Appendix 1

PROVISION OF BEHAVIORAL HEALTH SERVICES DURING OPERATION IRAQI FREEDOM ONE

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INTRODUCTION

In 2003, the US Army deployed four different medical units with behavioral health assets during Operation Iraqi Freedom One (OIF I). Each of these units provided varying levels or echelons of healthcare throughout the war zone. A review of care echelons and each behavioral health unit is discussed later in this appendix. The primary mission of these behavioral health units was to provide evaluation and treatment for all behavioral health disorders and operational stress issues, in addition to administrative psychiatric support services. The structure of each unit and how it delivered its services varied markedly, depending on numerous factors, including the unit supported, location, command, logistic support, and assigned personnel. Behavioral health assets were located throughout Iraq at the combat stress control (CSC) detachment or company, division mental health section (DMHS), combat support hospital (CSH), and area support medical battalion/company. Of these different types of behavioral health assets, two are medical units (CSH and area support medical battalion), and two are assigned directly to the combat units (DMHS and CSC). The area support medical battalion/company's behavioral health capability was phased out in 2007 and will not be discussed in this appendix; also, the forward support medical company (FSMC), as part of the forward support medical battalion (FSMB), may have had behavioral health assets assigned to it but this organizational structure will be phased out. Only the CSC company and detachment, DMHS, and CSH will be discussed.

Although many other resources on medical topics and military operations exist, this appendix focuses on helping behavioral health providers understand the challenges identified during the conventional ground phase of OIF I (2003), amid highly uncertain conditions characteristic of the early stages of combat operations, as well as potential differences between behavioral health operations during future deployments or campaigns.

During peacetime, US Army physicians, nurses, medical administrators, and enlisted medical personnel primarily work in post hospitals and clinics. The aforementioned behavioral health units have key personnel assigned to them at all times to operate the unit in garrison. During war or contingency operations, these personnel may receive activation orders to augment medical units through the Army's Professional Officer Filler Information System (PROFIS). PROFIS assigns personnel working in hospitals and clinics to deploying Forces Command (FORSCOM) units.

The Army attempts to assign behavioral health officers (psychiatrists, psychologists, social workers, psychiatric nurses, occupational therapists, and behavioral health specialists [formerly military occupational specialty 91X, now 68X]) who are geographically located close to their PROFIS unit (in many cases the personnel are located on the same base as the unit), so these personnel can train or coordinate with the unit in garrison. However, some personnel assigned to units as PROFIS providers have duty stations hundreds (and in some cases thousands) of miles away from their FORSCOM unit's home station or garrison. In addition, Reserve component medical and behavioral health units also participated in OIF I, with some active duty PROFIS personnel augmentees filling Reserve vacancies.

Most PROFIS personnel who met the deployment challenge—coming together to comprise the treatment aspect of the medical and behavioral health units—had never met prior to deployment, in contrast to FORSCOM units (combat arms, combat support, and combat service support branches) that train for wartime missions continuously in garrison, and US Army medical branches that perform "real life" missions on a daily basis. However, moving into a battlefield setting to treat medical and behavioral health casualties presents different challenges, such as the logistics of patient care in the austere or hazardous environment, compared to the more complex and heavier case loads typically managed in garrison medical organizations. Despite the challenges, most professional personnel adapted to their new environment and completed the medical mission admirably.

ECHELONS OF TREATMENT IN THE COMBAT THEATER

Every behavioral health unit in a theater of combat operations provides different treatment options, increasing with the treatment echelon (level) of care. There are five echelons of care, with echelon 5 possessing the most comprehensive or definitive options (similar to a medical center in the continental United States [CONUS]) and echelon 1 composed of self-aid, aid from other unit members (buddy aid), and care from combat medics. As the echelon increases, so does the evaluation capability and medical care provided. In terms of behavioral health assets, each unit at the battalion level—echelon 1—was assigned an enlisted behavioral health specialist whose activities were coordinated by the DMHS.

Each behavioral health specialist is an enlisted soldier or noncommissioned officer (NCO) with varying degrees of experience in the diagnosis, treatment, and management of behavioral disorders. Starting at the brigade level—echelon 2—a CSC detachment (also assigned at corps or echelons-above-brigade [EAB] level) focuses on interventions to prevent combat operational stress response casualties through critical incident debriefings, stress management classes, "walk-about" marketing contacts, and some restoration/fitness programs resembling brief day-treatment programs, as well as providing conventional clinic-based behavioral health evaluation and treatment. Each brigade also has an organically assigned behavioral health officer—usually a psychologist or social worker—who may conduct evaluations of brigade soldiers or facilitate command liaisons with area CSC/CSH elements. Echelon 3 consists of CSC companies providing fitness or restoration units, the CSH (which is typically assigned at corps-level EAB), and the DMHS, if the theater organization utilizes conventional division structure instead of modular independent brigades. On a linear battlefield, echelons of care also show predictable positions relative to the forward line of troops, but a nonlinear battlefield obscures this relationship, with many behavioral health resources (units or detached slices/elements) located across large areas, such as a forward operating bases (FOBs) or logistic support areas (LSAs). However, some behavioral health resources may support small camps or outposts with small elements positioned locally or rotating out from FOBs, depending on local needs, resources, distances, transportation/logistics, and expected travel-related hazards.

Prior to wartime deployment, all units (augmented with their PROFIS personnel) complete tasks such as medical screening; legal documents (wills, powers of attorney); weapons qualification; training in unexploded ordinance; CBRNE (chemical, biological, radiological, nuclear, and explosive) hazards; and all other training required by unit readiness training matrices. PROFIS personnel join the unit for this specified "train-up" period to ensure they are familiar with the standard operating procedures, mission essential task list, and internal workings of the host unit. Many PROFIS personnel may lack prior experience with the specific unit or its chain of command and may never have met face-to-face with any of the unit's members. The exception is DMHS, which operates in garrison with most of the personnel required during deployment, but may be augmented with PROFIS personnel depending on wartime mission requirements.

Garrison division mental health personnel will need to train all the personnel within the behavioral health section with whom they will be deploying. At a minimum, this training should consist of setting up standard operating procedures related to evaluation, diagnosis, treatment, clinic management, and prevention techniques. The training also gives the unit leaders an assessment of each team member's technical proficiency and experience, and the extent to which that provider is able to function independently. Supervision may be required depending on training, licensure, and credentialing levels.

ARRIVING IN KUWAIT

Prior to entering Iraq, most units from OIF I landed in Kuwait at the SPOD/APOD (sea [for equipment]/aerial [for personnel] point of embarkation/debarkation). Many units had expected to arrive at another SPOD/APOD in Turkey and approach from the north but received last-minute redirection to the overcrowded Kuwait staging area due to diplomatic issues. From the APOD, most units moved to a "cabal," or tactical assembly area, where they reassembled their operating capability and prepositioned while awaiting movement north into Iraq. These cabals were small base camps with minimal infrastructure located in the remote Kuwaiti desert. The majority of OIF I soldiers then convoyed into Iraq from Kuwait, loaded into high mobility multipurpose wheeled vehicles (HMMWVs or Humvees), family of medium tactical vehicles (FMTVs) or the older M939 series 2.5 ("deuce-and-a-half") vehicles, and 5-ton trucks. These convoys often took up to 3 days to complete because anytime a vehicle broke down, the entire convoy waited until the vehicle was remobilized or recovered. Furthermore, early-phase convoys also contended with nearby combat or threatened engagement by Iraqi Army forces. Additionally, the early unit convoys faced challenges related to unlabeled and undeveloped routes through an unmapped country with minimal signage and many roads that were inadequate for large and heavy military vehicles. While some units possessed global-positioning-satellite capability, many navigated with uncertain means in a landscape with few reliable visual landmarks during a season where large dust storms could completely obstruct visibility and stifle breathing for extended periods (soldiers deploying to OIF now fly directly into Iraq via the nearest air strip to where they will assume mission responsibility).

Units typically resided in tents, although some moved into dirty, decrepit, abandoned masonry structures. Tent space became very limited in both Kuwait

and Iraq during OIF I; many personnel were fortunate to have 2 linear feet of space on either side of the cot on which they slept and stored all their gear. Many less-fortunate soldiers, especially in combat arms units, did not have either a cot or a tent and slept on the ground or on their vehicles, in extremely variable stifling heat or bitter cold. Overcrowded tents, stress, and close living proximity accelerated viral spread and increased the frequency of infectious illnesses. Anecdotally, the average weight loss per soldier during the first month was 5 to 10 lb; many infantry soldiers lost 20 to 40 lb during the conventional ground combat phase due to limited food consumption, along with irregular and continuous combat operations. However, most soldiers within these units adjusted physically and behaviorally, bonding into a cohesive team and unit. During this period, officers had to avoid complaining, especially around the enlisted soldiers, who tended to lose respect for officers they heard complaining. However, among some officers, complaining, mostly through humor, was a helpful way to vent frustration, improving overall officer morale, mood, and bonding.

The largest stressor in Kuwait was not the Scud missile alerts and subsequent donning of the mission-oriented protective posture (MOPP) 4 suits (thick, carbon-based chemical weapons protection suits), or joint-service lightweight integrated suit technology (JSLIST) equipment, but boredom coupled with overcrowding and the austere environment, which tended to fuel gossip behaviors and interpersonal conflicts. Additionally, soldiers experienced emotional stress from a perceived conspicuous absence of information on each unit's specific mission, leading to speculation on justifications for deployment, chain-of-command motives, and when each unit would actually move forward to begin operations in Iraq. In most cases, unit equipment arrived in port (SPOD) after unit personnel had been flown into the APOD, causing personnel to wait in the cabals for their equipment while residing in overcrowded tents with minimal infrastructure or recreational opportunities.

Units with responsive and competent commanders who fostered group cohesiveness and subordinate communication, keeping their soldiers busy with mission-focused operational training, appeared to have less disruptive drama and stress-related behavioral health issues or conduct problems. These leaders effectively implemented the primary preventive actions to control and reduce the stressors known to increase combat and operational stress reactions, validating the basic precepts of combat psychiatry, as per Field Manual (FM) 4-02.51 (formerly FM 8-51), *Combat and Operational Stress Control*.

Most soldiers seen by medical personnel on the cabals were not "emergent," but rather had interpersonal problems with supervisors, were homesick or had home-front problems, or did not adjust well to the high operation tempo the deployment could demand. The first two stressors (unit/command problems and home-front worries) emerged as the top two most common stressors of deployed service members, as shown in the first and subsequent Mental Health Advisory Team (MHAT) reports. Each cabal had a small clinic set up for seeing medical emergencies and sick call, but these battalion aid station equivalents did not have behavioral health assets unless augmented individually by providers in units temporarily assembling at a particular base.

Privacy became an issue while evaluating patients on the cabals because no structures approximating "clinical space" had been set up, nor was there a mechanism for medical recordkeeping. Despite this, commanders knew where the medical units were located on the cabals and sent their personnel to "walk in" for evaluations. Soldiers were often evaluated by medical personnel who sat down with them on the sand, in the shade of a vehicle or tent. Documentation remained an unresolved issue without any means of copying files, and no soldier had a medical record to review or document care. Most of the medical notes completed during OIF I were handwritten on SF600 forms, and soldiers typically lost these notes. Records kept at facilities would not follow soldiers through their care at different locations. The Armed Forces Health Longitudinal Technology Application (AHLTA) or the Composite Healthcare System (CHCS) electronic medical records did not become operational until later rotations (approximately 2006–2007). The role of the behavioral health professional on the cabal during OIF I was primarily evaluation to determine which soldiers were safe and could move north to Iraq and which soldiers needed to be evacuated from theater for further evaluation, treatment, or administrative separation. Some soldiers had unexpected panic responses to the MOPP-4 protective mask. This required either prompt successful desensitization (sometimes with benzodiazepine-induced relaxation) to learn to tolerate the mask or evacuation from theater. Behavioral health emergency patients had to join a convoy to the hospital in Kuwait, which was staffed by one psychiatrist.

COMBAT SUPPORT HOSPITALS

Two combat support hospitals—the 21st and 28th CSHs—were at cabals in Kuwait by March 2003, preparing to deploy their hospitals north to Iraq after initiation of the ground invasion. Because the 21st CSH

was an early Medical Reengineering Initiative (MRI) CSH, it did not have a neuropsychiatric group as the 28th CSH had. The primary mission of the new MRI CSH was to perform split operations in two locations, separating into two smaller hospitals, both capable of operating independently but with the same chain of command. Campaign evolution soon demonstrated the need for smaller hospital organizations that maintained similar capability levels but provided more geographically dispersed support, prompting the 28th CSH to perform a split operation as well, as did all subsequent CSH units. The lack of a neuropsychiatric group meant that the behavioral health section of the 21st CSH brought no equipment such as bedding, tentage, or cots, and only a limited number of behavioral health personnel: a psychiatrist, a psychiatric nurse, and two behavioral health specialists. In contrast, the 28th CSH had a psychiatrist, a social work officer, three psychiatric nurses, and approximately six enlisted behavioral health specialists. The 28th CSH did not operate a separate neuropsychiatric ward and planned to use only one or two beds from the medical–surgical ward to house psychiatric patients. They also did not plan to operate an outpatient clinic or behavioral health holding capability (resembling a fitness program at a CSC).

Once operations commenced, the number of psychiatrically hospitalized patients exceeded the number of medical patients on the ward. Additionally, units often packed a ground evacuation vehicle with soldiers requiring behavioral health evaluations. These convoys would go directly to the CSH, bypassing other echelons and flooding the CSH with outpatient evaluations. Some units also sought to "medicalize" the behavioral problems within their unit and send misconduct cases to the CSH for presumed evacuation instead of administering disciplinary action and initiating administrative returns. These numerous outpatient evaluations resulted in many soldiers who did not require hospitalization or evacuation but needed several days of observation before returning to duty. Furthermore, delays in transportation also increased needs for a holding requirement and some supervision by behavioral health staff.

Once the 21st CSH split, a professional provider and a behavioral health specialist went with each hospital slice. As an MRI CSH, the 21st was composed of three companies: A Company (CO), B CO, and Headquarters CO. As stated above, the primary mission of the new MRI CSH was to perform split operations so that one slice could set up and operate independently of the other. B CO left approximately 5 days before A CO in mid-April and was located in Mosul, Iraq, approximately 160 miles north of A CO, which was located on a large airfield in Balad, Iraq, about 40 miles north of Baghdad. The 28th CSH set up its main unit initially in Camp Dogwood, a patch of desert near Baghdad, and subsequently packed up the tent hospital to move into a fixed facility (Ibn Sina) in Baghdad, maintaining a smaller slice in Tikrit.

One of the earliest goals of the CSH was to set up the emergency room (ER) and operating rooms (ORs) within 48 hours or less to be ready to accept patients. Once this "main line" is set up, the remainder of the CSH is then built adjoining it. There is no set procedure on how or where to put clinics, wards, and so forth, so the hospital is usually arranged by the experience within the command. For example, the 21st CSH in Balad had a section of tents between the ER and the OR that acted as an "exchange," so patients could overflow if needed into this area. The exchange made coordination of patients easier for mass casualty events, air evacuation, and movement to and from the ER, OR, and radiology. The 21st CSH set up an outpatient clinic in addition to inpatient services. In this case, the psychiatrist worked in both settings seeing routine outpatients as well as inpatients usually admitted through the emergency room. The outpatient service was located in the "specialty clinic" area of the hospital in an "office" consisting of half of one of the sections in the eight-section tent, with a field desk and two chairs. The 28th CSH had a similar arrangement, except that the behavioral health "clinic" was located at the other end of the hospital tent complex, away from any other clinics and next to the chaplain's "office." The clinic space also consisted of a small tent section, with patient interviews often conducted in hallways during busy periods.

As soon as the 21st CSH arrived at Balad, behavioral health consultations began. Because the 21st was the first medical treatment facility on the base, the psychiatrist and behavioral health specialist quickly started seeing patients. Initially, behavioral health patients were seen on an outpatient basis because the hospital ran sick call for the base from the specialty clinic. Three fourths of the behavioral health referrals at sick call were sent by the chain of command to rule out danger to self or others. These were soldiers who had threatened to hurt themselves or others. The other 25% needed medication refills because they did not deploy with enough medication or were close to running out after being in Kuwait for several months before moving forward into Iraq. The 28th CSH saw a similar preponderance of danger evaluations and medication refills. Units also sent numerous evaluations for chapter separation, conscientious objection, or other administrative issues. Army Reserve and Army National Guard units seemed to have a disproportionate number of chapter evaluations, as the active duty deployment gave these Reserve units an

unanticipated opportunity to evaluate actual duty performance and separate those incapable of meeting mission requirements. However, the main active duty unit supported by the 28th CSH, the 3rd Infantry Division (ID), appeared to supply most of the malingering and misconduct cases seen at this CSH.

The 21st CSH pharmacy section deployed with a small supply of paroxetine and fluoxetine, but these drugs were quickly depleted within the first week after the hospital was set up. However, the CSH was collocated next to a medical logistics battalion that was able to coordinate future medication supplies. After 6 to 8 weeks, the pharmacy stocked up on oral medications, including several selective serotonin reuptake inhibitors, second-generation antidepressants, stimulants, atypical antipsychotics, benzodiazapines, and sleep medications. The 28th CSH pharmacy also deployed with a minimal supply of medications, forcing providers to dispense medications in 1-week increments to delay or minimize stock-outs, which still occurred. In contrast to the 21st CSH, the 28th CSH did not have logistics support and sustained operations with the limited drug supplies the psychiatrists personally carried into theater. In addition, behavioral health specialists from the 28th CSH who went to Landstuhl Regional Medical Center (LRMC) in Germany on medevac escort missions requested and obtained medication resupply from the psychiatrists there to bring back into theater. For future reference, any psychiatrist deploying to an immature theater should have a lockbox (or several) of medications and coordinate as soon as possible with the medical logistics battalion and pharmacist for resupply.

The dynamics of a deployed CSH were such that it took a physician with a great deal of military experience as well as an approachable, healthy personality to function as the deputy commander for clinical services (DCCS). The DCCS is particularly helpful in organizing the physicians into a tight-knit team. The DCCS acts as a buffer between providers and along the chain of command, engaging in the medical administrative battles to allow other physicians to focus on their medical mission, and to ensure that their junior rank did not result in others ignoring or overruling their expert recommendations based on rank alone. The DCCS also mentors junior medical officers by arranging training—military and nonmilitary—as well as normalizing the deployment experience.

Many referrals to the CSHs were soldiers requiring dispositions from outlying behavioral health units. Early in OIF I, if a soldier was evacuated to a hospital remote from the referring unit, that soldier usually ended up being evacuated out of theater to Kuwait and then to Germany. Discussing cases with commanders and behavioral health teams during the early phases of OIF I was often difficult due to limitations in communication lines, which were down at least half the time. It was also not uncommon for all convoys to be halted for several days at a time secondary to increased fighting. This frequent lack of any communication abilities with commands, via either telephone line or in person, discouraged providers, overburdened holding capabilities, and led to medical evacuation of soldiers who might otherwise have returned to duty. The division psychiatrist had multiple examples of soldiers being dropped off at the DMHS clinic for an evaluation, and the unit then convoyed for hours back to their assigned FOB prior to contacting the DMHS. Although most of these soldiers received fit-for-duty dispositions, they remained at the DMHS for several weeks because no one could contact their command, and it could take 2 weeks or so for the referring unit to convoy back and pick up the soldier. At the 21st CSH, providers usually admitted soldiers for observation and safety to the medical–surgical intermediate care ward (and later, the five-bed neuropsychiatric unit of the 28th CSH). However, a theater policy to admit patients to a CSH for no more than 7 days resulted in evacuations to a higher level of care where return to duty (RTD) became even more difficult and improbable. Most unit commanders supported providers who recommended patient evacuation, but on some occasions they objected to evacuation and wanted their soldiers returned to them. A chain-of-command representative (the commander, first sergeant, or senior NCO) then came to the CSH or CSC to pick up the soldier in person.

The 21st CSH did not have neuropsychiatry assets to establish an inpatient milieu; behavioral health patients admitted to this CSH did not have the benefit of a psychiatric ward setting with groups, confidentiality, or a multidisciplinary approach to treatment. However, the milieu remained very limited and public at the 28th CSH as well. Patients had a few groups run by psychiatric nurses but shared the ward with medical and surgical patients. Nursing care was generally delivered to these patients by a psychiatric nurse; however, medical and surgical nurses also contributed to nursing care of psychiatric patients due to staffing necessities. While some staff sought to increase privacy by hanging blankets as dividers around a psychiatric patient's bed, this effectively identified them as a psychiatric patients and increased interest in them when they stepped out from behind the hanging blanket. Open space anonymity provided better confidentiality because other patients would not know why another patient had been hospitalized.

Very few psychiatric cases evacuated from Iraq

returned to Iraq. Once soldiers were evacuated to the 47th CSH in Kuwait, the psychiatrist assigned to the 47th noted that:

> most soldiers sent to Kuwait markedly improve as they "move Westward" and most of what is sent here for air evacuation to Germany (Landstuhl Regional Medical Center) is not battle fatigue and not severe behavioral illness but rather a failure to adapt to the deployment due to occupational stress and problems back home. Because of this, more soldiers were sent back to their commands with recommendations for administrative separation. However, many were transported out of the theater on a medical evacuation because they were "conditionally suicidal" but we still recommend for a chapter separation.

Some behavioral health providers were unwilling to make the recommendation for a chapter separation. One of the psychologists in a reserve CSC unit stated, "I'm just not comfortable making a decision like that that will have such an impact on someone's life," meaning that this provider thought a separation would affect a soldier's career in civilian life. However, these administrative duties remain an integral part of the job for military behavioral health providers, either in garrison or on deployment. During OIF I, the chief of psychiatry at LRMC stated that, "it helps Landstuhl tremendously to have recommendations like these because these soldiers look fine when they get there and we don't get to see them when they are in Iraq, when they have mentally decompensated." Such was the case in the CSHs in Iraq when soldiers were sent for evaluation from smaller behavioral health units (DMHS, CSC, chaplain, behavioral health technicians) or battalion surgeons embedded within combat units. These soldiers usually improved quickly but also decompensated quickly when told they were being sent back to their unit. Providers at the CSH would then spend extensive time trying to reach the unit at a distant location for collateral information via primitive telephonic infrastructure to make the necessary determinations. Without collateral information providers would often not know the relevant conditions and observed behaviors of the soldier. However, some units became more available for discussion when they received notification from the patient administrative section or the CSH patient administrative section that their soldier was in RTD status and needed pick-up for transportation back to the unit.

As stated, the policy of the CSH was to evacuate any soldier admitted for more than 7 days. Usually, units off the base could not be reached in this period of time and these soldiers were sent to Germany via the 47th CSH in Kuwait. However, the 28th CSH accumulated a large holding population awaiting RTD, sometimes exceeding the 7-day hospitalization policy if RTD appeared probable. Extensive holding populations entailed some risk and caused some concern to the hospital command, but the command then used its resources and influence to achieve contact with the original unit and arrange transportation. Some of the psychiatric patients at 28th CSH needed evacuation and went to LRMC, which facilitated pharmacy resupply, as already discussed. However, these evacuations presented another issue as it typically took 2 to 3 weeks for a behavioral health specialist who escorted the patient to return to the CSH for routine duties. Sometimes the CSH sent other nursing personnel on these missions, but that depleted other sections of their nursing or enlisted medical personnel. The poor lines of communication to units and limited treatment options presented challenges that the CSH units handled differently; the 21st CSH usually evacuated these soldiers from theater, whereas the 28th CSH held them for RTD to prevent personnel depletion (at the CSH and sending unit). Early in OIF I, when commanders were able to locate their soldiers and call or visit the CSH to see how they were doing, the commanders were occasionally angry that they had "lost" their soldiers to the medical evacuation system. Getting soldiers to agree to commit themselves to maintaining personal safety and return to their units was sometimes very difficult with only supportive therapy and "three hots and a cot," especially if the soldier had the expectation of release from theater.

Soldiers' mood and affect usually brightened when they were away from the stress of their unit; had some rest, a shower, and three meals; and were in an air-conditioned hospital. Many soldiers evaluated in this setting stated they had joined the Army for "college money" and "never thought [they] would deploy"; they often acted out when told they were going back to their units. This situation became an ethical dilemma for psychiatrists sending soldiers back to combat knowing they might be killed, injured, or deteriorate behaviorally, but these issues applied to any soldier ordered into a combat environment.

After the end of the major combat offensive, roughly the end of April 2003, it was not considered very dangerous for units to convoy to hospitals or clinics, although sporadic attacks with small arms and rocket-propelled grenades continued. However, after the insurgency became more organized, these ground convoys decreased in frequency as improvised explosive devices (IEDs) hidden around roadways became the primary weapon against coalition forces. Camps received regular mortar (indirect) fire after early July 2003, and the roadside IEDs and rocket indirect fire

attacks also increased dramatically. For example, the Balad (Arabic for "in the country or countryside") airfield (aka Camp Anaconda), a huge, sprawling airbase of many square miles, received multiple mortar attacks from July 3 to September 26, 2003. Most of these mortar attacks occurred in the quadrant of the base containing the CSH.

Commanders reported difficulty in referring soldiers to DMHS or CSC units where they would normally have been seen for evaluation and treatment. Because CSHs were located on large LSAs, units brought their soldiers to the CSHs when they convoyed to the LSA to pick up supplies. A very small percentage of cases seen involved florid psychosis or mania; most referrals were lower-ranking enlisted personnel with adjustment disorders. However, the behavioral, logistical, and combat stressors of OIF I affected all ranks and branches. For example the psychiatrist of the 21st CSH evacuated two aviators due to panic attacks and anxiety that affected their flying, caused in each case by "brown out" situations (caused by sand and dust from the rotor wash during landings). This resulted in such significant anxiety about future recurrences that it impaired overall mission capability. Other cases were more serious and involved stress confronted by higher level commanders.

Case Study A1-1: A 40-year-old combat arms battalion commander with 19 years active duty presented as a self-referral for worsening depressed mood with suicidal thoughts to shoot himself in the head with his 9-mm pistol. His brigade commander described him as "the strongest and most reliable battalion commander in the brigade." His depression centered on the lack of control he felt over the lives of his troopers and the lack of training his men had been given for "extra duties" such as security and patrols. While on a patrol two of his soldiers had been killed by insurgents. After admission to the hospital for 5 days followed by 3 weeks of outpatient treatment consisting of counseling and medication, his mood and suicidal thoughts continued to worsen. He was evacuated from theater for more intensive treatment. In follow-up, he was noted to be doing well and still on active duty.

Another factor that led to referrals to behavioral health was the guilt associated with killing enemy combatants or the sheer terror of seeing friends killed by insurgent attacks. Many soldiers did not confront these stressors until seen by a behavioral health provider. Many would break into tears when asked the simple question of whether or not they had killed anyone in combat. Another common source of guilt came (correctly or incorrectly) from whether one's actions or inactions led to a negative outcome for a friend, civilian noncombatant, or fellow soldier.

Case Study A1-2: A 22-year-old enlisted soldier presented to the CSH, referred by his unit for depressed and psychotic symptoms. He blamed himself for the death of his commander. His commander had reached up to catch a line that was falling on top of the Bradley fighting vehicle that the commander was on top of. It electrocuted the commander. The presenting soldier had been the gunner but was inside the vehicle at the time of the electrocution. He felt guilty and demonstrated severe depression with psychotic features, hearing voices telling him he was a "poor soldier" and that he "should have done something to help his commander," with whom he had a good working relationship. In reality, there was nothing he could have done to save his commander, yet he believed it was his fault that his commander died. Traumatic event management with the soldier and unit proved helpful in this case, and his psychotic symptoms improved significantly with an antidepressant and low-dose atypical antipsychotic medication, allowing him to return to duty.

One behavioral health unit referred a soldier to the CSH for medevac to LRMC for a "sleep study to rule out sleepwalking." While conceptually it was easy to send this soldier back to the unit for observation, the increase in mortar and rocket attacks made his return more complicated and potentially hazardous. The provider admitted this soldier instead, observing him at the CSH before sending him back to his unit. In most cases, sleepwalking referrals were returned to the unit after brief medical work-up to avoid an epidemic of sleepwalking "evacuation syndrome" in these units.

During the period in late 2003 when insurgent attacks increased, word began to spread that most units would remain deployed for a year rather than the 6 months many had expected. From May to June 2003, there were six suspected cases of self-inflicted gunshot wounds to the foot seen at the 21st CSH in Balad and several at the 28th CSH at Camp Dogwood. The psychiatrist at the 21st consulted for the surgical team to evaluate one of these cases that appeared suspicious.

Case Study A1-3: An orthopaedic surgeon consulted psychiatry to evaluate an enlisted soldier in his mid-20s to determine whether the soldier's injury was accidental or self-inflicted, and to assess the soldier's risk of self-harm. The soldier stated that he shot his foot by accident. During the initial evaluation he reported depressed mood "ever since I've been deployed," and noted that he wanted to go home. He also complained of having interpersonal problems with his chain of command. He reported poor sleep, guilt about the deployment, anergia, and poor concentration since being deployed. He denied having these symptoms prior to deployment and felt they would "go away if he were home." He expressed surprise that the orthopaedic surgeon would send him back to duty, even though his foot had a clean injury without any fractures. He commented that, "I might as well shoot myself intentionally in order to leave if I have go back there." The provider also noted that during the initial evaluation the soldier stated that his first concern

was where he would be "sent from here," expecting "that it would be Germany."

Initial psychiatric evaluation recommended that after sufficient orthopaedic recovery, he follow up with a CSC unit near his unit duty location with a stress management group. In the following days, his unit started a line-of-duty investigation, which contributed to his stress. The hospital chaplain then consulted psychiatry 3 days later when the soldier hinted that he would display violent behavior if he returned to the unit. When questioned about suicide or homicide, he stated, "I don't know what will happen if I go back to my unit." He still insisted that the initial incident was an accident. He denied pulling the trigger and could not come up with a reason for the weapon discharging. Ten days after the second evaluation, his chain of command contacted the hospital and informed the medical team that they wanted to court-martial the soldier. However, the line-of-duty investigation remained incomplete and would take 2 to 3 more weeks to complete. The CSH informed the unit that the soldier's foot had healed sufficiently for discharge from the hospital, but because of the unit's remote location and lack of medical facilities to change his foot dressings, he would need air evacuation to LRMC in Germany. When the soldier learned of this decision, his affect and mood brightened to euthymic and he reported, "I expected that." He appeared happy that he would be getting out of the Army, stating, "Any way is good." He reported feeling "glad that I'm not going back to my unit with a loaded weapon."

After the soldier had been at the CSH for approximately 6 weeks, due to the nature of his injury, the line-of-duty investigation, and the poor communication with his unit, he was sent to Kuwait for evacuation to Germany. However, his unit intercepted him in Kuwait and told him he was returning to Iraq for a court-martial, at which point it required several personnel to restrain him. He was nonetheless eventually evacuated from Kuwait to an Army hospital in Germany due to his combative behavior.

From June to July 2003, a suicide cluster occurred, with each case likely having had multiple contributing factors, but ultimately leading each individual to feel hopelessness and intolerable depression. These soldiers may have felt trapped in a situation with no clear departure or end date (unprecedented in this generation of deployed soldiers). Additionally, all soldiers carried their weapons and ammunition at all times. Added deployment stressors were the following: separation from family and loved ones; receiving "dear John/Jane" letters ending relationships; no lines of communication home; threat of being killed or injured; high temperatures; perceived harassment from chain of command; and poor sleep, latrines, hygiene, and food. Behavioral health planners and commanders discussed relocating the 113th CSC fitness teams from Mosul and Baghdad to the 21st CSH in Balad to start a neuropsychiatric unit after these suicides. This collocation never occurred, but a CSC fitness or restoration unit should collocate with an MRI CSH to share resources, treatment, and evaluation of soldiers, since the post-MRI CSH has limited behavioral health assets. (This arrangement worked very well during subsequent deployment rotations observed in the authors' subsequent deployments, including the 1908th CSC and 10th CSH in 2006 in Baghdad, and the 47th CSH and the 528th CSC at COB Speicher, in 2009.) Such collocation could improve RTD rates, as well as reduce evacuations from theater. At the 21st CSH in Mosul, the 98th CSC ran an outpatient clinic next to the hospital with two CSC psychiatrists (who admitted patients to the hospital if needed), a social worker, and five behavioral health specialists.

COMBAT STRESS CONTROL UNITS

The US Army's behavioral health community has long recognized the impact of acute and chronic stressors, as well as traumatic events, on the functioning of individual soldiers and military units. The Army currently maintains two types of CSC units: (1) CSC companies and (2) CSC detachments. The former are primarily staffed by reservists and contain 80 personnel of various disciplines, including psychiatrists, psychologists, psychiatric social workers, psychiatric advanced practice nurses, general psychiatric nurses, a medical-surgical nurse, numerous psychiatric technicians, and administrative support staff (eg, a cook, mechanics, and so forth), so they can function as self-sustaining units in a deployed environment. The active duty component CSC detachments grew 50% larger after the introduction of MRI units and are approximately half the size of a CSC company, but with fewer psychiatrists. Also, they do not contain the same mix of personnel as pre-MRI units or CSC companies.

CSC units are designated primarily as units tasked to perform preventative activities. As such, personnel in a CSC usually are configured into teams, known as prevention teams, consisting of one professional and two paraprofessionals (behavioral health specialists). These teams are usually assigned to specific units for which they provide primary and secondary prevention for combat-stress–related issues. Specifically, these teams present psychoeducational briefings focusing on suicide prevention, stress management, identification of combat fatigue or depression, and briefings preparing soldiers to reconnect with their families near the end of their deployment. At the beginning of OIF, military doctrine recommended critical event debriefing as the preferred intervention for traumatic events experienced by groups of soldiers. However, concurrent studies, both in the military and in civilian

settings, questioned the efficacy of these critical event debriefings.

Even more important to the practitioner, some studies reported that critical event debriefings had the potential to actually harm some participants, possibly through reexperiencing the trauma or by overwhelming the psychological defense mechanisms that had otherwise been allowing the soldier to manage the trauma without intervention. Furthermore, many providers had not attended courses certifying proficiency in conducting critical event debriefings. These factors contributed to a wide variation in the utilization of the debriefings and the consistency of responses to potentially traumatizing events. The military behavioral health community had previously promoted the utility of critical event debriefing to Army leaders during the years leading up to OIF, which resulted in commanders requesting a debriefing for their soldiers anytime any adverse event happened. The following case study describes some of the issues involved in this process.

Case Study A1-4: A military chaplain phoned a local CSC unit after a fire had broken out in a hangar that served as the "barracks" for a military unit. The chaplain said that the unit's commander had requested a critical event debriefing. The chaplain asked for the assistance of the CSC unit inasmuch as the chaplain was inexperienced in performing such a debriefing and because the large unit would require multiple group debriefings (debriefings are usually limited to 20 people).

The consulted behavioral health officer evaluated the situation and determined that no one's life had been threatened by the fire, only property was lost, and that finding new housing was the unit's most immediate concern. The CSC staff discussed the situation with the chain of command and decided that instead of critical event debriefings (where everyone participated in groups discussing their experience, both factual and emotional), they would take a different approach with this particular event. This approach consisted of a meeting with the whole unit at once. The unit's commander spoke first to reassure his unit that new housing was in process and expected imminently. Furthermore, the Army would help the soldiers replace items lost in the fire. The behavioral health staff then gave an educational briefing about stress management and coping skills to the assembled soldiers along with specific contact information if any soldier wanted individual meetings.

Adaptive doctrine allows these CSC teams more flexibility to evaluate and treat soldiers with combat fatigue and behavioral health disorders. The teams also engage in traumatic event management and critical event debriefings, providing evaluation and appropriate intervention for involved units. The teams provide consultation to military commanders, both in ways to help the whole unit prevent combat-stress–related dysfunction and also by performing command-directed behavioral health evaluations on individuals when commanders are concerned about their safety and reliability. Finally, the teams provide assessment and treatment for soldiers who self-refer for evaluation of their own distress.

These functions require that the prevention teams live with units and travel within the operational area of the units for which they provide support services. Due to the travel hazards in the evolving Iraqi theater and in any nonlinear battlefield, routine travel plans decreased somewhat during OIF I. These prevention teams are "assigned" to cover the unit, but are not actually organic to the unit, so living and integrating with the host unit becomes imperative to develop trust from the unit's leaders and soldiers. Without developing these strong relationships, including being perceived as available and "useful" to the commander and soldiers, a prevention team would not accomplish its defined mission; not due to lack of skill or personnel, but due to an inability to earn credibility and trust with their customers. Without the credibility, barriers inevitably arise and limit the prevention team's access to the soldiers who need their care.

Despite the task of prevention and the doctrinal mission of psychoeducation classes, this pivotal underlying mission of relationship-building conveys a similarity with marketing functions. Although philosophically debatable, a unit's referral rate from the first sergeant or sergeant major provides a useful practical indirect metric of a prevention team's effectiveness, as these NCO leaders keep their fingers on the metaphorical pulse of the unit and will only refer when their skeptical trust has been earned. Some CSC units sought to justify their existence by optimistically counting social and coincidental contacts as "prevention" (marketing) contacts to report as statistics, but these contacts provide minimal actual care. Genuine individual or small-group sessions, usually with credentialed providers, not initiated by CSC staff, constitute substantive care and adverse outcome prevention.

In contrast to the established doctrine promoting team travel, some observations provide insights requiring diligent consideration to optimally balance benefits with costs. Travel tended to increase breadth of contact, but greatly decreased the depth of intervention. Soldiers needing behavioral health services tend to get directed to nearby behavioral health components perceived as helpful and competent, and whose personnel accumulate into provider panels. These panels quickly evaporate when disrupted by travel, as soldiers move on instead of establishing a perceived new relationship with another provider. Command elements directing behavioral health activities often do not appreciate the

differences inherent in behavioral health relationships and expect a comparable portability from behavioral health as they might expect from other medical providers, such as sick call or dental or surgical services. New locations established after travel rarely yield a client/patient panel to match the size of the panel at the previous location.

Professional providers practicing in the best interest of beneficiaries maintain some degree of skepticism towards disruptive relocations that do not appear warranted or logical on clinical grounds. Directed activities may serve as perceived requirements or even a beneficial bullet in someone's reports or evaluations that actually detracts from collective soldier care. For example, an author questioned an ill-advised tasking that appeared more politically motivated than care-driven because the decision makers did not permit any merit discussion or consult actual subject matter experts. This particular tasking decimated a robust panel at a large base with ten to twelve substantive appointments per day while yielding two to three appointments per day after relocation. After returning in 8 weeks, the panel required another 8 to 12 weeks of rebuilding before approaching its previous productivity level.

CSC units also had a second type of function—restoration—with the restoration (formerly known as fitness) team. This team had more personnel assigned and usually operated from a stationary location, unlike the prevention teams. In addition to providing marketing activities similar to those provided by prevention teams, the restoration team also served as a treatment alternative for the prevention teams, commanders, or other nonbehavioral health providers, for soldiers who needed an evaluation and may have benefited from a spectrum of intervention activities ranging from prescriptions with interval aftercare to an intensive outpatient/partial hospitalization program equivalent to daytime groups and self-care quarters. By doctrine (specifically FM 4-02.51), restoration teams were meant to provide a stable place, somewhat removed from the front lines, where a soldier could be "restored" through the basic principles of the acronym BICEPS (brevity, immediacy, contact, expectancy, proximity, and simplicity). (PIES—proximity, immediacy, expectancy, and simplicity—was the previous acronym, used in FM 8-51.) Nonetheless, these treatment concepts led to the practice of "three hots and a cot," with the belief that the majority of combat stress casualties could be reconstituted in a short time, usually 1 to 3 days with close attention, to avoid accumulating large numbers or permitting extended care (> 3–4 day), which decreased the soldier's expectation of RTD, possibly prompting symptom sustainment to delay RTD and maximize reprieve at the relatively comfortable CSC. In concept, referrals managed with BICEPS would adapt better in the long run if returned to their units than if "medicalized" and evacuated. Doctrine also discourages labeling these soldiers as "patients," since labels also shape expectations (this appendix uses the term "patient" in the CSC context for consistency to denote a beneficiary receiving services, without intending to imply any particular treatment/intervention model or outcome expectation). In practical settings, care often transitioned fluidly across environments dictated by external circumstances (eg, care could occur at the CSC for one encounter, then a dining facility table, and then a CSH clinic office, with various combinations of pharmacological, psychological, educational, and behavioral interventions).

During OIF I, most restoration teams were based in camps that also housed a soldier's unit headquarters and that sometimes took frequent indirect fire. Thus, providers observed little difference between, or benefit from, quartering soldiers in the CSC versus leaving them with their host unit. While providing a respite from the immediate unit environment and command interactions may provide some benefit for certain cases, it may also adversely affect soldiers' perceived proximity to their unit and expectation for prompt RTD. Typically, documentation given to unit commanders recommended environmental and behavioral modifications as part of the treatment/restoration program, including the expected CSC aftercare. Anecdotally, by not keeping soldiers separated from their peers, commanders reduced the general unit perception that the soldier was "mental" or "crazy," thus reducing the stigma of care within these units. As discussed, restoration teams often functioned like community behavioral health clinics, providing psychiatric evaluation and treatment of ambulatory patients. This function also provided a referral resource for nonpsychiatric clinicians and the prevention teams.

The most common complaint from soldiers presenting to the CSC, consistent with the CSH, was for evaluation of "home-front issues," such as difficulties with significant others or family members at the home station or elsewhere in the United States or Germany. Depressed mood, insomnia, and anxiety, most commonly in the form of panic attacks, hypervigilance, or "jumpiness," remained prevalent symptom complaints, but frank posttraumatic stress disorder (PTSD) was very rarely diagnosed among soldiers during their deployment.

With the chief complaints listed above, most practicing psychiatrists would recognize that targeted psychopharmacologic interventions would have an important role in helping to alleviate symptoms. As previ-

ously mentioned, military doctrine for CSC was written to support a linear Cold-War–style combat campaign. Linear battlefields with conventional mobility warfare feature a rapidly moving, fluid battlefield requiring more prevention and triage than formal diagnoses, treatment, and aftercare plans. Doctrine writers appeared to conceive definitive psychiatric care (permitting RTD) as a separate activity to occur in rear areas after CSC doctrinal interventions failed to achieve prompt RTD, or after the rapidly moving campaign concluded. Thus, no provisions in FM 8-51, the doctrine at the beginning of OIF I, detailed how a CSC should obtain or store medications or a recommended formulary. Since the beginning of OIF I, the Army recognized this change in underlying assumptions and the consequent need to revise CSC doctrine in OIF II (2004). Of note, treatments with potentially sedating medications, especially atypical antipsychotics for insomnia or anxiety and benzodiazepines for anxiety, received increasing scrutiny. Media coverage of the issue and command concern understandably arose about ensuring that soldiers remain alert during missions. Providers must use these options responsibly to alleviate symptoms while recognizing that soldiers may display less optimal performance or alertness if their symptoms remain unaddressed. Benzodiazepines demonstrated good efficacy in overcoming or desensitizing acute stressors, but these drugs require vigilance, responsible prescribing, and commensurate psychological interventions. Without this attention, escalating use occurred frequently, leading to habituation and perpetuation of anxiety symptoms after return to CONUS.

DIVISION MENTAL HEALTH SECTIONS

During OIF I, combat forces deployed as entire divisions, under the organizational structure of the "Operational Force" (all divisions except the 4th and 25th IDs) or "Force XXI" (the 4th and 25th IDs had changed to Force XXI by the beginning of OIF I). This organization differed from the new "modular" organizational structure now in place due to the Army's transformation after OIF I. This appendix relates specifically to the DMHS assets during OIF I, prior to the Army's transformation to the current modular organizational structure and operation.

The organically assigned DMHS assets belong specifically to the division, as permanent and integral parts of the division in peacetime and wartime. During a deployment, the DMHS can occasionally receive supplemental behavioral health PROFIS personnel if there is a shortage of assigned but needed personnel. In contrast to the DMHS, CSH and CSC-type units have few organic medical assets and receive most of their medical personnel from PROFIS. DMHS personnel operate within the division, both in garrison and in a deployed environment, as the primary behavioral health resources for the division. They evaluate and treat division soldiers, liaison with chain of command, and provide command consultation services for the various units within the division.

In garrison, the DMHS usually operates from one location as a full behavioral health section, generally located near other division medical assets. If division brigades are located in different geographical areas, such as Germany or Korea, then the DMHS will have more than one operating clinic. DMHS staff provide the full range of behavioral health services, including

- evaluation for all behavioral health disorders (whether self-referrals, command referrals, or medical referrals);
- treatment, including individual therapy, group therapy, and medication management; and
- prevention services (usually via command consultation and liaison).

In divisions structured in either the Operational or Force XXI structure, the DMHS generally has one division psychiatrist, one division psychologist, one division social worker, and six to eight behavioral health specialists (military occupational specialty 68Xs, previously designated as 91Xs). Depending on the organizational structure of the division (ie, Operational vs Force XXI), DMHS personnel were either all assigned to the main support battalion (as part of the division support command brigade) or to a specific support battalion within the division.

In an Operational structured division (eg, the 101st Airborne [Air Assault] Division), all DMHS personnel were assigned to the main support battalion. However, in a Force XXI structured division (eg, the 4th ID), the DMHS operated together in garrison but were actually assigned to the various support battalions. In these divisions, the division psychiatrist and noncommissioned officer-in-charge (NCOIC) were assigned to the division support battalion. The other DMHS personnel were assigned to the FSMCs, part of the forward support battalions, designated to support a specific brigade combat team during deployment. Under this structure, usually one behavioral health officer (either the division social worker or division psychologist) along with one or two behavioral health specialists

were assigned to each of the FSMCs. However, with three FSMCs but only two available behavioral health officers (ie, a social worker and a psychologist), one FSMC would have a team of only behavioral health specialists assigned to it, with no assigned officer.

According to linear battlefield doctrine, the division psychiatrist provided behavioral health service support to division personnel evacuated from the maneuver brigades, as well as to personnel assigned or attached to units collocated with the division support units and division headquarters. However, as stated previously in this appendix, OIF I did not develop according to a "linear" battlefield model, particularly with the various maneuver brigades and brigade combat teams located on different FOBs throughout Iraq, with nonlinear patterns of enemy engagements or orientation of combat forces. Therefore, patients from the various maneuver brigades could be routed directly to the division or main support battalion according to doctrine, or directly to a nearby higher echelon of care (eg, CSC or CSH). Proximity became more important as travel hazards increased and soldiers understandably presented to the closest asset with the capability to adequately evaluate the problem and minimize overall risk.

Once receiving deployment orders, the DMHS shifted operations from the garrison mission to the deployment or operational mission. This included screening for and identifying division soldiers whose behavioral health conditions made them unsuitable for deployment, transferring their care to the garrison hospital behavioral health assets, and processing recommendations for medical separations (via Medical Evaluation Board) or administrative separations (ie, AR 635-200, Chapter 5-13/5-17), as indicated. Reserve component units frequently referred soldiers for evaluation prior to deploying, but sometimes these referrals occurred after arrival in theater when medical screening revealed that the soldier was taking mood stabilizers or antipsychotic medications for the treatment of bipolar disorder or psychotic disorders that the Reserve unit did not fully recognize. Subsequent screening processes became more comprehensive and prevented deployment of these vulnerable soldiers in later rotations. As expected, other routine referrals to behavioral health included cases of existing depression, anxiety disorders, or substance-use disorders.

Case Study A1-5: A 44-year-old E-8 reservist with over 25 years in service was referred for anxiety and alcohol dependence. He had been drinking one half of a fifth of whiskey in Kuwait every other day. Prior to deployment he drank a case of beer from Friday night to Sunday night, with an occasional beer on the weekdays. The soldier initially presented prior to deployment, secondary to increasing anxiety and depression related to recent activation to active duty and occupational difficulties. He minimized his alcohol use at this time. He was assigned as his unit's first sergeant but did not feel he could handle the position's responsibility. In addition to symptoms of anxiety, he also reported uncontrollable crying spells, poor concentration, fatigue, and decreased appetite. The initial CONUS provider diagnosed him with an adjustment disorder with anxious and depressed mood, starting him on citalopram, clonazepam, and zolpidem. He was found fit to deploy but directed to seek behavioral health services once he arrived in theater. He returned for aftercare 2 weeks later while still in CONUS and reported that his symptoms had improved and that he had stopped the prescribed medications.

After deploying to theater, his symptoms of anxiety returned and he sought help at the CSH in Kuwait. His provider restarted him on his previous medications but he stopped these again after 4 weeks. He subsequently presented again in relation to pending Uniform Code of Military Justice charges due to his alcohol consumption while deployed, a violation of General Order Number 1. He did not feel that he could go on with his job and was evacuated from theater for treatment of his alcohol dependence and anxiety.

As preparations for deployment continued, all garrison DMHS operations were shut down and the care of soldiers remaining behind transferred to the garrison hospital behavioral health assets, while the DMHS focused on equipment readiness, packing, and training for the upcoming deployment missions. Packing followed existing up-to-date load plans and focused on identifying what supplies and equipment would be needed in theater. Packing included inventory, assessment, and loading the equipment already "owned" by the DMHS, per the Table of Organization and Equipment (tents, light sets, field desks, chairs, cots, and vehicles). It also included assessing the need for and acquiring other anticipated useful supplies necessary to conduct the mission (eg, supplies for writing patient notes, maintaining charts, performing command referrals, writing mental status evaluations, useful templates, prescription pads, and any important resources such as textbooks or field manuals).

Of note, supplies of psychotropic medications were not obtained prior to leaving the garrison environment. Once deployed and OIF I began, the absence of pharmaceutical supplies quickly became apparent, with poor availability in theater and lengthy delays to establish dependable supply chains. By approximately midsummer 2003, a dependable supply chain had developed and medications became readily accessible through the division's own supply chains or at the various CSH units.

Maneuver brigades and their supporting units convoyed from Kuwait into Iraq during the initial

assault that began OIF I. Some combat units, such as the 101st Airborne (Air Assault) Division, that were directly involved in the initial assault "jumped" from one location to the next. This occurred from the beginning of formal combat operations until approximately May 2003, as units repositioned with a northerly movement direction and support units completed their convoys afterwards. As the mission evolved, permanent FOBs became established, with designated units operating out of a given location. During the previous "jumping" phase, conducting behavioral health and support operations had the unique challenge of operating in temporary environments without the stability, infrastructure, or luxuries of an established base. Prior to arriving and setting up at their permanent FOBs, the various maneuver brigades and supporting units (main and forward support battalions) remained in one location for only a few days to weeks, conducting operations from tents and makeshift buildings. Conditions remained austere for all units during this time, and did not provide ideal conditions for conducting sustainable operations. Fortunately the behavioral health mission did not have significant equipment requirements, and the DMHS teams experienced limited adverse effects because they required only a pen and paper to document encounters and a location to see patients. Providers could see patients in any safe, convenient, and relatively comfortable place. Providers utilized their ingenuity to create clinical spaces, for instance, in the small DMHS tent, in the back of a HMMWV, or in any "field-expedient" location providing a minimal amount of privacy for soldiers. Once established in the permanent FOBs, units dedicated more time and resources to setting up tents for permanent operations or occupying and improving old, abandoned Iraqi buildings on the FOB premises, converting them for living and working accommodations.

As previously mentioned, in a deployed environment, the DMHS section was divided into small two- to three-person teams (usually composed of a behavioral health officer—psychiatrist, psychologist, or social worker—and one or two behavioral health specialists) integrally located with the support battalion. Therefore, these were small operations, usually working out of a small tent or other accommodations, available 24 hours a day to accommodate soldiers who could present at any time (because soldiers presented unexpectedly day or night after convoying several hours from another FOB that lacked behavioral health assets). These DMHS teams were able to provide a range of behavioral health services and support to all the soldiers in the supported brigade and in their vicinity or catchment area. They were responsible for direct behavioral health patient care, as in garrison, with services that included

- evaluation of acute behavioral health issues whether presented via self-referral or command referral;
- command consultation; and
- treatment, including brief supportive therapy and medication management, if required.

In terms of the types of cases presenting for treatment to DMHS, the whole spectrum of behavioral health concerns was represented, from significant Axis I disorders to subthreshold symptoms consistent with adjustment disorders related to situational stressors (occupational, home-front, or other operational stressors, classified, per Army doctrine, as "combat and operational stress reactions") to misconduct stress behaviors. The most common cases presenting were those not meeting the threshold for actual significant Axis I disorders but rather were more consistent with misconduct stress behaviors (eg, substance abuse, fighting) or combat and operational stress reactions—problems that might formerly have been diagnosed, per the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition, terminology, as occupational problems, adjustment disorders, or even partner-relational problems. Soldiers were presenting with symptoms of stress related to the "operational" stress of functioning in an austere environment with extreme temperatures, extended separation from home and family, lack of privacy, and increased behavioral and physical demands. There was significant occupational stress from difficulties with peers or superiors; home-front stress from family, partner-relational, or financial concerns; or just frustration with the environment and the cumulative effect of the various stressors.

Soldiers also presented with symptoms of actual Axis I depressive disorders, anxiety disorders, bipolar illness, psychosis, and attention deficit hyperactivity disorder (ADHD), either newly presenting or with diagnoses present prior to deployment (the latter cases needing continued treatment and routine medication management, particularly for depression, ADHD, or anxiety). A significant number of soldiers also presented with substance use issues, usually related to alcohol or other drugs (such as "Iraqi valium," which they acquired illegally from Iraqis). The presentation of soldiers with acute stress disorder (ASD) or PTSD-type symptoms related to traumatic combat experiences was rarer at the beginning of OIF I prior to the maturation of the insurgency. However, by approximately August 2003, after the increase in insurgent attacks (eg, IEDs, rocket-propelled grenades, mortar attacks),

the number of soldiers presenting with ASD/PTSD symptoms notably increased. Overall, the ratio was approximately 6 to 4 for soldiers presenting with either "misconduct stress behaviors" (eg, substance abuse, assault on other soldiers) or subthreshold symptoms classified in Army parlance as "combat and operational stress reactions" to those presenting with significant Axis I disorders.

The number of patients presenting to DMHS usually ranged from eight to twelve soldiers per day. Soldiers generally presented as walk-ins (either as self-referrals or as command referrals). Most presentations were patients with an acute crisis; those who presented for routine treatment (ie, medication refills or follow-up) usually came whenever their operational mission would allow or, if located on another base, whenever they could "hop" a ride on a convoy that was traveling to the FOB where DMHS was located. Command referrals were usually acute (ie, for soldiers with imminent risk issues) but were also occasionally for routine, nonacute concerns.

In addition to evaluation and treatment of both acute and routine issues, DMHS teams accomplished other associated behavioral health activities, similar to those in a garrison-type environment. These included behavioral health evaluations, as required, for administrative separations (Chapters 13 and 14 separations) and recommendations to command for Chapter 5-13 or 5-17 administrative separation for soldiers whose conditions clearly indicated unsuitability for continued service. Sanity boards were also conducted for soldiers undergoing court-martial. In addition, evaluations were done occasionally for soldiers planning to attend drill sergeant or recruiting school upon redeployment. The DMHS staff also provided consultation on a regular basis to commanders, first sergeants, chaplains, other medical personnel, and Judge Advocate General personnel, to ensure the safest, most appropriate, and most efficient dispositions for soldiers.

Examples of cases that presented to DMHS included the following:

- soldiers who "locked and loaded" their weapon against their unit members; there were several cases a month of significant soldier versus soldier violence.
- soldiers in acute suicidal crises, including soldiers of all ranks, who had locked and loaded their weapon and held it to their head;
- a soldier with a past history of clinical depression who had been barred from convoys/patrols by his unit because he had been taking "pot shots" at local Iraqis;
- a soldier involved in "horseplay" with two other soldiers that "got out of hand" when the soldier pulled out his bayonet, which caused the threatened soldier to pull out his 9-mm pistol;
- single or married soldiers presenting in recurrent suicidal crises after learning that soldiers with whom they were sexually involved were, simultaneously, sexually involved with other soldiers in the unit;
- cases of soldiers who consumed alcohol and became belligerent, suicidal, and/or homicidal, and occasionally assaulted other soldiers, or held their squad at gunpoint while intoxicated (two cases occurred on one FOB);
- soldiers who made suicide attempts by overdose or who had unintentionally overdosed on "Iraqi valium" obtained from local Iraqis (with prolonged sedated, amnestic periods);
- multiple soldiers who "head-butted" brick or concrete walls (or fractured hands from punching walls) due to anger involving NCOs, coworkers, or home-front issues;
- a sergeant major with anxiety, panic attacks, and nightmares of death after being accidentally electrocuted by another soldier;
- soldiers with acute manic or psychotic presentations (although rarer); and
- soldiers with notable ASD- and PTSD-type anxiety symptoms resulting from involvement in combat operations.

The 4th ID DMHS psychiatrist/NCOIC team was collocated with a CSC restoration team on the same FOB, which was very helpful for soldiers who presented acutely and who could benefit from a brief period of restoration away from their acute stressors. Soldiers who required evacuation to higher echelons of care, including out of theater, were evacuated to the closest CSH.

From April 2003 to November 2003, the 4th ID psychiatrist and DMHS NCOIC at the 4th ID DSB, located at FOB Speicher in Tikrit, Iraq, evaluated over 600 soldiers. Of this number, 22 were referred to the CSC restoration program (due to operational stress reactions that made them temporarily nonmission capable), and 12 were evacuated to higher echelons of medical care (including some out of theater), resulting in an RTD rate of a minimum of 94.4%. This rate improved later in the year when the same team (although with a new division psychiatrist) saw an additional 480 soldiers from mid-November 2003 until March 2004, when the 4th ID redeployed stateside, with only three soldiers requiring evacuation out of theater.

SUMMARY

Over the past 8 years, behavioral health issues in the Army and the Department of Defense have changed greatly and continue to do so. This appendix is historical in nature. It may be used as a training tool for military residents and fellows (for example, in a military psychiatry seminar) or to assist in preparation of future providers deploying to an immature theater. The case studies may be used for discussions about varying stressors and other conditions that might be encountered during deployments. Regardless of the use of this material, the discussion of each major unit during OIF I and the challenges faced should be considered in future operations.

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