Chapter 6

THE DIVISION PSYCHIATRIST AND BRIGADE BEHAVIORAL HEALTH OFFICERS

CHRISTOPHER H. WARNER, MD*; GEORGE N. APPENZELLER, MD†; TODD YOSICK, LISW‡; MATTHEW J. BARRY, DO§; ANTHONY J. MORTON, MD¥; JILL E. BREITBACH, PsyD¶; GABRIELLE BRYEN, MSW, LCSW**; ANGELA MOBBS, PsyD††; AMANDA ROBBINS, PsyD‡‡; JESSICA PARKER, PsyD§§; AND THOMAS GRIEGER, MD¥¥

*Major, Medical Corps, US Army; Chief, Department of Behavioral Medicine, Winn Army Community Hospital, Building 9242, Room 20, 1083 Worcester Drive, Fort Stewart, Georgia 31324; formerly, Division Psychiatrist, 3rd Infantry Division, Fort Stewart, Georgia

†Colonel, Medical Corps, US Army; Commander, US Army Medical Activity, Alaska, 1060 Gaffney Road #7400, Fort Wainwright, Alaska 99703-7400; formerly, Deputy Commander for Clinical Services, Command Group, Winn Army Community Hospital, Fort Stewart, Georgia 31314

‡Major, Medical Service Corps, US Army; Deputy Director, Resilience and Prevention Directorate, Office of the Assistant Secretary of Defense for Health Affairs, Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury, 1335 East-West Highway, Silver Spring, Maryland 20910; formerly, Chief, Battlemind Training Office/Chief, Combat and Operational Stress Control, AMEDD Center and School, Fort Sam Houston, Texas

§Major, Medical Corps, US Army Reserve; Staff Psychiatrist, Rochester Veterans Affairs Outpatient Clinic, 465 Westfall Road, Rochester, New York 14620; formerly, Major, Medical Corps, US Army; Chief of Psychiatric Service USA MEDDAC and 10th Mountain Division Psychiatrist, Fort Drum, New York

¥Major, Medical Corps, US Army; Medical Director, Department of Behavioral Health, Moncrief Army Community Hospital, 4500 Stuart Street, Fort Jackson, South Carolina 29207-5720; formerly, Division Psychiatrist, 1st Armored Division, Wiesbaden, Germany

¶Major, Medical Service Corps, US Army; Neuropsychologist, Department of Psychology, Evans Army Community Hospital, USAMEDDAC, Fort Carson, Colorado; formerly, Group Psychologist, 1st Special Warfare Training Group, Fort Bragg, North Carolina

**Major, Medical Service Corps, US Army; Deputy Chief, Department of Social Work, Womack Army Medical Center, Stop A, Fort Bragg, North Carolina 28310; formerly, Brigade Behavioral Health Officer, 3rd Brigade Combat Team, 4th Infantry Division, Fort Carson, Colorado 80913

††Special Forces Assignment and Selection Psychologist, Special Warfare Center and School, Rowe Training Facility, Building T-5167, 1500 Camp Mackall Place, Marston, North Carolina 28363; formerly, Brigade Psychologist, 3rd Brigade Combat Team, 3rd Infantry Division, Fort Benning, Georgia

‡‡Captain, Medical Service Corps, US Army; Brigade Combat Team Behavioral Health Officer, 4th Brigade Combat Team, 10th Mountain Division, Fort Polk, Louisiana 71459

§§Captain, Medical Service Corps, US Army; Chief, Warrior Restoration Center, Department of Behavioral Medicine, Winn Army Community Hospital, 541 East 9th Street, Building 359, Fort Stewart, Georgia 31314-5674; formerly, Psychology Resident, Traumatic Brain Injury, Brooke Army Medical Center, San Antonio, Texas

¥¥Captain (Retired), US Navy; Associate Professor, Department of Psychiatry, Uniformed Services University of the Health Sciences, 4301 Jones Bridge Road, Bethesda, Maryland 20814

A portion of this chapter has been published as: Warner CH, Breitbach JE, Appenzeller GN, Barry MJ, Morton A, Grieger T. The evolving role of the division psychiatrist. *Mil Med*. 2007;172:918–924.

INTRODUCTION

The psychological effects of warfare have been well documented throughout history, with names such as nostalgia, soldier's heart, shell shock, battle fatigue, and most recently, combat operational stress. In the late 19th and early 20th centuries, military leaders began to recognize the impact of treating and addressing these reactions. This led to an increased presence of mental health providers on the battlefield. Since World War I, the United States Army has been deploying mental health assets to the front line for treatment of combat operational stress and to advise unit commanders on mental health issues and the effect of war on soldiers.[1–3]

The first battlefield psychiatrist for the US Army was Dr Thomas Salmon. During World War I, he noted the value of maintaining a psychiatrist on the division staff who works directly with the surgeon to provide consultation, as well as the importance of the role as a staff officer for the command.[2] Salmon created a successful battlefield management system incorporating treatment, prevention, and consultation. Unfortunately, many of those lessons learned were lost or were deemed unnecessary after the end of the war. It was not until World War II that General Omar Bradley again realized the value of organic mental health assets during the North African campaign of 1943 and reestablished the division psychiatrist position.[3] Since the Korean War, the division psychiatrist has led the division mental health activity (DMHA), both in garrison and during deployment.[1,3] The roles and responsibilities for a division psychiatrist and the DMHA were first outlined in Army Regulation 40-216, *Neuropsychiatry and Mental Health*, in 1957.[4]

The division psychiatrist serves as the leader of the division mental health team whose mission is to assist command in controlling combat operational stress through training, consultation, and restoration.[5] Until recently, the DMHA consisted of three providers (a psychiatrist, a psychologist, and a social worker), complimented by six mental health technicians (Figure 6-1). However, in the midst of the global war on terror, the Army began its largest restructuring since World War II, changing the emphasis from the division to the brigade combat team (BCT).[6] This restructuring effort was designed to make the Army a more modular force, increase efficiency and combat power, and increase the number of BCTs within the force.[6]

In conjunction with the restructuring, there has been a reorganization and an increase in the behavioral health assets assigned to each division. The new force structure eliminated a formal centralized mental health section and created a modular DMHA. The new modular DMHA structure, outlined in Figure 6-2, includes a division psychiatrist and senior noncommissioned officer located with the division surgeon at the division headquarters unit, and a brigade behavioral health officer (BCT BHO; 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 five to six mental health providers (psychiatrists, psychologists, and social workers) can be assigned to a DMHA. This new, modular design yields more providers and allows for projection of resources to commanders at lower levels (ie, battalion and company). With this rapid expansion and evolution of the DMHA, the role of the military mental health provider

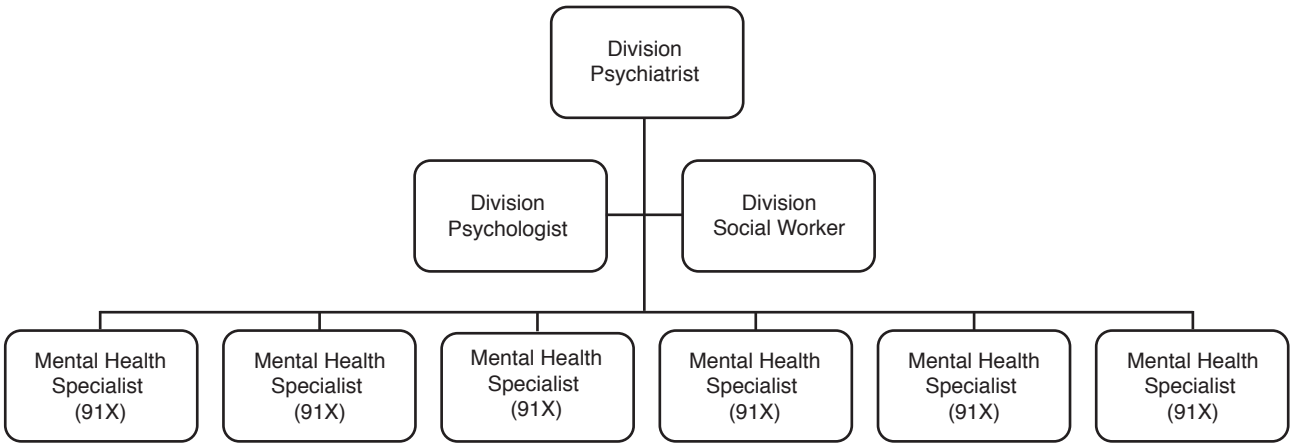

Figure 6-1. Prior structure of division mental health activity.

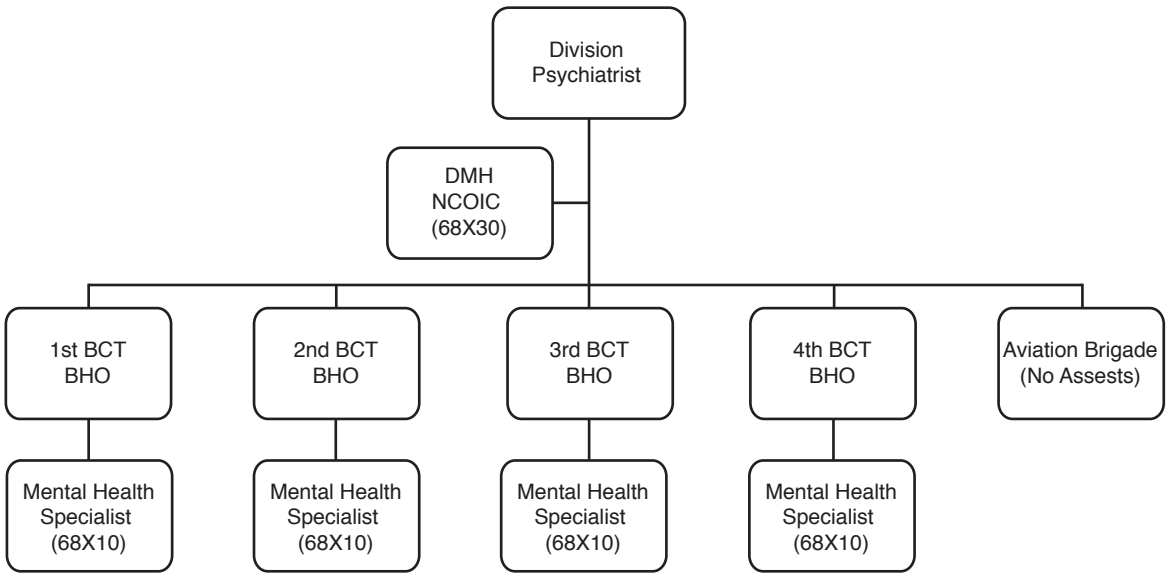

Figure 6-2. Current structure of division mental health activity in the modular Army.
BCT: brigade combat team
BHO: behavioral health officer (psychologist or social worker)
DMH: division mental health
NCOIC: noncommissioned officer in charge

has become more diverse and multifaceted.

The complex effects of combat on soldiers in modern warfare demonstrate the importance of combat and operational stress control during deployment and the need to monitor mental health issues following deployment.[7–11] This has led to recent updates in US Army doctrine, though, unfortunately, little guidance on the specific roles of division mental health has been provided.[12] The purpose of this chapter is to outline the role and utilization of the division psychiatrist and the BCT BHO in both the division and in the DMHA as defined by current military doctrine and based on the more than 10 combined years of deployment experience of the authors.

DOCTRINE

Although much has been published on the psychological consequences of combat and deployment, little has been published on the specific roles of the division psychiatrists, DMHA, or BCT BHOs in garrison or during deployment.[13–20] Army Regulation 40-216, *Neuropsychiatry and Mental Health*, the primary regulation associated with mental healthcare, has not been updated since 1984 and cites only that the division psychiatrist will lead the DMHA, serve as a consultant on neuropsychiatric issues, and in conjunction with the DMHA, provide care to soldiers with neuropsychiatric conditions.[4] Field Manual 8-51, *Combat Stress Control in a Theater of Operations: Tactics, Techniques, and Procedures,* was released in 1994 and updated in 1998.[5] It provided an outline of the overall mission and role of the DMHA and gave some additional insight into the roles and responsibilities of the division psychiatrist as a supervisor. This guidance was recently updated to outline combat and operational stress control (COSC) in Field Manual 4-02.51, *Combat and Operational Stress Control,* but provides little guidance on the operation of a DMHA or on the roles and responsibilities of a division psychiatrist and the BCT BHO.[12]

Lieutenant Colonel Albert Glass defined in his chapter "Lessons Learned" from *Neuropsychiatry in World War II* the need to maintain a strong regiment of active duty psychiatrists, both in war and in peacetime, to manage the operational needs of the armed services. He argued that civilian psychiatric agencies were unable to meet the ongoing demands and maintain the operational preparedness that military psychiatry requires. He also reviewed the complexity of psychiatric diagnosis and screening/selection in wartime, as it effects conservation of the fighting force.[1] In *Combat Psychiatry*, Lieutenant Colonel Glass specifically discussed the role of "Psychiatry at the Division Level." This in-depth review outlined the specific principles for the evaluation, treatment, and

disposition of soldiers in a combat environment. Additionally this chapter provided historical data analysis from World War II.[21]

Rock and colleagues discussed the historical development of US Army mental health resources in *War Psychiatry*, in a chapter titled "US Army Combat Psychiatry." This chapter provides insight into changes that were made in doctrine and in the development of division mental health units from World War I through Vietnam. However, as Army mental healthcare evolved into the 1980s, it moved away from the roles of the divisional units and focused on the development of nonembedded combat stress control units.[3] Although both chapters are an excellent source of information on the historical development of military mental health systems and the treatment role of division-level behavioral health officers, they provide little guidance on other duties and responsibilities of these positions.

In 1993, two relevant articles were published in *Military Medicine*. In the first of these, Engel and Campbell addressed the challenges facing a division mental health unit. They discussed the minimal attention focused on their role while not deployed and noted the importance of ongoing preventive missions based on their lessons learned from deployment to Operation Desert Storm.[14] In the second of these, Ritchie and White outlined the guidelines for becoming a successful division psychiatrist, providing practical guidance for preparing psychiatrists who were relatively new to the military on effective means of interacting and engaging with infantry commanders. Additionally, the latter article outlined the various duties and responsibilities of the position including (in their listed order of importance): behavioral health provider, supervisor of other behavioral health providers, educator of division medical providers, administrative psychiatry, consultation to command, planning and oversight of the division mental health section, and serving as an officer in the division.[15] This guidance was recently revised by Hill, Lange, and Bacon. Their focus was on what psychiatry residents should do to prepare for assuming the role.[16] Although these two articles did not deal with the role of the division psychologist or the division social worker, they did outline some of the duties and responsibilities expected of a unit behavioral health leader.

During Operation Iraqi Freedom, Warner, Appenzeller, and colleagues published a group of articles in *Military Medicine* on the roles and responsibilities of division mental health units in the new brigade combat team structure. These articles provided a roadmap of prevention, early identification, and intervention methods for other DMHAs. Additionally, the authors cited several advantages to the new structure, including the increased ability to provide mental health services closer to the front line and the ability to interact and regularly serve as consultants to lower levels of command. Additionally, they noted several limitations of the new structure, including dispersed command and control, increased independence of each provider with decreased supervision, and an increased risk for provider burnout due to the smaller teams. Although there was some discussion about garrison actions required prior to the deployment and the role of the division psychiatrist while in garrison, these articles were predominantly focused on the deployed role.[20,22,23]

Expanding beyond the role of the division psychiatrist to include other mental health providers, *Military Psychiatry: Preparing for Peace in War* addresses the evolving interface between the behavioral health leader and command. Chapter 9 highlights the heightened value by command of services mental health officers offer via command consultation, including cross service consultation needs.[24] Also discussed, in Chapter 10, is the need for mental health providers in recognizing the stressors of those in leadership positions and offering support to build resilience of those in command.[25] Chapters 11 and 12 approach the training needs of mental health workers, emphasizing the value of field training exercises,[26] and proposes a two-part training model to assist medical personnel and command in recognizing combat stress concerns and how to effectively triage combat stress casualties.[27]

PERSPECTIVES ON THE POSITION

According to one division commander, the division psychiatrist and the DMHA are responsible for "maintaining a 'finger on the pulse' of the unit."[28] This guidance provides a global commander's intent to the DMHA, but interpretation and execution of that intent is subject to individual variability.

There are multiple perspectives to consider, as illustrated in Figure 6-3. Division psychiatrists rely on their own perspectives, but must be cognizant of the requirements and expectations of the division surgeon and division commander. Similarly, the BCT BHO must consider the expectations of the division psychiatrist, brigade surgeon, and brigade commander. Additionally, behavioral health providers' different training backgrounds may influence which areas they are both competent and confident to address. For instance, a BCT BHO who is a psychologist has different skill capabilities than a social worker. Despite these training differences, all providers bring their own experiences to the position, which also influences their scope and

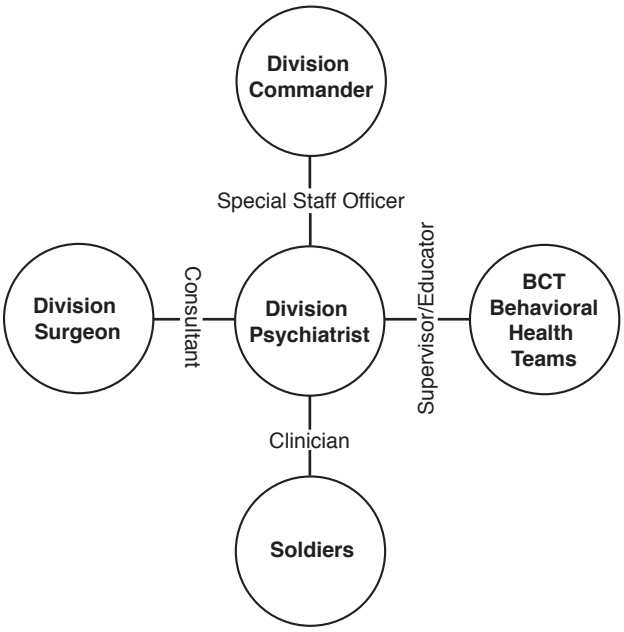

Figure 6-3. Perspectives on the position of the division psychiatrist.
BCT: brigade combat team

breadth of practice.

The division psychiatrist position tends to be assigned to junior officers following completion of their psychiatric residency or fellowship. Many enter the position as a company-grade officer (captain) and are promoted to field grade (major) while in the position. For many incoming division psychiatrists, this is their first opportunity to practice independently. Furthermore, few of the incoming division psychiatrists are familiar with the operation and function of a division staff and most have not attended their branch-specific career course.

Like the psychiatrist, the BCT BHO position tends to be assigned to a junior to mid-level officer. Many enter the position as a company-grade officer and some will be promoted to field grade while in the position. In the past, the psychologists would likely have just completed their internship training and have not done any other operational tour. However, that has changed recently with requirements for licensure for deployability. Currently, most psychologists have completed a 1- or 2-year postinternship tour prior to arriving to the BCT. For social workers, most have completed one tour, generally at a medical center working with a senior social work officer, and then are assigned to an operational billet. For many incoming BCT BHOs, this is their first opportunity to practice without a senior supervisor in their discipline. Like psychiatrists, few of the incoming BCT BHOs are familiar with the operation and function of a brigade staff, and most have not attended their branch-specific career course.

In keeping with their recent training program experience, both incoming division psychiatrists and BCT BHOs tend to focus on their roles as clinicians, and quite possibly, as educators for their enlisted mental health technicians and BCT primary care physicians. They may not rapidly embrace their roles as staff officers, advisors, and consultants to the division or brigade leadership or comprehend how these roles affect care for soldiers. In some instances, division psychiatrists have relinquished their leadership and administrative responsibilities to a brigade BHO to increase time available for their own clinical work. Similarly, for many BHOs, this is their first experience integrating with a line combat unit. The BHO must quickly adjust to training and operation tempo requirements that are expected in these units.

In contrast, division and brigade surgeons expect BHOs to act as advisors and consultants. They envision the psychiatrist or BCT BHO providing assistance in planning for the behavioral health aspects of the entire spectrum of operations and coordinating behavioral health support resources for garrison and deployed activities. They expect their behavioral health consultant to be able to identify the behavioral health threats to the units and make recommendations on preventive mechanisms for the division or brigade. They further expect the BHO to be familiar with the Army Medical Department (AMEDD) principles of treatment, evacuation, and restoration in theater. This includes arranging transportation, coordinating care for evacuated soldiers, and patient tracking.

Additionally, the division psychiatrist expects the BCT BHO to serve as both an advisor and a clinician. In many cases, BCTs are not collocated with their divisions, and division psychiatrists rely on the BCT BHOs to advise them on behavioral health issues that occur within the brigade. Furthermore, they expect the BCT BHO to be the primary provider of behavioral healthcare within the units and to be responsible for evaluating soldiers' behavioral health fitness for duty. Further requirements include training and developing the enlisted mental health technicians and consulting with BCT medical and command personnel.

Both division and brigade commanders expect their staff officers to be able to provide expert advice and alternative courses of action to enable them to make educated decisions in the best interest of the unit. Many commanders see BHOs as an important part of the division or BCT medical team and expect them to be experienced in analyzing behavioral health trends and their potential impacts on unit readiness.

In general, commanders have become very attuned to the behavioral health effects of combat and

deployment on their soldiers and look to the unit BHO to provide expert consultation on what they, as commanders, can do to mitigate the inherent stress of deployment, ensure proper surveillance of mental health issues upon redeployment, reduce the stigma of seeking care, and help their soldiers.

***Case Study 6-1**:* During one recent deployment, a division commander told his division psychiatrist that he was "concerned about the mental health of my unit and I want my commanders to know that we as a unit have the resources, ability, and concern to do something to help them." He frequently had the division psychiatrist travel with him throughout the theater of operations to ensure that the behavioral health team was aware of the various conditions soldiers were encountering but also for the subordinate commanders to see the importance that he placed on soldier behavioral health. The division psychiatrist was able to get a "finger on the pulse" of the units that they were visiting, identify the potential risks for combat and operational stress within the unit, and provide the commanders with recommendations on how to mitigate those risks.

These various duties, responsibilities, expectations, and external pressures on unit behavioral health officers pose a formidable challenge for relatively junior officers to properly prioritize their duties. In this setting, optimal performance will be achieved through proper professional development and updated doctrine.

DUTIES AND RESPONSIBILITIES

There are several areas of responsibility of particular importance to these junior officers. These will be discussed in this chapter; a comprehensive listing of the multiple duties and responsibilities of the unit BHO can be found in Exhibit 6-1.

Planning and Oversight for Behavioral Healthcare

The division psychiatrist or BCT BHO is the unit's subject matter expert on the behavioral health effects of combat and other deployments. Therefore, it is imperative that the division psychiatrist or BCT BHO serve as a staff officer within the division or brigade leadership to provide recommendations on the positioning and utilization of behavioral health resources, both in garrison and during deployment.

Prior to deployment the division psychiatrist is responsible for developing and implementing training programs for primary care providers, nonmedical officers, and noncommissioned officers. Training should focus on prevention and management of operational stress and other mental health problems that may be encountered during deployment.

During deployment, it is the responsibility of the division psychiatrist and the BCT BHO to assess the behavioral health threat of the environment and work closely with the command surgeon to review how behavioral health assets are being deployed and utilized within the operational environment. Sources of information include historical data from prior conflicts both in the unit and for that area, rates of combat stress in other units deployed to the conflict, rates of behavioral health issues in the unit in garrison, and effects of psychological profiles related to combat on the fighting strength. The division psychiatrists or BCT BHOs can make recommendations to their respective commands on where to position and how to implement the behavioral resources within the unit. Furthermore, the division psychiatrist should develop standard operating procedures for division mental healthcare, create traumatic event management plans, and provide guidance on the utilization of the Unit Behavioral Health Needs Assessment or other unit evaluation tools. Additionally, it is imperative to coordinate with external assets such as combat stress control units when they are positioned within the area of operations.

Key concepts to be considered when planning the distribution of resources are safety, security, and a close proximity to the units at greatest risk for combat operational stress reactions. This not only involves the division psychiatrist, but also the BCT BHO who must develop plans for allowing outreach from a primary clinic location to extend throughout the unit area of operations that requires logistical support.

Also of significance is the monitoring of, and guidance on, the use of psychotropic medications within the division and brigade, an area that has come under recent public scrutiny. The division psychiatrist needs to work with the medical logistic assets to determine which medications should be used in the area of operations and should help set guidelines for indications, use, and monitoring of psychotropics within the division. In general, use of antidepressants and mild sleep aids is common practice. Use of other psychotropics such as benzodiazepines, stimulants, and antipsychotics should be considered on a case-by-case basis and warrant increased vigilance. This topic is covered in great depth in Chapter 10, Psychiatric Medications in Military Operations, in this volume.

Although BCT BHOs are not credentialed to prescribe medication, they need to be aware of the utilization of psychotropics and their effects on the soldiers within the unit. The BCT BHO needs to work closely

EXHIBIT 6-1

DUTIES AND RESPONSIBILITIES OF THE UNIT BEHAVIORAL HEALTH OFFICER

Planning/Oversight for Division Mental Healthcare

- Plans and coordinates pre- and postdeployment mental health screening
- Provides recommendations on positioning of division mental health assets in garrison and deployment
- Develops division traumatic event management plan
- Consults with combat stress detachment (CSC) commander on placement of resources within division area during deployment
- Monitors and provides guidance on use of psychotropic medications
  - Determines which medications medical logistical personnel need to have on hand during deployments
  - Knows that use of antidepressants and mild sleep aids is common practice; use of other psychotropic medications such as benzodiazepines, stimulants, and antipsychotics should be considered on a case-by-case basis and based on current guidance from higher levels
- Liaisons with other support resources in garrison and during deployment
  - Consults with garrison medical treatment facility, Army Substance Abuse Program, chaplains, Army Community Services, Military OneSource, and local civilian mental health providers and hospitals
  - Works with deployment chaplains, combat stress detachments, and medical providers

Consultant to Commanders and Division Surgeon on Behavioral Health Trends/Issues

- Coordinates behavioral health prevention efforts
  - Provides routine consultative updates on behavioral health threats through monitoring of utilization rates of the division mental health clinic, behavioral health hospitalization rates, child/spouse abuse cases, DUI reports, positive drug test results, and pre- and postdeployment health assessment results
  - Oversees standardized Army Battlemind training for development of mental resiliency of soldiers, spouses, and their families
- Prepares for potentially traumatic events
  - Works with commanders, chaplains, and other medical personnel to develop a unit traumatic event management plan for addressing potentially traumatic events
- Monitors issues of public attention
  - Educates the commander about current ongoing issues of mental health significance and advises commander about potential mental health impacts of varying policy/strategic changes
  - Provides commander with information updates and potential questions/answers for media encounters about mental health prevention and ongoing issues within the unit

Supervisor of BCT Behavioral Health Officers and Enlisted Mental Health Specialists

- Serves as the officer in charge of division mental health
- Establishes the standard of care for practice within the division mental health activity (should be published in some format and reviewed on a regular basis)
- Supervises all BCT behavioral health officers
  - Conducts frequent supervision and chart reviews
  - Ensures that BCT behavioral health officers are adequately supervising their enlisted mental health technicians
- Manages continuing education
  - Develops a continuing education plan for each provider including local training (morning reports, routine training) and other opportunities (combat operational stress course, behavioral health short course)
  - Ensures that all providers are obtaining necessary continuing education requirements and completing necessary tasks for licensure, etc
- Officer and noncommissioned officer development
  - Ensures that all personnel are working towards advancement and achieving necessary requirement to include schooling (captain's career course, NCO Academy) and civilian schooling
  - Serves as a rater for all of the behavioral health officers

Educator of Division Medical Providers

- Ensures that all medical providers are educated about most recent practices in recognition and management of:
  - Posttraumatic stress disorder

(**Exhibit 6-1** *continues*)

Exhibit 6-1 *continued*

- Sleep disorders
- Depression and anxiety
- Psychiatric emergencies
- Traumatic event management
- Use of psychotropic medications during deployment

Clinician
- Serves as a direct provider both in garrison and during deployment
- Understands that care is generally limited to medication management because of limited resources

Administrative Psychiatry
- Performs command-directed evaluations
  - Knows that guidance is provided in Department of Defense Directive 6490.1 and Department of Defense Instruction 6490.4; (can be ordered by the commander or required by Army regulation)
- Performs security clearance evaluations
- Performs forensic exams (sanity boards)
- Writes medical evaluation boards (MEBs)
- Writes Army suicide evaluation reports (ASERs)

Officer and Leader in the Division
- Maintains personal readiness
- Serves as a leader and example for junior officers and enlisted soldiers

ASER: Army suicide evaluation report
BCT: brigade combat team
DUI: driving under the influence
MEB: medical evaluation board
NCO: noncommissioned officer

with the division psychiatrist, BCT providers, and the medical logistic assets as they determine which medications should be used in the area of operations, and know the guidelines for indications, use, and monitoring of psychotropics within the division.

Additionally, the unit behavioral health officer must consider other potential operational activities that might require behavioral health participation, such as detainee operations and preventive training, as well as the soldier resiliency programs. A comprehensive, division level, planning and oversight program, spanning the entire deployment lifecycle, will identify unforeseen obstacles while ensuring that access to care is not impeded by faulty screening programs, unprepared clinical services, or inadequate personnel staffing. At the brigade level it is imperative that a comprehensive planning and oversight program, including brigade behavioral health standard operating procedures (SOPs), be developed within the guidelines of the divisional mental health SOPs.

Attention has been focused on pre- and postdeployment screening by the media and Government Accountability Office for several reasons. These include reports of soldiers being identified during screening but not receiving their consultations or treatment, as well as multiple studies of returning soldiers indicating that rates of reported deployment-related symptoms can increase with time after returning from deployment.[7,9,10,29,30] The responsibility for overseeing an effective screening program (that commanders fully endorse) falls to the division psychiatrist and the DMHA. These plans must focus on education, early identification, and prompt treatment. Additionally, education and coordination must be made with commanders to ameliorate the stigma associated with behavioral healthcare.

Lastly, both during deployment and in garrison, the division psychiatrist must coordinate between, and communicate with, ancillary resources available both within the unit, such as the chaplains and medical providers, and external to the unit. These latter resources include the department of behavioral medicine at the local medical treatment facility and representatives from Military OneSource, Army Community Service, the Army Substance Abuse Program, social work services, garrison chaplain services, and civilian community agencies. Coordination and discussion with these assets arms the psychiatrist with an array of resources

available for individual soldiers, families, units, and commanders. In general, for BCTs that are collocated with their division headquarters, the responsibility of coordinating with external resources should fall on the division psychiatrist. However, for BCTs that are in isolated locations, it is the responsibility of the BCT BHO to perform this coordination.

Provide Consultation to Commanders and Command Surgeons on Behavioral Health Trends and Issues

One of the vital roles of unit behavioral health officers is the consultation that they provide to commanders and medical staff. There are many areas on which the psychiatrist or BCT BHO can provide expert advice. Three major areas of concern are prevention, responding to critical events, and dealing with current public affairs issues.

Preventive advice involves prioritizing the threats that have been identified and making recommendations to the medical staff and command on measures to be taken and areas requiring command emphasis. This includes monitoring ongoing trends such as utilization rates of the DMHA, behavioral health hospitalization rates, child and spouse abuse cases, driving under the influence reports, positive drug test results, Army Substance Abuse Program utilization, and pre- and postdeployment health assessment results. Additionally, longitudinal analysis should be made over a significant time frame to visualize current trends and examine behavioral health indicators from current and previous deployments. The outcome of crucial, predictive information could help direct placement and utilization of the limited resources available. Monitoring of these trends should be a regular action and the command should be updated on a monthly basis, in consultation with the command surgeon.

Additionally, a mental health service utilization tracking system that includes the unit, diagnosis, and primary stressor to identify smaller organizational trends, such as at the battalion level, can provide commanders at all levels with valuable information and facilitate targeted interventions.

Case Study 6-2*:* During a recent deployment, one DMHA was monitoring unit behavioral health trends and noted a significant spike in combat operational stress in a particular battalion. This trend was reported to both the battalion and brigade commander shortly after it developed. The commander then was able to relate that information with safety officer reports of a recent increase in accidents, coupled with a noted decrease in combat effectiveness. This led to the commander switching areas of operation to "give the unit a break" and resulted in both a rapid improvement in combat effectiveness for both units and maintenance of the ongoing combat mission.

In addition to prevention, unit behavioral health officers can have a significant effect in response to potential traumatic events. Working with the unit chaplains, medical resources, and commanders, the division psychiatrist can advise and determine how to respond to deaths, nonbattle injuries, casualties, and other significant events within units. The unit behavioral health officer should develop a traumatic event management plan for advising commanders and responding to soldiers' needs after these occurrences. Being successful in this realm involves good communication, a knowledge and understanding of current medical literature, and good relationships with unit commanders and support resources.

Case Study 6-3*:* During a recent deployment, one DMHA established a formalized traumatic event management policy. This policy provided clear guidance to the unit commanders and support personnel on how to respond after a potential traumatic event, including contacting the unit mental health and ministry teams to conduct a unit assessment and perform a debriefing if necessary. Additionally, if required, the debriefing would be a joint venture by the behavioral health providers and the chaplains. Whereas during a prior deployment, many of the commanders or chaplains often wanted to conduct sessions immediately upon the return of the unit or conduct full critical incident stress debriefings (which may be harmful), this plan provided clear guidance on how to respond to potentially traumatic events and helped to reduce confusion within the unit.[31] In this case, it was imperative for the BHO to educate command on the importance of the timing and the type of debriefings to reduce potential negative outcomes for the soldiers.

Educating and advising commanders on current ongoing issues of public attention is of critical importance. For example, recent media reports have been critical of the military on such topics as the ability to identify and treat posttraumatic stress disorder and the use of psychotropic medications in combat settings.[30–33] Both the division psychiatrist and BCT BHOs must be aware of these ongoing issues through their own reading and attention. They should be able to advise the commander of any potential questions from media encounters. Identification of these potential topics is accomplished through various sources of information including the unit public affairs officer and review of critical incident reports and serious incident reports. Information can also be gathered from local and national newspaper reports about behavioral health issues in the military and via ongoing communication with the various behavioral health consultants, fellow division psychiatrists, and BCT BHOs about such re-

quests. Responses to media queries should always be coordinated through the unit public affairs officer.

Education of command and support staff can be conducted through various methods: e-mail updates, power-point educational briefings, or prepared commander talking points. The method is at the discretion of the commander and is dependent upon how he or she best processes information. A recommended method is to prepare written talking points in a question-and-answer type format with bulleted responses. It will provide commanders with the information in a succinct format while also preparing them for potential questions from the media.

Supervise the Brigade Combat Team Behavioral Health Officers and Enlisted Mental Health Technicians

The division psychiatrist establishes the standards of care and practices for all the behavioral health providers in the division. The BCT BHO further refines and applies those procedures to the brigade. This task requires the setting of the standards and monitoring practices through ongoing supervision and routine feedback for all BCT BHOs. This is generally done first through a written SOP. Certain taskings or reporting requirements might require a fragmentary order. Areas that require SOPs include operation of the division mental health clinic, record keeping procedures, and management of high-risk personnel. Additionally, the division psychiatrist should establish a supervision policy for chart review and routine feedback, generally conducted on a monthly basis, to all brigade behavioral health officers. For BCTs that are not collocated with the DMHA, it is important for the BCT BHO to obtain the division SOPs and augment them to fit the working environment of the BCT.

Enlisted mental health technicians require ongoing supervision by a licensed provider. Mental health technicians must be supervised at the time of every new soldier encounter and as needed during follow-up evaluations. The supervising provider should use the context of the soldier encounter to teach the enlisted mental health technician about such topics as interviewing techniques, the epidemiology of behavioral disorders, and common adverse medication effects.

Providing this supervision can be challenging with some divisions because not all of the personnel are located at the same installation. Additionally, it is imperative that this feedback and supervision continue throughout deployments, keeping in mind that with the new BCT structure it is likely that BCTs and behavioral health staff from outside the division will be joining the unit during deployment.

An additional responsibility for division psychiatrists is the provision of accruing continuing education for themselves, the BCT BHOs, and the mental health technicians. The BCT BHOs share this responsibility and should be closely involved in the training and education of their assigned technicians. This includes ensuring that there are ongoing training opportunities for educational advancement and access to teaching on the latest information and practices in combat operational stress management. How that is implemented is the responsibility of each division psychiatrist, but consideration can be given to morning reports, monthly training sessions, use of "sergeant's time" training, utilization of local medical treatment facility training, or sending personnel to training conferences or schools.

All behavioral health officers should be encouraged to attend the annual Army Behavioral Health Short Course. This opportunity ensures that behavioral health officers earn sufficient continuing education credits to maintain licensure and promotes professional development, while providing an opportunity for collegiality among officers who are dispersed around the globe. Additionally, all soldiers in the DMHA should attend the combat operational stress course prior to deployment because it provides the most current training on theater policies, lessons learned, and ongoing practices. It also provides an opportunity for teambuilding, predeployment planning, and SOP guidance for those deploying units that are not collocated in garrison.

Lastly, there is the responsibility, as a supervisor, to provide opportunities and advice for career development for BHOs and mental health technicians. This includes counseling soldiers on their duty performance and affording them opportunities to participate in required training, such as the AMEDD career course. Additionally, both the division psychiatrist and the BCT BHOs need to ensure that they develop the writing skills necessary for contributing to, or initiating, developmental counseling forms, officer evaluation reports, noncommissioned officer evaluation reports, and awards.

Educate Division Medical Providers

Because there is only one psychiatrist for a unit of approximately 20,000 soldiers who are, at times, spread over several locations, teaching the unit's primary care providers about key behavioral health issues is imperative, as well as a force multiplier. This can be done through a variety of teaching modalities; creativity is encouraged. Key topics to cover include

postdeployment stress, psychiatric emergencies, sleep management, posttraumatic stress disorder, traumatic event management, and depression. This education should include information on recognition, diagnostic evaluation, and pharmacologic management. Pharmacologically, providers should understand the indications for use, common side effects, drug interactions, monitoring requirements, and deployment considerations of each somatic intervention.

The BCT BHO should take responsibility for developing and incorporating this curriculum with the BCT surgeon for providers within the unit. This becomes most important in the deployed environment where the division psychiatrist may not be located close to the brigade. It is incumbent on both the division psychiatrist and the BCT BHO to plan for the continuing curriculum during all portions of the deployment cycle.

Provide Direct Care of Patients

As previously mentioned, the division psychiatrist functions as the senior behavioral health provider for the entire division. Due to other demands, direct clinical opportunities for the division psychiatrist will be limited, and will most often involve brief interventions and medication management. However, to retain skills and credibility, it is important that the psychiatrist continue to maintain practice both during deployment and in garrison.

In garrison the division psychiatrist will be a provider at the consolidated division mental health clinic. Where the division psychiatrist should be located during deployment has been an area of ongoing debate since World War I.[3] With enhanced battlefield communication capabilities offering accessibility to other widely dispersed mental health providers, placing division psychiatrists within the division surgeon section allows them to perform as staff officers and consultants to the command while also providing consultative advice on care, medication management, and other guidance throughout the division via telephonic, e-mail, and, when required, face-to-face evaluations. However, the division psychiatrist should frequently travel to remote sites to provide on-site care, supervision, consultation, guidance, and teaching. This practice not only ensures that the division psychiatrist has a clear understanding of conditions and potential problems throughout the division, but it also enhances visibility from all elements of the forward line units.

The BCT BHO functions as the primary behavioral health provider for the entire BCT. In garrison, BHOs should work in a combined DMHA clinic when possible to help share the workload. When not possible, they are encouraged to collocate with their BCT troop medical clinic because it allows them to maintain close contact with the commanders, medical providers, and soldiers in their units. During deployment, BCT BHOs will routinely locate with their brigade troop medical clinic, but are encouraged to develop close relationships with the combat stress control units supporting their units, which may include collocating clinics.

In both settings, BCT BHOs will be challenged to adapt their schedules and modalities of care, based on the demands of the unit. In general, opportunities for long-term therapy will be very rare. Most interventions will utilize psychoeducation and brief supportive, cognitive, or group therapy modalities.

Fulfill Administrative Psychiatry Requirements

Both the division psychiatrist and the BCT BHO have a large number of administrative responsibilities. Command-directed mental health evaluations are defined in Department of Defense Instructions 6490.4[34] and Directive 6490.1,[35] which outline rules for both command-directed discretionary and nondiscretionary referrals. Nondiscretionary evaluations are those required by regulation, including drill sergeant, recruiter, and sniper evaluations. Additionally, all soldiers undergoing certain administrative ("chapter") separations require mental status evaluations. However, when commanders request evaluations for soldiers who do not require assessment by regulation, they use their discretionary authority to request assessment and feedback. In turn, the qualified unit behavioral health officer provides commanders with feedback and recommendations about their soldiers.

When performing a command-directed evaluation, the evaluator should provide the commander with a formal report of mental status (Department of the Army Form 3822-R, Medical Command Form 699-R) outlining feedback and recommendations. At a minimum, the report should address whether or not a diagnosis exists, a prognosis for the soldier's condition, any duty limitations, review of soldier safety and any safety interventions required, and the soldier's fitness for duty. Regulations require that the commander receive that report no later than 24 hours after completion of the evaluation.

Additionally, BCT BHOs must be familiar with the restrictions that their level of professional degree places on their ability to perform and sign command-directed evaluations. In general, non-PhD social workers are able to perform and sign nondiscretionary evaluations. Discretionary evaluations and those recommending a Chapter 5-13 (personality disorder) or a Chapter 5-17 (failure to adapt) discharge require

a PhD-level social worker, or a psychologist, or a psychiatrist. Psychologists who are BCT BHOs are able to perform and sign all forms required for command-directed evaluations.

BCT BHOs who are non-PhD–level social workers should develop contingency plans with their colleagues for performing discretionary command-directed evaluations either in garrison or during deployment. During deployment, this may require coordination with combat stress detachment assets in the area of operations. Additionally, if no psychologists or psychiatrists are available, then a physician (preferably the brigade surgeon) may serve as the signing authority.

At times, military mental health providers may perceive pressure to recommend use of these chapter separations as opposed to a fitness for duty and disability evaluation. This pressure often comes from the patient, the unit, or both who are primarily trying to expedite a rapid exit from the military for varying reasons. These chapter separations are often more expedient, requiring less paperwork and fewer levels of review. However, soldiers who are chapter separated are not afforded medical disability benefits and may reenter military service as early as 6 months after discharge. It is imperative that the military mental health provider conduct a thorough evaluation and ensure appropriate disposition as defined by the current military regulations. It is also important for the service member to understand the meaning and consequences of the evaluation and rationale for separation. This will ensure the best care for the patient, the military, and the society that the soldier may be returning to upon discharge from the military.

In addition, there are a number of other administrative requirements. These include security evaluations for unit soldiers applying for clearance, sanity boards and other forensic psychiatry evaluations when ordered by the courts, and medical evaluation boards when indicated for disposition through medical channels. These assessments all require that the evaluator be either a psychiatrist or psychologist. Lastly, unit behavioral health officers may be asked to perform line-of-duty investigations for those involved in events with unfortunate outcomes, and the Department of Defense suicide event reports when soldiers either make a suicidal gesture or attempt, or complete a suicide. These evaluations can be time consuming, but must be performed expeditiously because they provide commanders and the Army with important information.

Be an Officer and Leader in the Division

Lastly, all BHOs must remember that they are officers in the unit. The Army combat uniform does not display branch insignia; hence, it is imperative that as officers, the division psychiatrists or the BCT BHOs set the standard. They must ensure that they maintain personal readiness and weapons qualification, actively participate in physical training, and attend all functions. It can also be expected that they assume additional taskings; it is their responsibility to perform those duties to the utmost of their ability.

CHALLENGES OF THE POSITION

Balancing the duties and responsibilities of being a division psychiatrist or BCT BHO can be very challenging. There are several other factors that confront those in this position. First, division psychiatrists tend to be junior in rank to other division staff officers. With the recent Modified Table of Organization and Equipment (MTOE) adjustments, the division psychiatrist serves on the staff of the division surgeon (a lieutenant colonel) and works directly with several of the division surgeon's deputies (majors). Additionally, the majority of the officers who directly advise the commanding general are at field-grade level, while the division psychiatrist position has traditionally been filled by individuals shortly after residency who are still at the company-grade (captain) level. This makes it difficult for the individual to gain the trust of the key leaders and advisors. Furthermore, recent changes in assignments have introduced BHOs working for the BCTs who are senior in rank to the division psychiatrist, thus potentially placing psychiatrists in the position of supervising those who are senior to themselves.

The BCT BHO, in turn, serves as a direct advisor to the BCT commander and the BCT surgeon, but is not located within the same unit allocation as those individuals. With the recent MTOE adjustments, the BCT BHO is assigned to the medical company in the brigade support battalion, while the BCT surgeon is assigned to the BCT headquarters unit. This can be very difficult because company and battalion commanders may feel that the BCT BHO "works for them." They may attempt to restrict BHO and enlisted mental health technicians' access to the DMHA and the BCT commander without clearing information through them first. It is the responsibility of the BCT BHOs to work out agreements with their company and battalion commanders about places of duty, interaction with command staff, and required unit activities. BCT

BHOs are reminded to maintain appropriate bearing throughout these interactions and seek the assistance of their division psychiatrists and their BCT surgeons if they are having difficulty.

Access to the enlisted mental health technicians, both in a deployed and garrison environment, can be problematic. This may need to be addressed by the brigade surgeon, the support planning officer, or the division psychiatrist if the BCT BHO is having trouble gaining full use of the mental health technician.

Another challenge is that the BCT BHO works with the BCT surgeon to directly advise the BCT commander about behavioral health issues, but tends to be more junior than other BCT staff officers. In general, both the BCT surgeon and the BCT BHO are junior to mid-level captains or junior majors, while most of the BCT commander's deputies are mid-level to senior majors or other field-grade officers. Being more junior in experience, especially in the operational arena, makes it difficult for the individual to gain the trust of the key leaders and advisors. This requires the BCT BHOs to demonstrate respect, learn about the mission, and develop an understanding of unit capabilities. They must also rapidly adapt to the needs and demands of the BCT commander's staff for updates and information dispersal.

Additionally, both the division psychiatrist and the BCT BHO have to coordinate with other behavioral health resources within the area. While in garrison, the division psychiatrist needs to coordinate resources and the flow of information with the Medical Department activity, medical center, or the local civilian hospitals. This can be difficult at times because many in the hospital positions will not understand the full scope of the division-level BHO's duties and responsibilities. It is possible that they might request that a division psychiatrist, BCT BHO, or enlisted mental health technician work at the local facility and share duty responsibilities. There are no guidelines or specifics on this. Therefore, all such requests should be coordinated locally with the supervising command surgeon.

During deployment, similar coordination will be required. There is potential that a BCT can be spread over a large area through many small forward operating bases, making it difficult for the BCTs limited assets to respond to all of the behavioral health needs. It may be difficult to coordinate with corps-level behavioral health assets for coverage, which will depend on their commanders' opinions on the optimal emplacement of behavioral health resources. In these situations it is vital to have a theater behavioral health consultant who can address these issues.

Another consideration is that, currently, several of the divisions are spread over multiple sites while in garrison. In such situations, it is difficult to both gauge the climate and establish a channel of communication between the BCT BHO and the division psychiatrist. This can create a gap in information flow within the DMHA and can leave a BCT BHO feeling unsupported by the rest of the DMHA. Such a deficiency can persist, and even flourish, during deployment because communications can be unreliable in theater and BCTs may deploy under a different division command than they are assigned to in garrison. It is vital for both the division psychiatrist and the BCT BHO to maintain open communication lines for continued visibility and comprehension of the trends and activities in the units. This provides for continuity of ongoing unit initiatives.

In the theater of operations, assuming unanticipated roles, such as mental health consultant for detainee operations, may present another challenge. In most cases, detainee operations have designated mental health attachments; however, should this service require support of the division psychiatrist, review of local policy, current Army regulations, and Department of Defense guidelines is critical. Comprehensive reference documents would include Army Regulation 190-8, *Enemy Prisoners of War, Retained Personnel, Civilian Internees, and Other Detainees,* and Annex F of the *Mental Health Advisory Team (MHAT) II Report*.[36,37] These, along with current guidance from the US Army surgeon general, can assist the division psychiatrist in ensuring ethical mental healthcare of detainees.

Other stressors in the garrison environment are finances and personnel. The DMHA clinic may be "owned" by the division, where there is little emphasis on workload capture or compensation. Or, as is the case at Fort Drum, New York, DMHA may fold into a larger behavioral health department. Regardless of the specific arrangement, clear boundaries and working agreements must be established between the various organizations to address budgetary, logistical, maintenance, operational, and personnel issues.

There are several possible personnel issues that should be considered. First, in garrison the division resources are limited, as only the maneuver brigades are equipped with BHOs. Units such as the sustainment brigade and combat aviation brigade require support from both division and nondivision resources. Furthermore, it has not been uncommon for BCTs to be missing their full complement of personnel in garrison. This may result in BCT BHOs providing care coverage for soldiers from other brigades at the DMHA clinic or a BCT BHO arriving to the unit shortly before a deployment. During deployment, the division is likely to add BCTs, bringing additional providers who have been working under a different DMHA. It falls upon

the division psychiatrist to ensure that all behavioral health providers within the division are properly supervised and educated, and function under the same policies and standards of care.

Lastly, all BCT BHOs should expect to receive supervision, feedback, and information from their division psychiatrist, including those who are not collocated with their divisions. However, under certain circumstances, the BCT BHOs might need to seek supervision from their local Medical Department activity, such as when the division headquarters is deployed while the brigade remains in garrison.

FUTURE DIRECTIONS

With increased public awareness of the behavioral health effects of deployment and the shifting of the Army to a more modular force, the DMHA has many challenging roles. These roles involve a variety of duties and responsibilities that demand a clinically competent provider fluent in the art of multitasking and executive decision making. With the recent Army changes and the increase in size of the division mental health activity, it is imperative that capable, well-prepared psychiatrists, psychologists, and social workers are placed in these positions. With that in mind, several areas of discussion are provided for future consideration.

In the last two decades the US Army has shifted focus away from assets internal to the combat units toward placing emphasis on area support resources (combat support hospitals and combat operational stress control units), which provide coverage based on region rather than units.[3] Furthermore, the combat operational stress control units have larger, more diverse teams normally containing several psychiatrists, psychologists, social workers, and mental health specialists as well as occupational therapists and psychiatric nurses.[11] These units are then spread over a large area providing both preventive and restorative care, often with a centralized restoration center that can provide up to 2 weeks of care.[11]

Many of these units are called to active duty from the Army Reserve or from other branches of service. Few, if any, of these units have had any contact with the units in garrison and thus have not established consultative relationships with the commanders prior to the deployment. Therefore, they do not have the preestablished credibility necessary to provide effective education and consultation to commanders. The essence of this credibility is established in prior demonstration, to command, of the consultant's availability, utility of clinical skills and services, and perception that the consultant is not "investigating or blaming the unit for its problems."[34]

In addition, Department of Defense Directive 6490.5 states that each unit should have training, curricula, and guidance on combat operational stress control with a focus on primary, secondary, and tertiary prevention in garrison.[38] Combat operational stress control units are generally not available in garrison for teaching. Likewise, many medical treatment facilities are not currently capable of providing the primary and secondary prevention and training because of ongoing demands for treatment of soldiers and their family members. This role is, therefore, ideal for the division mental health team and allows for development of strong bonds with units and a sense of ownership among the behavioral teams in their units.

SUMMARY

Now, more than ever, the DMHA is critical. The new modular BCT structure projects mental health resources to lower levels and further toward the front lines. It also allows for development of long-term consultative and treatment relationships at the battalion and company level. This structure can also help to strengthen and emphasize pre- and postdeployment mental resiliency and medical provider training. Maintaining both division and combat stress control mental health resources in a collaborative working environment—where patient-specific issues and policy decisions are jointly determined—allows for continuity of training, education, consultation, and treatment during nondeployed times, with additional mental health resources available during a deployment. Similar lessons are being seen within the US Marine Corps and have led to the development of their Operational Stress Control and Readiness (OSCAR) program. Their program, like that of the US Army, increases the behavioral health resources within the units. That system is placing two psychiatrists within divisions, with one focusing toward the consultative and administrative aspects while the other is leading a multidisciplinary treatment team.

The position of division psychiatrist and BCT BHO presents many challenges, especially in the aspect of balancing responsibilities. The US Marine Corps is the only other US military service that embeds mental health assets with their soldiers and has recognized these same challenges. Because of the complexities

of staff, consultant, leadership, teaching, and clinical roles, future assignments to these positions should be based on knowledge, skills, and experience. Preferably, such individuals should be field-grade officers who have served at least one utilization tour after residency to gain experience as a practicing psychiatrist, and are graduates of the AMEDD career course. Additionally, as noted in the 5th iteration of the Mental Health Assessment Team's report, consideration should be given to expanding mental health resources within the divisions, including the addition of an enlisted mental health technician in each battalion and an aeromedically trained psychologist in each combat aviation brigade.

REFERENCES

1. Glass AJ. Lessons learned. In: Anderson RS, Glass AJ, Bernucci RJ, eds. *Neuropsychiatry in World War II. Vol I. Zone of the Interior.* Washington, DC: Government Printing Office; 1966: 735–759.

2. Bailey P, Williams FE, Komora PA, Salmon TW, Fenton N. *Neuropsychiatry.* In: *The Medical Department of the United States Army in the World War.* Washington, DC: Department of the Army, Office of The Surgeon General; 1929: 303–310.

3. Rock NL, Stokes JW, Koshes RJ, Fagan J, Cline WR, Jones FD. US Army combat psychiatry. In: Jones FD, Sparacino LR, Wilcox VL, Rothberg JM, Stokes JW, eds. *War Psychiatry.* In: Zajtchuk R, Bellamy RF, eds. *Textbooks of Military Medicine*. Washington, DC: Department of the Army, Office of The Surgeon General, Borden Institute; 1995: 149–175.

4. US Department of the Army. *Neuropsychiatry and Mental Health.* Washington, DC: DA; June 18, 1959. Army Regulation 40-216.

5. US Department of the Army. *Combat Stress Control in a Theater of Operations: Tactics, Techniques, and Procedures.* Washington, DC: HQDA; 1998. Field Manual 8-51, Change 1.

6. US Department of the Army. *2004 Army Transformation Roadmap*. Washington, DC: DA; July 2004.

7. Hoge CW, Castro CA, Messer SC, McGurk D, Cotting DI, Koffman RL. Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care. *N Eng J Med.* 2004;351:13–22.

8. Hoge CW, Auchterlonie JL, Milliken CS. Mental health problems, use of mental health services, and attrition from military service after returning from deployment to Iraq or Afghanistan. *JAMA.* 2006;295:1023–1032.

9. Southwick SM, Morgan CA 3rd, Darnell A, et al. Trauma-related symptoms in veterans of Operation Desert Storm: a 2-year follow-up. *Am J Psychiatry.* 1995;152:1150–1155.

10. Grieger TA, Cozza SJ, Ursano RJ, et al. Posttraumatic stress disorder and depression in battle-injured soldiers. *Am J Psychiatry.* 2006;163:1777–1783.

11. Appenzeller, GN, Warner CH, Grieger T. Postdeployment health reassessment: a sustainable method for brigade combat teams. *Mil Med*. 2007;172:1017–1023.

12. Department of the Army. *Combat and Operational Stress Control.* Washington, DC: DA; 2006. Field Manual 4-02.51.

13. Jones E, Palmer IP. Army psychiatry in the Korean War: the experience of 1 Commonwealth Division. *Mil Med.* 2000;165:256–260.

14. Engel CC, Campbell SJ. Revitalizing division mental health in garrison: a post-Desert Storm perspective. *Mil Med.* 1993;158:533–537.

15. Ritchie C, White R. Becoming a successful division psychiatrist: guidelines for preparation and duties of the assignment. *Mil Med.* 1993;158:644–648.

16. Hill JV, Lange C, Bacon B. Becoming a successful division psychiatrist: the sequel. *Mil Med.* 2007;172:364–369.

17. Leamon MH, Sutton LK, Lee RE. Graduate medical educators and infantry commanders: working together to train Army psychiatry residents. *Mil Med.* 1990;155:430–432.

18. Deeken MG, Newhouse PA, Belenky GL, Eshelman SD, Parker MT, Jones FD. Division psychiatrists in peacetime. *Mil Med*. 1985;150:455–457.

19. Noy S. Division-based psychiatry in intensive war situations: suggestions for improvement. *J R Army Med Corps*. 1982;128:105–116.

20. Warner CH, Appenzeller GN, Barry MJ, Morton A, Grieger T. The evolving role of the division psychiatrist. *Mil Med*. 2007;172:918–924.

21. Glass AJ. Psychiatry at the division level. In: Anderson RS, ed. *Combat Psychiatry: Experiences in the North African and Mediterranean Theaters of Operation, American Ground Forces, World War II*. Washington, DC: Government Printing Office; 1949: 45–73.

22. Warner CH, Breitbach JB, Appenzeller GN, Yates V, Grieger T, Webster WG. Division mental health in the new brigade combat team structure. Part I. Predeployment and deployment. *Mil Med*. 2007;172:907–911.

23. Warner CH, Breitbach JB, Appenzeller GN, Yates V, Grieger T, Webster WG. Division mental health in the new brigade combat team structure. Part II. Redeployment and postdeployment. *Mil Med*. 2007;172:912–917.

24. McCarroll JE, Jaccard JJ, Radke AQ. Psychiatric consultation to command. In: Jones FD, Sparacino LR, Wilcox VL, Rothberg JM, eds. *Military Psychiatry: Preparing for Peace for War*. In: Zajtchuk R, Bellamy RF, eds. *Textbook of Military Medicine*. Washington, DC: Department of the Army, Office of The Surgeon General, Borden Institute; 1994: 151–170.

25. Kirkland FR, Jackson MA. Psychiatric support for commanders. In: Jones FD, Sparacino LR, Wilcox VL, Rothberg JM, eds. *Military Psychiatry: Preparing for Peace for War*. In: Zajtchuk R, Bellamy RF, eds. *Textbook of Military Medicine*. Washington, DC: Department of the Army, Office of The Surgeon General, Borden Institute; 1994: 171–192.

26. Koshes RJ, Plewes JM, McCaughey BG, Stokes J. Educating mental health workers. In: Jones FD, Sparacino LR, Wilcox VL, Rothberg JM, eds. *Military Psychiatry: Preparing for Peace for War*. In: Zajtchuk R, Bellamy RF, eds. *Textbook of Military Medicine*. Washington, DC: Department of the Army, Office of The Surgeon General, Borden Institute; 1994: 193–213.

27. Lande RG. A model combat psychiatry training program for division personnel. In: Jones FD, Sparacino LR, Wilcox VL, Rothberg JM, eds. *Military Psychiatry: Preparing for Peace for War*. In: Zajtchuk R, Bellamy RF, eds. *Textbook of Military Medicine*. Washington, DC: Department of the Army, Office of The Surgeon General, Borden Institute; 1994: 215–226.

28. Major General WG Webster. Commander, Task Force Baghdad. Personal communication, September 17, 2005.

29. Government Accountability Office. *Post Traumatic Stress Disorder: DoD Needs to Identify the Factors Its Providers Use to Make Mental Health Evaluation Referrals for Servicemembers*. Washington, DC: GAO; May 2006: 1–34. Report No. GAO-06-397.

30. Milliken CS, Auchterlonie JL, Hoge CW. Longitudinal assessment of mental health problems among active and reserve component soldiers returning from the Iraq War. *JAMA*. 2007;298:2141–2148.

31. Jacobs J, Horne-Moyer HL, Jones R. The effectiveness of critical incident stress debriefing with primary and secondary trauma victims. *Int J Emerg Ment Health*. 2004;6:5–14.

32. Chedekel L, Kauffman M. Mentally Unfit, Forced to Fight. *Hartford Courant*. 2006, May 14, 2006. Available at: www.courant.com/news/nationworld/hc-unfit0515.artmay14,0,7374793.story. Accessed April 24, 2009.

33. Thompson M. America's medicated army. *Time*. June 5, 2008. Available at: www.time.com/time/nation/article/0,8599,1811858,00.html. Accessed April 24, 2009.

34. Department of Defense. *Requirements for Mental Health Evaluations of Members of the Armed Forces*. Washington, DC: DoD; August 28, 1998. DoD Instruction 6490.4.

35. Department of Defense. *Mental Health Evaluations of Members of the Armed Forces*. Washington, DC: DoD; October 1, 1997. DoD Directive 6490.1.

36. US Department of the Army. *Enemy Prisoners of War, Retained Personnel, Civilian Internees, and Other Detainees.* Washington, DC: DA; October 1, 1997. Army Regulation 190-8.

37. Mental Health Advisory Team (MHAT-II). *Operation Iraqi Freedom (OIF-II). Annex F: Internment Detainee Facility Assessment of Mental Health Advisory Team (MHAT) II. Report.* The US Army Surgeon General. January 30, 2005. Available at: www.armymedicine.army.mil/reports/mhat.html. Accessed September 4, 2008.

38. Department of Defense. *Combat Stress Control (CSC) Programs.* Washington, DC: Department of Defense; February 23,1999. DoD Directive 6490.5.