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Division Mental Health in the New Brigade Combat Team Structure: Part I. Predeployment and Deployment

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Objective: Recent Army transformation has led to significant changes in roles and demands for division mental health (DMH) staff members. This article focuses on predeployment and deployment. Methods: Surveillance of Combat and Operational Stress Reactions data, review of DMH implementation plans, and observations by staff members, providers, and soldiers were reviewed. Results: During the course of the deployment, the Task Force Baghdad DMH unit had >22,000 soldier encounters with 5,542 clinical encounters. The duration of the deployment and increased levels of threat later in the deployment resulted in increased stress problems but not a substantial or sustained increase in mental health casualties. Conclusions: Predeployment education and communication probably eliminated some problems during deployment, and communication among mental health and command units during deployment resolved most problems encountered.

Introduction

Behavioral health issues have been documented throughout the history of warfare.[1] Since World War I, the U.S. Army has been deploying behavioral health assets to the front line for treatment of combat operational stress.[2] Since World War II, division mental health (DMH) has existed both in garrison and during deployment.[3,4] By doctrine (Field Manual 8–51), the mission of DMH is to assist command in controlling combat operational stress through training, consultation, and restoration.[5]

In the midst of the war on terror, however, the Army is undergoing its largest restructuring since World War II, changing the emphasis from the division to the brigade combat team (BCT).[6] This restructuring effort is designed to make the Army a more modular force and to increase efficiency and combat power; it will increase the number of BCTs from 33 to 43.[6] This increase brings a host of explicit and implicit tasks and challenges that the behavioral health system must address.

In conjunction with the reorganization, there has been an increase in the behavioral health assets assigned to each division. Before the restructuring of the force, each division was staffed with a DMH unit consisting of three providers (a psychiatrist, a psychologist, and a social worker) and three to five enlisted mental health specialists. The new structure, outlined in Figure 1, includes a division psychiatrist and a senior noncommissioned officer located with the division surgeon at the division headquarters unit and a behavioral health officer (a psychologist or social worker) and an enlisted mental health specialist assigned to each BCT. Multiple BCTs are under the control of the division, such that six to eight mental health providers (psychiatrists, psychologists, and social workers) can be assigned to a DMH activity. This new modular design yields more providers and allows for projection of resources to commanders at lower levels (i.e., battalion and company). During its second deployment to Iraq, the 3rd Infantry Division (3ID) was the first division to make the transition to the BCT structure and then deploy in that format.

The purpose of this first in a series of articles is to outline the role, approaches, and utilization of the 3ID DMH in preparation for and throughout deployment to Operation Iraqi Freedom during the period from January 2005 through January 2006. Preventive actions taken, DMH utilization, and lessons learned from the predeployment and deployment phases are discussed.

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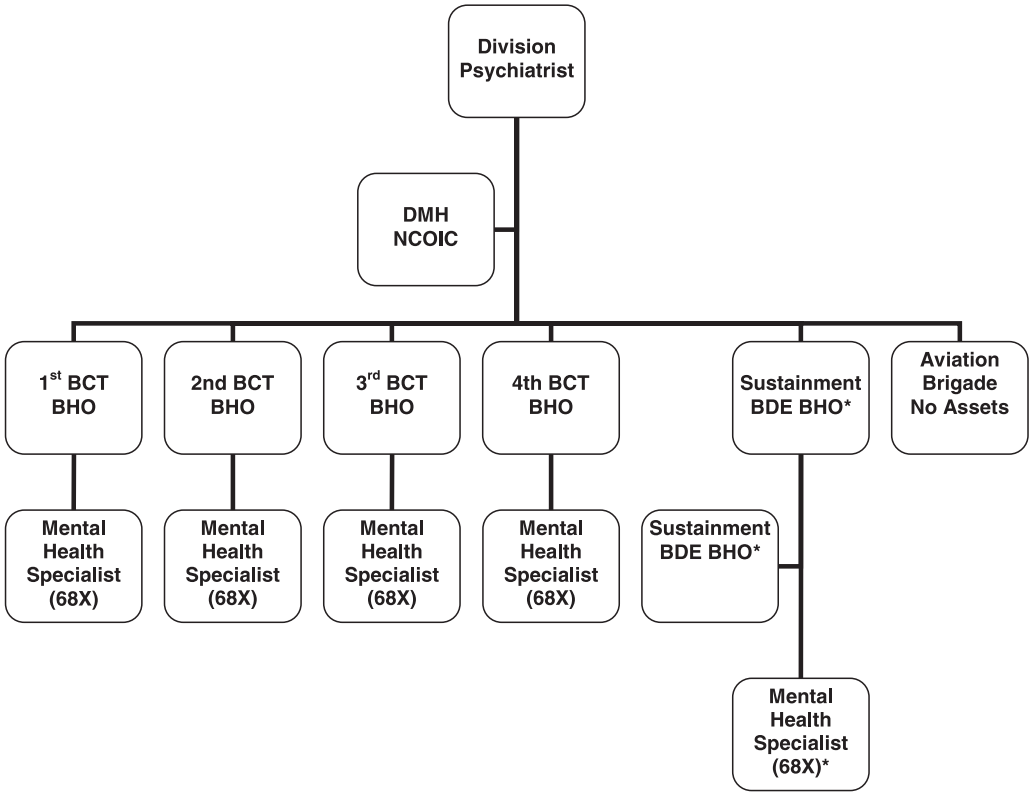

Fig. 1. Structure of DMH. BHO, behavioral health officer (psychologist or social worker); BDE, brigade; NCOIC, noncommissioned officer in charge. *, Positions filled only during time of deployment.

TABLE 1

MAJOR UNITS ASSIGNED TO TASK FORCE BAGHDAD IN 2005

Unit	Home Station
2nd BCT, 3ID	Fort Stewart, Georgia
4th BCT, 3ID	Fort Stewart, Georgia
3rd BCT, 1st Armored Division[a]	Fort Riley, Kansas
48th BCT[a]	Georgia National Guard
256th BCT[a]	Louisiana National Guard
1st BCT, 10th Mountain Division	Fort Drum, New York
2nd BCT, 101st Airborne Division	Fort Campbell, Kentucky
1st Battalion, 11th Armored Calvary Regiment[a]	Fort Irwin, California
42nd Military Police Brigade[a]	Fort Lewis, Georgia
36th Engineer Brigade[a]	Fort Benning, Georgia
Division Support Brigade, 3ID	Fort Stewart, Georgia
Combat Aviation Brigade, 3ID[a]	Hunter Army Airfield, Georgia; Fort Bragg, North Carolina; Fort Campbell, Kentucky

[a] Did not have behavioral health resources within the unit.

Methods

Predeployment Initiatives

Multiple initiatives were taken in the year before the deployment to make commanders more aware of the effects of combat and operational stress on combat effectiveness and to help decrease the stigma of seeking behavioral health care. Strong command emphasis encouraged soldiers to seek care and to maintain their readiness and effectiveness. Multiple educational briefings were conducted for senior and company-level leaders regarding the effects of stress on combat effectiveness. The senior psychiatrist on post facilitated a series of ongoing discussions with the brigade commanders about the behavioral health aspects of combat. Educational sessions were also conducted for family readiness group leaders, to help prepare upcoming family issues related to the deployment. The U.S. Military Academy Center for Enhanced Performance provided ongoing education for the leadership on how to mentally prepare for the challenges of deployment.

Task Force Baghdad

The 3ID deployed to Iraq as part of Task Force Baghdad in support of Operation Iraqi Freedom 3 during the period from January 2005 to January 2006. Task Force Baghdad was commanded by the 3ID commander and included the units outlined in Table I. Two of the 3ID brigades (1st BCT and 3rd BCT) were assigned to a different area of operation under the command of the 42nd Infantry Division. Task Force Baghdad consisted of 25,000 soldiers, on average, and reached a maximum of 50,000 soldiers during the deployment. 3ID DMH in Task Force Baghdad consisted of one psychiatrist, two social workers, two psychologists, and six mental health specialists from 3ID and two social workers and three mental health specialists from the 101st Airborne Division and 10th Mountain Division. In the middle of the deployment, some of these nonorganic elements redeployed and were replaced with elements from National Guard, reserve component, or XVIII Airborne Corps elements. Communication with non-3ID mental health providers was maintained to ensure adequate understanding of deployment

expectations, adequate supervision for nonlicensed providers, and appropriate distribution and use of mental health assets. Multiple other corps-level behavioral health assets supported Task Force Baghdad, including elements from an area support medical company, the 55th Combat Stress Detachment, the 883rd Combat Stress Detachment, and the 528th Combat Stress Detachment.

The predeployment plan was to locate the main DMH clinic with the division support brigade, to provide support to that brigade, the aviation brigade, and a maneuver brigade. Additionally, each maneuver brigade would have a satellite behavioral health clinic located with a troop medical clinic. Because many of the maneuver brigades were spread over multiple forward operating bases, each brigade clinician developed a coverage plan in conjunction with the local commanders, to ensure that behavioral health resources were available to all subordinate units. Throughout this deployment, the areas of operation remained relatively unchanged and units operated out of forward operating bases.

Deployment Mental Health Services

During deployment, Task Force Baghdad had an average population of 25,000 soldiers, with an average of one mental health provider per 3,100 soldiers. Mental health providers delivered prevention, treatment, and restoration services, with the majority of time spent in an acute care/treatment modality. Prevention missions included morale surveys, stress management groups, and command consultation. Treatments were focused on combat operational stress, using the forward psychiatry principles of proximity, immediacy, expectancy, and simplicity while returning to duty as many soldiers as possible.[3–5,7]

Throughout the deployment, the division commander placed a key emphasis on the importance of minimizing combat and operational stress and ensuring that soldiers received behavioral health care. He directed behavioral health to "establish a presence" in the environment and be actively involved with unit activities, missions, and events away from the behavioral health clinics. The division psychiatrist traveled on patrols and missions with the division commander, to view the terrain and the challenges presented to the soldiers. This action also reminded subordinate commanders of the emphasis placed on combat and operational stress control.

3ID DMH provided care to soldiers assigned to Task Force Baghdad, including U.S. and coalition forces. Services rendered included care for combat operational stress, brief supportive treatments, psychoeducational classes, critical incident debriefings, command consultative services, preventive evaluation and advisement, unit morale surveys, and pharmacologic treatment and monitoring. Medication management used predominantly antidepressant medications and sleep aids, monitored by either the division psychiatrist or a primary care physician deployed with the unit. Care and education were provided in clinics, classrooms, unit areas, walkabouts, and during combat support missions.

Debriefings after potentially traumatic events were conducted by using an integrated traumatic event management plan. DMH personnel met with combat stress control assets and chaplains to establish a plan for notifying the support personnel for each potentially traumatic event. The plan was provided to all brigade commanders, so that they could notify either the chaplain or the brigade behavioral health officer if they determined the need for support services. Chaplains/mental health providers would then be immediately available to greet involved soldiers upon return to the forward operating base, if desired by the command, to ensure that level I care ("buddy aid") was available to all involved parties, and to treat any initial stages of combat stress or shock. Information regarding the location and contact information for the chaplain and the behavioral health team was also provided to involved parties, and the command was encouraged to contact the support network to schedule a "debriefing" for parties directly involved in the incident, 36 to 72 hours after the event.

DMH conducted debriefings but not true critical incident stress debriefings, because the literature suggests that critical incident stress debriefings may prove harmful.[8] The voluntary debriefing most closely resembled an after-action review and was conducted by both chaplains and mental health representatives. The goals were to normalize experiences, to suggest actions/remedies for any troubling symptoms, and to offer contact information if additional services were desired. If the potentially traumatic event involved the death of a soldier, then the support team always attended the memorial service. Commanders could also use memorial services to consult with DMH personnel.

During Operation Iraqi Freedom 04–06, DMH had the opportunity to use a tracking system called the Surveillance of Combat and Operational Stress Reactions system, to help track both combat operation stress reactions and psychiatric disorders. Stress reaction contacts were defined as those related to deployment, and mental disorder contacts were defined as "disorders/issues that would occur in the absence of deployment." Tracking data from all DMH teams in Task Force Baghdad were submitted to the division psychiatrist and were then submitted to both the corps-level behavioral health consultant and the division surgeon's office in the disease non-battle injury report.

Throughout the deployment, record keeping was performed with paper charts. For providers not independently licensed in their fields, supervisors were required to travel frequently to provide required supervision.

Results

During the course of the 12-month deployment, DMH made >22,000 contacts with soldiers. The majority of the contacts were made either on a walkabout (seen outside of a clinic setting) or in a classroom setting. Of the 5,542 visits completed in a clinic setting, 3,888 (70.2%) were for combat operational stress reactions and 1,654 (29.8%) were for psychiatric disorders such as major depressive disorder (n = 553; 33.4%) or generalized anxiety disorder (n = 702; 42.4%). The top three factors accounting for combat operational stress were combat exposure (22.3%), peer/unit stressors (15.1%), and home-front stressors (35.2%). Figure 2 outlines the monthly distributions of psychiatric disorder and combat operational stress contacts. Figure 3 outlines the monthly distributions of the top three stressors.

Despite the large numbers seen, DMH contacts generally resulted in soldiers returning to duty. During the entire deploy-

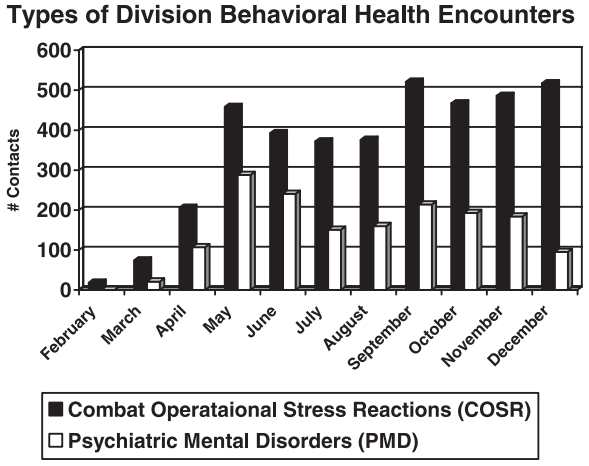

Fig. 2. Division behavioral health utilization for Task Force Baghdad 2005.

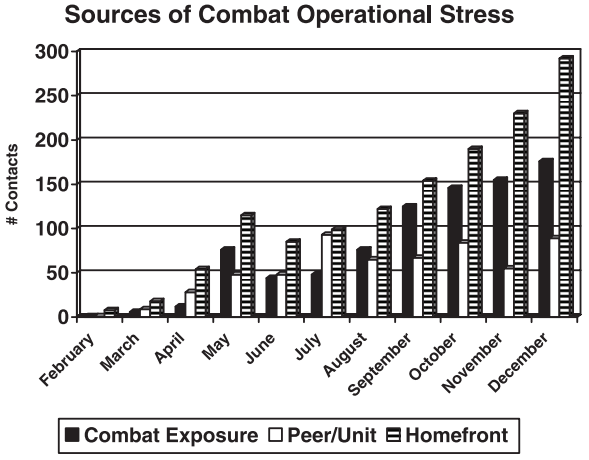

Fig. 3. Sources of combat operational stress for Task Force Baghdad 2005.

ment, only 95 soldiers (0.4% of the deployed force) were deemed nonormission capable. Nonormission-capable soldiers were placed on unit rest/unit watch, had their duties restricted, were sent to the restoration program, or were admitted to the combat support hospital. Of those 95 soldiers, 12 were eventually evacuated from theater. In all, there were 27 behavioral health evacuations from theater, or a rate of 0.1%. The other 15 patients were deemed unfit for continued deployment on their first evaluation by a mental health provider. The monthly determinations of nonmission-capable status and evacuations, along with theater death rates, are outlined in Figure 4.

Task Force Baghdad had five completed suicides during the deployment, for a rate of 20 cases per 100,000. This is similar to the suicide rate of 19.9 cases per 100,000 reported by Mental Health Advisory Team III for suicides in calendar year 2005 within the Operation Iraqi Freedom area.[9] The majority of the deaths involved first time-deployed, junior enlisted, Caucasian, unmarried men <30 years of age, with the cause of death listed as gunshot wound. None of those soldiers had been under mental health care or had known previous suicidal behaviors. The majority of the cases involved home-front/marital stressors. Unfortunately, no information was gathered about suicidal gestures/attempts in Task Force Baghdad.

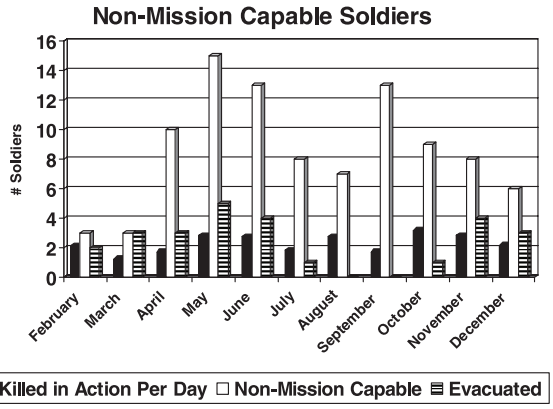

Fig. 4. Theater deaths, psychiatric nonormission-capable soldiers, and air evacuations for mental health reasons for Task Force Baghdad 2005.

Discussion

Challenges for coordinating behavioral health care began before DMH left the continental United States. Assets were realigned, with two BCTs from 3ID placed under the control of the 42nd Infantry Division and additional non-3ID units added to Task Force Baghdad. During predeployment preparation, several key tasks were identified. First, the new BCT format altered the command and control for each mental health provider and his or her team. Clearly defining the command and control and ensuring adequate logistical support from the BCT medical units were therefore challenges. Incorporating combat stress control elements into the Task Force Baghdad behavioral health coverage network presented an additional challenge, because those elements were under separate command and control. The colocation of many combat stress control elements at forward operating bases necessitated clear definition of combat stress control roles in prevention, treatment, and restoration.

The effectiveness of strong command support and the proactive presence of mental health providers in reducing the stigma of behavioral health care and in treating/preventing combat stress reactions is not clear. However, maintaining an active presence increased commanders' understanding of behavioral health issues and made resources more readily available to the soldiers.

The stability of the area of operations allowed for the establishment of permanent clinic facilities, a relatively consistent patient population, and continuity of care. Providers were able to perform short-term individual and group therapy, as well as medication management, near the front lines. An additional aspect of the mission was restoration. This included treating combat operational stress casualties in a controlled environment, typically one echelon of care higher than the brigade. The restoration efforts generally resulted in soldiers' return to duty; however, extended observation and lack of improvement sometimes resulted in a decision to evacuate the soldier from the theater of operations.

Tracking of behavioral health contacts facilitated examination of trends through the length of deployment and provided commanders with ongoing updates. In general, the distribution of overall behavioral health contacts increased throughout the period of deployment. Among soldiers seeking behavioral health care for psychiatric disorders, the distribution was bimodal,

with peaks in month 4 (May) and month 8 (September). Among soldiers seeking behavioral health care for combat/deployment stress issues, the distribution of contacts increased throughout the deployment, with notable peaks in month 4 (May) and month 8 (September). It is notable that stress reaction contacts continued to increase after September, with the highest levels seen in month 11 (December).

Prevention and proactive treatment of combat-related behavioral health issues requires knowledge of the trends and stressors a unit is facing. The top combat operational stressor for soldiers during deployment was home-front stress, marked by concern over deployment length and separation from family. In comparison with most past wars, soldiers had greater availability of communication with their families through telephone, electronic mail, and even video sessions on the Internet. Increased connectivity helped decrease some of the stress from separation but at times increased the stress for both the soldier and the family when problems/situations arose on either end. The second largest stressor for soldiers was combat experiences of receiving incoming artillery, rocket, or mortar fire; knowing someone seriously injured or killed; being near an improvised explosive device or booby trap explosion; receiving small arms fire; and/or having a member of their own unit become a casualty.

The rates of finding soldiers temporarily nonmission capable and air evacuation because of mental health problems partially paralleled U.S. soldier death rates throughout the period of the deployment. The rates of deaths attributable to improvised explosive devices increased from 13 in March 2005 to 35 in May 2005 and remained at the level of more than one death per day for the remainder of the deployment, with a peak of 59 deaths attributable to improvised explosive devices in October 2005.[10] Although not all of the deaths occurred in the Task Force Baghdad operating areas, the level of perceived threat among all soldiers in theater was likely elevated during this period.

Several key factors contributed to the success of DMH during the deployment. The relationships between the division commander and the division surgeon/division psychiatrist, along with the relationships the brigade behavioral health officers established with their BCT command staff members, were essential to the success of the DMH mission. Establishing these relationships was accomplished through attending command-level briefings, conducting unit needs assessments, conducting unit morale surveys, providing behavioral health command updates, participating in unit missions, and having an immediate presence after significant events. Establishing relationships with brigade- and battalion-level staff members and networking with chaplains, brigade surgeons, and command sergeants major were essential to mission success.

As always, there is room for improvement. In the future, we recommend using an electronic medical record system to allow for improved monitoring. Paper charts were cumbersome and allowed for extensive variation in the structure and content of clinical information. In addition, we recommend that, in the future, the Army not deploy providers without unrestricted licensure, to eliminate unnecessary travel for supervisors. Lastly, although the Task Force Baghdad suicide rate was not elevated over those of other areas or that of the U.S. Army, one suicide continues to be too many. We recommend increased theater suicide prevention training and improved monitoring of suicidal behaviors.

Conclusions

With the recent transition of the U.S. Army to a more brigade-centric structure, DMH has undergone a significant expansion and change in mission. 3ID was the first division to deploy in this new format. Predeployment education and communication probably eliminated some problems during deployment, and communication among mental health and command units during deployment resolved most problems encountered. Despite large numbers of contacts with mental health providers, the vast majority of all soldiers remained fit for the mission, and very few needed to be evacuated. As expected, the duration of the deployment and increased levels of threat later in the deployment resulted in increased stress problems, although not a substantial or sustained increase in mental health casualties.

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