general or off-hand statements can be construed as promises if one is not careful. Credibility can be easily ruined if perceived promises are not met.

TRANSLATION GUIDES AND DEVICES

3-19. During recent operations, some medical units devised flash cards that pictorially depicted a variety of medical complaints. Additionally, similar commercial products may also be available for use. Units developing or using this type of communications tool, must be cautious and ensure that the images used do not offend the cultural or religious beliefs of the individual.

3-20. In some cases, health care providers may be able to leverage advances in communications technology that can provide an automated translation service through a handheld device.

SECURITY CONSIDERATIONS

TEMPORARY DETENTION LOCATIONS

3-21. At the DCP and DHA, the Role 2 MTF providing support on an area basis may have to provide EMT to temporary concentrations of detainees being held.

- The security measures instituted at these points are dictated by the unit that established the collection point. Health care personnel should not enter the holding area until necessary security precautions have been taken.
- Health care personnel should inventory those medical supplies (especially sharps) and equipment they are taking into the enclosure. While in the enclosure, health care personnel must be alert and be prepared to defend themselves should the need arise. Prior to exiting the enclosure, health care personnel must ensure they have all supplies, equipment, empty vials, or medical supply packaging.

THEATER INTERNMENT FACILITY

3-22. Use of force, security, and control of detainees are entirely functions of the assigned facility security personnel; however, planning, training, and preparing for the use of force is a necessary element in maintaining order in a facility. The TIF commander and the medical commander ensure that health care personnel are trained and prepared for the effective use of force when necessary to protect themselves and the detainees. Health care personnel will also ensure that the use of force continuum is applied when force is required for self-defense. Health care personnel assigned the mission of providing health care to detainees at the TIF should be issued and trained on rules of engagement (rules for the use of force specific to that mission).

3-23. At the TIF, health care personnel should observe the same precautions as they would use at a DCPs and/or DHAs. The MP unit establishing the facility also dictates what security procedures will be observed when treating detainees at the facility. Health care personnel should never enter the general population area by themselves. Whenever possible, it is better to have the detainee taken to the established medical treatment area rather than having health care personnel enter confinement areas. The medical treatment area should have all medical supplies (especially sharps), medical equipment, and pharmaceuticals secured prior to permitting the detainee to enter the medical treatment area. Health care personnel must remain continuously alert while in the presence of detainees. Although health care personnel may treat the same detainee for a recurring or chronic condition and feel as though they have gotten to know the detainee, health care personnel should remain vigilant and be prepared to react if threatened.

3-24. In addition to medical items, health care personnel must secure any items that have the potential of being turned into a weapon, such as pens, pencils, or scissors.

MILITARY POLICE OVERWATCH

3-25. Medical interactions must always involve MP overwatch, especially when a detainee is outside of the compound, such as for examinations and treatment. As a rule, health care personnel do not carry weapons within the detention compound. This is for their safety and is generally dictated by the MP command. Since the vast majority of outpatient care occurs inside the detention compound, MPs must be vigilant in protecting the safety of health care personnel. Even the most friendly or helpful detainee may be harboring the desire to harm a Soldier, even if that Soldier is a health care provider.

3-26. Maintain close working relationships with the MPs, especially between guards and health care personnel. The MPs working inside the compound know their detainees very well and are able to provide valuable input into the detainee's health care or concerns. For instance, an MP knows which detainees repeatedly do not come up for head count and can point them out for medical evaluation. In addition, MPs tend to know the disposition of their detainees very well and can usually let the health care personnel know when a detainee is really ill or simply looking for attention.

ORDERLY CONDUCT

3-27. Detainees are always interested in what is going on at the gate, but they must not crowd health care personnel providing care. Detainees crowd around the person being evaluated and often try to offer input into the situation. Interactions must remain orderly to avoid confusion and potential escapes. Frequently, a detainee will need to come out of the wire for an examination. Having a large group of detainees crowded around the entry point while it is open, makes it very easy to overlook the one or more detainees that may be trying to escape. It is best to require the detainees to line up a short distance away from the gate so that the detainee, translator, and provider can accomplish the evaluation while maintaining privacy and dignity. Detainees must always wear their designated clothing (usually a jumpsuit type of garment) and have their identification band on hand. In addition to security, the MPs provide behavior control as well. Any detainee that fails to follow orders or rules can be disciplined appropriately by the MPs.

Note. Health care personnel should not discipline or participate in the discipline of detainees. Any problems should be immediately reported to the on-site MP authority.

WEAPONS AND AMMUNITION

3-28. Weapons and ammunition must be secured away from treatment areas. In some instances, MPs may allow health care personnel to maintain the security of their weapons within a separate area, if that area is completely removed from all detainee care areas and as long as that area is properly secured.

3-29. At Role 3 hospitals, detainees should be segregated from US, allied, and multinational patients. Detainees are guarded by nonhealth care personnel designated by the echelon commander while they are patients in the facility. All medical equipment, supplies, and pharmaceuticals should be stored and secured

off of the ward. Whenever possible, it is preferable to have detainees treated in a room outside of the ward setting. Whenever detainees are required to leave the ward, they should be escorted under guard to ensure they do not attempt to escape, injure hospital personnel or other detainees, or damage and/or destroy hospital property.

MEDICATION DOSAGE CONSIDERATIONS

3-30. Consider unit-dose packaging for chronic medications to prevent hoarding, bartering, overdose, and waste. At no time should a detainee have possession of his medications, except for albuterol inhalers, moisturizing creams, and antifungal or mild steroid creams. It is a common occurrence to find pills of various kinds during a “shakedown” or facility search. The MPs should bring the pills to health care personnel, in a bag labeled with the respective detainee’s ISN and name. The detainee medical record is then reviewed for evidence of those particular prescriptions and to ascertain compliance. Trading medications is a common occurrence and on occasion, a detainee will “cheek” his medication and store it for future use. The most worrisome use would be plans for an overdose, potentially as a distraction for an escape attempt, or to commit suicide.

Note. Standard precautions for narcotics apply. They should be kept secured in a double-lock system, either within the TIF or another secure location inside the main hospital.

HEALTH CARE PERSONNEL

Identification

3-31. Special identification for health care personnel (such as a “Red Cross” or “Red Crescent” brassard) can assist with facility security. It is extremely important for the MPs to know who has access to the facility on a regular basis. Although sight recognition occurs early on, rotations of both MPs and health care personnel do regularly occur throughout the medical areas and the TIF. Health care personnel should notify the facility noncommissioned officer in charge (NCOIC) of their areas whenever a change in personnel occurs.

Staffing

3-32. Adequate staffing will improve detainee behavior and help enforce compliance with medical recommendations and treatment. Health care personnel should have MP overwatch whenever interactions occur with detainees, regardless of whether the detainee is inside or outside the wire.

RIOTS AND ESCAPES

3-33. Sudden or unusual medical problems can distract attention from efforts to riot or escape. Many times, these distractions are well-planned and executed. Although the medical mission is to provide treatment, it is critical that all personnel follow proper precautionary measures to avoid friendly forces and detainees’ injuries or detainees’ escapes. Boycotts of medication or treatment are allowed, but must be well-documented. This usually occurs when the detainees try to make a statement or protest some action by MPs or other US Forces. In addition, with the exception of insulin, detainees may refuse medications or other treatment outright or by fasting. Proper documentation is required and the detainee must be aware of the consequences of his actions, to include serious medical problems or death.

3-34. Health care personnel will at all times be vigilant and not become complacent when around detainees. Many items in the MTF can be used as weapons to take lives or to take personnel hostage. When the detained personnel have taken over the internment facility, the health care personnel’s first option is to use force to defend themselves, their detainees, and other US and multinational forces. When this fails, members of the health care personnel designated in Article 25 of the GPW who have fallen into the hands of the detained personnel, shall become EPWs, but shall be employed on their medical duties in so far as the need arises. The health care personnel shall continue to fulfill their duties under the orders of

the adverse Party and shall preferably be engaged in the care of the wounded and sick of the Party to the conflict to which they themselves belong.

USE OF RESTRAINTS

STANDARD RESTRAINTS FOR ALL DETAINEE INPATIENTS

3-35. The degree of security and restraint exercised over detainees will reflect the conditions of and reasons for their internment and will recognize the potential for escape and difficulties of apprehension posed by detainees.

3-36. Ordinarily, detainee inpatients will be restrained consistent with command policy. This may include using two-point restraints at all times. The two-point restraints will be placed on opposing limbs (one arm and one leg) unless contraindicated due to the detainee's medical condition.

3-37. Restraints in addition to the two-point standard will be applied when detainees become combative or dangerous to themselves or others. Once the detainee becomes oriented or cooperative, the restraints in addition to the two-point standard will be removed. Restraint removal will be the result of a joint vetting process in close coordination with the commander of the security forces.

3-38. Restraints will be removed when detainees are transported between areas of the MTF. During such transfers, detainees will be accompanied by a medical staff member and an MP.

3-39. For exercise or physical therapy (PT), the detainee will not be restrained but will be escorted by medical staff and remain in clear sight of, and in close proximity to, the MP security personnel at all times.

3-40. Use of leather restraints in the MTF emergency room (ER) will be at the discretion of the ER physician and charge nurse, in consultation with the MTF commander.

RESTRAINTS FOR CIVILIANS/HOST-NATION PATIENTS

3-41. Patients deemed by authorities to be host-nation (HN) civilians, rather than detainees, are not routinely placed in restraints. However, they may be restrained for reasons of medical necessity. For security reasons, they will be accompanied off the wards at all times by staff members or MPs.

RESTRAINT NECESSITY

3-42. Unless a restraint procedure is deemed necessary based purely on medical criteria for the protection of the physical or mental safety of the detainee, other patients, or the MTF staff, health care personnel will not participate in the process of restraining the detainee. Rather, MP or other security personnel will be responsible for restraint of the detainees.

COMBATIVE PATIENTS (DETAINEES OR OTHERS)

3-43. Any patient who becomes combative, or when otherwise medically indicated, may be restrained for his own safety and that of other patients and staff.

3-44. A gradually increasing level of appropriate restraint will be used. The first level will be physical restraints and typically will be either standard leather restraints of the wrist and/or ankles or a bed sheet specifically used to secure the patient to the gurney.

PROCEDURES FOR USE OF MECHANICAL LEATHER RESTRAINTS ON DETAINEES

3-45. Personnel will comply with the following guidelines in connection with the use of mechanical leather restraints on detainees:

- Ensure that the detainee or any other patient is not able to manipulate the restraint buckle.
- Check the integrity of the restraints, examine the patient's skin for redness or breakdown, and check pulses distal to the restraint site at least every two hours.

- Check capillary refill within five minutes of the application of the restraints.
- Rotate sites daily if not contraindicated by the patient's medical condition.
- Ensure the patient is able to reach the urinal or offer toileting at least every two hours.
- Pad the extremity with an antiseptic wound care dressing before applying the restraint if skin redness or breakdown occurs at the location of the restraint.
- All ward staff members will be issued one restraint key. The MP guard for the ward will have one restraint key.

NONPATIENT COMBATIVE DETAINEES

3-46. The CDO will determine the appropriate policy as it pertains to these detainees. However, normally there will be an actual and perceived separation between the functions of interrogation, custody, and control, and detainee health care. At no time will health care personnel provide custody or control for detainees, whether or not they are patients. Detainee security and control are entirely functions of assigned security personnel, who are usually MPs.

3-47. Rare exceptions to this policy exist, such as where an extremely combative detainee is overpowering security personnel. If a detainee is so combative and violent that all available specialized restraint techniques are ineffective and the detainee is a danger to himself, other detainees, or DO staff, then pharmacologic restraints may be considered. If time allows, use of this level of restraint will require the authorization of the CDO. All pharmacologic restraint agents will be administered by a licensed clinician under strict medical standards of care. A detainee should be under one-to-one observation by security personnel overseen by an independent licensed health care provider for at least 12 hours after receiving a pharmacologic restraining agent.

SECTION II — PRIOR TO TRANSFER TO AN INTERNMENT FACILITY

MEDICAL SCREENING

3-48. The medical screening that can be accomplished at a DCP or a DHA is limited. Health care personnel assigned to the MP unit normally treat detainees at collection points; however, if these personnel are not available, the Role 2 MTF providing area support may be required to perform a hasty assessment of the detainees at the request of the detaining unit. Whenever possible these support requirements should be included in the operations order (OPORD). The purpose of this medical screening is to ensure the detainees do not have significant wounds, injuries, or other medical conditions (such as severe dehydration) that require immediate medical attention and/or medical evacuation. Medical personnel are screening for conditions which could deteriorate prior to the transfer of the detainees to a TIF. This screening does not include the use of diagnostic equipment such as x-ray or laboratory tests as these resources are not available at a DCP or DHA. Any medical treatment provided during screening would be entered on the Department of Defense (DD) Form 1380 (US Field Medical Card [FMC]). Each detainee has a completed DD Form 2745 (Enemy Prisoner of War [EPW] Capture Tag) to identify him. The detainees capture tag number is used as the identification number on the DD Form 1380. If the detainee is not to be evacuated through medical channels, one copy of the DD Form 1380 is provided to the detaining unit for inclusion in the detainee's medical record to be initiated and maintained at the TIF.

EMERGENCY MEDICAL TREATMENT

3-49. If health care personnel are not available, EMT is provided by the Role 2 MTF providing area medical support. Detainees whose medical conditions require hospitalization are treated, stabilized, and evacuated to a supporting MTF. All medical treatment provided to the detainee is annotated on DD Form 1380 and is evacuated with the detainee for inclusion in his medical records established at the Role 3 hospital. The ISN is only assigned at the TIF. Medical records initiated prior to assignment of the ISN will use the capture tag number for identification purposes.

MEDICAL EVACUATION

3-50. Injured and ill detainees requiring hospitalization are evacuated through medical channels prior to their being entered into the Detainee Reporting System (DRS). Health care personnel do not search, interrogate, or guard detainees being evacuated through medical channels. The echelon commander is responsible for providing this support.

3-51. Detainees evacuated from Roles 1 and 2 treatment facilities must be accompanied by all original medical documentation. The outpatient and screening documentation will accompany the detainee to the Role 3 hospital supporting the TIF.

3-52. Detainees treated at an FST should have an extended ambulatory record generated. When detainees are evacuated from Role 2 to Role 3 MTFs, a copy of the extended ambulatory record will accompany the detainees. The following minimum documentation is required to accompany the detainees if copying capabilities are limited:

- Operative notes.
- Transfer/narrative summary of care.
- Radiographs.

3-53. Whenever possible, detainees should be segregated from US, allied, and multinational forces during evacuation.

3-54. In the event that a detainee may require formal regulation, validation and movement in the patient movement system (particularly aeromedical evacuation), the United States Transportation Command (USTRANSCOM) surgeon and global validating flight surgeon will be consulted and will concur with the plan for the proposed patient movement of a detainee. This consultation will begin prior to entering any detainees in the US Transportation Command Regulating and Command and Control Evacuation System (TRAC2ES), the web system used for global patient movement validation, mission planning, and intransit visibility. Detailed detainee movement guidance should be in the operational plans.

Note. As with medical treatment, only **medical urgency** can justify the priorities established for medical evacuation.

FIELD SANITATION AND PERSONAL HYGIENE CONSIDERATIONS

3-55. At DCPs and DHAs, field expedient measures may be required to sustain field sanitation practices of detainees. If sanitation facilities are not feasible, commanders will provide personal hygiene/field sanitation facilities commensurate with those that they would provide for their Soldiers based on available resources and duration of stay. Cultural considerations should be taken into account and could affect the feasibility and success of sanitation measures. If health care personnel are requested to provide EMT at DCPs and DHAs, they should ensure they review how field sanitation measures are being implemented at the site. Any deficiencies noted should be corrected on the spot and reported to the chain of command and the DOMD.

ADMINISTRATIVE PROCESSING

3-56. The ISN is the DOD mandated identification number used to maintain accountability of detainees. The ISN is generated by the DRS.

3-57. Once the DRS creates the ISN, no component may be changed or corrected at the division, corps, and theater level without approval from the National Detainee Reporting Center (NDRC). All changes to an ISN must be requested in writing and approved by the NDRC.

3-58. The only authorized tracking document/number from point of capture until the issuance of an ISN is the unique capture tag number that is found on DD Form 2745. For example, if a detainee is evacuated to a Role 3 hospital from the point of capture, medical channels will use the capture tag number to track a

detainee through the medical facilities. Once an ISN is assigned to a detainee, all further documentation, to include medical records, will use only the ISN (no other numbering system will be used). Additionally, previously generated documents using the capture tag number should be annotated with the ISN. The DRS cross-references the ISN and the capture tag number for administrative purposes.

SECTION III — AT THE INTERNMENT FACILITY

MEDICAL SCREENING

3-59. The medical examination of detainees is an important process used to protect the detainee population from preventable illnesses or injuries through early detection of medical problems. The medical examination of detainees is for medical purposes only. As with any medical procedure, it is important to safeguard the dignity and privacy of the individual while also maintaining an environment of maximum safety and security for detainees, medical staff, and the staff of the TIF. For information on medical inprocessing screening tools refer to Appendix C.

INTERNMENT SERIAL NUMBER

3-60. Detainees are provided an ISN when being inprocessed to the TIF. The TIF is the only location where this number will be assigned. To identify detainees prior to the issuance of the ISN, the capture tag number (DD Form 2745) is used on all documentation concerning the detainee. Once the ISN is issued, existing records are updated.

3-61. Detainees require an identification number in order to begin medical processing, so that tests and medications can be ordered as required. This particular aspect is governed by the MP unit in charge of inprocessing. Any computer malfunctions or systems problems can affect how quickly a detainee is ready for medical screening. Of course, at any time if a detainee requires urgent or emergent care, capture tag numbers will suffice until the proper processing can be accomplished.

Note. No detainee will be refused care because an ISN cannot be provided up front.

PRIORITY OF PROCESSING

3-62. Detainees with identified medical conditions that require daily medication should be front-loaded for processing. This includes detainees with diabetes, high blood pressure (BP) or heart disease, asthma, and seizures. By front-loading these detainees, potential medical problems can be identified early-on and prevented and medications can be quickly restarted.

AVAILABILITY OF MEDICAL DOCUMENTATION

3-63. All medical documentation and medications from screening examinations or treatment at prior locations, such as the DCP or DHA, should be available for review and inclusion in the medical record. All documentation conducted on DD Form 1380, SF 600 (Medical Record–Chronological Record of Medical Care), SF 558 (Medical Record–Emergency Care and Treatment [*Patient*]), or other medical forms completed by the Role 1 or Role 2 MTF providing area support will accompany the detainee throughout the roles of health care. Many times, these records contain important information regarding the detainee's presentation and health status immediately after capture. Each entry helps to provide a chronological picture of the detainee's medical condition over time during the time of his initial detention. In addition, the MTF providing area support to the capturing unit may have taken useful photographs of injuries that are healing or may already be healed by the time the detainee arrives at the TIF.

WORKLOAD VARIANCE

3-64. Workload can vary widely based upon mission, enemy, terrain and weather, troops and support available, time available, and civil considerations (METT-TC). The staffing required to conduct medical inprocessing at the TIF must be adequate to ensure that detainees are provided with timely medical examinations and that all administrative requirements for the initiation of individual medical records and weight registries are successfully completed. Medical screening includes completing a medical history (to include immunizations), physical and dental examinations, and BH assessments. Diagnostic testing (such as a urinalysis) and administering immunizations are governed by command policy and medical necessity. In addition to the health care provider, sufficient staff is required to accomplish ancillary and administrative support functions. The clinical standing operating procedure (CSOP) should address procedures for obtaining augmentation of these resources, if required.

STANDARDIZED FORMS

3-65. Preprinted physical examination, BH, and dental screening forms can streamline initial inprocessing. Past medical history should focus on past and current communicable diseases (TB, HIV, and STD), major health problems (asthma, cancer, diabetes, epilepsy, hemophilia, heart disease, and hypertension), allergy to foods, medications, or insects, past surgeries, recent or current medication use, and social habits such as alcohol and tobacco use. Translating routine past medical history questions into the local language can accelerate the preprovider contact, as long as the detainee is able to read. Refer to Appendix C for sample preprint formats for the SF 600 for detainee physical screening and quality assurance screen of a detainee's medical record.

LINGUIST SUPPORT

3-66. Multiple linguists are necessary to keep each section of medical processing moving smoothly. Because of the nuances in medicine, an accurate medical examination is not possible without translator assistance. Ideally, one translator is necessary for each of the following sections: BH, roving, screening, and per each provider. It is difficult for two providers to share one translator and nearly impossible when there are three providers performing evaluations. As a preventive measure to preclude intelligence gathering, translators should be rotated. This prevents the development of detainee familiarity that can result in the flow of nonmedical information.

3-67. For additional information on linguist support refer to paragraphs 3-11 through 3-20 and Appendix G.

HEALTH STATUS INDICATORS

3-68. Baseline vital signs, including BP, heart rate, height, weight, and body mass index (BMI), help to determine a detainee's initial overall health status. As with all patients, these values are useful for comparison when a detainee presents at some future time with complaints. Weight and BMI are essential to evaluate a detainee's initial nutritional status, as well as his ongoing physical condition during confinement. A BMI less than 18.5 should prompt evaluation by a nutritionist. In addition, AR 190-8 requires that detainees have monthly weights registered on Department of the Army (DA) Form 2664-R (Weight Register) (Figure 3-1) and kept on file. Based upon tracking requirements set by the CDO and DOMD, this information may be obtained by either medical or MP personnel, and tracked electronically or in a separate, hard-copy format.

WEIGHT REGISTER					
For use of this form, see AR 190-8; the proponent agency is PMG.					
NAME (Last, first, MI)				INTERMENT SERIAL NUMBER	
WEIGHT	DATE	WEIGHT	DATE	WEIGHT	DATE
SAMPLE					

DA FORM 2664-R, MAY 82 EDITION OF 1 JUL 83 IS OBSOLETE APD V1.00

Figure 3-1. Sample Department of the Army Form 2664-R, Weight Register

REGULATORY SCREENING

3-69. Army Regulation 190-8 specifies that a medical officer will examine each civilian internee (CI) upon arrival at a facility and monthly thereafter. The CI will not be admitted into the general population until medical fitness is determined. These examinations will detect vermin infestation and communicable diseases especially TB, malaria, and STDs. They will also determine the state of health, nutrition, and cleanliness of each CI. During these examinations, each CI will be weighed, and the weight will be recorded on DA Form 2664-R.

3-70. For children up to 14 years of age, a tuberculin skin test (TST) will be administered. No chest x-ray is necessary if the TST is negative. The local medical officer will establish guidance for subsequent tests based on the TB experience of the population. Routine annual tuberculin testing of children is not warranted unless there is clear-cut evidence of high risk. Any CI with results suggestive of active disease must be started promptly on quadruple drug therapy and be kept in isolation until symptoms have resolved and multidrug therapy has been underway for two to four weeks. Current guidance from the Centers for Disease Control and Prevention (CDC), as well as the World Health Organization (WHO), recommends quadruple therapy for two months. This entails a four-drug regimen of isoniazid (INH), rifampin (RIF), pyrazinamide (PZA), and ethambutol (EMB) or streptomycin (SM) until the drug susceptibility results are known. If the drugs are given daily at the start of therapy and susceptibility results show no drug resistance, EMB or SM can be discontinued and the other drugs continued until PZA has been given for 2 months. Isoniazid and RIF should then be continued for another 4 months, including at least 3 months of therapy after the culture has converted to negative.

MEDICAL RECORD GENERATION

3-71. The initial care provided to detainees at Role 1 may be documented on DD 1380 but once detainees are evacuated to the role of care with the appropriate medical record folder (DA Form 3444-series [Alphabetical and Terminal Digit File for Treatment Record] or DA Form 8005-series [Outpatient Medical Record [OMR]), the color coded medical record containing the required demographic information will be initiated.

3-72. A medical record will be generated after the completion of the medical screening process. The physical examination, BH, and dental screening forms should be included, as well as a detainee dossier for identification purposes and a DD Form 2766 (Adult Preventive and Chronic Care Flowsheet) or DD Form 2882 (Pediatric and Adolescent Preventive and Chronic Care Flowsheet), as appropriate. Consider the inclusion of a quality assurance form that tracks the completion of all aspects of the medical screen and any detainee limitations on activity, diet, travel, or facility placement. This form should be signed by the examining provider at the end of the encounter and reviewed by the inprocessing NCOIC for completeness.

3-73. If the detainee was provided medical care at temporary detention locations, the FMC becomes a part of the detainee medical record.

DISPOSITION OF MEDICAL RECORDS

3-74. Detainee medical records will be processed for disposition as required by the following regulations and guidance:

- AR 40-66.
- AR 25-400-2.
- Quick Reference Guide to Documenting Operations for Deployed Units of the Army (available at: https://www.rmda.belvoir.army.mil/rmdaxml/rmda/QuickReferenceGuide_0805.pdf).

3-75. Detainee inpatient medical records and OMRs will be dispositioned to the following locations:

- Inpatient records and the extended ambulatory record will be dispositioned to the following record holding facility:
Director
Detainee Administration Systems and Biostatistics Activity
ATTN: MCHS-ISD
1216 Stanley Road, Building 126, Suite 25
Fort Sam Houston, Texas 78234-5053
- Outpatient records will be dispositioned upon release or final disposition of the detainee from detention. These outpatient records will be forwarded to the following record holding facility:
Washington National Record Center
4205 Suitland Road
Suitland, Maryland 20746-8001

RELEASE OF INFORMATION

3-76. The Health Insurance Portability and Accountability Act does not apply to the medical records of detainees and EPWs. Given that the Geneva Conventions require the military to provide the same standard of care to detainees and EPWs as US Forces, detainee/EPW medical records should be initiated and maintained at the same standard. The procedures outlined in AR 40-66 regarding the release of medical information for official purposes should be followed for detainee/EPW medical records.

3-77. Due to responsibilities of the TIF chain of command regarding the care and treatment of detainees/EPWs, they are entitled to some medical information. For example, detainees suspected of having infectious diseases such as TB should be separated from other detainees/EPWs. Releasable medical information on detainees and EPWs includes that which is necessary to supervise the general state of health, nutrition, and cleanliness of the security force, detainees, and EPWs and to detect contagious diseases. The information released should be used to provide health care, to ensure the health and safety of detainees and EPWs, to ensure the health and safety of the personnel operating or working in the TIF, to ensure law enforcement on the premises, and to ensure the administration and maintenance of the safety, security, and good order of the facility.

3-78. Detainees should be entitled to copies of their medical records upon release from the TIF. Copies of medical documentation provided to released detainees will have all US military unit designation, health

care provider, and other medical support personnel information (for example, name or provider number) redacted (removed or obliterated).

DOCUMENTATION OF EXISTING MEDICAL CONDITIONS OR INJURIES

SCARS, MARKS, AND TATTOOS

3-79. All identifying scars, marks, and tattoos should be clearly documented on a body diagram. Many detainees will become curious or even fearful when asked to display all of his tattoos. Clarify to the detainee that this documentation serves for identification purposes only. However, some tattoos have significance other than body art, which is why these should be carefully documented for future reference.

DETAILED DOCUMENTATION OF INJURIES

3-80. Areas of injury must be clearly documented and described in detail during the initial inprocessing physical. This process is important for continuing wound care and notification of the wound care team. Wound care is essential for all new detainees requiring ongoing treatment. Consider admission for any detainees with large or infected wounds.

IDENTIFICATION OF EXISTING MEDICAL CONDITIONS

3-81. Medical conditions should be identified in the preprovider screening and confirmed by the provider prior to examination. Occasionally, detainees will believe that they have a certain illness or condition based upon their current or past symptoms. It is essential for the provider to verify all affirmative responses so that ongoing medical conditions can be treated and questionable conditions and medical concerns can be clarified by the provider.

PRESCRIPTIONS AND INITIAL TREATMENT

3-82. Provide prescriptions, consults, and initial treatment as needed. Some detainees will know their prior medications by name and efforts should be made to restart these same medications, if indicated. Most times however, detainees will only know that they were taking a pill for their condition. Be sure not to overmedicate; if questions remain about a diagnosis, encourage follow-up in the facility prior to starting treatment.

SEGREGATION OF MEDICALLY CHALLENGED DETAINEES

3-83. Consider segregating detainees with medical conditions, wounds, or physical impairments for ease of treatment. Having these detainees in a centralized facility area improves treatment compliance and follow-up.

MEDICAL PHOTOGRAPHY

3-84. Army Regulation 190-8 prohibits the photographing, filming, or videotaping of individual detainees except for facility administration and intelligence/CI purposes. Health care personnel are permitted to photograph detainees to document preexisting conditions, injuries, and wounds. The individual's identity should be clearly visible. These photographs are invaluable if a claim of unnecessary surgery or amputation is made. Any detainee who requires amputation or major debridement of tissue should be photographed. Once taken, these photographs are maintained as part of the individual's medical record.

3-85. Consider the use of photography for documentation and treatment purposes. Detainees may arrive at the TIF with photographs of wounds or injuries taken by health care personnel at the DCP or DHA. These are helpful to monitor the resolution or progression of injuries and are filed in the detainee's individual medical record.

3-86. Medical photography can also be used for medical diagnosis and treatment and used for the management of a number of medical conditions. Contact the Office of The Surgeon General (OTSG) Clinical Consultant to obtain current guidance for submission of teleconsultations at e-mail derm.consult@us.army.mil. This consult capability is used only in a deployed environment. Generally a teleconsultation consists with a brief summary that includes presentation and symptoms, current medical problems, prior treatments and response to treatment and family history of similar conditions, along with one or more clear photographs of the area in question. Most often, an e-mail response will arrive in less than twelve hours and will include a differential diagnosis and potential treatment plans.

3-87. The Army teleconsultation program may be used to assist with diagnosis and the management of medical conditions for detainees. A number of specialties participate in this program providing reach-back in a number of areas including burn-trauma, cardiology, dermatology, infectious diseases, nephrology, PVNTMED, occupational medicine, and toxicology. Health care providers may visit the Deployment Health Clinical Center Web site (<http://www.pdhealth.mil>) for a complete list of available consultation programs for deployed providers.

COMPLETION OF MEDICAL INPROCESSING

3-88. Necessary medical treatment and wound care should be addressed at the completion of medical processing. It is essential to expose and visualize all wounds to document the size and current condition of the wound. On most detainees, wound care for existing injuries will be adequate; however, on occasion, wounds can be infected or even necrotic upon evaluation. Although medical inprocessing is not sick call, detainees may not have received health care for several days and may require some sort of treatment for existing injuries or medical conditions. This generally applies to elevated BP and blood sugar. Detainees will also complain of headache, muscle and joint aches, heartburn, or upper respiratory infections, and these problems can usually be treated adequately with over-the-counter (OTC) medications. Detainees not fit for internment life should be admitted for further assessment and treatment.

ALLEGATIONS OF ABUSE OR MISTREATMENT

3-89. Allegations of abuse or mistreatment, by either multinational or HN forces, should be referred to CID with a copy of the provider's physical examination and any applicable laboratory or radiology studies. Most times, the investigator will need to interview the provider to obtain any additional information. Allegations of abuse by multinational forces are fully investigated, but allegations of abuse by HN forces are generally for information collection only and that information is forwarded on to HN authorities. For additional information refer to paragraphs 1-44 through 1-60.

MONITORING

MEDICAL SURVEILLANCE

3-90. Medical surveillance is the ongoing, systematic collection of medical data that is essential to the evaluation, planning, and implementation of public health practice and prevention. In particular, it includes medical data related to individual patient encounters and the use of that data in the calculation of disease and nonbattle injury (DNBI) rates for a defined population for the primary purposes of prevention and control of health and safety hazards. During medical surveillance, PVNTMED assets monitor the detainee population in order to identify and reduce incidents and counter health threats. The senior PVNTMED officer in the task force is required to establish a medical surveillance program for detainees. Information that is collected is maintained on a database that can be made available to the command, international inspectors, and PVNTMED personnel to track disease trends, as required.

3-91. Medical surveillance identifies the population at risk, identifies potential and actual exposures, determines protective measures, and assesses an individual's health. The final link is the application of this data to prevention and control.

3-92. The data collected from this assessment forms the health status of detainees. It identifies the endemic and epidemic diseases present in the detainee population; provides the facility commander with pertinent information on which to monitor changes in the detainee health status; and provides the basis to perform health interventions, as necessary. Medical surveillance data is used to monitor the implementation and effectiveness of PMM and the maintenance of field sanitation and hygiene practices. For example, an increase of acute diarrheal disease within a subpopulation of the detainees may necessitate an epidemiological investigation to determine the cause of the outbreak and to ensure the spread of disease is contained. Once the source of the disease outbreak is determined, PMM can be devised and implemented to ensure there is not a recurrence.

3-93. Health risk communications and instructions can be developed and disseminated to the detainee population to promote an understanding of the health threat faced by the facility and to enhance compliance with required PMM, field sanitation requirements, and personal hygiene standards to counter the threat.

MONTHLY WEIGHT

3-94. To ensure the continued health of detainees, international law requires that each detainee be screened monthly by health care personnel. During this screening, the detainees weight is recorded on DA Form 2664-R which provides a concise, chronological weight history for the detainee. Significant fluctuations in weight can signal an underlying medical condition or can indicate that the detainee diet is not meeting his nutritional requirements. The cause of any significant fluctuations must be investigated by health care personnel. Detainees with significant weight fluctuations are given a more thorough physical to determine if an underlying medical condition exists or if a disease process is present. If the physical examination does not identify the underlying cause, a thorough evaluation of the individual's diet and work schedule should be undertaken. Findings and recommendations for adjustment of diet should be made to the facility commander. Cumulative data on weight fluctuations should be included in the medical surveillance activities conducted at the facility to ensure trends are identified as rapidly as possible and corrective measures implemented.

3-95. When conducting monthly weigh-ins, health care personnel should also be alert to the signs and symptoms of communicable diseases, louse infestations, hydration status, and other indicators of health status. If a detainee has any signs of unexplained physical injuries (such as burns, fractures, severe sprains, or bruises), health care personnel should ask the detainee about the cause of the injury. However, health care personnel do not investigate allegations or suspected incidents of abuse. Any cases of suspected abuse, both by TIF personnel or other detainees, should be documented and immediately reported to the TIF commander, the supporting CID, and the DOMD.

MEDICAL CONDITIONS

3-96. Detainees requiring periodic evaluations (for example, detainees with diabetes or TB) should be tracked to maintain compliance with laboratory testing standards, among other pertinent issues. Given the potential for rapid movement of detainees between compounds and/or between internment facilities, it is essential that these detainees are not lost to follow-up.

SICK CALL

3-97. Gather and chart DNBI data from the daily disposition log (Figure 3-2) to quickly address emerging trends or problems. This is most easily accomplished by documenting the ISN, body system (cardiac, respiratory, and so forth) and chief complaint on a matrix.

DAILY DISPOSITION LOG				
NAME	ISN	COMPOUND	INJURY OR ILLNESS	DISPOSITION
Doe, John	12345	East	Dehydration	RTC
Smith, Matt	23456	North	FUO	RTC
Jones, Al	34567	East	TB	Evacuate

Figure 3-2. Sample daily disposition log

MONITORING DETAINEE IN SEGREGATION

3-98. Detainees maintained in segregation will be monitored daily to assure health and well-being and to address current medical complaints. By protocol, a licensed independent provider (physician, physician assistant [PA], or nurse practitioner) must screen and sign off on each detainee; however, local guidance may allow for a nurse to perform this screening as well. Given the segregation status of these detainees, it is usually more expedient for the provider to use this requirement as a sick-call opportunity as well. A translator is helpful, but not essential in this situation and either an English-speaking detainee or a hired linguist, if available, is appropriate.

MONITORING MEDICATIONS

3-99. Monitor medication compliance in each compound by detainee to optimize treatment. A good way to accomplish this goal is by creating a spreadsheet (Figure 3-3) that lists each ISN, drug allergies, the medication, route and dosage, start date, number of refills, and whether the medication was “A” (administered), “R” (refused), or “NS” (no-show). No-shows can be further broken down to provide a reason (such as “FV” [family visit]), if desired. By tracking in this manner, medication compliance can be easily monitored and reported.

COMPOUND	DETAINEES ON MEDS	ISN	ALLERGIES	MED AND DOSE	ROUTE AND TIME	START	REFILLS	MON DAY	MON NIGHT	TUE DAY	TUE NIGHT
LIB1	1	150131	None	Glucotrol 5 mg	4 tab b.i.d.	30 Apr 05	2	A	A	A	A
LIB1	1	150131	None	Metformin 500 mg	2 tab b.i.d.	27 Apr 05	2	A	A	A	A
LIB1	1	150131	None	Aspirin 81 mg	1 tab q.d.	27 Apr 05	4	A		A	
LIB1	2	151996	None	Norvasc 10 mg	1 tab q.d.	15 Apr 05	2	A		A	
LIB1	2	151996	None	Atenolol 50 mg	1 tab b.i.d.	21 Apr 05	2	A	A	A	A
LIB1	3	153722	None	Ibuprofen 800 mg	1 tab b.i.d.	03 May 05	2	FV	A	A	A
LIB1	4	154097	None	Gabapentin 100 mg	2 tab q.d. pm	02 May 05	8		R		A
LIB1	4	154097	None	Metformin 850 mg	1 tab b.i.d.	28 Apr 05	0	A	A	A	A
LIB1	4	154097	None	Cozar 50 mg	1 tab q.d.	09 Apr 05	0	A		A	
LIB1	4	154097	None	Flomax 0.4 mg	1 tab q.d.	21 Apr 05	2	A		A	
LIB1	4	154097	None	Flonase spray	2 sprays q.d.	09 Apr 05	2	A		A	

Figure 3-3. Example medication tracking matrix

3-100. All medications to be administered to detainees must be dispensed by health care personnel. Depending upon the detainee’s medical condition, health care providers, when possible, should prescribe medications which can be dispensed on a once or twice a day basis. To ensure the safety of detainees, medications are dispensed in unit doses by health care personnel. Health care personnel must verify the identity of the detainee (usually a wristband), obtain their signature on the medication issue register (Figure 3-4) and watch/verify that the detainee takes the prescribed dose. When dispensing oral medications, the detainee’s hands and mouth should be inspected to ensure the detainee swallowed the medication and is not attempting to hoard the medications for later use. The medication issue registry is primarily used to accurately track the medications each detainee takes, as well as to prevent medication duplications and potentially dangerous interactions. A local form can be developed to document the dosing schedule and the receipt and administration of the medication to detainee. This register requires the detainee to sign for his medications and when he has completed his course of treatment, can be filed in his medical record.

Detainee Name <i>Doe, John</i>		ISN <i>123456</i>	Domicile Location <i>Block C, Tier 1</i>		Physician <i>LTC Smith</i>
Type of Medication <i>Ibuprofen</i>			Dosage <i>200 mg</i>		
Prescription Label Date <i>01/01/05</i>			Instructions <i>Take 2 tablets, 2 times a day</i>		
<p>Detainee <u>John Doe</u> was notified on the <u>1 January 2005</u> by guard <u>SGT C. Brown</u> that the medication had arrived and is to be taken as prescribed.</p> <h1 style="text-align: center;">SAMPLE</h1>					
MEDICATION ISSUE REGISTER					
DATE	TIME	DETAINEE SIGNATURE	PILL COUNT	ADMINISTERED BY	INVENTORIED BY
01/01/05	1700	-----	20	-----	<i>(health care provider signature)</i>
01/01/05	1715	<i>(detainee signature)</i>	2 -- 18	<i>(health care provider signature)</i>	-----
01/01/05	2045	-----	18	-----	<i>(health care provider signature)</i>

Figure 3-4. Sample medication issue register

ROUTINE MEDICAL CARE

DAILY CONTACT

3-101. Regulatory guidance requires that detainees must be offered the opportunity for daily medical contact. Medication administration and emergency medical care are considered medical contact.

3-102. Different levels of sick call (full or modified) can assist with compliance. Sick call may be offered in stages. For example, Stage 1 sick call involves care through the wire with or without offering medication. Health care specialists may also offer OTC medications for simple problems, such as headache, upset stomach, or minor musculoskeletal pain. Blood draws and intravenous (IV) fluids/medications can be completed at the wire as well, based upon the provider's guidance and the health care specialist's confidence level. Stage 2 sick call involves evaluation by a licensed provider at the wire and the detainee may be removed from the wire, if necessary, for a more complete examination. Stage 3 sick call requires movement of the detainee into the treatment tent for more in-depth evaluation and treatments, as needed. These treatments can involve nebulizer treatments, cardiac rhythm strips, IV fluids, and minor procedures. Finally, Stage 4 sick call requires transport to the hospital facility for urgent evaluation and treatment.

SICK CALL WORKLOAD MODELING

3-103. Evaluation of at least 10 percent of the facility population per sick call is appropriate, based upon staffing and documentation requirements. This strategy assures that a baseline number of detainees are receiving medical care on a regular basis. Standard documentation guidelines should apply, meaning that either a short or expanded SF 600 be completed for each encounter, depending upon the problem's complexity. In addition, the medical commander may opt to set a schedule based upon the common complaints within the facility. For example, each sick call might start with a dedicated number of acute illness appointments, followed by time on a dedicated day for specific specialty care such as optometry, cardiac, diabetes, or musculoskeletal problems that are recurrent or acute.

PROVIDERS

3-104. Unlicensed personnel may perform sick call under the supervision of a licensed provider. This includes Army health care specialists, United States Air Forces (USAF) medics, United States Navy (USN) medical corpsmen and independent duty medical technicians/corpsmen. As an alternative, enlist the support of nursing personnel to further triage and assess detainees as they present. A licensed provider (physician) should assist on-site in the evaluation of detainees that are more difficult, either at the time of the initial presentation or at a dedicated later timeframe. Each SF 600 should be reviewed and countersigned by a licensed provider.

OVER-THE-COUNTER MEDICATIONS

3-105. All prescription medications must be ordered by a licensed provider; however, if compound dispensary stock allows, the provider may directly dispense common medications out of the on-site stock. Over-the-counter medications do not require approval prior to dispensing, however unlicensed providers must be fully trained by either a licensed provider or licensed pharmacy staff regarding each medication, its indications, and any potential side effects.

SICK CALL PRACTICES

3-106. Timeframes are established for sick call and distribution of medication to avoid abuse of the medical system. Medication pass (distribution) should not extend past a two-hour timeframe, unless there are extreme circumstances; however, most compounds can complete medication distribution within one hour. Detainees must present for any sort of medical encounter with his identification band on hand. This aids in confirmation of that detainee's identity. In addition, the detainee must have water on hand for medication consumption. Absence of either the identification band or water can cause major delays in

medication distribution as well as sick call. Allow a certain amount of time for sick call. Usually this should not exceed three hours, especially if there is no overhead cover for the personnel performing sick call. Setting limits permits the health care specialist or provider to command the situation, in contrast to allowing the detainee to dominate the encounter. Consider using a sign-up sheet, distributed at night, for the next day's sick call "appointments." Experience shows that an "open-access" system, now popular in clinics nationwide, can be cumbersome and overwhelming. Allow a standard number of sick call slots and plan for acute illness visits as well.

ASSISTANCE WITH MEDICAL COMPLIANCE

3-107. Enlist the help of the facility hierarchy and the MPs to attain the fullest compliance with medication distribution and sick call. Upon arrival of a new group of cadre personnel, whether medical or MP, the health care personnel and the guards for each compound should discuss such issues as medication noncompliance and its consequences, detainee good order and discipline during medication pass and sick call, and MP overwatch during detainee interactions. Generally, each compound has a "chief" and a chain of command that wields a great deal of power among the detainees within that compound. These men can be very influential and health care personnel should capitalize on their authority to ensure the mission's success. If feasible, consider allowing the compound chief to designate which detainees should be seen for sick call, ultimately making him responsible for the success of his compound's medication pass and sick call and reproducing the hierarchy commonly seen in the local population.

CONSUMPTION OF MEDICATIONS AND COMPLIANCE

3-108. Verify consumption of medication to avoid cheating, which can lead to hoarding, bartering, and overdose. A detainee must present for medication pass with his identification band to assure that the medication is dispensed to the proper detainee. He must also have water on hand to accompany his medication dose. Consider requiring the detainee to also roll up his sleeves, so that he cannot hide his medication in them. As the detainee takes his medication, he must demonstrate a swallowing action and open his mouth after swallowing to verify consumption of the medication, moving his tongue around to show that the medication is no longer in his mouth. He must also show his hands, front and back, with fingers spread widely, to verify that he does not have the medication in his hands. Many times during a shake-down, MPs will find medications in a detainee's possession and, upon investigation, medical records will not show that the detainee has a prescription for that medication. Unfortunately, this problem can lead to adverse events, like allergic drug reactions, episodes of low BP or blood sugar, and even death.

3-109. Detainees may refuse to take medication unless this refusal represents an immediate hazard to their health (such as refusal of insulin in an insulin-dependent diabetic). If a detainee fails to present for medication distribution for three days and has been counseled by an independent licensed health care provider, he may have the prescription removed from the distribution database. A detainee refusal of medication must be documented in his medical record.

3-110. Refer to paragraph 3-100 for information on monitoring and tracking medication administration.

FOLLOW UP FOR DETAINEE TRANSFERS AND COMPLIANCE

3-111. Follow up on all intercompound or interfacility detainee transfers to maintain compliance with medication. Normally, there is a constant flow of incoming new detainees corresponding with ongoing operations throughout the AO. When the operational tempo is high, detainee movement tends to increase, usually within the facility as well as between facilities. A high-quality tracking mechanism vastly improves the ability of health care personnel to move medications with the detainees. In addition, open lines of communication within the medical staff, as well as with the MP Operations Staff Officer, US Army (S3) is essential to knowing where detainees are and where they will be moving at any given time. It is common for medications to lag a day behind the detainee during transfers within the facility. During interfacility transfers, it is also extremely helpful to use e-mail communications with the accepting facility so that the health care personnel at the new facility are aware of the incoming medical detainees, their diagnoses, and their medications. e-mail serves two important roles by providing a hard copy of the

information for the accepting provider and by serving as documentation of transfer notification for medicolegal purposes, as well as common courtesy.

MEDICAL EVACUATION

3-112. When a detainee requires evacuation to a higher role of care, the TIF control center is notified and arrangements are made for medical evacuation support. Translator support is required to facilitate EMT en route to the hospital. Translator support may be provided by radio transmission or a translator may be onboard the ambulance. The health care personnel onboard the ambulance will remain in radio contact with the health care provider at the Role 3 hospital throughout the evacuation. A TIF facility guard also accompanies the detainee throughout the evacuation. After treatment, the detainee is returned to the TIF by ambulance, if appropriate. If the detainee is to be admitted to the Role 3 hospital, the ambulance crew returns the TIF facility guard to his duty station. The evacuation and medical treatment received is documented in the detainee's health record and on the ambulance run sheet.

3-113. When a detainee returns to the TIF from the hospital, he is examined by the TIF facility physician. The hospital provides clear and concise instructions for follow-on care to be given at the TIF. Medical equipment and supplies normally not available at the TIF but required for the continued care of the detainee are provided by the hospital. The TIF physician coordinates with the hospital any appointments required for continued care.

FOLLOW UP FOR DETAINEE RETURNING FROM HOSPITAL FACILITIES

3-114. All detainees returning through medical channels should be evaluated in the ER before transfer to the processing center to determine a need for further hospitalization. This process can be cumbersome at times, but it nearly eliminates the possibility of losing ill or injured detainees to follow-up within the system after their arrival. Detainees who arrive by the usual means (such as a convoy or with a unit) are usually brought immediately to the processing center and standard medical inprocessing can occur after assignment of an ISN, if necessary. Detainees who arrive via ground or air ambulance or who are released from the hospital should be medically inprocessed as well.

3-115. Complete medical records should accompany all detainees returning from another MTF. When a detainee arrives at the processing center from another internment facility, health care personnel on-site must review all medical documentation to identify detainees that require ongoing medication, physical examination, or treatment. This information is given to the provider for disposition of the detainee. When a detainee arrives from another MTF, records documenting prior treatment are essential for continuity of care and are extremely helpful for the accepting medical staff in the ER.

3-116. Medical records and medications should accompany all returning detainees in order to assure continuity of care. A summary and a complete record of studies for each detainee arriving from other MTFs should be available electronically or in hard copy. Each interhospital transfer should always be preceded by physician-to-physician contact in the form of a telephonic or an electronic communication. It is also prudent to remember to extend the same courtesy when a detainee transfers from your care to another TIF or MTF.

3-117. Required follow-up studies and treatment should be noted and easily accessible to assure compliance with the treatment plan. Critical issues can be overlooked when a detainee transfers between internment facilities. Therefore, it is practical to use redundant methods of communication (such as transfer summary, telephone conversation, and e-mail summary). Because the detainee population can be very large, it is critical to maintain a database of *must-do* items and each provider will have his own tracking methods that work best. When detainees transfer specifically for studies or treatments, health care providers must make every effort to provide timely feedback to the referring provider. Rules of medical etiquette still apply in a CZ and no one wants to be left in the dark about a detainee's outcome.

AFTER HOURS MEDICAL AVAILABILITY

3-118. In addition to general transportation services, the organic or task-organized ambulance assets may be used as a local emergency medical services (EMS) team. Guidelines for EMS functions and treatment should be formulated with input from the physician staff, compiled and approved by the chief, emergency medicine, and the hospital commander. In this role, the health care specialists on-shift answer calls regarding acute detainee medical problems. These calls are generally routed from the compound to a centralized control center, which logs the request and then contacts the EMS team by radio. The health care specialists perform a brief problem-oriented history and evaluation and then call the ER physician to report their findings and receive further treatment guidance. Depending upon the skill and scope of practice of the health care specialists, this guidance may range from simple transport for further evaluation to on-site treatment of the problem. This service should be available 24-hours per day and should cover those times when the compound health care specialists are unavailable for immediate evaluation and treatment.

HUNGER STRIKES

3-119. In the case of a hunger strike medical treatment or intervention may be directed without the consent of the detainee to prevent death or serious harm. Such action must be based on a medical determination that immediate treatment or intervention is necessary to prevent death or serious harm, and, in addition, must be approved by the commanding officer of the detention facility or other designated senior officer responsible for DO.

3-120. Procedures for identifying and referring to the medical staff, a detainee suspected or announced to be on a hunger strike, will include obtaining an assessment from qualified health care personnel of whether the detainee's action is reasoned and deliberate or the manifestation of a mental illness. Upon medical recommendation, the detainee may be placed in isolation.

3-121. Any detainee refusing food for 72 hours is considered to be on a hunger strike and will be referred for medical evaluation and possible treatment. Health care personnel will isolate the detainee in a single-occupancy observation room and denying contact with other detainees, when medically advisable. If measuring food and liquid intake/output becomes necessary, health care personnel may place the detainee in a special management unit or in a locked hospital room. The detainee may remain in the special management unit, based on the detainee's medical condition, until health care personnel determine a move advisable. The medical officer will immediately report the hunger strike to the TIF commander.

3-122. Medical staff shall monitor the health of a detainee on a hunger strike. If the detainee is engaging in a hunger strike due to a mental condition, appropriate medical action will be taken. During the initial evaluation of a hunger-striking detainee, the medical staff will—

- Measure and record the detainee's height and weight.
- Measure and record vital signs.
- Perform a urinalysis.
- Conduct a psychological/psychiatric evaluation.
- Examine the detainee's general physical condition and if clinically indicated, proceed with radiographs and or laboratory studies.
- Take and record weight and vital signs at least once every 24 hours during the hunger strike.
- Take other medical measures as required.

3-123. If a large number of detainees participate in the hunger strike, then additional assets may be required to prevent death or serious harm them.

3-124. After the hunger strike, the medical staff will provide follow-up medical and psychiatric care for as long as necessary.

3-125. Before medical treatment is administered against the detainee's will, the staff must make reasonable efforts to convince the detainee to accept treatment voluntarily. Forced medical treatment will

be administered only after the medical staff determines that the detainee's life or permanent health is at risk.

SECTION IV — DETAINEE OUTPROCESSING

OUTPROCESSING PROCEDURES

3-126. Release is the process of returning a detainee to his country of birth or citizenship or to the point of capture. A detainee who is not sick or wounded is released at the end of hostilities, or at any other time, as directed by the OSD. Sick and wounded detainees will not be released against their will during hostilities.

DETAINEE RELEASE PROCESS

3-127. For direct release of the detainee back into the community, the following requirements should be met:

- When required by the applicable Geneva Conventions, the detainee is advised in writing of the release to enable him to notify his next-of-kin.
- For release from a TIF, the following requirements should be considered: The SECDEF or his designee will send official notification of transfer or release from the TIF and the applicable staff agencies will execute orders that will delineate the responsibilities and procedures to undertake.
 - The releasing unit must prepare, maintain, and report to the chain of custody and transfer/release documentation according to current transfer and release procedures as directed by the SECDEF.
 - Individual detainee preparation to include, at a minimum, segregation, outbriefing, medical screening, and execution of conditional release statements for those detainees being released.
 - Movement routes to transfer location. Coordinate all routes through the appropriate GCC.
 - Due to operations security (OPSEC) concerns, only make public notification of a release and/or transfer in consultation and coordination with OSD.

3-128. For additional information on the detainee release process refer to FM 3-19.40.

SECTION V — MEDICAL LOGISTICS

FORMULARY

3-129. A formulary must be established for all MTFs providing detainee health support that is specifically tailored to the detainee health care mission. The Defense Medical Standardization Board (DMSB) is a joint DOD activity, which provides policy and standardization guidance relative to the development of Deployable Medical Systems (DEPMEDS) and medical materiel used for the delivery of health care in the Military Health System (MHS). In executing this mission, the DMSB maintains information to include national stock numbers on all medications available within the MHS. This listing is available at the DMSB Web site: <http://www.jrcab.army.mil>. The mailing address is Director, Defense Medical Standardization Board, 1423 Sultan Drive, Fort Detrick, Maryland 21702-5013. The DOMD must ensure that pharmaceutical requirements are identified and a formulary developed as early as possible in the mission planning process. Specific planning considerations include—

- Endemic and epidemic diseases in the AO.
- Chronic health problems within the AO to include nutritional deficiencies.
- Dosing requirements of various medications (such as requiring administration twice a day versus four times a day).

- Detainee demographics (such as age and gender).
- Medications currently available within the AO for civilian health care.
- Special considerations (such as requirement to provide maternal/child, pediatric, and/or geriatric health care).
- Requirements for chemoprophylaxis (such as for malaria) and/or immunizations.
- Sufficient stockage of medications to combat disease outbreaks within the detainee population (such as meningitis, TB, or influenza).

3-130. In addition to medical supplies, the supporting MEDLOG unit will provide medical equipment maintenance and repair and optical fabrication and repair services as required to the detainee population. Coordination for this support is through the DOMD.

SUPPLY/RESUPPLY

3-131. In DO, a MEDLOG unit may not be available within the immediate AO. Coordination for Class VIII (medical material) supply/resupply, medical equipment maintenance, eyewear fabrication, and blood management takes on an added importance in DO. Prior to the operation, the number of days of supply, which the in-country medical organizations will require is determined. A critical items list of supplies which will be in high demand is also prepared. Preconfigured push packages must be developed to maintain appropriate stockage levels in country until MEDLOG elements enter the theater, become operational, and line order requisitioning procedures can be instituted.

3-132. In determining what supply items are to be stocked for DO, security and safety are prime considerations.

MEDICAL EQUIPMENT

3-133. There are several factors to consider when equipping an MTF or hospital for DO—

- Roles of treatment—In many hospital settings, it is possible to move patients to a higher role of care to provide treatment not available at that particular location. However, in DO moving a detainee to another facility may present a security risk or produce a logistical challenge. Ensure you have the requisite diagnostic equipment for chronic and recurring medical conditions present in the detainee population.
- Availability of replacement parts/servicing—Ensure that the equipment available to the hospital can easily be repaired or serviced by medical maintenance technicians. The availability of parts or technicians that can repair or operate a particular piece of equipment may also add to nonmission capable time. This may adversely affect the MTF's ability to treat detainees on-site.
- Lifetime of equipment—The equipment used in DO will receive a lot of use. The equipment must be able to handle adverse environmental conditions and frequent or over use. Health care personnel should perform operator maintenance frequently and be aware of potential equipment failures due to extended use.
- Compatibility with restraints—The equipment, especially beds and dental chairs, should always be compatible with restraints.

3-134. Medical equipment used for DO will conform to Food and Drug Administration (FDA) standards and maintenance intervals as required for DOD personnel and multinational forces.

SECTION VI — DETAINEE DECEDENT AFFAIRS

SECRETARY OF DEFENSE POLICY

3-135. Department of Defense Directive 2310.01E and AR 190-8 establishes the policy and procedures for investigations of possible violations of protection afforded EPWs, RPs, civilian internees, and other detainees (ODs), including procedures in cases of deaths of such persons. The body will be handled as

directed by the Office of the Armed Forces Medical Examiner (AFME). The determination of the cause and manner of death will be the sole responsibility of the AFME or other physician designated by the AFME.

3-136. Title 10 United States Code (USC) 1471, DODD 5154.24, and DOD Instruction (DODI) 5154.30 provide that the Office of the AFME has primary jurisdiction and authority within DOD to determine the cause and manner of death in any DOD death investigations of EPW, RPs, civilian internees, and ODS in the custody of the US Armed Forces.

DETAINEE DEATH NOTIFICATION PROCESS

3-137. When an EPW, RP, or detainee in US custody dies, the attending medical officer will immediately notify the medical commander/DOMD, or the commander of the facility (or if the death did not occur in a facility, the commander of the unit that exercised custody over the individual). The commander of the facility will immediately report the death to the CID, the responsible investigative agency. The CID will contact the Office of the AFME to determine whether an autopsy will need to be performed.

3-138. The attending medical officer will immediately furnish the TIF commander, medical commander/DOMD, or other officer charged with the detainee custody before death, the following information:

- Full name of deceased.
- Internment serial number of deceased.
- Date, place, and cause of death.
- Statement that death was or was not the result of the deceased's own misconduct.
- When the cause of death is undetermined, the attending medical officer will make a statement to that effect. When the cause of death is finally determined, a supplemental report will be made.

3-139. The TIF commander, medical commander/DOMD or other officer charged with custody of the person before death, will notify the DRS of the death immediately by the most expeditious means available.

DETAINEE DECLARATION OF DEATH

3-140. Upon declaration of death, the remains will be placed in a clean body bag and secured awaiting instructions from CID or from the appropriate investigating agency (if CID is not present in the AO, the Navy Criminal Investigative Service or the Air Force Office of Special Investigations are the other investigating agencies that can be used). The remains will not be washed and all items on or in the body will be left undisturbed except for weapons, ammunition, and other items that pose a threat to others. The body will not be released from US custody without written authorization from the investigative agency concerned or the AFME.

3-141. The attending medical officer and the appropriate commander will complete a DA Form 2669-R (Certificate of Death). The DA Form 2669-R will be reproduced locally on 8 1/2- by 11-inch paper. The form can be found in AR 190-8 and will be used by the US Army only. Copies will be made out to provide distribution as follows:

- Original—Information center.
- Copy—DRS, if necessary.
- Copy—The Surgeon General as required by AR 190-8.
- Copy—EPW, RP, or detainee personnel file.

3-142. The TIF commander will appoint an officer to investigate and report—

- Each death or serious injury caused by guards or suspected to have been caused by guards or sentries, another detainee, or any other person.
- Each suicide or death resulting from unnatural or unknown causes.

3-143. One copy of the investigating officer's report will be forwarded to the DRS.

3-144. Special agents from the CID will investigate deaths from other than natural causes per AR 195-2. A copy of the CID report of investigation, if any, will be attached to the TIF commander's report.

BURIAL, RECORD OF INTERMENT, AND CREMATION

3-145. If a detainee's remains cannot be returned to his family, the deceased detainees will be buried honorably in a cemetery established for them according to DA Pam 638-2 and FM 4-20.64. Deceased detainees will be buried, if possible, according to the detainees' religious beliefs, social and cultural background, and tribal or ethnic taboos. Deceased enemy prisoners of war, who cannot be returned to their family or their government, will be buried according to the rites of their religion and customs of their military force. Unless unavoidable circumstances require the use of collective (group or mass) graves, detainees will be buried individually. The supporting mortuary affairs (MA) element will record any later movement of the remains. The US will also care for the ashes of cremated persons. Ashes will be kept by MA personnel until proper disposal can be decided according to the wishes of the power on which that person depended. A body may be cremated only due to imperative hygiene reasons, the detainee's religion, or the detainee's request for cremation. When a body is cremated, this fact together with the reasons will be set forth in the death certificate.

3-146. If a detainee dies at sea, the body will not be buried there unless absolutely necessary. If the body has to be buried at sea, the procedures prescribed for US troops will be followed as far as possible; however, a US flag will not be used. When death occurs during a land transfer, the responsible officer will follow the same procedures for burial prescribed for US military personnel.

3-147. The personnel file of a deceased person with all pertinent records will be forwarded to the DRS.

Chapter 4

Functional Specialties

This chapter discusses different health care areas and/or services pertinent to detainee health care operations.

SECTION I — NURSING SUPPORT TO DETAINEE OPERATIONS

4-1. Quality patient care must be provided regardless of the reason for the capture. This further emphasizes the separation of custody and health care. Nursing care must be provided to the same standards and quality that is given to nondetainee patients. Even in this highly stressful environment, nurses must maintain compassion, concern, and professionalism, all of which are components of quality nursing care.

FACILITY INPROCESSING

4-2. The established inprocessing area is where new detainees are brought for their initial inprocessing into the TIF. Most of the inprocessing requirements are custody operations and are discussed primarily in FM 3-19.40. The medical portion of inprocessing is covered with a medical screening process, which normally includes: routine vital signs, height, weight, optometry screen, dental screen, immunizations, review of systems, past medical and surgical histories, and a BH screen. All medical screening information should be placed in the detainee's individual medical record created during the screening process.

4-3. At a minimum, the nursing staff required should be the minimum number of MOS 68WM6s to adequately complete all required tasks. The actual number should be based on workload (the average number of detainees inprocessed).

4-4. Responsibilities of the nursing staff in the inprocessing area include all those tasks associated with the medical screening process in a clinic. In addition to completing the tasks, documentation of all immunizations and screenings must be completed. The detainee's name and ISN are recorded on all documentation.

4-5. The identification and documentation of abuse that has occurred at any point from time of capture to time of screening is also an important function in the inprocessing area. Any time abuse is alleged, suspected, or identified, it must be reported to the chain of command, DOMD, and the supporting CID.

CARE IN THE DETENTION COMPOUND

4-6. The majority of the care within the TIF can be provided by the health care specialists under the supervision of a provider (such as a physician or a PA). The ratio of health care specialists to detainees should be determined based on the overall health of the detainee population.

4-7. Advanced practice registered nurses (APRNs) may be used as physician extenders in the TIF for those patients who require more in-depth care than the health care specialist can provide. The scope of practice for APRNs is discussed in AR 40-68.

4-8. Disease management will be practiced in the TIF, with care focused on certain disease processes and managed by a provider. Specialty clinics may be staffed for specific diseases such as diabetes to ensure compliance with treatment regimens, to monitor disease progress, and to ultimately decrease unnecessary use of emergency care.

INPATIENT/FACILITY NURSING CARE

UNDERSTANDING CULTURAL DIFFERENCES

4-9. Prior to deployment, the staff should receive instruction on cultural differences, especially those relating to health care practices and beliefs, nursing practices in the locale, and roles. Other cultural information such as general history of the country and political events leading up to the deployment should also be addressed in order for the staff to understand why patients may act or respond in certain ways and to understand the motivations of the people in general. Because of the great potential for treating HN civilians in addition to the detainees, knowledge of the available health care in the immediate geographical area is also helpful and will enable the staff to plan for adequate continuation of care after discharge from the facility.

WARD

4-10. The nursing staff establishes and maintains the ward routine to include staff schedules and patient activities. Ward rules are communicated to the detainee and are maintained by the staff. The nursing staff ensures that all patient care activities are accomplished in a timely and safe manner. Nursing staff must be conscious of security precautions at all times and ensure that all medical items and other items which could be used as a weapon are properly secured.

SEPARATION OF CUSTODY AND HEALTH CARE

4-11. There must be a complete separation of custody and health care operations. No staff member will participate in any form of custody operations at any time. Health care personnel do not provide guards for detainees.

4-12. Interrogations will not be conducted on the ward. Health care personnel providing detainee medical care will not assist or provide medical information to interrogators. Approval for interrogations to be conducted with a detainee must come from the CDO and be routed through the DOMD and hospital commander. Personnel from CID may conduct investigations with detainee, but only after notification of hospital command/operations staff.

Supplies and Equipment

4-13. All supplies and equipment must be safeguarded to ensure they do not present a safety hazard to detainees and staff. Ward personnel must be aware that even ordinary items, such as pens, pencils, or plastic containers can be used to fashion a weapon. All supplies and equipment not in use should be secured.

4-14. Vulnerability checks assess environmental safety and security in relation to DO in the inpatient and outpatient care areas of the hospital. Vulnerability checks should be done at least weekly in each detainee care area. Examples of vulnerability checks include checking for sharps at the bedside or the presence of weapons in the detainee care area.

Alarms

4-15. A personal alarm system should be established to quickly gain staff reinforcement and back-up security forces (MPs) as necessary. Simple personal alarms such as a whistle are effective and inexpensive. Alarms are sounded for detainee escape attempts, detainee attempts to overcome a staff member, an uncooperative or combative detainee, minor or major disturbances, and any other instances as deemed appropriate by the staff on duty.

SECTION II — NUTRITION CARE

4-16. The mission of nutrition care is to provide comprehensive nutrition care, to include medical nutrition therapy, nutritional assessment, nutrition risk screening of inpatients, nutrition education and health promotion, consultation to the commander on nutrition-related issues pertaining to Soldiers, contractors, and detainees. It is also to provide safe, wholesome foods to inpatients, including therapeutically modified diets and consultation to the unit managing the contract for the detainees' menu and feeding program.

NUTRITIONAL REQUIREMENTS

4-17. Army Regulation 190-8 provides guidance on the nutritional care of detainees. These requirements are—

- The daily food rations will be sufficient in quantity, quality, and variety to keep detainees in good health and prevent loss of weight or development of nutritional deficiencies.
- Account will be taken of the habitual diet of the prisoners.
- Detainees who work may be given additional rations when required.
- Sufficient drinking water will be supplied to detainees.
- Detainees will, as far as possible, be associated with the preparation of their meals and may be employed for that purpose in the kitchen. Furthermore, they will be given the means of preparing additional food in their possession. Food service handlers must have training in sanitary methods of food service.

ENTRANCE NUTRITION SCREENING

4-18. All detainees should be screened on entrance to the TIF as part of the medical inprocessing. As a minimum, height and weight should be obtained and the BMI should be calculated to assess the detainees' weight status and to identify detainees that are underweight. This can be obtained by nutrition care personnel or by health care specialists trained to calculate and assess BMI. Detainees that are identified with nutrition-related medical problems should be referred by the health care specialist, PA, or physician to nutrition care. The BMI is calculated as weight in kilograms (kg) divided by the square of height in meters, or using English units: multiply weight in pounds by 703 and divide twice by height in inches. Assess BMI as follows:

- Underweight: less than 18.5.
- Desirable: 18.6–24.9.
- Overweight: 25.0–29.9.
- Obese: 30.0–39.9.
- Morbidly Obese: 40 or greater.

Note. When the BMI is calculated by health care specialists or other nonnutrition care personnel, underweight detainees are referred to nutrition care for consultation and further follow-up.

MONTHLY DETAINEE WEIGHT TRACKING

4-19. Nutrition care personnel should be prepared to initiate or participate in monthly weigh-ins of the detainees. The weights are recorded on DA Form 2664-R and this form is placed in the detainees' medical record. The weigh-ins should be coordinated with the TIF's staff. The weigh-ins may be conducted during detainee headcounts or during other times when the detainees are assembled as a group.

CULTURAL CONSIDERATIONS

4-20. Upon notice of deployment, nutrition care personnel should familiarize themselves with the eating habits and practices associated with foods in the area to which they will be deployed. These considerations will need to be taken into account for menu design or recommendations and may even play a role in feeding times during certain religious holidays. For example, the Iraqi diet is a high carbohydrate diet that consists primarily of rice and Arabic flat bread, a variety of fruits and juices, vegetables (such as cucumbers and tomatoes), different vegetable/beef/lamb/chicken stews, eggs, and hot, sweetened tea called *chai*. The Islamic diet consists of acceptable and forbidden foods. *Halaal* foods are considered lawful and permissible, while *Haraam* defines unlawful and forbidden foods. Permissible foods include: all types of fish, poultry, goats, sheep, cattle, camel, buck, buffalo, and rabbits. *Haraam* foods are pork and pork products, all carnivorous (meat eating) animals and birds (such as lions, tigers, vultures, and eagles), any *Halaal* animal that has died due to natural causes or been killed by a wild animal; food containing *Haraam* items such as fish prepared with wine or desserts containing wine or other liquor. Contamination of a *Halaal* item with a non-*Halaal* one will render it non-*Halaal/Haraam* and unacceptable. The utensils should be separate when preparing *Halaal* and non-*Halaal* foods to prevent contamination. During the Muslim holy month of Ramadan, the predawn meal is termed *sahur*, the breakfast meal, *iftar* is served after sunset, and an overnight meal may be provided to maintain adequate caloric intake.

DETAINEE MENU

4-21. The dietitian has a responsibility in ensuring the nutritional adequacy of the menu served to the detainees. A nutrient analysis should be performed using either an online nutrient database, such as the US Department of Agriculture (USDA), Agricultural Research Service National Nutrient Database for Standard Reference, Release 20, available at the Nutrient Data Laboratory Home Page, <http://www.ars.usda.gov/ba/bhnrc/ndl>, or computer software such as Food Processor® or Nutribase®. Based on this analysis recommendations are then made to the personnel in charge of negotiating the contract feeding service. The primary nutrients of concern are: total energy, total protein, vitamins A, C, D, Thiamin (B1), Riboflavin (B2), Niacin (B3), calcium, iodine, and iron. The menu should take into account foods natural to the region and be in keeping with the detainees' customary diet. Minimum requirements can be based on the Dietary Reference Intakes (DRIs) values. Ideal estimates of protein should be based on an individual's weight, but can also be calculated as twelve to fifteen percent of total calories. Many detainees will likely have wounds still in the healing process and thus require additional protein to form new tissue. Vitamin C is needed on a daily basis as it is a water-soluble vitamin and its primary sources are citrus fruits and fortified juices. Calcium is needed, in conjunction with vitamin D, to maintain bone health and assist with healing fractures. Iron is needed to prevent anemia. Iodine needs can be met by preparing foods with iodized salt. Recommended nutrient minimums, based on the DRI, Food and Nutrition Board, Institute of Medicine (IOM) of the National Academies (available at <http://www.iom.edu/CMS/3788/4574.aspx>), are as follows:

- Energy: 2500 calories.
- Protein: 75–95 grams (g).
- Vitamin A: 900 microgram (mcg) retinol equivalents.
- Vitamin C: 90 mg.
- Thiamin (B1): 1.2 mg.
- Riboflavin (B2): 1.3 mg.
- Niacin (B3): 16 mg.
- Calcium: 1000 mg.
- Vitamin D: 5 mg.
- Iodine: 150 mcg.
- Iron: 8 mg.

DETAINEE FEEDING OPERATIONS

4-22. A smaller contingent of nutrition care personnel may deploy in the event that staff and detainee feeding services are supplied by a contracted dining facility. The detainee menu may be managed by the Logistics Staff Officer, US Army (S4) of the unit in charge of securing the detainees or another entity involved in DO. A memorandum should be prepared daily to inform the contract dining facility personnel of the food needs of the hospital. This memorandum should address detainee census, accounting for potential admissions throughout the day, as well as extra food items to be distributed as nourishments to the wards. Nourishments may include extra fruit, juice, milk, and nutritional supplements. The nourishments should be adequate to provide snacks for in-between meals and at nighttime. This daily food request will help prevent meal shortages, as well as food waste.

4-23. Use the space allotted to the nutrition care section to prepare therapeutic diets, to assemble detainee trays, and to store and maintain supplies, nourishments, supplements, and enteral formulas. Within space constraints, if feasible, set up pantry areas on the wards to expedite detainee feeding. However, nutrition care personnel must always be aware of security concerns and not leave pantry areas unsecured. As a minimum, the following equipment is required: refrigerator, microwave, blender for each section or pantry area, table work surface, and shelves. Ensure or implement a system for ordering and retrieving food from the contract dining facility or having the food delivered by the contract service to the hospital. Additionally, as a minimum, set up a Class I (rations) account to have ready access to the medical diet supplemental rations. Procedures for food service to detainees are governed by command policy and SOP. Coordination between nutrition care and nursing staff is required. For additional information on medical field feeding operations, refer to FM 4-02.56.

THERAPEUTIC DIETS

4-24. Therapeutic diets will be prepared to accommodate each detainee's diet order per individual medical record or DA Form 1829 (Hospital Food Service–Ward Diet Roster). *The Manual of Clinical Dietetics*, published by the American Dietetic Association, is the primary reference for therapeutic diet instructions. The menu components for these diets come from foods prepared by contract dining facilities, nutrition supplements ordered through the hospital S4, and the medical diet supplemental rations. The following are the primary therapeutic diets available under field conditions:

- Detainees on a regular diet will use the standard menu provided for the detainee by the contract dining facility. Detainee preferences, to include in-between meals and snacks, may be incorporated into the diet to the maximal extent possible within the menu and available supplement constraints. Commercially prepared supplements (such as high protein preparations) provide a protein supplement and approximately 30 g of carbohydrate.
- A high calorie/high protein diet is designed to provide additional calories and protein to the regular diet. Additional calories and protein may come from the addition of snacks between meals, increased portion sizes, nutrition supplements available, and milkshakes made with nutrition supplements.
- The clear liquid diet is designed to provide fluid and energy in a form that requires minimal digestion. Between-meal snacks are encouraged to provide adequate calories. Diet consists of broth, juice, gelatin, and sports drinks. This may be supplemented with a commercially prepared protein-fortified clear liquid.
- A blenderized liquid diet is designed to provide adequate nutrition to detainees unable to chew, swallow, or digest solid foods. It may also be used as a transitional diet from clear liquid diet to solid foods. The diet consists of foods and fluids blenderized to a liquid form that can be taken through a straw. Between-meal snacks are encouraged to provide adequate calories and nutritional supplements may also be included.
- The mechanically altered diet is designed to minimize the amount of chewing required to ingest foods and includes blended, chopped, ground, or pureed foods to promote ease of chewing. Between-meal snacks are encouraged to provide adequate calories.

- A cardiac prudent diet is intended to assist with the reduction in serum cholesterol and consists of modifications in fat, cholesterol, sodium, caffeine, and fiber. The dietitian or the nutrition care specialist (MOS 68M) needs to work with the contract facility to ensure that the base hospital diet is low in sodium and low in fat to accommodate the parameters of the diet. Additional fruits and vegetables can be added to increase fiber.
- A diabetic diet is intended to assist with maintaining or improving the blood glucose control of diabetic detainees. At a minimum, the diabetic diet will provide three meals and one evening snack per day. Carbohydrate consistency will be evenly distributed across the three main meals. The amount of carbohydrates per meal will depend on the calorie level of the diet order.

CLINICAL DIETETICS

4-25. The detainees' medical nutrition therapy will be planned and will include collaborative nutritional screening, assessment, and monitoring to enhance recovery, promote optimal nutritional status, and decrease health risks. Dietitians and nutrition care specialists perform the professional and supportive duties required to ensure the prescribed diet is served.

4-26. Nutrition risk screening is accomplished for all detainees admitted to the hospital. The criteria for nutrition risk screening will be locally developed and periodically updated. Detainees determined to be adequately nourished will be rescreened at designated intervals prescribed by command policy and CSOP. Typically, most intensive care unit (ICU) detainees should be seen by the dietitian. Nutritional care will be documented in the detainee's medical record and may include: subjective dietary history information; objective medical, clinical, anthropometric, and diet order information; the assessment of the detainee's nutritional status; recommendations and or plans for implementation of nutritional intervention; and quantifiable dietary goals. Inpatient nutritional care will be documented on the SF 509 (Medical Record—Progress Notes) and outpatient care will be documented on the SF 600. The SF 513 (Medical Record—Consultation Sheet) is used to document response to consultations. A dietetic consultation is not required for a nutritional assessment.

SECTION III — EYE CARE

4-27. This section discusses the eye care provided to a detainee population. The eye care assets may be task-organized from supporting medical treatment and MEDLOG units based on METT-TC and the detainee workload.

4-28. The role of the eye care provider in DO will normally fall to an optometrist. Optometrists will manage the day-to-day clinical aspects and refer detainees to the supporting ophthalmologist for specialty care.

- *Optometrist.* Independent primary health care provider who conducts examinations to detect, prevent, diagnose, treat, and manage ocular related disorders. Additionally, conducts the initial diagnosis and management of eye injuries.
- *Ophthalmologist.* A medical doctor who specializes in eye and vision care. He is specially trained to provide the entire spectrum of eye care and performs complex and delicate eye surgeries.

DETAINEE SCREENING

4-29. All detainees will undergo a vision screening, to include measurement of best-corrected visual acuity, during inprocessing. The screening can be accomplished with a written form or done by interview. If any problems are detected during the screening or if the best-corrected visual acuity is worse than 20/40 with both eyes together, then an SF 513 should be generated. At a minimum, the following information should be obtained:

- Is the detainee presently experiencing any problems with his eyes/vision?
- Does the detainee wear/need glasses and if so, for what purpose? Are the glasses present?
- Does the detainee have any history of ocular disease, trauma, or surgery?

- Does the detainee require medications for eye-related problems? What are the names of the medications and are they present?

AUTOREFRACTOR PROTOCOL

4-30. In a detainee population, language barriers may present unique challenges to provider-detainee interactions. The use of an autorefractor is a quick and accurate way to obtain objective information to fabricate eyewear. A protocol to facilitate the use of the autorefractor is—

- Detainees will receive a visual screening during inprocessing or as required during sick call. Criteria for production of eyewear includes, but is not limited to—
 - Lost or broken glasses.
 - Complaint of decrease in vision.
 - Worse than 20/40 vision.
- Health care specialists will check detainee visual acuity on eye charts in the detainee's native language when available. Detainees with vision of 20/40 or worse may request eyewear. Screening of detainees with complaints of near-vision problems or over the age of 40 will be done as prescribed in the CSOP.
- Health care specialists operating the autorefractor follow the procedures provided in the manufacturer's instructions.
- If the autorefractor reliability number is not six or greater, the test will be repeated up to three times to get a better reading. If the reading remains low after repeated testing, these findings will be reported to the optometrist.
- Upon completion of the examination, the information is documented as prescribed in the CSOP and transmitted to the theater fabrication facility for the production of the required eyewear. Eyewear will then be distributed through the facility supply channels.

EYE EXAMINATIONS AND EYEWEAR

4-31. Detainees may get routine eye examinations for eyewear. This is done in coordination with the physician through sick call and generation of an SF 513. The physician should attempt to obtain and document on the consult, the chief complaint, duration of symptoms, and any eyewear present and best-corrected visual acuity (if known). Detainees will be sorted by the indicated immediacy and date. The eye care section will schedule detainees in the clinic. Detainees with uncorrected visual acuity of worse than 20/40 (with both eyes together) at distance or near are eligible for clear prescription eyewear. Eyewear will be ordered as prescribed in the CSOP from the supporting MEDLOG unit. Eyewear is returned to the physician or eye care section for dispensing.

EMERGENCY SERVICES

4-32. Any acute injury or presentation should be immediately sent to the eye care section for evaluation. If the injury is beyond the capabilities of the eye care section then the detainee may need to be evacuated to the supporting ophthalmologist. Detainee medical evacuations are arranged as required by the facility SOP.

CATARACT SURGERY

4-33. The capability for cataract removal may not exist in a theater. Should these assets become available, theater policy will be established to define eligibility criteria.

EYE TRAUMA AND SPECIFIC EYE DISEASE

4-34. For nonopen-globe trauma, the optometrist and/or physician should initially treat the trauma. Determination can then be made of the need for evacuation for specialty care. Open-globe trauma merits immediate transfer to an ophthalmic surgeon. The optometrist and/or physician at the TIF will manage

glaucoma. In theater, it is unlikely there will be the required medical equipment to perform grid or pan retinal photocoagulation for diabetic retinopathy. Detainees normally will not be evacuated out of the country of capture for treatment.

DIABETES CLINIC

4-35. All newly diagnosed and processed diabetics should be sent to a multidisciplinary diabetic clinic, if available. When medical assets are available, this clinic normally consists of optometry/ophthalmology, podiatry, family practice, internal medicine, and nutrition care. The following documentation should accompany the detainee when he attends the clinic:

- Five days worth of twice daily random blood sugar readings.
- A glycosylated hemoglobin (HgbA1c) test, blood chemistry, and urinary analysis (UA). The last three tests should be within one week prior to the clinic.

4-36. At the clinic, the eye care physician/optometrist will conduct the following tests:

- Refraction and best-corrected visual acuity.
- Slit lamp exam of anterior chamber.
- Dilated fundus examination of posterior chamber.

4-37. Retinopathy that needs treatment will be referred to the appropriate ophthalmologist, if such assets are available in theater. Eyewear will not be ordered for anyone whose blood sugar is deemed uncontrollable or significantly above the target value.

4-38. When medical assets are available within theater, podiatry will conduct a comprehensive foot evaluation; family practice/internal medicine will conduct a physical review of systems and medications and make recommendations about treatment; and nutrition care will educate about diet and portion control.

SECTION IV — EAR AND HEARING CARE

4-39. This section outlines the hearing assessment needs of the detainee population. It is important to determine the hearing needs of each detainee. At a minimum, the following information should be obtained:

- Is the detainee presently experiencing any problems with his ears/hearing?
- Is the detainee experiencing communication difficulties? Are such difficulties the result of hearing loss? If so, does the detainee need medical treatment or an assistive listening device (ALD)?
- Does the detainee have any history of otologic disease, trauma, or surgery?

4-40. An audiologist or certified audiometric technician/ear-nose-throat specialist can provide the hearing assessment. The level and type of care (such as an initial threshold screening versus diagnostic evaluation) will depend on the staffing expertise available.

- Audiologist. Independent primary health care provider qualified to provide a comprehensive array of professional services to include audiologic identification, assessment, diagnosis, and treatment of persons with impairment of auditory and vestibular function and prevention of impairments associated with them.
- Certified audiometric technician/ear-nose-throat specialist. Trained and certified to provide initial hearing threshold assessments using the Defense Occupational Environmental Health Readiness System—Hearing Conservation (DOEHRS-HC) or other microprocessor audiometer.

4-41. Detainees identified as having ear/hearing problems will undergo a hearing test, to include an otoscopic inspection and air-conduction thresholds using the DOEHRS-HC test software. If any problems are noted that require referral to an audiologist, then an SF 511 (Medical Record–Vital Signs Record) should be generated.

- Hearing testing must be performed in an acoustically-treated booth that meets or exceeds the standards outlined in DA Pam 40-501, if available in theater.

- Diagnostic audiological equipment must be available on site or at an appropriate facility for further detainee care evaluation when indicated.

4-42. Assistive listening devices should be available to detainees experiencing communication difficulties. The ALD allows hearing impaired detainees the ability to communicate with other individuals and also allows other individuals to communicate with a detainee who is hearing impaired.

SECTION V — BEHAVIORAL HEALTH SERVICES

4-43. Behavioral health services will be provided to detainees based on the availability of medical resources and patient workload. Resources to provide this care may be task-organized and may include inpatient and outpatient care. Health care personnel providing BH services to detainees may include a psychiatrist, psychologist, social worker, BH nurse, occupational therapist, and BH specialist.

4-44. All detainees will receive a BH screen (Appendix B) at the time of inprocessing prior to distribution into the general population. A translator will be used to translate between the screener and detainee. The BH screen will be conducted by a BH team member. Each detainee will be screened individually to maximize privacy. The BH screen will include whether the detainee has a present suicide ideation, history of suicidal behavior, history of or current psychotropic medication use, current BH complaint, history of BH treatment, and/or a history of treatment for substance abuse. During the BH screen, each detainee will be observed for general appearance and behavior, evidence of abuse and/or trauma, and current symptoms of psychosis, depression, anxiety, and/or aggression. After screening, each detainee will be recommended for either placement into the general population, placement into the general population with appropriate referral to BH, or referral to BH for an emergency assessment prior to movement into the general population. The screening will begin with an introduction and explanation of the nature and purpose of the screen. Each question will be asked by the screener and translated by the translator. Under no circumstance will a translator conduct the screen. Behavioral health screening forms (Appendix B) will not be presigned and detainees will not be screened in groups. The original completed screen will be placed in the detainee's individual medical record.

4-45. If the BH team member determines that a detainee is a suicide risk, based on the results of the screening, he will ensure the detainee is placed on a suicide watch and will make a referral to a credentialed BH provider as outlined on the screening form.

BEHAVIORAL HEALTH EVALUATIONS AND TREATMENT

4-46. All detainees who are referred for a BH evaluation will have an SF 513 completed by the consulting physician/health care practitioner prior to the detainee being evaluated. The SF 513 will have, at a minimum, the detainee identification information, a brief description of the symptoms, a clinical question (such as "rule out depression"), and be signed by the referring health care practitioner. The comprehensive BH assessment will include identification data, chief complaint, history of present illness, past BH history, family BH history, past medical history, current medications, allergies, social history, BH review of systems, mental status examination, formulation, multiaxis BH diagnosis, and treatment plan. Provider-to-provider communication from the consulting provider to the credentialed BH provider is required. Feedback will be given to the consulting provider after the detainee has been evaluated and the treatment team has formulated a treatment plan.

SUICIDE PREVENTION

4-47. To prevent detainees from attempting or committing suicide while in custody, all staff members must remain alert for indications that detainees are possible suicide risks. This is done through comprehensive intake screening, casual observations by health care personnel and/or TIF security personnel, reports from other detainees concerning a detainee's behavior, and other ways. Once a detainee has been identified as a possible suicide risk, an assessment shall be conducted to try to determine the degree of such risk. Once detainees have been identified and assessed as possible suicide risks, procedures and steps shall be taken to protect detainees from self-harm.

OBSERVATION AND DOCUMENTATION

4-48. Staff members shall continually observe detainees for indicators of possible suicide risk and will accurately and thoroughly document all such observations. Detainees deemed suicide risks will be closely observed and physically checked at specified intervals to ensure their safety. All staff members will follow basic guidelines for the effective management and supervision of detainees deemed risks. This will feature a high level of interpersonal interaction with detainees—listening to and talking with them. Detainees may also use suicidal behavior to attain increased attention or privileges. Therefore, they may show absolutely no signs of depression or distress.

Classification

4-49. Detainees will be properly classified for housing and level placement to facilitate the most effective monitoring and supervision to ensure safety.

Referral of Detainees

4-50. Referrals of detainees who may be suicide risks shall be made to the supporting BH providers. Behavioral health providers will follow through on all such referrals to determine most appropriate actions.

Security Procedures

4-51. Procedures shall be followed to minimize the possibility that detainees can harm themselves. This will involve placement of detainees in suicide-resistant cells, removal of items that detainees may use to harm themselves, and conducting thorough searches to uncover harmful items.

CRISIS INTERVENTION

4-52. Procedures will be followed to intervene in suicidal crisis situations of detainees, to de-escalate difficult feelings and emotions, and to ensure safety. Steps, as prescribed in the TIF SOP, will be followed to properly intervene in apparent hangings or other suicide attempts by detainees. This will include appropriate follow-through procedures to calm detainees and ensure provision of appropriate medical and psychological care. Following any detainee suicide attempt or completed suicide, appropriate written reports are prepared fully describing elements of the incident. Traumatic event management (TEM) may be conducted following serious suicide attempts or completed suicides of detainees. The purpose of such debriefing is to analyze the incident and determine whether future suicide prevention procedures and responses can be improved. In addition, TEM sessions may be scheduled for staff members involved in serious detainee suicide attempts or completed suicides in order to address psychological/emotional needs and concerns of staff members. A suicide prevention program is considered a team effort involving all TIF staff.

OTHER RISK IDENTIFIERS AND ASSESSMENT OF DEGREE OF RISK

Indications of Severe Depression

4-53. Theater internment facility security personnel and other staff members must remain alert for indications of possible suicide risk among detainees. Some of the more common signs and symptoms of severe depression include—

- Extreme feeling of sadness.
- Apparent feelings of hopelessness and helplessness.
- Guilt and self-blaming.
- Lack of energy and lack of interest in activities.
- Withdrawal from other people, including other detainees.
- Eating problems (eating very little or too much).
- Sleep problems (inability to sleep well or sleeping too much).

Note. Any of the above indications of depression combined with a detainee's talk of suicide, wishing for death, or similar statements is a *serious* suicide indicator.

Other Indicators

4-54. Other indications of possible mental or emotional illness or distress include, but are not limited to, the following:

- Extreme agitation which lasts for longer than seems normal. This may be characterized by high-level tension, anxiety, and possibly very strong emotions such as guilt, rage, or a wish for revenge.
- Alternating *manic* and *depressed* behavior. Manic behavior is commonly characterized by a period of hyperactivity, racing thoughts, excessive talking, great energy, flight of ideas, concocting grandiose schemes, claiming to need little sleep, and possible obnoxious behavior.
- Unduly suspicious thought patterns.
- Delusions and/or hallucinations.

Other Behaviors

4-55. Other behaviors which could indicate possible suicide risk, include a detainee—

- Giving away possessions, particularly when he is not going anywhere.
- Behaving (suddenly) in a very calm, resigned manner, particularly if he has previously been agitated or depressed.
- Harming or attempting to harm himself physically, even if it does not seem like an actual suicide attempt. This is particularly significant if the detainee cuts himself in the neck area or makes deep vertical cuts or slashes on a wrist.

Referral

4-56. If there is reason to consider a detainee a suicide risk for any of the above reasons, medical or facility personnel will refer the detainee to BH for a professional suicide risk assessment. This is done by completing an SF 513 or by simply communicating with a BH staff member.

DOCUMENTATION OF OBSERVATIONS AND INFORMATION

4-57. The person completing the intake screening form will accurately and thoroughly document any information indicating that a detainee is a possible suicide risk. In addition, any staff member noticing any indication that a detainee may be suicidal will document his observations in a log and contact the BH team.

4-58. Military police may make an initial classification decision of detainees as being on suicide-watch status prior to a BH assessment.

4-59. If a staff member feels that a detainee should be carefully observed on a continuous basis in order to ensure the detainee's safety, he will place the detainee in an observation cell adjacent to the level control point, if available. The detainee should be searched and all items that he can use in a suicide attempt should be removed. Also, if the detainee makes suicidal gestures with articles of clothing he should have everything removed from the cell except his underwear. The detainee should have continuous monitoring while in the observation cell. The BH team should be notified and should evaluate the detainee prior to returning him to general population. The TIF security personnel will log in each time a BH professional evaluates a suicidal detainee.

4-60. Placing a detainee in the general population is a good option for a detainee who seems to be having a difficult time, who may be having suicidal thoughts, and could well benefit from being around other people rather than alone. However, this option should only be used if the other detainees with whom the suicidal detainee is being housed can be trusted not to make him feel worse. If possible, the other detainees may be

asked to keep an eye on the suicidal detainee; however, they should not be asked or directed to keep him from committing suicide. In general, any detainee placed in general population will be considered a fairly low suicide risk. The decision to return a detainee to the general population will be made by a BH provider.

BEHAVIORAL HEALTH RECOMMENDATIONS

4-61. If the MP staff has any problems, concerns, or disagreements about any suggestions for care of a detainee made by the BH staff, he will contact the chain of command. However, the MP shall not just disregard the BH worker's recommendation. In some cases, it may be helpful to ask a suicidal detainee to agree to a nonsuicide pact. This is a short-term, time-specific agreement by the inmate not to attempt suicide. It must be for a specific time frame, such as between the time of agreement and 0800 the next morning. If it is not time specific, it is unreasonable and impractical. This tool can be especially useful during nighttime hours, which are difficult for many people. It is a tool that can be used to help an inmate get through a short but intense period of emotional crisis. If you use a pact, however, be sure to ask the inmate to let you know if he feels, at any time during the period of time agreed on, that he cannot live up to the agreement. A detainee's nonsuicide pact must be reported to a BH provider.

MANAGING SUICIDAL DETAINEES

4-62. If a detainee seems to be undergoing a severe emotional crisis in which a suicide attempt seems imminent, BH should be notified. Before professional help arrives, and if a detainee is actually about to commit suicide, the staff member should do the following:

- Approach the detainee calmly and with concern. Do not panic.
- Ask how you can help.
- Listen carefully without challenging. Avoid arguing with the detainee.
- If necessary and if possible, physically prevent the detainee from harming himself.

REMOVAL OF DETAINEE FROM SUICIDE WATCH

4-63. If a staff member feels that a detainee may be safely removed from suicide-watch status, he may so recommend to a supervisor. The supervisor will then assess the recommendation and the situation and, if deemed appropriate, may then recommend to the BH team that the detainee be removed. The BH team member provides the recommendation to the psychiatrist or psychologist for resolution. Under no circumstances will TIF security personnel or other staff members remove a detainee from suicide watch status without the permission of a BH provider. A credentialed BH provider will be consulted to determine the appropriateness of removal from suicide-watch status.

INTERVENTION IN A SUICIDE ATTEMPT

4-64. If an MP or other staff member comes upon a detainee who is hanging, he will—

- Immediately call for backup and notify the EMT personnel and the BH team.
- When entering a tent or segregation cell, immediately lift the hanging victim's body to relieve pressure on his neck. Support the victim's head when doing so.
- Cut the item by which the detainee is hanging. Cut it either above or below the knot if possible, so that the knot can be preserved as evidence.
- Provide first aid, as required.

4-65. If a detainee has made a suicide attempt by any method other than hanging, the same basic sequence for a hanging should be followed, except for cutting down the victim. The first aid applied will depend on the specific method of suicide used by the inmate. If the detainee has made a cutting attempt, try to control bleeding with direct pressure first. Call the EMT personnel to evaluate the detainee further. Whenever possible, the detainee should be evaluated and treated in the compound. The responding EMT personnel will determine if the detainee needs to be evacuated to an MTF for treatment. After medical treatment has been rendered, the detainee should be observed in the observation cell until an evaluation by the BH

professional can be accomplished. If the detainee took an overdose of medication, call the EMT personnel immediately so proper care can be rendered. The BH assets should be notified after medical clearance has been obtained. Following any suicide attempt by a detainee, the BH assets will be notified immediately regardless of the time of day.

FOLLOW UP

4-66. The detainee should be placed in the observation cell after any suicide attempt that does not require hospitalization. Additionally, staff members will log the incident into their respective logs and report to higher HQ as directed by their internal SOP. In the event of a successful suicide, the staff member will contact his immediate supervisor, higher HQ, and the BH assets immediately. Documentation into respective logs should be completed.

4-67. The facility commander will review all incident report forms on suicide attempts or suicide incidents to ensure compliance with policy and to be aware of any problems or concerns. In addition, the commander has the option to schedule a session following any serious attempt by a detainee or a completed suicide. The BH assets will talk with the involved staff members to review policy and discuss the event after every serious attempt or completed suicide. Traumatic event management is highly encouraged but not mandatory. Following a suicide, BH services will be made readily available for all staff members who desire it.

SECTION VI — PREVENTIVE MEDICINE

4-68. Unit field sanitation teams as prescribed by AR 40-5 and FM 4-25.12 are the first line of defense for ensuring that field sanitation standards and PMM are properly maintained. Preventive medicine personnel will provide direct oversight and support to these teams, as necessary. Preventive medicine personnel may be required to assist in establishing and/or inspecting a detention facility. The United States Army Center for Health Promotion and Preventive Medicine (USACHPPM) Technical Guide (TG) 307 provides detailed public health standards, criteria, and guidance for planning, establishing, operating, and inspecting internment facilities. Additional information on field sanitation devices (for example latrines and handwashing stations) is contained in *Field Hygiene and Sanitation*. Occupational and environmental health surveillance are also required within the facility and if detainees are engaged in work at off-site locations. This appendix provides a sample PVNTMED checklist for monthly inspections of DCPs, DHAs, and TIFs (Table D-1).

POTABLE WATER

4-69. Preventive medicine personnel inspect water supplies for potability. Water point inspections are documented on DA Form 5456 (Water Point Inspection). Preventive medicine personnel document the inspection of potable water containers within the compound on DA Form 5457 (Potable Water Container Inspection).

4-70. Water needs vary according to climate, sanitation facilities available, and the detainees' normal habits, religious, and cultural practices. Water consumption planning factors should be the same as for US Forces. These factors are—

- 1.5 gallons per person per day for drinking in temperate climates.
- 3.0 gallons per person per day for drinking in tropical and arid climates.
- 2.0 gallons per person per day for drinking in arctic climates.
- 1.7 gallons per person per day for personal hygiene.
- 1.7 gallons per person per day for centralized hygiene (showers) (1 shower per week per person).
- 2.8 gallons per person per day for food preparation.
- 3.1 gallons per person per day for laundry.

- 1.24 gallons per person per day for medical treatment.
- Detainees of certain religious faiths (such as Islam) should be provided an additional 0.5 to 1.5 gallons (2 to 5 liters) of potable water per person per day for washing and drinking associated with religious practices.
- Detainees who practice anal washing following defecation require an additional 0.25 to 0.5 gallons (1 to 2 liters) per day.

4-71. Sufficient potable water should be available to provide each detainee a minimum of 4 gallons (15 liters) per day. If detainees are preparing their own food, 8 gallons (30 liters) per day are required. Needs may increase based on climate and religious/cultural practices. There should be at least one water distribution point per 250 detainees.

4-72. Water quality must meet the field water requirements specified in Technical Bulletin, Medical (TB MED) 577. Preventive medicine personnel inspect water supplies for potability, by testing them daily for pH and free available chlorine (FAC) and conducting weekly bacteriological and chemical testing.

4-73. For showering and bathing, disinfected nonpotable water (with at least 1 parts per million [ppm] FAC) may be used for centralized hygiene (such as showers) unless schistosomiasis and/or leptospirosis are endemic and prevalent. Otherwise, potable water should be provided. Detainees should have access to showers at least once per week. One showerhead should be provided per every 25 detainees.

4-74. Detainee clothing should be laundered at least once a week preferably in an Army field laundry or a commercial central laundry facility. When centralized laundry services are unavailable, there should be at least one clothes washing station per 100 detainees. Specific criteria for planning for detainee clothes washing, to include water volumes and temperatures, are provided in the USACHPPM TG 307.

PEST MANAGEMENT SERVICES

4-75. Pest management activities are conducted within the TIF to reduce the incidence of disease within the detainee population.

- Vector/pest surveillance and control will be conducted as prescribed by TB MED 561. Fly control shall be conducted according to Armed Forces Pest Management Board (AFPMB) TG 30. Mass delousing is rarely necessary and dangerous if done incorrectly. Infested detainees should be kept separated from the general population until adequately treated on an individual basis by health care providers, thoroughly showered with soap and water, and dressed appropriately in laundered clothing.
- Adequate collection and disposal of refuse is required to maintain adequate sanitation within the facility. One 32-gallon refuse collection container is required per 25 detainees. If the detainees prepare their own food, one 32-gallon container per 17 detainees is required. Inspections should be conducted on a regular basis by the detainee supervisor or PVNTMED personnel to ensure containers are covered to minimize attracting insects and rodents. These containers must be emptied and cleaned daily.
- Latrines and handwashing devices are established and maintained daily. The types and number of latrines established are determined by the number of detainees and the length of time they will be held at a location. For TIFs, latrines are normally provided at ratios of at least one for every 25 male detainees and one for every 17 female detainees. Whenever possible, urinals should be provided at a ratio of at least one for every 50 male detainees. Urinals may replace up to 50 percent of the male latrine requirement. Field expedient measures (such as individual waste collection bags) may be required at temporary locations, such as the DCP. Facilities must be maintained properly to control fly populations. Handwashing devices should be located between or adjacent to all latrines and urinals. There should be at least one handwashing device per every five latrines.

FOOD SANITATION

4-76. Preventive medicine personnel ensure that food service facilities that serve detainee populations meet all food service sanitation requirements specified in TB MED 530. Only food from approved sources may be used. The detainee food service operations must be inspected routinely for sanitation and the results of these inspections are documented on DA Form 5162-R (Routine Food Establishment Inspection Report).

4-77. If food is prepared at a central dining facility and brought to the detainment facility in insulated food containers, particular attention must be paid to holding temperatures and maximum time food can be served from the container. Keep cold foods below 40° Fahrenheit (F) (4° Celsius [C]) and hot foods above 140°F (60°C) to prevent bacterial growth. Food should be served within 3 hours of preparation.

4-78. If food is prepared in the detainment facility, food preparation and handling areas should be screened to exclude flies and other pests from exposed food. Food service personnel must meet the medical screening and food service sanitation training requirements outlined in TB MED 530. Therefore, if detainees normally prepare and handle the food, they must be trained in food preparation and handling by qualified personnel.

4-79. Detainees may also have personal food items within their designated living space. These items should be inspected to ensure food hygiene and safety requirements are adhered to. Containers used to store these items must protect them from potential contamination such as from insects and dirt. Additionally, if the food item is sensitive to heat and/or cold, it must be maintained in a manner that will protect it from spoilage.

4-80. It is possible that a detainee may bring into the facility a domesticated animal and may then request permission to slaughter the animal. If so, the supporting medical command (MEDCOM) and other medical command and control (C2) unit should be contacted to coordinate veterinary service support.

4-81. Preventive medicine personnel provide sanitary control and surveillance of food preparation and dining facility sanitation. Food service facilities for detainee populations must meet the sanitation requirements provided in TB MED 530 and *Field Hygiene and Sanitation*. Detailed food service sanitation guidance, including kitchen locations with respect to other facilities; use of locally procured foods; food protection; food service worker training; handwashing facilities; soakage pits; mix of meals, ready-to-eat (MREs) and hot meals; and cultural and religious considerations are described in the USACHPPM TG 307.

ENVIRONMENTAL SANITATION

4-82. Preventive medicine personnel also inspect detainment facilities for environmental sanitation. To enhance sanitary conditions, they provide training in personal hygiene practices and field sanitation to detainees. Standards for personal hygiene and field sanitation practices should be posted in detainee areas in their native language and explained to them upon initial entry into the facility.

4-83. The safe disposal of wastes creates the first barrier to direct and indirect transmission of disease. The provision of appropriate facilities for urination and defecation and for solid waste management is essential for detainee health, safety, and dignity.

4-84. Human wastes should be disposed of in latrines that are designed, constructed, and maintained in a sanitary manner and acceptable to detainees, taking into account cultural norms, ease of cleaning, and privacy. At least one latrine should be provided per every 25 males and one latrine per every 17 females.

4-85. The USACHPPM TG 307 provides specific guidance on human waste disposal in austere environments; the variety of latrines and urinals available for field use; locations of latrines with respect to water supplies and food service areas; availability of toilet paper and handwashing devices; and the use of privacy screens.

4-86. Refuse containers (33 gallon) should be provided at a ration of one for every 25 detainees and should be clearly marked, lined with plastic bags, and covered with tight-fitting lids. Additional guidance for

refuse container location; collection frequencies; burial, and incineration is provided in the USACHPPM TG 307.

4-87. Ideally regulated medical wastes should be disposed of using modern, high-quality incinerators available at local national hospitals or through contractors. If unavailable, medical wastes should be separated and disposed of in a correctly designed, constructed, and operated inclined-plane incinerator with a vapor burner, as described in FM 4-25.12. Additional guidance regarding medical waste disposal is found in the USACHPPM TG 307.

CONTROL OF COMMUNICABLE DISEASES

4-88. Medical screening for communicable diseases must occur at inprocessing and during monthly medical exams according to AR 190-8 and theater policy. Detainees are immunized based on theater policy. Seriously ill detainees, especially those with communicable diseases, should be segregated from the general detainee population. Detainees with respiratory infections, especially TB, should be masked with a standard surgical mask and segregated in areas that do not share recirculated air with the remainder of the population until they are no longer infectious.

4-89. Medical surveillance data must be collected, analyzed, and reported for the detainee populations at detention facilities. Detainee DNBI data is collected daily and reported at least weekly through medical channels according to theater policy.

GUIDELINE LISTING

SITE SELECTION AND SHELTER

4-90. Detention facilities can vary greatly, from short-term holding areas in forward locations that may consist of little more than several strands of concertina wire, to large, long-term I/R facilities that house thousands of detainees. Poor site selection and facility design can increase the risk of disease and injuries for detainees and for cadre.

4-91. Refer to USACHPPM TG 307 for comprehensive guidance on site selection, shelter, water, food, waste management, vector and pest control, and basic communicable disease control.

4-92. To determine total land area requirements, use a minimum factor of 320 square (sq) feet (ft) (35 sq yards [yds], or 30 sq meters) per person to ensure ample space for shelters, roads, firebreaks, public facilities, and administrative and support facilities, such as medical. For a 5,000-person internment facility, the minimum land area is about 37 acres.

4-93. Covered living space should provide a minimum of 40 sq ft per person. Air circulation is improved and respiratory disease rates lowered if more space can be provided (up to 80 sq ft). Beds or mats should be separated by a minimum distance of 2.5 ft. Maximum occupancy for military tentage is 20 occupants per general purpose (GP) large and 12 occupants per GP medium. Small shelters with few occupants are preferable to large shelters with many occupants.

4-94. Adequate ventilation is critical. The minimum amount of air circulation needed is 12 cubic ft per minute (cfm) per person, at least 4 cfm (33 percent) of which should be fresh (outside) air. Recirculated air should be filtered. Natural ventilation may be adequate to achieve this degree of circulation in temporary shelters such as tents, but mechanical ventilation will likely be required to comply with these standards inside buildings. Ambient temperature in shelters should be maintained at 66°F to 78°F, but lower temperatures may be acceptable if detainees are provided warm clothing and blankets. Relative humidity should be maintained between 30 percent and 50 percent in buildings. A minimum of 20 foot-candles of light should be provided at 30 inches from the ground for all interior spaces.

4-95. Site selection and facility design criteria considers land topography; drainage; space for people and support facilities; vectorborne disease threats, like mosquito and rat breeding areas/food sources; roads, firebreaks; shelter spacing; and facility layout. Detailed sanitation and hygiene criteria for site selection and facility layout are found in the USACHPPM TG 307.

CLOTHING

4-96. Each detainee is provided distinctive clothing (such as brightly colored jumpsuits) in sufficient quantity. Detainees should be issued permethrin-impregnated clothing, which are normally effective for 20 washings before requiring retreatment. Only trained personnel using proper equipment and/or supplies should apply permethrin. For additional information on clothing and the marking of clothing refer to FM 3-19.40.

PREVENTIVE MEDICINE INSPECTION PROCEDURES

4-97. A critical element in the prevention of disease and injury is consistent monitoring and evaluation. Detention facilities require regular, periodic assessment of the sanitary and hygiene standards and requirements and to ensure the overall appropriateness, effectiveness, and impact on detainee populations. Preventive medicine personnel should be knowledgeable of detainee facility policies and procedures, as well as the local cultures, customs, and endemic, environmental, and communicable disease threats.

SECTION VII — PHARMACY SERVICES

RESPONSIBILITIES

4-98. The MTF commander is responsible for operation of the pharmacy and exercises careful supervision over all phases of its operations. At Role 1 and 2 MTFs, the senior physician supervises the receipt, storage, and issuance of medications. The chief, pharmacy services at the supporting Role 3 hospital provides consultation and assistance on pharmaceutical issues arising at the supported facilities. Within the Role 3 hospital, the commander ensures that—

- Supervision is exercised directly, either by a—
 - Subordinate officer who is a graduate of a recognized school or college of pharmacy and licensed to practice pharmacy in one of the states of the US, Puerto Rico, or the District of Columbia.
 - Physician acting as the officer in charge (OIC) or in an equivalent status when no pharmacist is on duty at the facility.
- Policies are established to ensure—
 - Rational prescribing, taking into consideration pharmacoeconomic aspects of various medication alternatives so that health care providers use cost-effective therapies at the MTF.
 - Quantities of drugs prescribed do not exceed amounts required to provide sound medical treatment. Detainees are not permitted to retain medications in their possession with the exception of such medications as fast-acting inhalants for asthma.
 - Prescribed medications are available in individual dose packaging.
 - When feasible, medications are prescribed that require administration only one or two times a day.

4-99. The pharmacy chief is charged with the duties of recognizing, identifying, selecting, ordering, preparing, safeguarding, evaluating, and dispensing all pharmaceutical substances of whatever kind and combination used in preventive, curative, and diagnostic medicine. The chief and his staff are responsible for keeping abreast of new developments in the field of pharmacy and for operating the pharmacy in compliance with federal laws, accreditation standards defined by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), when applicable, and standards of pharmaceutical care as prescribed by AR and policy. In doing so, the chief is responsible for—

- Assisting and advising health care providers in the writing of prescriptions, medication orders, and other matters involving the use or misuse of medications.
- Inspecting locations within the facility where medications are stocked/stored.
- Ensuring documentation for the administration of medications to detainees is completed and maintained. If appropriate, documentation on the administration of medications to detainees or

a detainee's refusal to take prescribed medications will also be filed in the individual detainee's medical record.

- Maintaining adequate reference material for use by pharmacy personnel and other professional staff served by the pharmacy.
- Disseminating information to the professional staff concerning advances in the field of pharmacy and related matters.
- Disseminating via appropriate media (for example, memorandums or e-mail), pharmacy information on drug items, preparations available for use, prescribing policies, and items of interest to the medical staff.
- Operating a pharmacy sterile products program within the hospital to include the preparation and delivery of pharmaceutical sterile products to patient care areas.
- Operating a unit dose or other point of use drug distribution system to ensure a safe, efficient, and economical method of drug distribution.
- Consulting with the professional staff on the appropriate use of medications, including interactions and cautions related to the use of alternative forms of medicines such as dietary supplements and herbal remedies, if appropriate.
- Conducting staff assistance visits and consultation services to Roles 1 and 2 MTFs organic/collocated with the TIF.

CONTROLLED SUBSTANCES

4-100. Controlled substances are drugs so designated by the DEA. The DEA assigns controlled substances to one of five schedules according to the abuse potential and degree of control required. A list of controlled substances in each schedule and changes are published in the Federal Register and in the Supply Bulletin (SB) 8-75-series.

4-101. Military treatment facility commanders may designate items as locally controlled if they deem them subject to potential abuse or diversion. The method of accountability for such items will be either as Schedule II or Schedules III-V as determined by the commander.

4-102. The receipt, storage, distribution, and inventory of controlled substances are prescribed in applicable regulations, policies, and established procedures and standards.

INDIVIDUALS AUTHORIZED TO WRITE PRESCRIPTIONS

4-103. Uniformed physicians, dentists, veterinarians, and podiatrists engaged in professional practice at MTFs are authorized to write prescriptions.

4-104. The following personnel are authorized to write prescriptions only for selected medications as established under the provisions of AR 40-68 and/or approved by the local commander:

- Uniformed optometrists, APRNs, PAs, physical therapists, occupational therapists, and pharmacists engaged in professional practice at MTFs and privileged to prescribe medications.
- Other nonphysician health care providers not listed above but assigned to an MTF and granted limited prescribing privileges.
- Contract civilian health care providers as permitted by their credentialing and scopes of practice.

SIGNATURES

4-105. With the exception of physician order entry via the Armed Forces Health Longitudinal Technology Application (AHLTA), no prescription or order will be filled in the pharmacy unless it bears the signature of an individual authorized to write prescriptions. Signature stamps are not authorized for prescriptions. The pharmacy service will maintain a system that allows their staff to validate the signature of individuals privileged to write prescriptions within their MTF.

4-106. Ward stock orders for controlled substances will be signed by individuals authorized to write prescriptions or by a registered nurse.

4-107. Medical treatment facilities with electronic ordering capability may use electronic signatures if security measures are provided.

Dispensing

4-108. The MTF commander/physician ensures adherence to the DOD Tri-Service pharmacy policy guidance for dispensing medications. Wards, clinics, and other activities within the hospital will normally use the pharmacy as the source of supply for drugs required for administration within the MTF. Roles 1 and 2 MTFs will adhere to established procedures in the unit SOP.

4-109. Dispensing procedures.

- All medication will be dispensed only upon receipt of a properly written or automated prescription.
- Military treatment facilities will follow a generic dispensing policy. Orders written by staff providers for trade name drugs will automatically be dispensed with the generic equivalent when possible.
- The MTF will develop written procedures for dispensing controlled medications that comply with federal laws and ARs.

Prescription Forms

4-110. Department of Defense Form 1289 (Prescription Form) is the standard form. Information pertaining to drug manufacturer, lot number, and expiration date is not required on any DD Form 1289 written in an Army MTF, if there is a drug recall procedure established that can be readily implemented. DD Form 1289 is not used for multiple medications, single prescriptions only.

4-111. The MTF commander/physician may authorize use of a locally developed multiple prescription form. The MTF commander/physician may authorize use of other official forms for use in prescribing medications (for example, SF 600, SF 558, or DA Form 4256 [Clinical Record—Doctor's Orders]).

4-112. Bulk drug orders, DA Form 3875 (Bulk Drug Order), a local form, or an automated system will be used for ordering all noncontrolled drugs or preparations in bulk quantities for use in a ward, clinic, or other activities. Items requiring maintenance of a stock record card will be issued only upon receipt of a properly written and authenticated prescription form or locally approved form.

Prescription Writing

4-113. Prescriptions will be stamped, typed, or written in ink and signed in ink by an authorized prescriber. As an exception to this rule, electronic prescriptions generated through AHLTA, to include prescriptions for Schedules II through V controlled substances, may be filled by the pharmacy contingent upon established security measures (see AR 40-3). Otherwise, prescriptions for Schedule II substances require an original prescription.

4-114. Prescriptions will be dated and signed on the day when written.

4-115. In accordance with current policies, authorized military and DOD providers who are authorized to prescribe, dispense, and administer controlled substances will record their DEA number or social security number on all prescriptions written for controlled substances in the course of their official duties.

4-116. Prescriptions for controlled substances written at Army MTFs will have the amount prescribed shown both in numerals and spelled out in words.

Accounting for Controlled Substances Used in the Manufacture of Pharmaceutical Preparations

4-117. Department of Defense Form 1289 or an equivalent automated record will be used to account for all controlled substances used in the manufacture of pharmaceutical preparations. Such orders will be authenticated and signed by a licensed provider or registered nurse and will be filed in the appropriate prescription file.

Labeling

4-118. Labeling requirements for drugs issued in bulk to wards, clinics, and other authorized agencies will be prescribed by the commander. The container label will include the drug name and strength, manufacturer, lot number or locally assigned lot number, and expiration date.

4-119. Labels for intravenous admixture solutions prepared by the pharmacy service will comply with federal law and appropriate standards of practice.

Numbering and Filing

4-120. All hard copy prescriptions and orders filled by the pharmacy will be placed in files established and maintained in the pharmacy. Controlled substance prescriptions will be numbered serially and signed for by the individual who picked up the medication. Two series of numbers will be used; one series for Schedule II controlled substances, alcohol, and alcoholic liquors and one series for Schedules III, IV, and V controlled substances. A corresponding file will be established for each series of numbers. Pharmacies using AHLTA or any other computer system will develop a suitable alternative method to number, check, and file prescriptions.

Stock Record

4-121. The pharmacy/MTF will maintain a record of receipts and expenditures of all controlled substances, ethyl alcohol and alcoholic liquors, and of such other drugs as may be designated by the commander. A separate record will be maintained on DA Form 3862 (Controlled Substances Stock Record) for each dosage form in which the item is supplied except where an equivalent locally approved automated accounting record is used.

Disposition of Drugs Confiscated from Detainees

4-122. At the point of capture, medications found on detainees will be confiscated, inventoried, placed in a bag, and identified with the detainees name and capture tag number. Health care personnel will determine what condition the medication is being taken for and whether it was prescribed by a doctor. (In many cultures, medications that require a prescription in the US can be purchased over the counter. Detainees may, therefore, be self-medicating and not under the care of a doctor.) If it is medically determined that the detainee requires daily medication, appropriate arrangements will be made for the administration of the required medications while in temporary holding facilities or while en route to the TIF.

4-123. Medications will be provided to health care personnel during the TIF inprocessing medical screening.

4-124. Health care personnel will determine the disposition of medications confiscated from detainees.

4-125. With the exception of the types of medication discussed in paragraph 4-126, medications possessed by detainees while in the TIF are considered contraband and will be confiscated. Contraband will be documented and then destroyed under medical supervision.

Self-Administration

4-126. Detainees may be allowed to administer medications to themselves when a delay in receiving medications may adversely affect the detainee's health or when the detainee is receiving topical products on an as-needed basis. Albuterol inhalers and topical creams and ointments are suitable examples. In all cases, the detainee's name and ISN (or capture tag number) will be placed on the medication package or the medication itself.

INSPECTION AND DISPOSITION OF PRESCRIPTION FILES AND RECORDS

4-127. Prescription and allied records will be subject to inspection at all times.

4-128. Prescription files, controlled substance records, and other records maintained in the pharmacy/MTF will be retained and disposed of according to AR 25-400-2. Any alternative method of storage and disposal must be approved by the appropriate records management officer.

SECTION VIII — DENTAL CARE**DENTAL RESOURCES WITHIN THE THEATER**

4-129. This section discusses the policies and procedures for providing dental care to a detainee population. Limited detainee emergency dental care can be provided by the physician and PA at a Role 1 MTF and consists of the relief of pain and antibiotics to treat infection. Operational dental care is provided by the dental officer in a Role 2 MTF and a dental company, area support. Operational dental care consists of emergency dental care and essential dental care. Essential dental care consists of definitive restoration, minor oral surgery, endodontic, periodontic, and prosthodontic procedures, as well as prophylaxis.

4-130. At Role 3 hospitals, a maxillofacial surgical capability is available to minimize loss of life and disability resulting from severe oral and maxillofacial injuries and wounds.

4-131. The size of the dental element providing support to a TIF is dependent on METT-TC factors including the size of detainee population and availability of dental resources in the geographical area. Dental personnel and equipment are not organic to MP unit/TIF medical sections and therefore augmentation of dental assets is required.

CONCERNS AND ISSUES DEALING SPECIFICALLY WITH DETAINEE DENTAL OPERATIONS

4-132. The primary unique concern in detainee medical operations is security. Designing the placement and location of chairs and the clinic floor plan de-emphasizes detainee privacy and increases emphasis on security within the TIF. Equipment and supplies should be accounted for at all times. All instruments should be inaccessible to detainees. Detainees should be visible to guards at all times. Detainees should not have ready access to exits. During detainee treatment times, staff weapons are not permitted in the clinic.

EXAMINATIONS

4-133. Initial screening examination of detainees is used to identify obvious swelling, trauma, abscess, excessive bleeding, and lesions.

- Screening is done as a "look-see," which is completed by using a flashlight and tongue depressor.
- When one or more of the above are noted, the detainee should be brought to the dental clinic immediately for a more involved examination with x-rays and treatment, if necessary.

- Prescriptions are written as deemed necessary for the treatment of the detainee's dental condition.

4-134. Screening examination findings are recorded on SF 603 (Health Record—Dental) and placed in the detainee's medical record which was initiated during the medical screening conducted when the detainee was inprocessed to the TIF.

- Obvious findings recorded include extractions (such as root tips or nonrestorable caries), restorable caries, and partially impacted wisdom teeth.
- Detainees are asked if pain is involved and the response is noted.

TREATMENT SCREENING PROCEDURES

4-135. After detainees have been medically inprocessed to the TIF, periodic screens may be required to intercept dental emergencies.

4-136. A specific detainee may be referred for dental evaluation and treatment from a number of areas. The procedure for requesting a specific detainee to report for dental evaluation and treatment is to provide a memorandum to the MPs the night before, requesting the detainee report in the morning. Detainee can be referred by—

- Consults turned in from doctors.
- Medical inprocessing screens.
- Sick call.
- Follow-ups from the previous day.

4-137. When detainees come for treatment, treatment is documented on a new SF 603.

- The detainee's name and ISN is written in pen and his domicile location is entered in pencil as this may change.
- The SF 603 and any SF 603A (Medical Record—Dental-Continuation) are maintained in the detainee's individual medical record. The medical record is requested from the supporting PAD, as required.

4-138. Evaluation and determination of required treatment consists of the following—

- The dentist and translator screen the detainee's medical history for any adverse reaction to previous dental treatment.
- The detainee is asked where and what kind of pain he is experiencing. This is documented on the SF 603A.
- Radiographs are taken of the teeth that the detainee has complained about. The dental officer determines whether other teeth need to be x-rayed that may require dental treatment.
- Once taken, the dentist is notified and reads the x-ray. The assistant is then told what type of treatment to set up for.
 - Detainees are informed through a translator of treatment required.
 - They have the opportunity to either accept or refuse treatment.
 - If treatment is refused, they are informed of the complications that may result from not having treatment.

4-139. Detainees often do not get to eat breakfast before they come in the morning; therefore, the dental clinic maintains nutritional support drinks in the clinic, for those detainees who—

- Need to take pain medication immediately.
- Will have extensive oral surgery (several teeth taken out in one day).
- Are diabetic (given before receiving treatment).

4-140. Once the dental procedure is completed, if a—

- Prescription is required and subsequently written; it will include the detainee's name, ISN, and domicile location.

- *Stat* dose is written, the assistant will take it down to the pharmacy to have it filled.
- Prescription is written for the detainee to take later; this is indicated across the top and turned in to the pharmacy.

4-141. Once the detainee is finished with the dental procedure, the MP is asked to return the detainee back to the compound, hospital ward, or holding cell, as appropriate.

- Postoperative instructions are given through a translator.
- An immediate dose of medicine is given (if required). (Detainees are not permitted to have medications on their person. After the initial medication is given in the clinic, other doses of the medication will be provided per established procedures in the TIF SOP.)
- The guard is asked to bring in the next detainee. For security reasons, a maximum number of detainees permitted in the clinic at one time is established. This is dependent upon the size of the area and the number of providers.
- Follow-up detainees will be requested and seen as needed.

WEAPONS

4-142. No weapons are allowed in the clinic when detainees are scheduled. Weapons are turned in at PAD office. If individual detainees are treated during nonscheduled hours, weapons are turned in at PAD office or stored in secure areas within the clinic.

TRANSLATOR

4-143. A translator is required during all dental treatment of detainees. The translator is required to assist the dental officer in ensuring the medical history is accurately reviewed, to inform the detainee of the procedures to be performed, and to translate the concerns of the detainee to the dental officer and of the dental officer to the detainee during treatment.

PHOTOGRAPHS AND RADIOGRAPHS

4-144. There are stringent regulations pertaining to the photographing of detainees. Medical photographs will only be used to document preexisting conditions and traumatic injuries and to provide a basis for justification of why treatment was performed. Any medical photographs taken become a part of the detainee's medical record.

SICK CALL AND EMERGENCIES

4-145. Dental emergencies (such as bleeding, externally expanding abscesses, pain, and trauma) are treated immediately after ER notification, dental evaluation, and confirmation of urgency.

HOSPITAL PATIENTS

Inpatients

4-146. Inpatients are treated on a per-consult basis either at the bedside or in the clinic based on ambulatory capacity. All detainee inpatients must be under guard when leaving the ward and continuously while they are off the ward. Detainee inpatients cannot move within the facility or to the clinic unless under guard.

Dental Inpatients

4-147. Detainees admitted for reasons related to dental emergencies may be admitted by the ER physician per dental consult and emergency care required. Discharge is per mutual agreement between medical and dental staff.

SECTION IX — VETERINARY SERVICES

4-148. Veterinary service support requirements for DO are based on the mission and the size of the force supported. Veterinary units inspect food production sites for safe food manufacture storage and conveyance. These units are responsible for sanitary inspections and food screening at places of procurement, production, storage, and conveyance. These inspections are an integral part of assuring food safety, security, and quality assurance for detainees.

4-149. Veterinary units will provide animal medical care to military working dogs (MWDs) located at the TIF. This support provides Level I and II veterinary care that includes emergency treatment, stabilization, and evacuation. Refer to FM 4-02.18.

4-150. Veterinary personnel have oversight of the husbandry and welfare of any animals maintained for food in the facility and will assist with oversight of animals slaughtered on premises to prevent conveyance of illicit material in the animal carcass, as well as to confirm safe food handling practices.

Appendix A

Medical Code of Conduct in Detainee Operations

This appendix discusses the rules of conduct for all medical personnel involved in providing health care to detainees. This appendix discusses the interactions of such personnel with each other, with detainees, and with detainee family members. It prescribes certain activities of personnel who, by reason of their duty assignment or of their entrance into an MTF providing health care services to detainees, are subject to the jurisdiction of the MTF commander and/or the commander of an internment or holding facility.

SECTION I — DEFINITION OF TERMS

A-1. This section defines terms used in this appendix to ensure there is a clear understanding of the parameters of the code of conduct. When the term *will* is used, compliance is mandatory. When the term *may* is used, it is permissive.

A-2. Terms requiring definition are—

- *Anything of value* includes, but is not limited to: money, food, candy, photographs, any items defined as contraband or any other gift or personal service having monetary (however negligible), informational, or even merely sentimental value.
- *Contraband* is any item, article, or substance not authorized to be possessed by detainees or health care personnel while performing their duties around detainees. This term also includes any items or substances that can reasonable be expected to cause physical injury or adversely affect the security, safety, and good order of the institution where detainees are present or the custody and control of detainees. Contraband includes but is not limited to—
 - Guns and firearms of any type, their component parts (including ammunition clips or magazines).
 - Explosives and ammunition.
 - Incendiary devices or mechanical and/or chemical components thereof.
 - Knives (including pocket knives).
 - Razor blades or blades of any type.
 - Currency (not carried on the person).
 - Intoxicants or alcoholic beverages.
 - Cellular phones and unauthorized radio transmitters.
 - Photographic equipment including film or digital cameras.
 - Printed material and video tapes that do not comply with the theater policy.
 - Recording devices (video or audio).
 - Extra clothing not worn or authorized at the job site.
 - Glass containers (unless approved by the MTF commander or the commander of the internment/holding facility).
 - Metal fingernail files.
 - Weight-lifting dietary supplements (such as creatine).
 - Personally owned or retained handcuff keys.

- *Fraternize* is to engage in social interaction with detainees beyond that necessary to perform assigned duties. Fraternalization includes, but is not limited to: dating, courting, flirting, horseplay, personal friendships, and similar activities. Fraternalization includes any act, association, interaction, or relationship the circumstances of which are such as to lead a responsible person to conclude that the good order and discipline or the custody and control mission has been prejudiced.
- *Detainee* is any person who is in US custody.
 - *Security internee* is any person who is detained for imperative reasons of security as specified in the mandate set forth in the UN Security Council Resolution 1546.
 - *High value detainees* are security internees of significant intelligence or political value.
 - *Former detainee* is any person previously held as a detainee.
- *Gambling* is participating in any game of chance for anything of value. *Games of chance* include, but are not limited to: placing wagers on the outcome of the use of authorized recreational equipment, sports events, or other events.
- *Knowingly* is to act in a deliberate manner with awareness of the nature of one's conduct.
- *Prohibited person* is a detainee, former detainee, relative, or friend of a detainee or former detainee or any other person acting on behalf of a detainee or former detainee.
- *Relative* is a person connected with another by blood or by legal relationship (relationship by marriage or adoption).
- *Sexual misconduct* includes, but is not limited to: any acts or attempts to commit acts that involve sexual contact, sexual abuse, sexual assault, or sexual harassment.
 - *Sexual contact* is the intentional touching, whether directly or through clothing, of a person's genitalia, anus, groin, breast, inner thighs, or buttocks with the intent to gratify the lust or sexual desires of the person being touched or of the person touching.
 - *Sexual abuse* or assault includes, but is not limited to: forced or coerced sexual intercourse, oral or anal sodomy, and sex with instruments.
 - *Sexual harassment* is verbal or physical sexual conduct that creates a hostile, offensive, or intimidating work environment. This includes, but is not limited to, unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature when: submission to or rejection of such conduct is made either explicitly or implicitly a term or condition of a person's job, pay, or career; submission to or rejection of such conduct by a person is used as a basis for career or employment decisions affecting that person; or such conduct interferes with an individual's job performance or creates an intimidating, hostile, or offensive environment.

SECTION II — RULES FOR APPROPRIATE INTERACTION BETWEEN HEALTH CARE PERSONNEL AND DETAINEES

A-3. The provision of health care to detainees within MTFs or other facilities (such as dispensaries located within internment or holding facilities) is a unique role within the military structure. This role is governed by rules and regulations designed to ensure the provision of health care while ensuring personal safety and maintenance of security, custody, and discipline in an internment/holding facility environment. Health care personnel must ensure that their actions, both on- and off-duty, do not undermine their ability to function effectively among detainees or compromise established health care, safety, security, and custody guidelines.

RESTRICTIONS/LIMITATIONS

A-4. Health care personnel will not—

- Fraternalize with or act with undue familiarity towards a detainee, a former detainee, or a family member of a detainee or former detainee. Any contact or communication (oral or written, direct or mediated) between a health care worker and a detainee will be for an official purpose only.

- Place hands on or touch a detainee except in self-defense or to—
 - Prevent escape.
 - Prevent injury to persons or damage to property.
 - Render medical assistance.
 - Conduct a search or inspection for other than medical reasons.
 - Apply the priorities of force, as specified.
 - Demonstrate *how-to* procedures in training.
- Visit or enter the personal space of a detainee, former detainee, or family member of a detainee or former detainee except in the performance of official duties.
- Engage in any act or attempt to engage in any act of sexual misconduct with a detainee, former detainee, or family member of a detainee or former detainee.
- Engage in any act or attempt to engage in any act of sexual abuse, assault, or harassment of a detainee.
- Knowingly allow a detainee to engage in sexual misconduct with another detainee.

A-5. Health care personnel are reminded that MP personnel have primary responsibility for security, custody, and control.

A-6. The information in this appendix is not intended to limit health care personnel's inherent authority and obligation to take all necessary and appropriate actions to defend themselves, their units, and other US Forces.

UNAUTHORIZED POSSESSION OF GOODS AND SERVICES

A-7. Unless specifically authorized in advance by the CDO, health care personnel, detainees and family members of detainees will not—

- Possess any items of contraband within the internment/holding facility or any MTF providing medical care to detainees.
- Accept from, give to, or exchange with a detainee, former detainee, or a family member of a detainee or former detainee anything of value.
- Accept gratuitously, as a gift or otherwise any service from a detainee, former detainee, or a family member of a detainee or former detainee. *Courtesy work* of any nature or value (nominal or otherwise) is not permitted.
- Engage in any activity which constitutes gambling under this policy with a detainee, a former detainee, or a family member of a detainee or former detainee.
- Engage in any financial dealings, commercial transactions, or commercial activity with a detainee, a former detainee, or a family member of a detainee or former detainee, including but not limited to—
 - Obtaining a loan from or making a loan to a detainee, a former detainee, or a family member of a detainee or former detainee, however negligible the amount.
 - Purchasing from or selling to a detainee, a former detainee, or a family member of a detainee or former detainee, except in the performance of official duties.
- Use their official position to secure unauthorized privileges or benefits for themselves or others, including detainees, former detainees, or family members of detainees or former detainees.
- Engage in unauthorized communications with detainees, former detainees, or family members of detainees or former detainees. Health care personnel and detainees, unless specifically authorized in advance by the MTF commander, DOMD, or the CDO, will not—
 - Write to, or accept correspondence from, a detainee, a former detainee, or a family member of a detainee or former detainee, except in the performance of official duties.
 - Assist detainees in communicating with any other person via any channel which is not authorized and subject to supervision or censorship.

- Communicate via e-mail, chat rooms, or in any other manner with a detainee, former detainee, or a family member of a detainee or former detainee, except in the performance of official duties.

UNAUTHORIZED DISCLOSURE OF INFORMATION

A-8. Unless specifically authorized in advance by the MTF commander, DOMD, or the CDO, health care personnel and detainees will not—

- Review detainee medical or dental treatment files without having a clearly established and official need to know. Information extracted from these files will be used only for official purposes.
- Discuss the following matters with a detainee, a former detainee, a family member of a detainee or former detainee, the general public, or anyone else not having a need to know, except in the course of official business:
 - Allegations of misconduct against any medical personnel.
 - Allegations of misconduct against any internment or holding facility personnel.
 - Recommendations of any individual board, panel, or hearing body and/or the vote of any member of such entity.
 - Detainee mail, notes, or other written material of detainees.
 - Requests from former detainees for assistance in obtaining employment, including requests for recommendations.
 - Any information from the medical or dental treatment records of a detainee or former detainee. Only MTF personnel whose assigned duties include the disclosure of such information may reveal such information.
 - Information concerning particular incidents, occurrences, disturbances, acts of misconduct, or the handling of incidents involving detainees occurring at MTFs or at other facilities located at detainee internment or holding facilities. Only the PAO should release information regarding such incidents, upon approval by the MTF commander, DOMD, internment or holding facility commander, or the CDO. Inquiries from the general public should be referred to these officials.
 - Information concerning plans, operations, and procedures that are designed to maintain the security, custody, or control of detainees, detainee internment or holding facilities, and the security of MTFs that provide medical care to detainees.

MAINTAINING CUSTODY AND CONTROL

A-9. Unless specifically authorized in advance by the MTF commander, DOMD, or the commander of the internment or holding facility, MTF personnel and personnel at units providing health care to detainees will not—

- Consume alcoholic beverages or other intoxicants of any kind during their normal tour of duty, including mealtime. Personnel will discontinue consumption of alcoholic beverages sufficiently in advance of scheduled tours of duty to avoid any impairment from full performance of their assigned duties. (Nothing in this appendix authorizes consumption of alcohol at any time, to the extent that such consumption is prohibited by any other order, regulation, or directive.)
- Allow a detainee or family member of a detainee to become uncontrolled or unsupervised. All personnel providing medical care to detainees will coordinate at all times with assigned MP security personnel to ensure detainee security, custody, and control.
- Allow detainees assigned to a detail under their supervision to leave a medical care site without valid authorization and appropriate supervision, custody, and control.
- Condone, ignore, or overlook any misconduct by detainees. Medical personnel will immediately correct any such misconduct, if possible and in any case, report actual or suspected

detainee misconduct through the chain of command and to the MP personnel assigned to provide security, custody, and control of detainees receiving medical care.

HOSTAGE SITUATIONS

A-10. Becoming a hostage while providing medical care to detainees, especially in an internment or holding facility setting, is always a possibility. Personnel should remember if they find themselves in a hostage situation that hostages—

- Do not have any rank once they have been taken and they should not act as if they do. They should avoid making demands or giving orders and should not give suggestions to their captors.
- Should listen carefully for clues regarding the emotional state of the detainees who have taken them hostage.
- Should remain calm and alert; and they should not become aggressive.
- Should avoid political or religious discussions.
- Should not make any promises that they cannot fulfill.

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Appendix B

Detainee Behavioral Health Care

This appendix discusses the minimum standards for integrating the mandates of the Geneva Conventions and AR 190-8 for detainee BH care. The components of these mandates include standards, training, services, resources, staffing, and cross-cultural compatibility.

COMPONENTS

B-1. The Geneva Conventions and AR 190-8 established the foundation, or minimum standards, for detainee BH care. These standards and expected practices establish Level I of a three-level model (see Table B-1). Internment facilities may adopt Level II or III to meet their custodial objectives. These include—

- Level I that is based on standards and expected practices corresponding to the Geneva Conventions and AR 190-8.
- Level II that contains Level I and is based on the remaining *mandatory* standards and expected practices. Level II standards exceed the Geneva Conventions and AR 190-8 requirements and satisfy the standards and expected practices deemed essential.
- Level III that contains Level II and *nonmandatory* performance standards and expected practices. Level III standards exceed the Geneva Conventions and AR 190-8 requirements and satisfy all BH requirements.

Table B-1. Continuum of health care standards and expected practices

<i>Level I</i>	<i>Level II</i>	<i>Level III</i>
Access to Care	Access to Care	Access to Care
Clinical Services	Clinical Services	Clinical Services
Continuity of Care	Continuity of Care	Continuity of Care
Referrals	Referrals	Referrals
Transportation	Transportation	Transportation
Treatment Plan	Treatment Plan	Treatment Plan
Emergency Plan	Emergency Plan	Emergency Plan
Infirmary Care	Infirmary Care	Infirmary Care
Pregnancy Management	Pregnancy Management	Pregnancy Management
Health Screens	Health Screens	Health Screens
Health Appraisal	Health Appraisal	Health Appraisal
Periodic Examinations	Periodic Examinations	Periodic Examinations
Behavioral Health Program	Behavioral Health Program	Behavioral Health Program
Behavioral Health Screen	Behavioral Health Screen	Behavioral Health Screen
Behavioral Health Appraisal	Behavioral Health Appraisal	Behavioral Health Appraisal

Table B-1. Continuum of health care standards and expected practices (continued)

<i>Level I</i>	<i>Level II</i>	<i>Level III</i>
Behavioral Illness and Developmental Disability	Behavioral Illness and Developmental Disability	Behavioral Illness and Developmental Disability
Pharmaceuticals	Pharmaceuticals	Pharmaceuticals
	Suicide Prevention and Intervention	Suicide Prevention and Intervention
	Detoxification	Detoxification
	Chronic Care	Chronic Care
		Health Education
		Behavioral Health Evaluations
		Management of Chemical Dependency

B-2. Training is critical to effective correctional operations. Medical staff, BH staff, and custodial staff must undergo initial (or orientation) training, as well as ongoing training to keep their skills honed. See Table B-2 for staff training standards and expected practices. See Table B-3 for humane treatment standards and expected practices.

Table B-2. Staff training standards and expected practices

<i>Level I</i>	<i>Level II</i>	<i>Level III</i>
Health Authority	Health Authority	Health Authority
	Provision of Treatment	Provision of Treatment
	Personnel Qualifications	Personnel Qualifications
	Credentials	Credentials
	Emergency Plans	Emergency Plans
	Emergency Response	Emergency Response
		Employee Orientation

Table B-3. Humane treatment of detainees standards and expected practices

<i>Level I</i>	<i>Level II</i>	<i>Level III</i>
Segregation	Segregation	Segregation
Research	Research	Research
Use of Restraints	Use of Restraints	Use of Restraints
	Confidentiality	Confidentiality
	Informed Consent	Informed Consent
	Involuntary Administration	Involuntary Administration
		Grievances
		Notification
		Special Needs
		Privacy
		Transfer
		Sexual Assault

B-3. Specific services correspond to each level of the detainee BH care program. For example, at Level I services include initial intake assessments, crisis intervention, BH appraisal, daily sick call, brief

counseling, stabilization/acute hospitalization, special BH evaluations, and staff consultation. Levels II and III build on Level I services and broaden the scope of care. See Table B-4 for the services by level.

Table B-4. Services by level

<i>Program Services</i>	<i>Level</i>			<i>Description</i>
	<i>I</i>	<i>II</i>	<i>III</i>	
Initial screening assessment	X	X	X	Brief interview during inprocessing or intrafacility transfer; BH services information given.
Appraisal	X	X	X	In-depth assessment of suicide, violence, sexual-victimization, predatory behaviors, and substance abuse risks.
Crisis intervention	X	X	X	Around-the-clock emergency response services.
Sick Call	X	X	X	Daily triage services.
Brief counseling	X	X	X	One to four sessions focused on a specific stressor or problem.
Stabilization/acute hospitalization	X	X	X	Around-the-clock emergency stabilization.
Special BH evaluations	X	X	X	Specialized testing of severely mentally ill and developmentally disabled detainees. Assessment for legal/administrative issues.
Maintenance of BH records	X	X	X	Documentation of BH care as required by SOPs.
Consultation	X	X	X	Interactive education of custodial staff.
Segregation monitoring	X	X	X	Behavioral health staff is notified when detainee is transferred to segregation. Detainee receives daily BH visits.
Pregnancy management	X	X	X	Specific focus on pregnancy testing, prenatal care, and emotional support.
Medication evaluation	X	X	X	Medication evaluation and treatment.
Individual psychotherapy		X	X	Elective in-depth therapy aimed at significant change in behavior, emotions, or attitudes.
Suicide prevention and intervention	X	X	X	Educational training in suicide risks and warning signs. Staff training in suicide watch procedures. Protocols for detainee follow-up. Traumatic event debriefings for staff and detainees.
Substance detoxification		X	X	Medically supervised substance detoxification.
Case management		X	X	Detainees with behavioral disorders are managed from admission to transfer or discharge.
Specific treatment groups		X	X	Special therapies for specific BH issues (for example: torture, posttraumatic stress disorder, substance abuse, or self-mutilation)
Transitional care services		X	X	Partial hospitalization services.

Table B-4. Services by level (continued)

<i>Program Services</i>	<i>Level</i>			<i>Description</i>
	<i>I</i>	<i>II</i>	<i>III</i>	
Educational classes			X	Ongoing program of health education and wellness information.
Chemical dependency program			X	Standardized diagnostic needs assessment tools; multidisciplinary treatment team; and abuse risk assessments.
Sexual assault evaluation and treatment			X	Forensic evaluation after sexual assault; clinical assessment and treatment.
Vocational and educational programs			X	Inclusion of occupational and activity therapists in detention facility's academic and vocational training programs.
Residential care services			X	Long-term hospitalization services.

B-4. Detainee BH care requires adequate resource support. Infirmery services, in particular, demand considerable resources to ensure a safe environment for staff and patients. The inpatient psychiatric ward is equipped with 0.5 to 1 psychiatric patient bed for every 100 detainees. See Table B-5 for performance improvement standards and expected practices.

Table B-5. Performance improvement standards and expected practices

<i>Level I</i>	<i>Level II</i>	<i>Level III</i>
Statistical Reports	Statistical Reports	Statistical Reports
Internal Review and Quality Assurance	Internal Review and Quality Assurance	Internal Review and Quality Assurance
Staffing	Staffing	Staffing
Health Records	Health Records	Health Records
	Peer Review	Peer Review
		Transfers
		Inactive Records

B-5. The staffing model is a function of number of patients, staff-to-patient ratios, and model level. Nurse-to-patient bed ratios guide staffing requirements for the inpatient psychiatric ward of the infirmery.

B-6. The Detainee Behavioral Health Care Program is compatible with all cultural beliefs. Cultural beliefs about mental illness were identified in psychiatric literature and compared with the program model. These beliefs did not necessitate modification of the model itself. This cross-cultural information, however, was readily applicable to clinical understanding of the nuances of patient presentation (access to care) and pathology and to therapeutic techniques. Cross-cultural training is important for all clinicians. The most important aspects of cultural factors affecting clinical care are discussed in Table B-6.

Table B-6. Cross-cultural clinical considerations

Category	Information
Stigma and Barriers to Care	<p>Patients may delay seeking treatment for months or even years and are disappointed upon seeking treatment as a result of cultural beliefs surrounding mental illness.</p> <p>In certain areas of the world, the word <i>madness</i> is often associated with possession and sorcery and some precipitating factors are considered to be intimately linked to social relationships.</p> <p>Attitudes towards mental illness have no relationship with age, educational level, marital status, gender, and personal exposure to people with mental illness.</p> <p>Even among the well-educated (including physicians), many people are more likely to believe that spirits are the primary cause of mental illness, not genetic factors.</p> <p>Supernatural explanation seems to be too deeply imprinted during upbringing to be erased by education and beliefs surrounding cause of symptoms may dissuade or impede persons from seeking medical assistance.</p>
Therapist-Patient Relationship	<p>Trust is important to all patients.</p> <p>Patients may not trust the interviewers (therapists), may fear that confidentiality will be breached, and may be reluctant to share personal information with either the interviewers or the interpreters.</p> <p>Clinicians may be uncomfortable with the potential torture and/or trauma experienced by detainees and may avoid asking related questions.</p> <p>Clinicians should declare an open commitment to supporting human rights, while at the same time remaining objective.</p> <p>By avoiding overidentification with the patients, clinicians will be more likely to ask difficult questions that will aid in both diagnostic assessment and treatment.</p>
Diagnostic Considerations	<p>Posttraumatic stress disorder (or syndrome) model is a useful conceptual and therapeutic approach to the psychological impact of trauma on patients from other ethnocultural backgrounds.</p> <p>Traumatized patients frequently have multiple somatic complaints, severe depression, or dissociative and paranoid symptoms.</p>
Treatment Considerations	<p>The clinician must be careful to elicit a trauma story at the pace dictated by the detainee.</p> <p>A medical practitioner may have the advantage over a nonmedical psychotherapist because a medical approach is familiar to detainees.</p> <p>Proceed at a slow pace, especially as the trauma story unfolds.</p> <p>Medication may be useful in reducing the severity of intrusive and hyperarousal symptoms, allowing the therapeutic process to proceed more effectively.</p> <p>Grief over loss of status, money, friends, family, as well as over other losses is often a central theme in the therapeutic process.</p> <p>Self-worth is often seriously damaged and issues related to the meaning of life and religion are often in the forefront of their minds.</p> <p>Risk for retraumatization is high.</p> <p>Group therapy diminishes a sense of isolation and learning that others have a similar experience is beneficial.</p> <p>At all stages, careful explanation and education is required.</p> <p>Anything resembling interrogation should be avoided.</p> <p>Retelling the trauma story is a common element in therapy and is independent of any particular theoretical orientation.</p> <p>Cognitive restructuring is another common therapeutic theme as are homework, oral/written testimony of the experience, medication, stress management, and relaxation techniques.</p> <p>Family and group assume greater importance and may be needed in therapy.</p> <p>Use of traditional approaches, when combined with Western approaches, may be helpful.</p>

Table B-6. Cross-cultural clinical considerations (continued)

Category	Information
Interpreters	Interpreters should not act merely as translators, but as culturally appropriate and empowered agents operating with the therapist allowing a clearer understanding of both verbal and nonverbal communication and evaluating the cultural significance of what is being said. Bilingual interpreters can overidentify with patients and may have difficulty maintaining appropriate professional distance. If the bilingual interpreter has a role expectation beyond that of interpretation, such as a culture broker or paraprofessional, these issues remain potentially troublesome.

Appendix C

Medical Inprocessing Screening Tools

This appendix provides three medical inprocessing screening tools. These sample formats can be preprinted on the SF 600 to facilitate detainee medical inprocessing to the TIF.

PHYSICAL EXAMINATION

C-1. The inprocessing physical examination begins with a review of all systems. Figure C-1 provides a sample inprocessing format which may be overprinted on the SF 600. This overprint provides a flexible tool which will facilitate a standardized inprocessing medical screen.

BEHAVIORAL HEALTH INPROCESSING SCREENING

C-2. As discussed in Chapter 4, detainees inprocessing to the TIF should undergo a BH screen. This screening is documented and included in the detainee's individual medical record. Figure C-2 provides a sample BH screening checklist which can be used to document the screening.

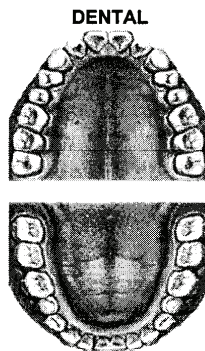
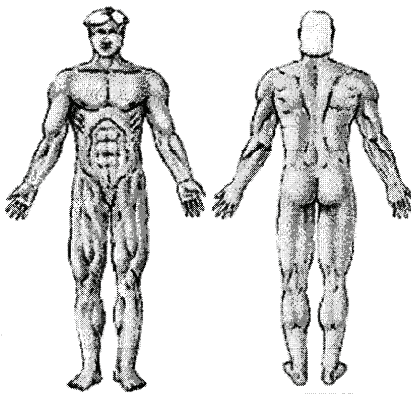
QUALITY ASSURANCE SCREEN

C-3. Upon completion of the medical inprocess screening, a quality assurance check of the medical record is accomplished to ensure the detainee has completed all of the requirements and that the documentation is in order. Figure C-3 provides a sample checklist for ensuring the completeness of the medical screening process.

**DETAINEE HEALTH AND MEDICAL RECORD
SCREENING EXAMINATION (CONTINUATION SHEET)
(SF 600 OVERPRINT)**

DETAINEE INFORMATION

ISN _____ COMPOUND _____
 NAME _____
 DOB _____ AGE _____ SEX _____



T _____ BP _____ / _____ PULSE _____ BICEPS CIRC _____ HEIGHT _____ WEIGHT _____ BMI _____

DETAINEE HAS AN OVERALL () GOOD () FAIR () POOR STATE OF NUTRITION

VISION: NORMAL () GLASSES ()

HEARING: NORMAL () ABNORMAL (EXPLAIN)

OVERALL APPEARANCE (CONTINUE DETAILS ON REVERSE SIDE)

HEENT _____
 SKIN/SCARS/BRUISING _____
 CARDIOPULMONARY SYSTEM _____
 MUSCULOSKELETAL _____
 HERNIA _____
 GENITALIA _____
 NEUROBEHAVIORAL _____

SCREENER: _____
 PRINT/SIGN _____ DATE _____

PROVIDER _____
 PRINT/SIGN _____ DATE _____

Figure C-1. Inprocessing overprint for Standard Form 600 (continued)

**DETAINEE HEALTH AND MEDICAL RECORD
SCREENING EXAMINATION (CONTINUATION SHEET)
(SF 600 OVERPRINT)**

DETAINEE INFORMATION

ISN _____ COMPOUND _____

NAME _____

DOB _____ AGE _____ SEX _____

CONSULTATIONS

APPLIANCES, SPECTACLES, OR PROSTHESES REQUIRED? ___ YES ___ NO

DESIRES TO BE A BLOOD DONOR (IF YES, RECORD BLOOD TYPE) BLOOD TYPE _____ ___ YES ___ NO

DID DETAINEE REPORT ABUSE BY COALITION FORCES AFTER CAPTURE? ___ YES ___ NO

IMMUNIZATIONS (CIRCLE)

DT YES/NO	MMR YES/NO	POLIO YES/NO	HEP A YES/NO	HEP B YES/NO	TYPHOID YES/NO	OTHER
--------------	---------------	-----------------	-----------------	-----------------	-------------------	-------

LABS (CIRCLE)

CBC YES/NO	CHEM 7 YES/NO	UA YES/NO	PPD YES/NO	OTHER
---------------	------------------	--------------	---------------	-------

CHEST X-RAY: NAD ()

LIMITATIONS

ACTIVITY RESTRICTIONS: _____

DIET RESTRICTIONS: _____

OTHER RESTRICTIONS: _____

OK FOR TRAVEL GO/NO GO

(IF "NO GO" LIST REASONS/ACTIONS) _____

SCREENER: _____

PRINT/SIGN DATE

PROVIDER _____

PRINT/SIGN DATE

PAGE 3

Figure C-1. Inprocessing overprint for Standard Form 600 (continued)

**DETAINEE HEALTH AND MEDICAL RECORD
QUALITY ASSURANCE SCREEN
(SF 600 OVERPRINT)**

DETAINEE INFORMATION

ISN _____ COMPOUND _____
 NAME _____
 DOB _____ AGE _____ SEX _____

EXAMINATION PER AR 190-8	DATE COMPLETED	TRAVEL GO/NO GO	CORRECTED TO GO	COMMENT
MEDICAL EXAMINATION				
DENTAL SCREENING				
CHEST X-RAY/TB SCREEN				
NUTRITION SCREENING				
BEHAVIORAL HEALTH SCREENING				

LIMITATIONS

ACTIVITY RESTRICTIONS: _____

DIET RESTRICTIONS: _____

OTHER RESTRICTIONS: _____

TRAVEL GO/NO GO _____

IF "NO GO" LIST REASONS _____

SCREENER: _____

PRINT/SIGN

DATE

PROVIDER _____

PRINT/SIGN

DATE

Figure C-3. Quality assurance checklist tool

Appendix D

Preventive Medicine Inspection Checklist

This appendix provides a sample internment facility inspection checklist (Table D-1) for use when inspecting a DCP, DHA, or TIF.

Table D-1. Sample internment facility inspection checklist

Preventive Medicine Inspection Checklist		Yes	No
Definitions: Short-term: Up to 5 days anticipated use. Long-term: Over 5 days up to 45 days anticipated use. Temporary: No permanent or semipermanent construction such as guard towers or permanent fencing. Example: a DCP or DHA			
Name	Facility		
Building	Location		
OIC/NCOIC			
Telephone number or other contact information			
Unit	Higher Headquarters		
Type Facility: Short-term temporary _____ Long-term temporary _____			
Except as noted, requirements are the same for both type facilities.			
Location			
Camp Size. Adequate area is available for camp?			
Note. Estimated requirement of 320 square feet per person which equates to 37 acres for a 5,000-person camp. (1 Acre = 43,560 square feet; 37 Acres = 1,611,720 square feet. For reference 37 acres is approximately 1,270 feet by 1,270 feet square)			
Sleeping			
Are adequate sleeping areas provided?			
Note: Covered living space should provide a minimum of 40 square feet per person with an optimum requirement of 80 square feet per person. Beds or mats should be separated by a minimum distance of 2.5 feet.			
If both male and female detainees, are separate facilities provided?			
Clothing			
Is adequate clothing provided?			
Is clothing suitable for environment, heat, cold, exposure to sun and wind?			
If required by command surgeon, is clothing pretreated with permethrin?			
Clothing available should be 110 percent of the camp population and of a variety of sizes to allow for weekly exchange of clothing. Is exchange clothing provided while detainees are washing their clothing?			

Table D-1. Sample internment facility inspection checklist (continued)

<i>Preventive Medicine Inspection Checklist</i>	Yes	No
Laundry Facilities		
Short-term: 1 sink or bucket, preferably with a wringer, per tent plus detergent.		
Long-term: Commercial laundry, if available; Army field laundry, individual machines.		
Are adequate laundry facilities provided based on the anticipated use of the camp?		
Are showers provided for long-term (greater than 5-day occupancy)?		
Solid Waste: Are adequate waste containers provided (two-hundred 33-gallon trash cans for a 5,000-person camp)?		
Are cans covered and clean?		
Is there evidence of flies or other insects or rodent harborage?		
Is there medical or hazardous waste produced?		
Is this waste disposed of in accordance with command directives?		
Are waste collection and disposal personnel protected?		
Describe:		
Latrines		
Note. Excavated (for example, slit trench) and receptacle (for example, burn-out and chemical) latrines are permissible, however, excavated latrines are not recommended for long-term camps. Minimum distances for both short- and long-term camps are: 100 feet from water supplies; 300 feet from any water source; 300 feet downwind from dining facility or food service operation; and 50 feet from dwellings.		
Are minimum distances met?		
Are latrines located at the lowest elevation so rain water run off drains away from the camp?		
Are latrines cleaned daily?		
Are a minimum of one latrine for every 25 male detainees and one latrine for every 17 female detainees provided?		
Are adequate supplies available for the type of waste disposal used?		
Are adequate handwashing facilities (one for every five latrines) with proper supplies available near latrines and food operations?		
Potable Water		
Does the quantity of potable water provided comply with the water consumption planning factors applicable to the type of camp and facilities provided? <ul style="list-style-type: none"> • 1.5 gallons per person per day for drinking in temperate climates. • 3.0 gallons per person per day for drinking in tropical and arid climates. • 2.0 gallons per person per day for drinking in arctic climates. • 1.7 gallons per person per day for personal hygiene. • 1.7 gallons per person per day for centralized hygiene (showers) (one shower per week per person) • 2.8 gallons per person per day for food preparation. • 3.1 gallons per person per day for laundry. • 1.24 gallons per person per day for medical treatment. • Detainees of certain religious faiths (for example, Islam) should be provided an additional 0.5-1.5 gallons of potable water per person per day for washing and drinking associated with religious practices. • Detainees who practice anal washing following defecation require an additional 0.25-0.5 gallons per day. 		
Does the quality of the potable water provided meet field water requirements specified in TB MED 577? Note. Use DA Form 5457 and DA Form 5456 for potable water container and water point inspections.		
Vector Control		
Is there any evidence of insect and or rodent infestation?		

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Appendix E

Planning Checklist for Medical Support to Detainee Operations

This appendix provides a planning checklist for the conduct of medical support to DO. Medical units and personnel may be called upon to provide health care to a detainee population on an area support basis or as a direct support mission collocated with an internment facility. During the planning process, each medical unit should plan for supporting DO in the event they are called upon to do so. This checklist should not be considered as all inclusive, each operation will have its own unique requirements that must also be considered. This checklist is intended to be thought provoking and serve as an initial point of consideration. Some areas of consideration may overlap as they may affect more than one AMEDD function.

GENERAL CONSIDERATIONS

E-1. Are there any cultural, religious, or social beliefs that impact on the provision of health care? *(Health care personnel must be aware of the detainee's beliefs when prescribing courses of treatment. Some cultures and religions have dietary restrictions or prohibitions concerning the use of blood and blood products. Detainee compliance with prescribed courses of treatment will be higher if they are not contrary to their beliefs. Social norms must also be considered as they pertain to gender considerations and interactions. Health care personnel should be familiar with hand gestures which might be offensive to someone from another culture. Additionally, health care personnel must ensure they understand the importance of respectfully handling detainees' religious documents, books/scriptures, and articles. [For additional guidance concerning detainee religious considerations consult the supporting chaplain.]*

E-2. Are interpreters available to translate detainee complaints to the attending health care personnel? *(Has a local language guide been developed to assist asking medical questions? Have pictograph translation tools been developed? Are translation technologies that may augment translation capability available? Is a commercial product available? Could visual products used offend the detainees [such as detailed, realistic drawings of the human body?])*

E-3. Is there a PAO assigned to the TIF or to the medical unit? *(If there is not a PAO assigned—what is the theater policy on release of information concerning detainee health care operations? What procedures are there for when inquiries are made by NGOs or other organizations present in the AO? What is the policy concerning the ICRC? Has this policy been articulated and disseminated to all health care personnel assigned to the detainee health care mission?)*

E-4. How is the information flow within the facility managed? *(What types of outside information reaches the detainee population? What are the sources of this information? Can negative information on detainee health care that is propagated by the enemy be countered? How is the detainee population impacted [such as compliance with treatment regimes, refusal to take prescriptions, or detainees not seeking medical assistance] by this negative information?)*

E-5. What is the probable composition of the detainee population? *(What is the probable age range of detainees? What will be the percentage of detainees who are female? Will there be any children requiring pediatric care? Will there be any pregnant women? Will there be detainees requiring geriatric care? Will there be any detainees suffering from major behavioral disorders?)*

E-6. **What is the health status of the general population in the AO?** *(What are the endemic and epidemic diseases? What are the ten leading causes of death? What is the nutritional status of the population? What is the dental status of the population? Do pregnant women receive prenatal care? Do children receive immunizations? If so, what kinds? What is the mental status of the population [such as has the nation been at war for a long period of time]? Has the civilian population been exposed to atrocities? Is there a continuing threat of violence or civil unrest? Does the civilian population have the basic necessities for life [housing, food, work, and a feeling of security or safety]?)*

E-7. **What is the visitation policy for detainees?** *(Will detainees be permitted visitors? If detainees may have visitors what are the PVNTMED considerations [such as introduction of diseases] posed by visitors? Will detainees be permitted to accept food products from visitors? What PVNTMED measures may be necessary [such as storing food products in domicile area]?)*

E-8. **What are the capabilities of the HN medical infrastructure?** *(What are the capabilities of the local medical infrastructure? Can they support the needs of detainees? Do they have the capability to accept detainees who require medical specialty care? What is the HN's capability with regards to the treatment and management of those suffering from mental disorders? Are there any facilities in country that can manage this population? Has an evaluation of the HN medical infrastructure been accomplished? Refer to Tables E-1 and E-2 for an evaluation checklist.)*

Table E-1. Evaluation of available public health services

Public Health System/Services
• Number of public health personnel, facilities, and capabilities.
• Hospitals by type and location (such as general medical, psychiatric, or orthopedic).
• Number of hospital beds by type (such as surgical, intensive care, intermediate care, or general medicine).
• Number of operating room tables and table hours.
• Medical clinics (private, public, or sponsored by NGOs) and locations.
• Number of physicians per population.
• Number of physicians by specialty.
• Ancillary services available (such as PT, occupational therapy (OT), diagnostic laboratory, prosthetics capability, community health nurses, magnetic resonance imaging [MRI], computed tomography [CT] scan, or respiratory therapy).
• Number of nonphysician health care providers (such as PAs, nurse practitioners, podiatrists, audiologists, or optometrists) by type.
• Medical evacuation/casualty transport systems (public, private, and military ground and air ambulances).
• Number of dental providers and types of dental care available (such as emergency and essential care and/or oral surgery).
• Number of BH clinics and available services.
• Number and types of BH personnel (such as psychiatrists, psychologists, social workers, and the like).
• Number and types of medical research facilities.
• Veterinary medicine personnel, facilities, and capabilities.
• Pharmaceutical manufacturing.
• Availability and types of medical equipment, medical equipment repair, and medical supplies.
• Availability and quality of blood and blood products.

Table E-1. Evaluation of available public health services (continued)

<ul style="list-style-type: none"> • Availability, quality, and production capability of medicinal gases.
Public Health System/Services
<ul style="list-style-type: none"> • Optical fabrication capabilities.
<ul style="list-style-type: none"> • Assistive listening devices fabrication capabilities.
<ul style="list-style-type: none"> • Prosthetics manufacturing capabilities.
<ul style="list-style-type: none"> • What type of sterilization/sanitation equipment capabilities are in service?
<ul style="list-style-type: none"> • Number, types, and capabilities of medical laboratories (such as public health, clinical/diagnostic, and research).
<ul style="list-style-type: none"> • Names and titles of key personnel within the public and private health care infrastructures.
<ul style="list-style-type: none"> • Number, types, and location of medical schools or medical training centers.
<ul style="list-style-type: none"> • Determine the leading causes of death of the general population or specified subpopulations.
<ul style="list-style-type: none"> • What is the infant mortality rate?
<ul style="list-style-type: none"> • What is the life expectancy (in years)?
<ul style="list-style-type: none"> • Determine the prevalence of endemic and epidemic diseases in the AO.
<ul style="list-style-type: none"> • Determine the prevalence of HIV/acquired immunodeficiency syndrome.
<ul style="list-style-type: none"> • Determine the prevalence for STDs (such as gonorrhea, syphilis, hepatitis, and herpes).
<ul style="list-style-type: none"> • Determine the OEH risk (to include heat and cold injury, exposure to loud noise/radiation/toxic industrial materials [TIMs], and poisonous or toxic flora and fauna).
<ul style="list-style-type: none"> • Determine the nutritional status of the general population or specified subpopulations.
<ul style="list-style-type: none"> • Determine immunization level of general population or specified subpopulations.

Table E-2. Evaluation checklist for a host nation medical treatment facility

Medical Facility Checklist
<ul style="list-style-type: none"> • Is the medical facility a private, public, military institution, or provided by an NGO?
<ul style="list-style-type: none"> • Is the medical facility a hospital, clinic (such as outpatient, emergency, or substance abuse), doctor's office, or long-term care facility?
<ul style="list-style-type: none"> • Where is the facility located? How accessible is it (such as on a major thoroughfare, on side streets, or accessible by air)?
<ul style="list-style-type: none"> • What type of care does the facility provide (such as emergency and general medicine, surgical, orthopedic, maternity/obstetrics, pediatric, psychiatric, rehabilitative, or long-term care)?
<ul style="list-style-type: none"> • What are the number and types of beds (such as surgical, intensive care, intermediate care, or general medicine)?
<ul style="list-style-type: none"> • What ancillary services are available (such as PT, OT, audiology, respiratory therapy, diagnostic x-ray, nuclear medicine, PVNTMED, or diagnostic laboratory services)?
<ul style="list-style-type: none"> • What is the staffing level of the facility?
<ul style="list-style-type: none"> • Does the facility provide outpatient services? If so, what types of care?
<ul style="list-style-type: none"> • What is the standard of care provided at the facility? How does it compare to US facilities?
<ul style="list-style-type: none"> • How are medical professionals credentialed? What is their scope of practice?
<ul style="list-style-type: none"> • What is the nosocomial infectious disease rate for the facility?

Table E-2. Evaluation checklist for a host nation medical treatment facility (continued)

<ul style="list-style-type: none"> Does the facility have the capability to isolate infectious disease patients?
Medical Facility Checklist
<ul style="list-style-type: none"> What types of medical equipment are available in the facility (such as diagnostic [CT scan or MRI], rehabilitative, or patient care [ventilators, respirators, or orthopedic])?
<ul style="list-style-type: none"> What types of support services are available (such as laundry, housekeeping, or food service)? Are there shared services with another facility? If not, how are the patients fed (such as by relatives)?
<ul style="list-style-type: none"> Does the facility have an emergency room? Is it staffed and equipped to provide trauma care?
<ul style="list-style-type: none"> What is the capacity of the facility to respond to a mass casualty situation (resulting from urban combat, terrorist incidents, man-made or natural disasters, or employment of chemical, biological, radiological, and nuclear [CBRN] weapons)?
<ul style="list-style-type: none"> What is the level of medical supplies maintained within the facility (days of supply)?
<ul style="list-style-type: none"> How is the facility resupplied with expendable and nonexpendable medical supplies? Are medicines readily available or must they be obtained on an individual case basis? Are relatives required to obtain required medications? Is local vegetation collected and used for medicinal purposes?
<ul style="list-style-type: none"> Does the facility have the capability to collect, test, and store blood? What are the diseases for which blood is tested?
<ul style="list-style-type: none"> If the facility cannot collect and test blood, where do blood and blood products come from? Has it been tested? Does the facility have a refrigerated storage capability? What are the maximum units of blood which can be stored?
<ul style="list-style-type: none"> Does the facility have its own ambulances (number and type [air and ground]) or is this a service which is provided by another agency/business?
<ul style="list-style-type: none"> Is the hospital accredited by its parent nation and/or hospital organization (such as in the US by the JCAHO)?
<ul style="list-style-type: none"> Does the facility perform its own medical equipment maintenance or must be it sent out for repair?
<ul style="list-style-type: none"> Does the facility have dependable electric service? Does it have a backup generator for power outages?
<ul style="list-style-type: none"> Does the facility have running water? If not, from what source does the staff obtain water? Is it potable or does it require treatment before use?
<ul style="list-style-type: none"> Does the facility have an operational environmental control system? Heat? Air conditioning?
<ul style="list-style-type: none"> What sanitation facilities are available in the facility? Restrooms for patients and staff? Bath tubs/showers for patients? Handwashing stations/capabilities in patient care areas? Disposal capabilities for general, medical, and human waste? Disposal capabilities for wastewater? How are medical and hazardous waste segregated and disposed of?
<ul style="list-style-type: none"> Does the facility have a pest management problem (rats, ants, flies, lice, and/or other animals and insects)?
<ul style="list-style-type: none"> Other. Any other issues, concerns, or situations that affect the specific facility being evaluated.

TRAINING

E-9. **Have all unit members received refresher training in the Law of Land Warfare and military regulations?** *(Have unit members been briefed on the aspects of the Geneva Conventions, international laws, and military regulations as they pertain to the treatment and care of EPWs, detainees, and civilians?)*

E-10. **Have all unit members received an orientation briefing to the AO?** *(Have unit members received an orientation briefing to the cultural, social, economic, and religious beliefs, practices, and language of the civilian population in the AO. Did the orientation include information on endemic and epidemic diseases and OEH threats found in the AO? If there are different sects or subpopulations in the AO, have these been delineated?)*

E-11. **Have all unit members received refresher training in medical ethics?** *(Has refresher training in medical ethics been conducted? Did training address the ethical issues of treating EPWs and detainees as developed and directed by OTSG? Did the training address the recognition of the signs and symptoms of abuse/maltreatment and how to report it? Does the MTF [above Role 2] convene a medical ethics board when ethical issues arise? Do medical personnel know the reporting process when an alleged or suspected abuse occurs?)*

E-12. **Have all unit members received refresher training in field hygiene and sanitation?** *(Has refresher training on field hygiene and sanitation practices been conducted? Did the training include personal protective measures for the individual, the small unit leader, and the unit? Did the training address field sanitation and personal hygiene requirements for internment facilities, DHAs, or DCPs and what actions are required if deficiencies are noted?)*

E-13. **Have clinical and PAD personnel received training on the creation, maintenance, storage, and disposition of detainee medical records?** *(Have all providers and administrative personnel been trained on the requirements for creating and maintaining detainee medical records? Have tactical standing operating procedures been developed at all roles of care delineating procedures for creating and maintaining these records? Have all personnel been trained on the release and/or access to a patient's medical information/record?)*

E-14. **Are training aids available (such as posters, handouts, and pocket-sized cards) that can be displayed or given to unit members to reinforce training?** *(Has the unit produced or obtained training aids covering areas such as medical ethics, Geneva Conventions, reporting of abuse or mistreatment, or similar subjects to serve as reminders to unit members?)*

E-15. **Has training been conducted for unit members/care givers on the hazards and recognition of combat and operational stress reactions resulting from working in an internment facility?** *(Unit members should receive training on stress prevention and the recognition of signs and symptoms of stress resulting from working in internment facilities. Who will provide the stress prevention training/refresher training which should be accomplished periodically during the deployment? Is there a unit-level peer mentor program in place? What is their scope of training? Who will provide training and consultation for the peer mentor program?)*

E-16. **Have unit members received training on self-defense and how to act if taken hostage?** *(Have unit members received training in self-defense techniques? Have unit members been instructed on how to act if taken hostage? Have unit members been instructed on how to react if a riot or unruly detainees are encountered? Have unit members received training in the separation of providing medical care and not performing custody and control functions?)*

E-17. **Has medical education that can earn the medical staff continuing education units and initial capabilities training been conducted?** *(Have instructors been identified to conduct training? What are the instructors' qualifications and credentials? Have medical focus training areas been identified that are unique to the AO?)*

COMMAND, CONTROL, COMMUNICATIONS, COMPUTERS, AND INTELLIGENCE

E-18. **What medical information systems are available?** *(Have the appropriate medical information systems been considered for installation in particular for Class VIII support and medical epidemiological reporting of infectious disease? Are medical information systems available for preparing and maintaining medical records and reports? In Role 3 facilities, are the pharmacy functions, to include provider prescription functions, automated?)*

E-19. **What are the command and support relationships between key participants?** *(What is the relationship between the organic MP unit medical personnel and the supporting medical unit/task force? What is the relationship to the CDO? What is the relationship with the DOMD? What command relationship exists within the facility [MP, MI, and medical]? Is there an actual perceived separation of detention functions? Do medical personnel participate in any form of custody or interrogation operations? Do MPs or security personnel participate in any health care functions? Are interrogation personnel of all types forbidden from access to any and all medical information on detainees?)*

E-20. **What is the potential threat against the TIF?** *(Is the internment facility and its collocated medical units a potential target for enemy combatants, terrorists, or insurgents? Is there a possibility that the internment facility could fall under a siege? Is there the possibility that CBRN weapons could be employed against the facility? How do these threats impact medical support and are plans in place to mitigate the adverse effects should an event occur?)*

E-21. **What is the morale of the facility (both cadre and detainees)?** *(What is the morale of the care givers, the guards, and the detainees? How does this affect good order and discipline? What actions can be taken to improve morale, if it is low? What are the causes of low morale?)*

PREVENTIVE MEDICINE

E-22. **What PVNTMED assets/resources are available/organic to the internment facility?** *(What organic resources does the MP unit operating the facility have? What is the scope of their training? Do they have required supplies and equipment? Will they require augmentation to support the TIF operation? What is the availability of PVTMED assets to augment the TIF? Are other Service PVNTMED assets available for support? Are there plans for contracted PVNTMED support?)*

E-23. **What is the level of awareness of the detainee population to basic field sanitation and personal hygiene practices?** *(Will PVNTMED personnel be required to conduct PVNTMED training to the detainee population? Are handouts, posters, or other training aids on PVNTMED practices available in the detainees' language? Are there any social, religious, or cultural considerations that may impact PVNTMED practices and reduce compliance with appropriate standards?)*

E-24. **What is the frequency of required PVNTMED inspections?** *(Are the organic internment facility PVNTMED personnel going to conduct the routine PVNTMED inspections and at what frequency? Are the organic resources going to require augmentation to accomplish the inspection mission? Has a unit needs assessment been requested by the commander from a combat and operational stress control-type unit or element? What is the recommended frequency for a formal unit needs assessment? How often are x-ray machine surveys conducted and who conducts them?)*

E-25. **Has a site survey been accomplished for proposed or existing internment facility locations?** *(Was an environmental health site assessment and an equivalent base camp assessment done prior to establishing the internment facility? Are there any indications of environmental contamination at the site? If a preexisting facility is to be used, does it have the minimum space requirements for detainee domiciles/cells, adequate ventilation, and sufficient sanitary facilities/devices for the supported population? What are the environmental considerations of the area surrounding the facility or upon which it was developed? What is the impact of weather conditions [such as heavy rains] on the site/facility [such as flooding]? There are several site surveys available.)*

E-26. **Has the facility been planned, designed, and constructed to comply with sanitation and hygiene standards and criteria?** *(Has adequate space been provided for detainee living space? Are adequate sanitation, feeding, and medical facilities provided? Was the site selected considering disease and injury threats?)*

E-27. **What vector and pest control activities are required at the facility?** *(Are there clinical evidence of vectorborne diseases? What is the immune status of the population? What are the pathogens of concern and what is their behavior/ecology? Are there factors in the facility that increase the risk of vectorborne diseases? Does the facility have any signs of rodent activity? Is there an insect or arthropod infestation within the facility or on the grounds? If yes, what is the source of the infestation? Is aerial spraying required?)*

E-28. **Are adequate supplies of appropriate and safe food provided in quantities and quality to meet detainee needs?** *(Are food sources approved by military veterinarians? Are food service personnel trained and adequately supervised in food service sanitation? Do food service personnel apply sanitary practices during food transport, storage, preparation and serving? Do food service facilities meet Army sanitary requirements?)*

E-29. **Are medical and OEH surveillances being conducted?** *(What surveillance activities are being performed? How often is the data collected and what is the frequency of reporting? Who is analyzing data to determine trends and patterns?)*

E-30. **How are the needs for field hygiene and sanitation being met at temporary holding areas?** *(Do temporary holding areas have sufficient latrines and handwashing devices? Are field expedient measures being employed [such as individual waste collection bags]? Are field latrines being properly constructed and cleaned daily? How are all types of waste [garbage, hazardous waste, and regulated medical waste] segregated, stored, transported, and disposed of?)*

E-31. **Are quantities of adequate quality water provided for potable and nonpotable uses?** *(Are adequate supplies of potable water available at convenient locations? Are adequate supplies of appropriate quality water conveniently available for personal hygiene and laundry? Are the appropriate sanitary control and surveillance activities conducted on potable and nonpotable supplies? Are detainee clothes laundered properly at least weekly?)*

MEDICAL TREATMENT

E-32. **What medical equipment is available within the internment facility?** *(What types of diagnostic and treatment equipment are in the medical treatment area? Is the internment facility equipped with any major pieces of medical equipment, such as x-ray, ultrasound, medical laboratory equipment, dental chairs, or hand-held x-ray? Is special medical equipment required for subpopulations within the detainee population such as pediatric, geriatric, or maternity?)*

E-33. **What is the extent of medical screening conducted from the point of capture, through temporary internment sites, to the internment facility?** *(Is medical screening and treatment at the point of capture or in temporary holding areas conducted by a dedicated medical staff or is it provided by Role 1 and Role 2 MTFs on an area support basis? What do the screening protocols encompass prior to arrival at the internment facility? If a detainee requires immediate medical care which cannot be provided at the temporary holding area, how is medical evacuation support coordinated/obtained? Who provides the personnel required to guard the detainee during evacuation? How is the medical care provided at temporary holding areas documented and what is the disposition of this documentation?)*

Note. Medical personnel do not guard detainees. Guards must be provided by either the echelon commander or the supporting MP units.

E-34. **What are the medical screening requirements at the internment facility?** *(What medical screening [such as physical examination, height and weight, diagnostic testing, and immunizations]*

procedures/protocols are required by international law and what procedures/protocols are required by command policy? What will the requirements be for a BH assessment? Will this be conducted routinely on all detainees or on an "as indicated" basis?)

E-35. What tracking mechanisms are in place to monitor detainee patients within the MTF? *(Do security personnel always maintain custody and control of detainees during the provision of health care? What is the policy for the use of restraints by medical personnel? Are all medical examinations and health care interactions documented? How are detainees identified (arm band, identification card, or other)? Do detainees have more than one form of identification on them at all times? Is an individual medical record created for each detainee? Does the medical record incorporate all medical documentation initiated in temporary holding areas [normally restricted to a completed DD Form 1380])?*

E-36. What sick call services will be provided? *(How will daily sick call be conducted? Will the detainees be brought to a medical treatment area or will medical personnel conduct sick call within the detainee compounds or at the wire? What medical services are available at sick call? How are specialty consultation requirements being met? Will detainees have to be transported to an MTF [not collocated with the internment facility] for routine or diagnostic care?)*

E-37. What are the medical criteria for requesting a compassionate release of a detainee for medical reasons? *(What are the established criteria for considering a detainee for a compassionate release based on his medical condition? How is the request initiated? Who must it be staffed with? If approved, how is the detainee outprocessed and what coordination is accomplished with the civilian/HN medical infrastructure?)*

E-38. What is the capability to provide prosthetic devices as required? *(What is the command policy concerning prosthetic devices? Are prosthetic devices manufactured in the HN or neighboring countries? Are amputations resulting from mines and/or explosive devices a significant medical issue among detainees?)*

E-39. How will detainee medications be distributed? *(Is there a policy that medications should be prescribed for administration one or two times daily, when feasible? Will the medications be distributed in the detainee compound or in the medical treatment area? Are all medications distributed by medical personnel? What are the documentation procedures for the distribution of medications? Must detainees sign that they have received their medication? Have procedures been established should a detainee refuse to take prescribed medication? Have the personnel distributing the medication been instructed on how to check to ensure the medication was swallowed/ingested?)*

E-40. Is there a mass casualty plan? *(Has a mass casualty plan been developed and rehearsed? What is the potential for the internment facility to be either bombarded or attacked? Has the plan been synchronized with the facility commander and staff? Should the facility come under attack, how will wounded detainees be located, acquired, and treated? Also, include estimate of a triage point and coordination for the use and augmentation of nonmedical vehicles to assist in transporting casualties. During the mass casualty, is there a plan to secure/guard detainees [by nonmedical personnel] while receiving medical care to both ensure their safety and control?)*

E-41. Is there a plan for the outbreak of a contagious disease? *(Is there a strategy for medical disease surveillance to facilitate early detection of an outbreak? Has a plan been developed to manage an outbreak of contagious disease within the detainee population? Is there the capability to establish a medical holding area where ill detainees can be isolated from the rest of the population? Will augmentation of the medical staff be required if such an event occurs? What is the MTF's infection control plan to prevent outbreaks?)*

E-42. How is EMT provided? *(Does the facility have medical personnel on duty on a 24-hour basis? Where is EMT provided [in medical treatment area or in the compound]? If the detainee must be evacuated to a higher role of care, how is medical evacuation arranged? Can the health care specialist providing emergency care communicate directly with the supporting hospital ER? Can the health care specialist communicate with the hospital ER while providing en route medical care on the*

evacuation platform? Have guard personnel been trained in enhanced first aid measures [CLS skill level]? Is there at least one guard on duty for each shift with CLS training? Have medical personnel received initial and periodic refresher training on the proper techniques for restraining combative patients? Are there sufficient restraints available to meet the unit's needs?)

E-43. Will medical photography be used to document traumatic injuries, wounds, or preexisting conditions? *(Does the unit have the appropriate photography equipment to document detainee injuries? Is there a command policy on obtaining photographic documentation of injuries? Has training been conducted on the need to ensure such photographs are correctly filed in the detainee's medical record and safeguarded from unauthorized release?)*

E-44. What are the requirements for medical screening for detainees being released from custody? *(Are detainees medically outprocessed from the internment facility? What arrangements are made for detainees taking medication and/or undergoing medical treatment for chronic illnesses? For traumatic injuries? Is there a CMO liaison that can assist in coordinating continuing medical support requirements with the civilian/HN medical infrastructure? Has the detainee indicated whether he felt he had a positive or negative medical experience? If negative, will he reveal why he feels this way? Has the detainee requested a copy of his medical records?)*

HOSPITALIZATION

E-45. What hospitals are established in the AO? *(Are these US facilities? What are the capabilities of these hospitals? What is the anticipated length of stay of detainee patients? What is the difference in length of stay for detainee patients versus US or multinational forces? How does the difference in length of stay affect the professional mix of health care providers?)*

E-46. What are the surgical requirements for the detainee population? *(Are detainees requiring surgical intervention treated at FSTs? What are the follow-on surgical requirements of a detainee treated at an FST? Does the collocated medical unit at the internment facility have a surgical capability? If not, how is surgical care coordinated for on a routine basis? On an emergency basis? Will augmentation of surgical capability be required for a mass casualty situation [such as an attack on the internment facility]?)*

E-47. What ancillary services are available by the hospitals within the AO? *(If convalescence for some injuries/illnesses is anticipated to occur, is ancillary support such as PT or OT available within the hospital and/or theater? What other rehabilitative services are required for the detainee population?)*

E-48. What is the policy on physical separation of patients? *(Are detainee patients separated from other patients [for example, US Forces, multinational forces, and government employees and civilian contractors] when health care is administered? Are detainee patients separated by gender? Are detainee patients kept far enough apart to prevent passing of notes, weapons, and information? Are detainees afforded personal privacy during physical examinations and medical care?)*

E-49. What procedures/notifications are required when a detainee is admitted to a US facility? *(Will a detainee be evacuated from the point of capture or a temporary holding facility directly to a hospital? Will a detainee be evacuated from the point of capture or a temporary holding facility directly to a hospital collocated with the internment facility? Will the detainee be evacuated from the internment facility to a collocated hospital or to another hospital facility within the theater?)*

E-50. Has a formulary been established for prescription drugs? *(Does it include medications for diseases endemic to the local area? Does it include medicine for chronic diseases/conditions? Does it contain medications for maternal and child health? Are the medications available in the local area, so that treatment can continue once the detainee is released? Are psychotropic medications included in the formulary?)*

E-51. How will detainees be transferred from one hospital to another within the AO, if required for specialty care? *(Who will provide the transportation assets? What coordination is required to affect the transfer? Who will provide security and guard detainees?)*

E-52. **Is there a CMO liaison to assist in coordinating follow-on medical care in the civilian community for detainees requiring continued medical care after release?** *(Is follow-on medical care in the civilian community coordinated for detainees being released? Who performs this task? What are the specific capabilities of the civilian medical infrastructure?)*

E-53. **How often will security inspections be conducted to identify security risks within the hospital and/or treatment areas?** *(Security risks—A hospital setting can present many items which can be used as a weapons for a detainee to injure himself or his caretakers [both medical (such as syringes) and nonmedical (such as pens and pencils)]. All medical supplies should be selected for functionality and safety. Who will conduct these inspections?)*

E-54. **What is the policy on body cavity examinations/searches?** *(Are body cavity examinations done by medical personnel for medical reasons only? What is the command policy concerning security personnel performing body cavity searches? Are hernia examinations forbidden during routine screening? Are all body cavity examinations/searches and hernia examinations performed by medical personnel of the same gender as the detainee patient?)*

E-55. **Are detainee patients' medical information kept private to the extent possible?** *(Is all detainee medical information restricted from interrogation personnel? Is the internment facility chain of command entitled to detainee medical information for health and welfare reasons? What procedures are used to provide necessary information [such as documentation similar to a physical profile]? Do medical personnel report all medical information gained during a medical interaction that may seriously jeopardize the health and safety of the detainee, other detainees, and/or facility staff to the proper authorities?)*

E-56. **Is a policy established for decedent affairs?** *(Are all detainee deaths reported to the CDO, DOMD, and CID? What is the command policy on the performance of autopsies? How are the deceased detainee's next of kin notified and who is responsible for performing this notification? Does the AFME have primary jurisdiction and authority within DOD to conduct a forensic investigation to determine the cause and manner of a detainee death? Has the final disposition of the detainee's medical record been completed?)*

NUTRITION CARE

E-57. **Are dietitians available to provide consultation on nutrition care issues?** *(Dietitians are normally assigned to Role 3 hospitals. However, they may be consulted by any medical unit which requires their expertise. Dietitians should evaluate the nutritional value of the detainees' diet to ensure there is a sufficient caloric intake and that the minimum essential daily requirements for vitamins and minerals are achieved. If detainees are performing work assignments, their nutritional requirements should be reevaluated to ensure their caloric and macronutrient intake is sufficient/appropriate for the type of work being performed.)*

E-58. **Is the data obtained from the monthly required weigh-ins analyzed to determine trends and to ensure detainees with significant weight changes are identified?** *(A monthly weigh-in is required for all detainees. This may be accomplished in a variety of setting, such as the medical treatment area, at the dining facility prior to a meal, or at headcounts. The weight must be recorded on DA Form 2664-R for each detainee. This data must be reviewed to determine trends and identify detainees with specific weight-related conditions. The organic medical personnel can evaluate the data, but should consult with a dietitian if any issues are identified.)*

E-59. **Are there any cultural, religious, and/or social considerations related to diet?** *(Does the detainee's religion have any restrictions on the type of food which can be consumed? If there are prohibited items, what precautions are required to ensure that how the food is prepared does not affect its status [cross-contamination from prohibited foods to acceptable foods]? Does the detainee's religion dictate fasting during certain times or during religious holidays? How can the detainee's diet be adjusted to compensate for periods of fasting?)*

E-60. **What are the ramifications and procedures to be followed should detainees go on a hunger strike?** *(What are the procedures for managing hunger strikes? What are the medical ramifications should the hunger strike become prolonged? What is the theater policy on intervention?)*

E-61. **Are medical supplemental rations available?** *(Are special medical diets and/or supplements available for detainees who are not inpatients? Do certain clinics need to maintain a stock of liquid nutritional supplements for detainees undergoing treatment [such as the dental treatment area for patients undergoing oral surgery or for diabetic patients?])*

E-62. **What is the command policy on providing MREs to feed the detainee population?** *(What is the command policy on the use of MREs for detainees? Can MREs be used at the point of capture or temporary holding areas? What is the maximum length of time MREs can be used? When MREs are used, how are detainees with religious- or social-based dietary restrictions accommodated?)*

DENTAL SERVICES

E-63. **What units will provide dental services for the detainee population?** *(Will dental resources be available within the medical treatment area [dental resources are not organic to the internment facility medical contingent]? If there is a medical unit collocated at the facility, does it have organic dental resources? If not, how will dental problems be referred for care?)*

E-64. **What dental services are available in the AO?** *(What is the theater policy on dental care for detainees?)*

E-65. **What dental conditions will necessitate the evacuation of patients from the internment facility to a dental treatment facility within the AO?** *(What oral conditions cannot be treated satisfactorily in the internment facility? What coordination is required to arrange for the evacuation of dental patients? What organization provides oral and maxillofacial referral care for detainees?)*

BEHAVIORAL HEALTH, NEUROPSYCHIATRIC CARE, AND STRESS CONTROL

E-66. **Who is responsible for the detainee BH programs and treatment?** *(Who will provide BH services to the detainees? What accommodations will differences in language require? What services will be available within the internment facility? Will BH resources be collocated with the supporting medical unit? Are there any HN BH providers that may be contracted for the purpose of managing and treating detainees with mental disorders?)*

E-67. **How will detainees with BH and NP conditions and/or stress-induced reactions be evacuated, if required?** *(On dedicated medical vehicles? On general transportation assets? Will NP patients require an escort, sedation, or restraints for evacuation by aircraft? What facility within the AO will detainees requiring inpatient psychiatric care be regulated to?)*

E-68. **Who will conduct TEM assessment for staff?** *(Who within the facility provides follow-up care, if required?)*

E-69. **How are detainees screened for BH disorders/stress during the initial medical screening conducted when the detainee is inprocessed to the TIF?** *(Will a BH professional be part of the inprocess medical screening team? What procedures are followed if a detainee appears to be suicidal or expresses suicidal thoughts?)*

E-70. **What are the procedures if a detainee attempts to commit suicide?** *(Have guard personnel been trained on appropriate procedures and notifications if a detainee attempts to commit suicide? How are the emergency treatment personnel notified? What are the procedures to be followed [security, segregation, observation, and treatment] after a suicide attempt? What are the identified protocols for the use of mechanical and/or chemical restraint? What are the protocols for other management techniques such as line-of-sight and attendant arms-length behavioral management?)*

MEDICAL EVACUATION AND MEDICAL REGULATING

E-71. **Do medical evacuation vehicles/aircraft require armed escort while performing their mission?** *(If yes, what units will provide this support? What is the response time? Can ground evacuation vehicles only move as part of convoys or are they permitted to move independently? Are ground ambulances used within the compound? If the detainee must be evacuated from the internment facility and collocated medical unit, will he be moved by ground or air ambulance? What coordination is required for security and guards?)*

Note. Medical personnel do not guard detainees during medical evacuation. Guards and other required security are provided by the echelon commander and/or supporting MPs.

E-72. **How will medical evacuation be requested when a detainee requires evacuation through medical channels from the point of capture or temporary holding facility directly to a hospital?** *(How will medical evacuation be requested from the point of capture or temporary holding facility? What unit will provide guards/escorts for detainees? Is there more than one facility detainees can be taken to? Who regulates their flow to hospitals within the AO?)*

E-73. **Has a policy been established on detainee evacuation?** *(Is the priority of casualty care and evacuation based solely on severity of wounds or illness? Are enemy casualty and detainee evacuation methods the same as but separate from that provided to other casualties and patients? Are detainees ever evacuated/transferred out of country?)*

MEDICAL LOGISTICS

E-74. **What is the Class VIII stockage level?** *(Has theater policy been established and disseminated concerning the days of supply required for Class VIII in support of US medical units conducting detainee health care operations? Have medical supplies/pharmaceuticals normally not carried in medical equipment sets been identified and available in sufficient quantities to support the detainee population with chronic health conditions, maternal and child health care, obstetrical/gynecological care, pediatric care, and geriatric care? Have initial support requirements for Class VIII been sufficient, if not, have adequate measures been put into play to remedy supply support shortages?)*

E-75. **What are the requirements and considerations for the use of blood and blood products in detainee health care?** *(Are there any cultural, religious, or social prohibitions on the use of blood and blood products for any of the subpopulations of detainees? What is the source of supply of blood and blood products? If the source comes from within the local area, how is the blood collected? What tests are performed on the blood after collection? How is the blood tracked and matched to the detainee transfused? What procedures are required for emergency use [transfusion] of blood? What documentation is required for the informed refusal of the use of donated blood? Does the facility have a refrigerated storage capability? What is the maximum number of units of blood which can be stored?)*

E-76. **How will resupply be affected?** *(Are units using line item requisitioning or are preconfigured push packages being used? Will supply point distribution be used? Will medical vehicles/aircraft provide backhaul for medical supplies, equipment, and blood?)*

E-77. **What reports are required to be submitted to the supporting MEDLOG facility?** *(Are these reports automated? Are automated systems interoperable? What are the report formats and suspense times/dates? If automation is not available how are requisitions processed?)*

E-78. **Have daily logistics requirements been determined?** *(Internment facility planners should identify the type of day-to-day support needed to run and maintain the facility. Those requirements are subsequently reported to the higher HQ to ensure required assets are available for support.)*

VETERINARY SERVICES

E-79. **What type of rations is to be provided to the detainee?** *(This is dependent upon the anticipated availability of food sources within the theater. What is the maximum length in days that MREs can be used to feed a detainee population? Are food sources and services contracted for the facility?)*

E-80. **Will US Forces provide veterinary inspection of subsistence for hygiene (safety), wholesomeness, and quality for the internment facility?** *(Will veterinarians inspect local food sources used for subsistence for detainee populations? Are local food sources available? Will food be purchased outside of the AO and shipped in?)*

E-81. **What are the animal medicine requirements for MWDs within the facility?** *(Where is the veterinary treatment facility located? Will injured or ill MWDs have to be evacuated for treatment? If yes, does the handler have to accompany the animal? Will the animal require sedation? What type of platform will be used for the evacuation?)*

E-82. **Are there any veterinary PVNTMED aspects of the operation within the facility?** *(Is there a zoonotic disease threat within the facility? Are there any food animals maintained in the compound? Are there any feral or wild animals with access to the facility? Are there any unauthorized pets? If animals, other than MWDs, are in the compound, have they been immunized [such as for rabies]? Are diseases such as anthrax endemic to the AO? Will an epidemiological investigation be conducted should an outbreak occur? Who will conduct the investigation?)*

MEDICAL LABORATORY

E-83. **What diagnostic/clinical capabilities are available at the internment facility?** *(The organic MP medical personnel at the internment facility do not have a diagnostic/clinical laboratory capability. If there is not a collocated medical unit, will the medical asset organic to the internment facility be augmented to provide this capability? Is the capability available a Role 2 [medical company] or Role 3 [hospital] capability? If there is a Role 2 capability, what specific tests can be processed at the facility? What specimens would have to be forwarded to the supporting Role 3 hospital to be accomplished? What are the procedures for packaging and forwarding specimens to the next role of care for evaluation? Has the stockage level for laboratory supplies and reagents been assessed/determined?)*

E-84. **What is the capability and capacity of the medical laboratory resources supporting the facility to store and process blood?** *(What is the storage capacity of the medical unit supporting the internment facility? Will the medical unit be limited to only O positive and negative red blood cells [similar to a Role 2 capability] or will other blood types be available [similar to a Role 3 capability]? What is the capability of the laboratory to type and cross match blood? Is there sufficient storage, refrigeration, freezer, and room temperature space for all supplies? Are the laboratory/blood bank environmental conditions proper for laboratory work and proper functioning of equipment?)*

E-85. **How are specimens/samples collected, packaged, and chain of custody maintained on suspect biological warfare (BW) and chemical warfare (CW) agent materials?** *(Should suspect BW or CW agents be used against the internment facility, what are the procedures for collecting and packaging specimens/samples? How is support from the technical escort unit [TEU] coordinated? What if TEU support is not available? How are specimens/samples escorted and chain of custody maintained? To what facility are these specimens/samples submitted for presumptive and confirmatory identification? How are routine specimens collected, packaged, and transferred to the next higher level of laboratory support? How are specimens collected and transported within the facility to ensure specimen integrity, identification, and security? How are laboratory results reported back to the health care provider [such as electronic, paper, distribution, or carrier/messenger]?)*

CHEMICAL, BIOLOGICAL, RADIOLOGICAL, AND NUCLEAR ENVIRONMENT

E-86. **What actions are to be taken if CBRN weapons are used against the facility?** *(Do detainees have individual protective equipment or does the facility have adequate equipment available? Have detainees been instructed on what procedures to follow in the event of an attack? Has a medical response plan been developed to provide required support in the aftermath of such an event? Will medical augmentation be required?)*

E-87. **What actions are to be taken in the event an accidental release of TIMs takes place in or near the internment facility?** *(What is the medical response plan in the event detainees are exposed to a TIMs release? Will medical assets require augmentation? How will detainee exposures be documented?)*

Appendix F

Sample Extract Mission Essential Task List with Collective Tasks

This appendix provides a sample mission essential task list (METL) for a Role 3 hospital unit with task-organized elements providing medical support to DO. This abbreviated METL and associated collective tasks are illustrative in nature and are provided to provoke thought regarding DO. This sample METL is not all-inclusive and should be modified to the specific unit type/task force executing a DO mission. Some collective tasks pertain to unit-level operations. For example, the collective task “Perform Mortuary Affairs” does not imply that the supporting medical unit will perform MA functions for DO; rather, the medical unit must be prepared to perform unit-level MA procedures should a unit member become a casualty. Once the unit establishes the collective tasks associated with each mission essential task, the individual tasks can be delineated to support each of the collective tasks. Table F-1 provides a sample extract METL with collective tasks.

Table F-1. Sample mission essential task list

<i>METL Task</i>	<i>Collective Task Number</i>	<i>Collective Task</i>
Defend Hospital Area		
	63-1-1038.08-855A	Supervise OPSEC Program
	63-2-1016.08-855A	Employ OPSEC Measures
	63-2-1003.08-855A	Conduct Tactical Road March
	63-2-1006.08-855A	Defend March Elements
	63-2-1011.08-855A	Set Up Hospital Defense
	63-2-R306.08-855A	Employ Physical Security Measures
	63-2-1024.08-855A	Defend Hospital Area
	63-2-1026.08-855A	Reorganize Hospital Defense
	63-1-1001.08-855A	Conduct Mission Analysis
	63-1-1002.08-855A	Conduct Intelligence Preparation of the Battlefield
	63-1-1003.08-855A	Formulate Feasible Courses of Action
	63-1-1004.08-855A	Develop Intelligence Estimate
	63-1-1009.08-855A	Prepare OPLAN/OPORDs and Annexes
	63-1-1012.08-855A	Plan Hospital Area Tactical Operations
	63-1-1017.08-855A	Establish Communications
	63-1-1022.08-855A	Operate the Tactical Operations Center (TOC)
	63-1-1045.08-855A	Provide C2
	63-1-1052.08-855A	Direct Response to Threat Actions

Table F-1. Sample mission essential task list (continued)

<i>METL Task</i>	<i>Collective Task Number</i>	<i>Collective Task</i>
	63-1-1053.08-855A	Direct Area Damage Control Operations
	63-2-1014.08-855A	Plan Area Damage Control Operations
	63-1-1040.08-855A	Maintain Communications
Establish Hospital Area of Operations		
	63-1-1019.08-855A	Supervise Establishment of Subordinate Elements and Hospital HQ
	63-1-1020.08-855A	Establish TOC, Administrative Areas, and Operational Areas
	08-1-0218.08-855A	Establish Hospital HQ Area
	63-2-0008.08-855A	Establish Company HQ Area
	08-2-0220.08-855A	Establish Hospital Operational Areas
	63-1-1011.08-855A	Develop Occupation Plan
	63-1-1017.08-855A	Establish Communications
	63-1-1045.08-855A	Provide C2
	63-1-1040.08-855A	Maintain Communications
Perform Hospitalization Support and Services Operations		
	08-1-0225.08-855A	Prepare for Hospitalization Support and Services Operations
	08-1-0226.08-855A	Coordinate Hospitalization Support and Services Operations
	63-1-1042.08-855A	Provide Personnel Service Support
	63-1-1043.08-855A	Provide Administrative Service Support
	10-2-C320.08-855A	Provide Unit Supply Support
	08-1-0249.08-855A	Provide Medical Supply Support
	43-2-R322.08-855A	Perform Unit-Level Maintenance
	08-2-R303.08-855A	Conduct Battlefield Stress Reduction and Prevention Procedures
	19-3-3106.08-855A	Handle EPWs
	19-3-3105.08-855A	Process Captured Documents and Equipment
	08-2-0314.08-855A	Treat Hospital Casualties
	10-2-C318.08-855A	Perform MA Operations
	08-1-0230.08-855A	Perform PAD Services
	08-1-0231.08-855A	Provide EMS
	08-1-0233.08-855A	Provide Movement of Patients
	08-1-0234.08-855A	Perform Staff Administrative Functions
	08-1-0235.08-855A	Provide Orthopedic Cast/Traction Services
	08-1-0236.08-855A	Provide Central Materiel Services
	08-1-0237.08-855A	Provide Medical Consultation and Treatment Services
	08-1-0238.08-855A	Provide Respiratory Therapy Functions
	08-2-0700.08-855A	Perform PVNTMED Operations
	08-1-0239.08-855A	Provide Nursing Services

Table F-1. Sample mission essential task list (continued)

METL Task	Collective Task Number	Collective Task
	08-1-0240.08-855A	Provide Pharmacy Services
	08-1-0241.08-855A	Provide PT Services
	08-1-0534.08-855A	Provide OT Services
	08-1-0242.08-855A	Perform Surgical Services
	08-5-0001.08-855A	Provide Eye Surgery Services
	08-2-0317.08-855A	Provide Dental Services
	08-1-0244.08-855A	Provide Laboratory Services
	08-1-0245.08-855A	Provide Blood Banking Services
	08-1-0246.08-855A	Provide Neuropsychiatric Services
	08-1-0252.08-855A	Provide Patient Convalescent Care
	08-1-0247.08-855A	Provide Radiology Services
	08-1-0250.08-855A	Provide Nutrition Care Services
	08-1-0248.08-855A	Provide Comprehensive Religious Support to Patients and Unit Members
	63-1-1022.08-855A	Operate the TOC
	63-1-1045.08-855A	Provide C2
	63-1-1040.08-855A	Maintain Communications
Plan Hospitalization Support and Services Operations		
	08-2-R303.08-855A	Conduct Battlefield Stress Reduction and Prevention Procedures
	08-2-0314.08-855A	Treat Hospital Casualties
	08-1-0241.08-855A	Provide PT Services
	08-1-0534.08-855A	Provide OT Services
	63-1-1001.08-855A	Conduct Mission Analysis
	63-1-1002.08-855A	Conduct Intelligence Preparation of the Battlefield
	63-1-1003.08-855A	Formulate Feasible Courses of Action
	63-1-1004.08-855A	Develop Intelligence Estimate
	63-1-1005.08-855A	Develop Personnel Estimate
	63-1-1006.08-855A	Develop Logistics Estimate
	63-1-1007.08-855A	Develop a Hospitalization Support and Services Estimate
	63-1-1009.08-855A	Prepare OPLAN/OPORDs and Annexes
	63-1-1011.08-855A	Develop Occupation Plan
	63-1-1012.08-855A	Plan Hospital Area Tactical Operations
	63-1-1045.08-855A	Provide C2
	63-2-1014.08-855A	Plan Area Damage Control Operations
Perform Theater-Level Detainee Health Care Support and Service Operations		
		Establish Coordination with the Designated DOMD
		Establish and Maintain Split-Based Operations C2

Table F-1. Sample mission essential task list (continued)

<i>METL Task</i>	<i>Collective Task Number</i>	<i>Collective Task</i>
		Conduct Health Threat Assessment for Detainee Population
		Perform Medical Inprocessing for Inpatient Detainees
		Establish Identification of Detainee Patients
		Establish Detainee Medical Record
		Maintain Detainee Medical Record
		Perform Inpatient Hospitalization Support for Detainees
		Evacuate Detainee Patients Within Theater
		Move Detainee Patients Within Theater
		Perform Initial Medical Screening/Physical Examination of Detainees
		Perform Dispensary/Sick Call Support for Detainees
		Establish Wound Care Clinics
		Provide Oversight for Detainee Health Care at DCPs and DHAs
		Perform Dental Services for Detainees
		Perform Behavioral Health Services for Detainees
		Coordinate/Plan for Linguist Support
		Report Abuse/Suspected Abuse of Detainees
		Coordinate for Security of Detainee Patients
		Perform Credentialing/Privileging of HN and Multinational Health Care Providers
		Perform Mass Casualty Operations
		Perform Geneva Conventions/Law of Armed Conflict Training
		Perform Orientation on Separation of Health Care from Custody and Control
		Perform Orientation on Separation of Health Care from Interrogation Operations
		Perform Medical and OEH Surveillance of Detainee Population

Appendix G

Linguist Support

This appendix expands the discussion of linguist support in Chapter 3.

LINGUIST CATEGORIES

G-1. The commander and staff must identify linguist requirements by category—

- Category I—Have native proficiency in the target language (Level 4-5) and an advanced working proficiency in English. May be locally hired or from a region outside the AO. They do not require a security clearance. Must be screened by the Army counterintelligence support team.
- Category II—Are US citizens screened by Army counterintelligence personnel and are granted access to *secret* clearance by the designated US government personnel security authority. Have native proficiency in the target language (Level 4-5) and an advanced working proficiency in English.
- Category III—Are US citizens screened by Army counterintelligence personnel and are granted either *top secret (TS)/sensitive compartmentalized information (SCI)* clearance or an interim TS/SCI clearance by the designated US government personnel security authority. Meet a minimum requirement of Interagency Language Round Table Level 3. Are capable of understanding the essentials of all speech in a standard dialect. Must be able to follow accurately the essentials of conversation, make and answer phone calls, and understand radio broadcasts and news stories, and medical and oral reports (both of a technical and nontechnical nature).

SOURCES OF LINGUISTS

G-2. There are various sources that a medical commander can use to obtain the linguists necessary to support detention health care operations. It is vital to know the advantages and disadvantages of each type of linguist and to carefully match the available linguists to the various aspects of the operation.

ACTIVE ARMY

G-3. A number of MOSs in the MI field have language-qualified Soldiers. Due to their Soldier skills, English proficiency, and security clearances they can be very useful as translators/interpreters. However, these are usually low-density MOSs and these Soldiers cannot normally be spared to be used as translators.

G-4. In addition to MI-related MOSs there are some special operations forces-related MOSs that also have qualified linguists. Particular attention, however, must be paid to the recorded language proficiency and test date of these individuals since standards vary by field. Again, these tend to be low-density MOSs and the Soldiers are normally not available to accomplish translator functions.

G-5. The Army also includes numerous Soldiers of all grades who are proficient in a foreign language and are receiving foreign language proficiency pay but whose primary duties do not require foreign language proficiency. They may have attended a civilian school to learn a foreign language or they may have acquired proficiency through their heritage. They have the advantage of being trained Soldiers and are therefore readily deployable to all areas of the battlefield. These Soldiers may have the specific vocabulary and military skill knowledge for certain linguist support missions. For example, a health care specialist who speaks the local language would be an invaluable asset to the medical unit. There are disadvantages in that they already have another job and units are reluctant to give up personnel especially if they are in

key positions. Their capabilities are difficult to assess. Since they are not required to take the Defense Language Proficiency Test if they are not receiving foreign language proficiency pay, it is often difficult for the S1 to identify them as a linguist or for a nonlinguist to judge the level of their foreign language capability.

RESERVE COMPONENT

G-6. Reserve Component (RC) language-dependent MOSs include those discussed above in the Active Army (paragraphs A-3 and A-4). Reserve Component linguists have the same set of advantages and disadvantages as listed above for Active Army language-dependent MOSs. The RC also includes linguists in MOS 97L (translator/interpreter). These Soldiers are specifically trained to be a translator and interpreter. They have the same advantages as the Active Army linguists. An added advantage is that since their sole job is translation and interpretation, they do not have to be removed from another job in order to be used as a linguist.

OTHER SERVICE LINGUISTS

G-7. Other Service linguists have the advantage of deployability, loyalty, and clearance, but must often have to learn the Army system and specific Army vocabulary. They are also difficult to obtain since their parent Service probably also lacks a sufficient number of trained linguists. Other Service linguists, however, will be valuable in joint operation centers and joint activities. When serving as the joint task force HQ, Army commanders and staffs must be aware of the linguists in the other Services in order to plan for the participation and optimize their employment.

CONTRACT UNITED STATES LINGUISTS

G-8. United States civilians can be contracted to provide linguist support. They have an advantage over HN hires in that their loyalty to the US is more readily evaluated and it is easier for them to be granted the necessary security clearance. However, there may be limitations on the deployment and use of civilians. A careful assessment of their language ability is important because, in many cases, they use “old-fashioned” terms or interject US idioms.

MULTINATIONAL LINGUISTS

G-9. Multinational linguists have their own set of advantages and disadvantages. These linguists may be unfamiliar with the US military system unless they have previously participated in a multinational operation with US Forces. They may have a security clearance, but clearances are not necessarily equal or reciprocal, automatically guaranteeing access to classified or sensitive information between nations. They support the command’s interest but may have differing priorities or responsibilities within their assigned AO. These linguists also are already fulfilling specific duties for their own nation, which may also have a shortage of linguists. The major disadvantage to acquiring and maintaining multinational linguist support is that they are outside the C2 (via military authority or military contract) of the US Forces. These linguists will be valuable in multinational operations centers and activities.

HOST NATION CONTRACT LINGUISTS

G-10. Local national hires will provide the bulk of your linguist support. They are usually less expensive to hire than US civilians and will know the local dialect, idioms, and culture. The expertise of these linguists in particular areas or subject matters can be an asset. However, there are several potential problems with using HN hires, to include limited English skills, loyalty considerations, and security concerns; therefore, a screening interview or test is necessary to determine their proficiency in English. These individuals must also be carefully selected and screened by Army counterintelligence personnel (with US linguist support) initially and periodically throughout their employment.

Appendix H

Immunizations

This appendix stipulates responsibilities for the establishment of detainee immunization programs and provides general guidance to establish policies for their implementation. Special considerations for developing a detainee immunization program are provided as a list of considerations to assess when developing these programs. Immunizations for detainees serve a dual purpose. While they are beneficial to the detainee for their personal protection, they also serve as a force multiplier for our forces. The goal is to keep the detention facility population as healthy as possible to decrease the strain on the medical assets. Immunizations provide an effective way of reducing the risk from specific diseases.

MILITARY VACCINE AGENCY

H-1. The Military Vaccine Agency is the central office that provides military leaders, health care providers, and Soldiers a synchronized access point for information, education, and coordination of the anthrax, smallpox, influenza, and other vaccination programs. The Agency coordinates the Army's overall vaccination program, monitors other Services' program implementation plans, and executes the Army's implementation plans. For additional information on the immunization program refer to AR 40-562, AR 190-8, and DODI 6205.4.

RESPONSIBILITIES

THE SURGEON GENERAL

H-2. The Secretary of the Army, as the DOD Executive Agent for the Immunization Program, has appointed The Surgeon General to implement this program. The Surgeon General will—

- Provide technical assistance to the GCC through the Military Vaccine Agency.
- Provide advice to the DOMD and/or task force surgeon on the detainee immunization policy.
- Monitor vaccine supplies and distribution for detainee immunization programs.

DETAINEE OPERATIONS MEDICAL DIRECTOR/TASK FORCE SURGEON

H-3. The DOMD and/or task force surgeon (if a DOMD is not designated)—

- Develops the theater detainee immunization policy to protect detainees against diseases that may be a significant cause of death or illness (for example, influenza or tetanus-diphtheria).
- Implements detainee immunizations in consonance with the Law of Land Warfare, international conventions, protocols, and law and accepted professional ethical standards with regard to the proper and ethical health care of detainees.
- Ensures immunization policies maintain uniformity of procedures and provides detainees with standard of health care to approximate that afforded US Armed Forces.
- Ensures immunizations provided to detainees are voluntary and free of charge and known risks associated with the vaccine are clearly provided to the detainee (in his own language) before beginning with the immunization.
- Ensures all detainee immunizations are annotated in the detainee's medical record.

INTERNMENT FACILITY SURGEON

H-4. The TIF surgeon will—

- Implement the DOMD/task force surgeon's detainee immunization program.
- Inform the DOMD/task force surgeon of any specific infectious diseases or medical conditions that may require modification to the detainee immunization program.
- Ensure health care personnel do not conduct any form of medical research that involves detainees (DODD 3216.2), even if the detainee grants permission. Maintenance of standard immunization statistics (such as adverse effect rates) absent of any detainee personal identification data is acceptable for the management of this program.

SPECIAL DETAINEE IMMUNIZATION POLICY CONSIDERATIONS

H-5. Without special permission from the Army Surgeon General's Human Subjects Research Review Board, detainees will not be immunized with any vaccines under investigational new drug or emergency use authorization status. For additional information refer to OTSG Regulation 15-2.

H-6. When there is a threat or use of BW agents, it is DOD policy that the GCC will determine requirements for immunizing non-US military personnel. Specific details of this policy are contained in DODI 6205.4.

H-7. Factors to consider in deciding which vaccinations to offer include—

- Physicians should consider the likelihood of a detainee's preexisting immunity to preclude individual detainees from receiving irrelevant vaccinations.
- Seasonal threats (such as influenza) may affect the timing of certain vaccination programs.
- Religious beliefs and practices will be considered, but should not provide justification for not offering immunizations to detainees.
- The anticipated length of detention, endemic population risk factors, and living conditions will be considered.
- Because detainees will be informed in their own language about the relative benefits and risks of the specific immunizations offered, interpreters must be available to medical personnel administering immunizations.
- Detainee medical inprocessing provides an opportunity to accomplish screening and immunizations. As a staff safety and security issue, it is essential to maintain needles and other sharp items accountability. Sharp items should never be out of sight of the health care provider and should be maintained well outside of the reach of the detainees at all times.

DETAINEE IMMUNIZATION RECORDS

H-8. Detainee immunizations will be annotated in the detainee's medical record as they would for any other patient. When possible, the entry should also include the name of the vaccine in the detainee's native language.

Glossary

A	administered
AFJI	Air Force joint instruction
AFME	Armed Forces Medical Examiner
AFPMB	Armed Forces Pest Management Board
AHLTA	Armed Forces Health Longitudinal Technology Application
AHS	Army Health System
ALD	assistive listening device
AMEDD	Army Medical Department
AO	area of operations
AOC	area of concentration
AOR	area of responsibility
APD	Army Publishing Directorate
APO	Army post office
Apr	April
APRN	advanced practice registered nurse
AR	Army regulation
ASCC	Army service component commander
ASD(HA)	Assistant Secretary of Defense (Health Affairs)
attn	attention
B1	thiamin
B2	riboflavin
B3	niacin
BAS	battalion aid station
bde	brigade
BH	behavioral health
b.i.d.	twice a day
BMI	body mass index
BP	blood pressure
BSC	behavioral science consultation
BSCT	behavioral science consultation team
BUMEDINST	Bureau of Medicine and Surgery instruction (US Navy)
BW	biological warfare
C	Celsius
C2	command and control
C&E	collection and exploitation
CBC	complete blood count
CBRN	chemical, biological, radiological, and nuclear
CDC	Centers for Disease Control and Prevention

Glossary

CDO	commander, detainee operations
cfm	cubic feet per minute
CG COMDTINST	Coast Guard commandant instruction
chem	chemical
CI	civilian internee
CID	Criminal Investigation Division
circ	circumference
CLS	combat lifesaver
CMO	civil-military operations
CSOP	clinical standing operating procedure
CT	computed tomography
CW	chemical warfare
CZ	combat zone
DA	Department of the Army
DA Pam	Department of the Army pamphlet
DCP	detainee collection point
DD	Department of Defense
DEA	Drug Enforcement Agency
DEPMEDS	Deployable Medical Systems
DHA	detainee holding area
DMSB	Defense Medical Standardization Board
DNBI	disease and nonbattle injury
DO	detainee operations
DOB	date of birth
DOD	Department of Defense
DODD	Department of Defense directive
DODI	Department of Defense instruction
DOEHRS-HC	Defense Occupational Environmental Health Readiness System—Hearing Conservation
DOMD	detainee operations medical director
DRI	Dietary Reference Intake
DRS	Detainee Reporting System
DT	diphtheria-tetanus
EMB	ethambutol
EMS	emergency medical services
EMT	emergency medical treatment
EPW	enemy prisoner of war
ER	emergency room
ETOH	alcohol
F	Fahrenheit
FAC	free available chlorine

FDA	Food and Drug Administration
FM	field manual
FMC	United States Field Medical Card
FMI	field manual interim
FST	forward surgical team
ft	feet
FUO	fever of unknown origin
FV	family visit
g	gram(s)
G2	Assistant Chief of Staff (Intelligence)
G2X	Assistant Chief of Staff, Intelligence (Human Intelligence and Counterintelligence)
GC	Geneva Convention Relative to the Protection of Civilian Persons in Time of War, 12 August 1949
GCC	geographic combatant command
GP	general purpose
GPW	Geneva Convention Relative to the Treatment of Prisoners of War, 12 August 1949
GWS	Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field, 12 August 1949
HCT	human intelligence collection team
HEENT	head, eyes, ears, nose, and throat
HEP	hepatitis
HgbA1c	glycosylated hemoglobin
HIV	human immunodeficiency virus
HN	host nation
HQ	headquarters
I/R	internment/resettlement
ICRC	International Committee of the Red Cross
ICU	intensive care unit
IG	Inspector General
INH	isoniazid
IO	international organization
IOM	Institute of Medicine
ISN	internment serial number
IV	intravenous
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
JOA	joint operational area
Jul	July
kg	kilogram
LAB	laboratory

Glossary

MA	mortuary affairs
MC	Medical Corps
mcg	microgram
MCO	Marine Corps order
MCRP	Marine Corps reference publication
med/meds	medical; medicine; medication(s)
MEDCOM	medical command
MEDLOG	medical logistics
METL	mission essential task list
METT-TC	mission, enemy, terrain and weather, troops and support available, time available, and civil considerations
mg	milligrams
MHS	Military Health System
MI	military intelligence; middle initial
min	minute
MMR	mumps, measles, rubella
Mon	Monday
MOS	military occupational specialty
MP	military police
MRE	meal, ready-to-eat
MRI	magnetic resonance imaging
MTF	medical treatment facility
MWD	military working dog
NATO	North Atlantic Treaty Organization
NCOIC	noncommissioned officer in charge
NDRC	National Detainee Reporting Center
NGO	nongovernmental organization
NP	neuropsychiatric
NS	no-show
OD	other detainee
OEH	occupational and environmental health
OIC	officer in charge
OMR	outpatient medical record
OMT	operational management team
OPCON	operational control
OPNAVINST	Office of the Chief of Naval Operations instruction
OPORD	operations order
OPSEC	operations security
OSD	Office of the Secretary of Defense
OT	occupational therapy
OTC	over-the-counter

OTSG	Office of The Surgeon General
PA	physician assistant
PAD	patient administration division/patient administrator
PAO	public affairs office(r)
pH	hydrogen ion concentration
pm/PM	post meridiem; provost marshal
PMG	Provost Marshal General
PMM	preventive medicine measures
POW	prisoner(s) of war
PPD	purified protein derivative
ppm	parts per million
PT	physical therapy
PVNTMED	preventive medicine
PZA	pyrazinamide
q.d.	every day
R	refused
RBC	red blood cells
RC	Reserve Component
RIF	rifampin
RP	retained person/personnel
RTC	return to compound
S1	Personnel Staff Officer, United States Army
S3	Operations Staff Officer, United States Army
S4	Logistics Staff Officer, United States Army
SB	supply bulletin
SCI	sensitive compartmentalized information
SECDEF	Secretary of Defense
SF	standard form
SGT	sergeant
SIPRNET	secret internet protocol router network
SIR	serious incident report
SJA	staff judge advocate
SM	streptomycin
SOP	standing operating procedure
sq	square
STD	sexually transmitted disease
T	temperature
tab	tablet
TB	tuberculosis
TB MED	technical bulletin, medical

Glossary

TEM	traumatic event management
TEU	technical escort unit
TG	technical guide
TIF	theater internment facility
TIM	toxic industrial material
TOC	tactical operations center
TRAC2ES	Transportation Command Regulating and Command and Control Evacuation System
TS	top secret
TST	tuberculin skin test
Tue	Tuesday
UA	urinary analysis
UN	United Nations
US	United States
USA	United States Army
USACHPPM	United States Army Center for Health Promotion and Preventive Medicine
USACIDC	United States Army Criminal Investigation Command
USAF	United States Air Force
USAMEDDC&S	United States Army Medical Department Center and School
USDA	United States Department of Agriculture
USN	United States Navy
USTRANSCOM	United States Transportation Command
WHO	World Health Organization
WQAS-E	water quality analysis set-engineer
yds	yards

References

SOURCES USED

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