



Operation Iraqi Freedom (OIF-II)
Mental Health Advisory Team (MHAT-II)
REPORT

30 January 2005

**Chartered by:
The U.S. Army Surgeon General**

The views expressed in this report are those of the Operation Iraqi Freedom Mental Health Advisory Team members and do not necessarily represent the official policy or position of the Department of Defense, the U.S. Army, or the Office of The Surgeon General.

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OPERATION IRAQI FREEDOM (OIF-II)
MENTAL HEALTH ADVISORY TEAM
EXECUTIVE SUMMARY

INTRODUCTION

The Office of The Surgeon General (OTSG) established the Operation Iraqi Freedom (OIF-II) Mental Health Advisory Team (MHAT) in July 2004 to follow up on the OIF-I Mental Health Advisory Team, to assess OIF-II related mental health (MH) issues, and to provide recommendations. The MHAT-II conducted a comprehensive assessment of the OIF-II behavioral healthcare (BH) system, focusing its assessment and recommendations on three broad areas and the OIF-II Suicide Prevention Program (see below).

- (1) The BH needs assessment of the OIF-II area of operations (AO)
- (2) The BH delivery system of the OIF-II area of operations
- (3) The BH training requirements of the OIF-II area of operations
- (4) Implementation of the MHAT-I recommendations for the OIF-II area of operation Suicide Prevention Program

FINDINGS

The MHAT-II found that like OIF-I Soldiers, OIF-II Soldiers are experiencing numerous combat stressors. However, noncombat deployment stressors related to quality of life have shown considerable improvement since OIF-I. Deployment length remains a top concern for OIF-II Soldiers. Fifty-four percent of OIF-II Soldiers reported their unit morale as low or very low. However, unit morale was significantly higher in OIF-II compared with OIF-I, when 72% of Soldiers reported low or very low unit morale.

Mental health and well-being improved from OIF-I to OIF-II, reflected by a lower percentage of Soldiers who screened positive for a MH problem in OIF-II compared with OIF-I (13% vs. 18%, respectively). Acute or posttraumatic stress symptoms remain the top MH concern, affecting at least 10% of OIF-II Soldiers. Soldiers in transportation and nonmedical combat service support (CSS) National Guard and Reserve units had significantly higher rates of MH problems and lower perceptions of combat readiness and training than Soldiers in other units.

The OIF-II behavioral healthcare system has improved compared with OIF-I. Most BH personnel in theater report conducting outreach on a regular basis. Coordination is occurring between BH personnel, Unit Ministry Teams (UMTs), and primary care providers (PCPs). The BH return-to-duty (RTD) rates are high and comparable to OIF-I. Both the number of BH personnel in theater and the ratio of BH personnel to Soldiers are higher in OIF-II than in OIF-I. Behavioral health personnel are more evenly distributed in OIF-II than in OIF-I. Combat stress control (CSC) units, medical

companies with MH sections, and combat support hospitals (CSHs) can manage routine and surge period demands for holding Soldiers with BH problems.

Forty percent of Soldiers with MH problems reported receiving professional help during the deployment. This was significantly higher than the 29% of Soldiers with MH problems who received professional help in OIF-I. Stigma and organizational barriers to receiving care remain concerns for Soldiers. Forty-one percent of Soldiers surveyed reported that they had received adequate training in handling the stressors of deployment. This was significantly higher than the 29% of Soldiers who reported receiving adequate training during OIF-I.

There was no significant difference between the prevalence of BH disorders among Soldiers in custodial positions in detainee operations and those of other Soldiers surveyed in OIF-II. Custodial staff members shared stressors in common with OIF-II peers. Behavioral health care was conducted in accordance with combat and operational stress control (COSC) doctrine. Insufficient training in correctional BH diminished optimal support for custodial staff.

The majority of OIF-I Mental Health Advisory Team recommendations has been implemented or is in the process of being implemented. Opportunities for improvement still exist in the OIF-II behavioral healthcare system. While coordination between BH care personnel, UMTs, and PCPs is good, coordination could increase between these three professional groups. Significant challenges remain in providing BH care. Two thirds of Soldiers reported receiving training in handling the stresses of deployment and/or combat, and less than half reported the training in managing the stress of deployment was adequate. Most BH personnel received pre-deployment refresher training in BH/COSC tactics, techniques, and procedures, but reported additional training is needed. Standards of care, documentation management, and statistical reporting methods were unclear to some BH personnel. Behavioral health care personnel are using multiple methods to assess the BH/COSC needs of Soldiers and units; a standardized needs assessment process needs to be implemented.

For the same 7-month period (1 March–30 September 2004), 23% fewer Soldiers were evacuated for BH problems in 2004 than those evacuated in 2003. Evacuation procedures and policies have matured as evidenced by written standing operating procedures (SOPs), increased accountability, efficient information tracking, and improved transmission of clinical information between levels of care.

The community-based Army Suicide Prevention Program (ASPP) objectives have been adapted and a unit Suicide Prevention Program is evident at all OIF major commands of the combat units in Iraq as recommended. The January-December 2004 suicide rate for Soldiers deployed in OIF-II was 8.5 per 100,000, which is lower than Calendar Year (CY) 2003 and recent Army historical rates.

RECOMMENDATIONS

Continue to improve awareness of MH issues, access to care, and efforts to reduce stigma. Considerations include:

a) Emphasizing the role of leaders at all levels in facilitating recognition of MH concerns, training in handling the stresses of deployment, and encouraging the use of available resources.

b) Assuring that there is accessible MH support to all units throughout the theater.

c) Where feasible, integrating MH care with primary care in troop medical clinics/battalion aid stations (BASs) so that MH care becomes routine in these settings.

Develop and assess the effectiveness of standardized training modules to prepare Soldiers to handle the psychological demands of deployment and combat-related stressors throughout the deployment cycle. Establish/maintain deployment policies that support Soldier morale and well-being across various forward operating bases (FOBs). Improve Soldier and leadership training in BH issues.

Continue to support BH services to Soldiers by:

- Continuing forward-deployed outreach to facilitate Soldier access to BH services.
- Ensuring all BH personnel can provide (with supervision and medical support) the full range of BH services.
- Completing the development and fielding of a Unit Needs Assessment Program and Survey Tool.
- Utilizing an empirically derived staffing model for BH personnel allocation and distribution.
- Publishing the updated field manual (FM).
- Completing the development of the Behavioral Health COSC Course.
- Researching and developing a program for burnout and compassion fatigue.

Continue BH services to Soldiers in Detainee Operations in accordance with COSC doctrine and MHAT-II staffing recommendations. Supplement COSC doctrine with

training in specific stressors unique to corrections and in best practices to provide care to custodial staff. Consider parallel BH programs for Soldiers and detainees.

Continuously assess how well the BH needs of families are being met in the rear.

Continue existing (community-based) objectives of the ASPP for OIF Soldiers and units during pre-deployment, deployment, and re-deployment. Continue monitoring and reporting of completed suicides and serious suicide attempts with the Army Suicide Events Report (ASER).

Continue the appointment of a Theater/Area of Operation BH consultant to advise The Surgeon on BH issues.

OPERATION IRAQI FREEDOM (OIF-II)
MENTAL HEALTH ADVISORY TEAM
REPORT

INTRODUCTION

The Office of The Surgeon General (OTSG) established the Operation Iraqi Freedom (OIF-II) Mental Health Advisory Team (MHAT) in July 2004 to follow up on the OIF-I Mental Health Advisory Team, to assess OIF-II related mental health (MH) issues, and to provide recommendations. The MHAT-II conducted a comprehensive assessment of the OIF-I behavioral healthcare (BH) system, focusing its assessment and recommendations on three broad areas and the OIF-II Suicide Prevention Program (see below).

- (1) The BH needs assessment of the OIF-II area of operations (AO)
- (2) The BH delivery system of the OIF-II area of operations
- (3) The BH training requirements of the OIF-II area of operations
- (4) Implementation of the MHAT-I recommendations for the OIF-II area of operation Suicide Prevention Program

This report contains the MHAT-II's key findings and its recommendations.

This report consists of three major parts: 1) the OIF-II Mental Health Advisory Team Executive Summary, 2) the OIF Mental Health Advisory Team Report, and 3) the Annexes to the OIF-II Mental Health Advisory Team Report. The annexes contain the assessment methodologies, results, and recommendations for the BH system.

CONVENTIONS

The OIF-II Mental Health Advisory Team referred to the BH system when discussing its findings. The BH continuum of care encompasses not only traditional mental health (MH) care efforts but also many efforts of a primary and secondary prevention nature that have traditionally not been counted as MH services. To avoid confusion, the MHAT will designate all of these services as BH services.

Also, many preventive interventions are referred to as combat stress control (CSC) services. Recently, the three services (Army, Navy, and Air Force) agreed to refer to these services as combat and operational stress control (COSC) services. The units are still referred to as CSC units; however, the services are COSC services. The MHAT also referred to behavioral healthcare providers. Table 1 defines those military personnel considered BH care providers.

Table 1: Behavioral Healthcare Providers by AOC/MOS	
AOC/MOS	Description
60W	Psychiatrists
65A	Occupational Therapists
66C	Psychiatric Nurses
73A	Social Workers
73B	Clinical Psychologists
91W/91WN3	Health Care Specialists
91X	Mental Health Specialists

OPERATION IRAQI FREEDOM (OIF-II) MENTAL HEALTH ADVISORY TEAM REPORT

REASON FOR THE MENTAL HEALTH ADVISORY TEAM (MHAT-II)

At the request of the Multi-National Corps-Iraq (MNC-I) senior leadership, the Office of The Surgeon General (OTSG) established the OIF-II Mental Health Advisory Team in July 2004 to follow up on the OIF-I Mental Health Advisory Team, to assess OIF-II related MH issues, and to provide recommendations (See the Charter at Appendix 1). Specifically, the MHAT was directed to focus its assessment and recommendations on three broad areas and the OIF II Suicide Prevention Program (see below).

- (1) The BH needs assessment of the OIF II area of operations (AO)
- (2) The BH delivery system of the OIF II area of operations
- (3) The BH training requirements of the OIF II area of operations
- (4) Implementation of the MHAT-I recommendations for the OIF-II area of operation Suicide Prevention Program

For each of these factors, the MHAT assessed challenges associated with:

- (a) Command and Control.
- (b) Communications.
- (c) Resource Support.
- (d) Policies.

THE MENTAL HEALTH ADVISORY TEAM ANALYSIS OF OBJECTIVES

To consult with the BH leaders in OIF-II and in the evacuation chain, the MHAT traveled to Kuwait, Iraq, and Landstuhl Regional Medical Center (LRMC) in Landstuhl, Germany.

The MHAT left the Continental United States (CONUS) Replacement Center at Fort Bliss, Texas on 27 August 2004, and stayed in Kuwait and Iraq from 28 August until 18 October 2004.

In Kuwait, the MHAT consulted with the leadership of the Coalition Forces Land Component Command (CFLCC), the (b)(2)-2 Medical Brigade, and combat units (see Table 1).

Table 1: CFLCC Interviews

Transporters	Combat Arms	Support	Signal	Medical
(b)(2)-2	(b)(2)-2	(b)(2)-2	(b)(2)-2	(b)(2)-2

In Iraq the MHAT consulted with the leadership of the Multi-National Corps-Iraq (MNC-I), the (b)(2)-2 Medical Brigade, and combat units (See Table 2).

Table 2: MNC-I Interviews

(b)(2)-2

The team also collected data, with the help of researchers from United States Army Research Unit–Europe (USARU-E), from LRMCC, Germany from 13-17 October. The team consulted with relevant local MH personnel and Army Medical Department (AMEDD) leadership.

The MHAT approached this mission as an opportunity to reassess the Army BH system in an active combat campaign. The MHAT-II again used the Soldier Well-being Survey developed by the Walter Reed Army Institute of Research (WRAIR) under a research protocol, using established scales for which there are comparative data from other units (See Annex E, Appendix 6).

The MHAT-II also assessed the BH system. The MHAT surveyed and interviewed BH providers, PCPs, Unit Ministry Teams (UMTs), and the command group's senior leaders in sampled units (see Tables 1 and 2). The instruments used in assessing the BH system are found in Annex B. The MHAT-II assessed the OIF-II behavioral health care resources, services provided, training, coordination, application of CSC doctrine, medical evacuation system, and other factors. In addition, the MHAT-II assessed the status of OIF-II suicide prevention efforts.

The MHAT also examined systemic issues relative to the BH system. Particular focus was given to command and control of BH units, their ability to communicate horizontally and vertically, the adequacy of their resource support, and existing policies.

FINDINGS

FINDING #1. Like OIF-I Soldiers, OIF-II Soldiers are experiencing numerous combat stressors. However, noncombat deployment stressors related to quality of life have shown considerable improvement since OIF-I. Deployment length remains a top concern for OIF-II Soldiers. Fifty-four percent of OIF-II Soldiers reported their unit morale as low or very low. However, unit morale was significantly higher in OIF-II compared with OIF-I, when 72% of Soldiers reported low or very low unit morale.

- **Combat Stressors**

Operation Iraqi Freedom (OIF-II) Soldiers reported higher rates of incoming rocket and mortar attacks than OIF-I Soldiers, and OIF-II Soldiers also experienced the escalation of improvised explosive device (IED) attacks. However, combat experiences thought to be more likely to be associated with MH problems, such as seeing dead or seriously injured Americans, handling human remains, or killing an enemy combatant were all somewhat higher during the initial ground combat in OIF-I than in OIF-II.

- **Non-deployment Stressors**

The most frequently reported noncombat stressor in OIF-I was uncertain re-deployment date, with 87% of Soldiers reporting high or very high trouble or concern. In OIF-II, this item was endorsed at that level by only 41% of Soldiers. Many quality of life concerns such as lack of privacy, lack of personal space, and difficulties communicating back home were reported much less frequently in OIF-II than in OIF-I.

- **Deployment Length**

Long deployment length was the most commonly reported noncombat stressor in OIF-II; 52% of Soldiers reported high or very high concern about this issue, 16% reported moderate concern, and 32% reported low or very low concern.

- **Unit and Personal Morale**

The percent of Soldiers reporting low or very low unit morale was 54%, with 9% reporting high or very high unit morale, and the remainder reporting at the medium level. Although 54% of Soldiers reported their unit morale as low or very low, this was improved from the OIF-I survey, when 72% of Soldiers reported low or very low unit morale. The percent of Soldiers reporting low or very low personal morale decreased from 52% in OIF-I to 36% in OIF-II

FINDING #2. Mental health and well-being improved from OIF-I to OIF-II, reflected by a lower percentage of Soldiers who screened positive for a MH problem in OIF-II compared with OIF-I (13% vs. 18%, respectively). Acute or posttraumatic stress symptoms remain the top MH concern, affecting at least 10% of OIF-II Soldiers. Soldiers in transportation and nonmedical combat service support (CSS) National Guard and Reserve units had significantly higher rates of MH problems and lower perceptions of combat readiness and training than Soldiers in other units.

- **Soldiers Who Screened Positive for a MH Problem**

A lower prevalence of MH problems was reported by OIF-II Soldiers compared with OIF-I Soldiers. In OIF-II, 17% of Soldiers reported currently experiencing a moderate or severe stress, emotional, alcohol, or family problem, compared with 23% in OIF-I ($p < .001$) and 14% ($p < .001$) in a pre-deployment sample. Thirteen percent of OIF-II Soldiers screened positive for acute stress/posttraumatic stress disorder (PTSD), depression, or anxiety compared with 18% in OIF-I ($p < .001$).

- **Acute or Posttraumatic Stress Symptoms**

Acute stress/PTSD was the most prevalent condition (10%) compared with 15% in OIF-I ($p < .001$). The distribution of diagnoses differed somewhat, with only 7% of Soldiers in Kuwait reporting acute stress/PTSD compared with 11% in Iraq.

- **Transportation and Nonmedical CSS Mental Health Rates**

A higher rate of screening positive for depression, anxiety, or acute stress/PTSD was observed among the transportation and support personnel (e.g. Forward Support Battalion (FSB) and Corps Support (CSB) units) compared with Soldiers in combat and other units. Overall, 17% of Soldiers from transportation and support units screened positive for one of these conditions compared with 13-14% of

Soldiers from combat arms units, and 8% of all other unit types ($p < .002$). In Iraq, transportation and support units had a prevalence rate of acute stress/PTSD of 19% compared with 11% in combat units and 7% in other unit types.

FINDING #3. The OIF-II behavioral healthcare system has improved compared with OIF-I. Most BH personnel in theater report conducting outreach on a regular basis. Coordination is occurring between BH personnel, UMTs, and PCPs. Behavioral health return-to-duty (RTD) rates are high and comparable to OIF-I. Both the number of BH personnel in theater and the ratio of BH personnel to Soldiers are higher in OIF-II than OIF-I. Behavioral health personnel are more evenly distributed in OIF-II than OIF-I. Combat stress control units, medical companies with MH sections, and Combat Support Hospitals (CSHs) can manage routine and surge period demands for holding Soldiers with BH problems.

- **Behavioral health personnel are conducting outreach services.**

Sixty-nine percent of BH personnel surveyed reported that they were conducting COSC outreach services either weekly or several times a week, and 71% reported consulting with unit leaders once a week or more. Behavioral healthcare personnel reported they were actively involved in conducting educational classes, psychological debriefings, and suicide prevention training. They also indicated they were providing services at the Soldiers' worksite as well as their own.

- **There is coordination between BH care personnel, UMTs, and PCPs.**

Seventy-eight percent of the PCPs reported on their survey that BH personnel had given them information about where to refer Soldiers for MH problems, and 76% reported they had received information about the services offered by BH personnel for Soldiers. Many chaplains (83%) reported they had received information from BH personnel on where to refer Soldiers for MH problems, and 88% reported that they had been educated on the services provided by BH personnel for Soldiers.

- **Behavioral health RTD rates are high and comparable to OIF-I.**

All forward-deployed BH assets in OIF-II Iraq had high RTD rates (>95%, see Table 1, Annex B). The BH units (CSC units, Area Support Medical Battalions (ASMBs), Area Support Medical Companies (ASMCs), and CSHs) subordinate to the Medical Brigade in Iraq returned 86% of the diagnosed psychiatric outpatient and inpatient Soldiers to duty. (b)(2)-2

- **Both the number of BH personnel in theater and the ratio of BH personnel to Soldiers are higher in OIF-II than OIF-I.**

Last year (OIF-1), the overall ratio of BH personnel to Soldiers was 1/851. As of 1 October 2004, 232 BH personnel (see Table 1) are providing services to an estimated 94,500 Soldiers in Kuwait and Iraq, for a ratio of 1/407—a ratio over twice that of OIF-1.

- **Behavioral health personnel are more evenly distributed in OIF-II than OIF-I.**

The OIF-II ratios varied from 1/160 to 1/888 (with a standard deviation of 227), while the OIF-I ratio of BH personnel to Soldiers varied from zero (no BH personnel) to 1/3,292 by region (with a standard deviation of 1,038). Further, 76% of Soldiers live on Forward Operating Bases (FOBs) where BH personnel are collocated. In general, as the size of the FOB population decreased, the number of BH personnel to Soldiers also decreased, and the variance in the distribution of BH personnel within each size category increased.

- **Combat stress control units, medical companies with MH sections, and CSHs can manage routine and surge period demands for holding Soldiers with BH problems.**

On both routine and on an emergent basis, “holding capacity” is available at CSC units and at brigade, division, and ASMCs. Each of the CSH slices are able to hold/admit Soldiers with BH problems on the intermediate care wards. Theater BH personnel interviewed indicated that, in general, a Soldier deemed to require an inpatient level of care is only held long enough to be stabilized, evaluated, and prepared for evacuation out of theater. All of the CSHs have partnered with CSC units to provide synergistic BH treatment services.

FINDING #4: Forty percent of Soldiers with MH problems reported receiving professional help during the deployment. This was significantly higher than the 29% of Soldiers with MH problems who received professional help in OIF-I. Stigma and organizational barriers to receiving care remain concerns for Soldiers. Forty-one percent of Soldiers surveyed reported that they had received adequate training in handling the stressors of deployment. This was significantly higher than the 29% of Soldiers who reported receiving adequate training during OIF-I.

- **Soldiers Receiving Professional Help during the Deployment**

Although there was an increase in use of MH services among Soldiers with MH problems from OIF-I to OIF-II, there was no evidence of changes in perceptions of stigma and other barriers among these Soldiers between OIF-I and OIF-II. Among Soldiers who screened positive for depression, anxiety, or PTSD, 53% reported that their unit leadership might treat them differently, and 54% reported that they would be seen as weak. Organizational barriers to care, which leaders can potentially influence, included concerns that it would be too difficult to get to the location of BH services, reported by 20% of Soldiers with MH problems, difficulty getting time off from work (39%), and not knowing where to go for help (22%). These findings were almost identical to findings from OIF-I.

- **Soldier Training in Handling Stress and Suicide Awareness**

Overall, 77% of Soldiers in OIF-II reported that they had received suicide prevention training in the past year, and 69% reported that they had received training in handling the stresses of deployment and/or combat. Forty-eight percent of OIF-II Soldiers surveyed reported that the training in identifying Soldiers at risk for suicide was sufficient (not different from the 45% who endorsed this in OIF-I). Although only 41% of Soldiers reported that the training in managing the stress of deployment was adequate, this rate was higher than the rate of 29% reported by OIF-I Soldiers ($p < .001$).

FINDING #5: There was no significant difference between the prevalence of BH disorders among Soldiers in custodial positions and those of other Soldiers surveyed in OIF-II. Custodial staff members shared stressors in common with OIF-II peers. Behavioral health care was conducted in accordance with COSC doctrine. Insufficient training in correctional BH diminished optimal support for custodial staff.

- **Soldier Stress Levels and Prevalence of Behavioral Health Disorders**

The Soldier Health and Well-being Survey revealed that positive screenings for PTSD, anxiety, and depressive disorders among military police (MP) officers (and Soldiers in other military occupational specialties (MOSs) serving as custodial staff) were equivalent to those for other Soldier MOSs in OIF-II (see Annex A, Finding #4 and Figure 3 for further details). In focused group interviews, custodial staff reported comparable stressors to those of their OIF-II peers.

- **Behavioral Health Care Delivery**

Interviews with senior BH providers indicated that appropriate functional areas of COSC doctrine were implemented for Soldiers at the internment facilities. Custodial and medical staff descriptions of BH services confirmed sufficient adherence to COSC doctrine and availability of services.

- **Training in Correctional Behavioral Healthcare**

Insufficient training in correctional behavioral healthcare delayed providers in providing support as they familiarized themselves with correction's unique stressors, procedures, philosophies, and situations.

FINDING #6: The majority of OIF-I Mental Health Advisory Team recommendations has been implemented or is in the process of being implemented. The OIF-II behavioral healthcare system has improved (see Finding #3). Opportunities for improvement still exist in the OIF-II behavioral healthcare system. While coordination between BH personnel, UMTs, and PCPs is good, coordination could increase between these three professional groups. Significant challenges remain in providing BH care. Two thirds of Soldiers

reported receiving training in handling the stresses of deployment and/or combat, and less than half reported the training in managing the stress of deployment was adequate. Most BH personnel received pre-deployment refresher training in BH/COSC tactics, techniques, and procedures, but reported additional training is needed. Standards of care, documentation management, and statistical reporting methods were unclear to some BH personnel. Behavioral health personnel are using multiple methods to assess the BH/COSC needs of Soldiers and units. A standardized needs assessment process needs to be implemented.

- **Coordination between BH personnel, UMTs, and PCPs is valuable.**

All three groups are valuable resources for each other and together represent a force multiplier for Soldier support. Although the great majority of respondents indicated they were informed of where to refer Soldiers for BH care, increased coordination would further capitalize on the strengths of these three professional groups.

- **Significant challenges remain in providing BH care.**

Forty percent of the BH personnel surveyed agreed that there was inadequate transportation to conduct outreach activities, 30% agreed that there was inadequate communication between BH/COSC and supported units, and 27% reported traveling to supported units was too dangerous. Although 40% felt that arranging convoys to supported units was not difficult, 21% reported having to cancel missions due to the inability to arrange convoys.

- **Less than half of Soldiers trained in handling the stresses of deployment reported the training was adequate.**

Sixty-nine percent of the Soldiers reported they had received training in handling the stresses of deployment and/or combat, and 41% reported that the training in managing the stress of deployment was adequate. (This rate was higher than the rate of 29% reported by OIF-I Soldiers ($p < .001$)). Twenty-three percent reported not receiving suicide training in the last year. Such training is vital given that a fellow Soldier is often turned to for support.

- **Training of BH Personnel**

Behavioral health personnel were more confident in their training this year (OIF-II) due to the pre-deployment refresher training they received, but there were still areas of identified need. Identified areas included cross-cultural (Iraqi) evaluation and treatment, Combat and Operational Stress Control Workload and Recording System (COSC-WARS), and sexual assault and substance abuse evaluation and treatment.

- **Standards of Care, Documentation Management, and Statistical Reporting Methods**

Behavioral health personnel report a lack of clarity on clinical and administrative requirements. Fifty-seven percent of the BH personnel agreed that the standards of BH care in theater were clear. Just over half (53%) agreed that COSC service standards were clear. Of the BH personnel surveyed, only 41% agreed that standards for clinical documentation were clear; 33% felt that the standards for records management were clear, and 35% that the transfer of clinical BH information between levels of care was clear.

- **Standardized Needs Assessment Process**

Although BH personnel report talking informally to Soldiers (92%), medical personnel (77%), unit commanders (71%), and chaplains (71%) to gather data for a needs assessment, less than half use instruments of any kind. Forty-two percent conduct focus groups or locally developed surveys. Thirty-nine percent use validated surveys/instruments.

FINDING #7. For the same 7-month period (1 March– 30 September), 25% fewer Soldiers were evacuated for BH problems in 2004 than those evacuated in 2003. Similarly, evacuations for all medical-surgical problems fell 12.1% in the same time frame. Evacuation procedures and policies have matured as evidenced by written standing operating procedures (SOPs), increased accountability, efficient information tracking, and improved transmission of clinical information between levels of care.

- **For the same 7-month period (1 March–30 September), 25% fewer Soldiers were evacuated for BH problems in 2004 than in 2003.**

Behavioral health accounted for only 6.1% of all OIF-II Army medical-surgical evacuations, falling from 7.1% from OIF-I. When compared with other medical-surgical specialties, BH was the fourth leading reason for evacuation in OIF-II, falling from third in the year before.

- **Evacuation procedures and policies have matured.**

The LRMC has made marked improvements in the evacuation procedures since the MHAT-I visit. The Deployed Warrior Medical Management Center (DWMMC) has completed its critical SOPs. Transmission of clinical information from OIF-II to LRMC substantially improved from OIF-I (83.5% v. 44.8%). The BH records at LRMC were assembled in accordance with hospital SOPs. Clinical documentation at LRMC was forwarded to the next level of care in 92.7% of cases. Interviews with evacuees indicated that they were very satisfied with their care during the evacuation process.

FINDING #8: The community-based Army Suicide Prevention Program (ASPP) objectives have been adapted, and a unit Suicide Prevention Program is evident at all OIF major commands of the combat units in Iraq as recommended.

Surveillance of completed suicides with use of the standardized suicide event reporting has been implemented. The January-December 2004 suicide rate for Soldiers deployed in OIF was 8.5 per 100,000, which is lower than CY 2003 and recent Army historical rates.

- **The community-based ASPP objectives have been adapted, and a unit Suicide Prevention Program is evident at all OIF major commands of the combat units in Iraq as recommended.**

All major commands of the combat units surveyed in Iraq indicated that they have a designated proponent to manage the suicide prevention program and had leader and Soldier suicide awareness training in the past year.

- **Surveillance of Completed Suicides**

Army Suicide Event Reports (ASERs) for completed suicides for OIF-II have been submitted as required, according to the ASER program manager.

- **January-December 2004 Suicide Rate for Soldiers Deployed in Operation Iraqi Freedom**

The OIF 2004 confirmed suicide rate was 8.5 per 100,000 Soldiers. This rate is lower than the 2003 OIF rate of 18.0 per 100,000 and the Army average annual rate for the 9-year period 1995-2003 of 12 per 100,000.

RECOMMENDATIONS

Immediate Implementation

1. Continue to improve awareness of MH issues, access to care, and efforts to reduce stigma. Considerations include:

a) Emphasizing the role of leaders at all levels in facilitating recognition of MH concerns, training in handling the stresses of deployment, and encouraging the use of available resources.

Leaders have a critical role in fostering unit morale and cohesion, and assuring that Soldiers have the equipment and training needed for mission success, sufficient recovery time, and training in how to best cope with the deployment stressors. Soldiers and leaders need training in how to recognize signs of operational stress and posttraumatic stress, and how they can receive help when needed, to include buddy aid, and medic, chaplain, and MH professional support, etc. Training should also include the fact that increased use of alcohol is associated with PTSD symptoms, which can lead to alcohol-related adverse behaviors. Leaders also play an important role in reducing organizational barriers to care, such as assuring that Soldiers get the needed time and have the means to get to a MH appointment. They may also be able to effect perceptions of stigma, although there is no research yet to support this.

b) Assuring that there is accessible and visible MH support to all units throughout the theater.

This requires adequate equipment for division MH personnel and CSC teams to conduct outreach, establish predictable MH services at battalion levels, and provide adequate supervision to 91X mental health specialists or noncommissioned officers (NCOs) working remotely (e.g. availability of up-armored vehicles, communication), and location of personnel to assure that Soldiers have regular and predictable access to MH professionals.

c) Where feasible, integrating MH care with primary care in troop medical clinics/battalion aid stations (BASs) so that MH care becomes routine in these settings.

Mental health care should become as routine as all other primary care. Considerations to facilitate this include utilizing the same facilities, entrances, and waiting areas that are used for routine medical care, as well as the same record keeping system used by PCPs, limiting the details of the MH notes to those necessary to assure continuity of clinical care and safety. It is also important to assure robust collaboration between MH professionals, chaplains, PCPs, and unit leaders.

2. Develop and assess the effectiveness of standardized training modules to prepare Soldiers to handle the psychological demands of deployment and combat-related stressors throughout the deployment cycle. Establish/maintain deployment policies that support Soldier morale and well-being across various FOBs. Improve Soldier and leadership training in BH issues.

- **Standardized Training Modules**

Training Soldiers in suicide awareness and in dealing with the stresses of deployment has many potential benefits. Standardized training materials need to be further developed and applied before, during, and after deployment that teaches these skills to Soldiers and leaders. A particular emphasis should be given to educating Soldiers and leaders about the likelihood of posttraumatic stress symptoms following

combat experiences, normalizing these symptoms, and providing education about the benefits of earlier treatment, the methods available, and information on how to access services if the symptoms are causing functional impairment.

- **Soldier and Leadership Training in BH Issues**

Train Soldiers and leaders in how to crisis manage BH issues—suicidal ideation, homicidal ideation, recognition of combat and operational stress reactions, depression, hyper-anxiety, and PTSD. This training should be incorporated into officer and enlisted schools, ongoing officer and NCO development programs, and during pre-deployment and post-deployment briefings. Most importantly, this training must be skill-based and performance-focused.

- **Deployment Policies and Soldier Morale and Well-being**

Focus group data, consistently voiced throughout the theater, provided some insight into concerns that Soldiers have that might contribute to low perceptions of unit morale. Some things for leaders to consider to improve the morale related to issues that Soldiers raised in focus groups include:

1) Uniform policies that are consistent, not overly restrictive, and meet the “common sense” test are important to Soldiers.

2) Leaders should ensure that Soldiers are adequately informed, that policies are clearly expressed, that rumors are addressed, that Soldiers receive positive feedback, and that subordinates are allowed to seek clarification of orders or policies without their leaders responding defensively or considering the Soldiers disloyal.

3) Leaders should emphasize the importance of not scheduling additional duties during downtime and should assure that Soldiers get sufficient rest to maintain optimal cognitive acuity (generally 7-8 hours sleep per 24-hour period).

4) Leaders should assure that clear and consistent family emergency leave policies are communicated to Soldiers.

3. Continue to support BH services to Soldiers by: continuing forward-deployed outreach to facilitate Soldier access to BH services, ensuring all BH personnel can provide (with supervision and medical support) the full range of BH services, completing the development and fielding of the Unit Needs Assessment Program and Survey Tool, utilizing an empirically-derived staffing model for BH personnel allocation and distribution, publishing the updated field manual (FM), completing the development of the BH Combat and Operational Stress Control Course, and researching and developing a program for burnout and compassion fatigue.

- **Forward Deployed Outreach**

Aggressive outreach may be one of the reasons for the increase in utilization of BH services (from 29% to 40% from OIF-I), and it should continue. Behavioral health personnel are better distributed in OIF-II than in OIF-I.

- **Behavioral Health Personnel Providing the Full Range of BH Services**

Personnel who conduct outreach at the unit level or are the sole provider at a particular location should be able to provide the range of services to include clinical evaluation and treatment, triage, referral to the next level of care, prevention, consultation, and education. Likewise, clinical staff at large FOBs (at CSHs, restoration units, etc.) should be able to provide outreach routinely.

- **Needs Assessment Program and Survey Tool**

Last year, the MHAT recommended that a standardized needs assessment program and tool be developed and fielded to all BH assets. This need was recognized again this year. Walter Reed Army Institute of Research is in the process of completing development of such a tool. It is recommended that this tool be transitioned rapidly for widespread use.

- **Empirically Derived Staffing Model**

Future staffing decisions need to take into consideration the operational environment in theater, the overall Army OPTEMPO, and other factors. Military planners need to tailor the BH force package based on the size of the force, the distribution of the force (number of FOBs), the amount/type of services desired in theater (see Annex B, Appendix 5, Tab A for full discussion of the staffing model), and the availability of personnel and resources to provide this staffing level.

- **Publication of the Updated COSC Field Manual**

It is important that the CSC field manual (FM 8-51) be rewritten to reflect the many changes in Army and COSC practice and evolving doctrine noted in the OIF-I Mental Health Advisory Team report. Those changes have been drafted by the MHAT for incorporation into the programmed successor to FM 8-51, FM 4-02.51. Changes noted in doctrine from this report should also be integrated into the draft and then published as quickly as possible.

- **The BH Combat and Operational Stress Control Course**

The MHAT recommends the creation of an “all disciplines” COSC course. This Army Medical Department Center and School (AMEDDC&S) course will serve as a foundation course for all BH disciplines in combat and battlefield BH doctrine and practice. This course should be a requirement of all new BH officers within their first year of service. Further, all BH officers should be required to attend this course upon accepting a table of organization and equipment (TO&E) or professional filler system

(PROFIS) assignment. A refresher/update course should also be created for those who have attended.

- **Burnout and Compassion Fatigue**

Thirty-three percent of BH personnel reported high burnout, 27% reported low motivation, and 22% reported low morale. Fifteen percent agreed that the stressors of deployment impaired their BH job. If our providers are impaired, our ability to intervene early and assist Soldiers with their problems may be degraded. It is vital to understand the processes of provider burnout and compassion fatigue in order to prevent and intervene in order to preserve the care in our caregivers.

4. Continue BH care services to Soldiers in detainee operations in accordance with COSC doctrine and MHAT-II staffing recommendations. Supplement COSC doctrine with training in specific stressors unique to corrections and in best practices to provide care to custodial staff. Consider parallel BH care programs for Soldiers and detainees. If adopted, keep staff member participation in both programs at the same time to a minimum to prevent any perception of ethical conflicts.

- **Behavioral Health Care in Accordance with Supplemented COSC Doctrine**

Combat and operational stress control doctrine provides a generic model for BH care and effectively anticipates the common stressors and emotional reactions of Soldiers in military operations. Additional training can prepare BH providers to anticipate the stressors inherent in the correctional setting and implement the best practices to support custodial staff (see Annex F, Appendix 10, Tab D).

- **Parallel BH Care Programs**

Correctional literature advocates for independent BH programs to encourage custodial personnel to access care. Traditionally, custodial staff members underutilize BH care when staff or services are shared. Perceived conflicts in advocacy and confidentiality prevent staff members from seeking care.

5. Continuously assess how well the BH needs of families are being met in the rear.

The well-being of military families is essential to the health of Soldiers deployed to OIF. Soldiers continue to express many concerns about the ability of rear detachment commanders and family readiness groups (FRGs) to adequately support families, a finding also identified in surveys conducted among spouses of Soldiers deployed to OIF/Operation Enduring Freedom (OEF). The data suggest the Army needs to establish permanent clinical social work support at least at the brigade level to support FRGs, to consult with rear detachment commanders, to help families cope with the deployment stressors, and to ensure families receive needed services.

6. Continue existing (community-based) objectives of the ASPP for OIF Soldiers and units during pre-deployment, deployment, and re-deployment. Continue monitoring and reporting of completed suicides and serious suicide attempts with the Army Suicide Events Report (ASER).

- **Continue existing objectives of the ASPP for OIF Soldiers and units during pre-deployment, deployment, and re-deployment.**

Strategies of the ASPP should be applied to the OIF force through actions in the following five areas: Proponency, Awareness, Training, Surveillance, and Help-Seeking Behavior. See the MHAT-I report for detailed descriptions of these five areas.

- **Continue monitoring and reporting of completed suicides and serious suicide attempts with the ASER.**

Enough precedence exists to support the strategy of reducing suicide occurrence by reducing the occurrence of serious suicide attempts (leading to hospitalizations and evacuations). A critical component of this strategy is the monitoring of suicide attempts as an outcome metric for suicide prevention actions. Serious suicide attempts (that result in hospitalizations or evacuations) should be included within Army medical surveillance as reportable medical events analogous to communicable disease and other reportable events. See the MHAT-I report for rationale for use of the ASER as a means of data collection.

7. Continue the appointment of a theater/area of operation BH consultant to advise The Surgeon on BH issues.

The OIF-II Behavioral Health Consultant has been instrumental in advising The Surgeon on distribution of BH assets in theater for the delivery of BH care in the area of responsibility (AOR), coordinating training and providing BH personnel consultation support; and consulting with The Surgeon on BH matters. Having a BH consultant to oversee the planning, coordination, and integration of BH assets in theater will help to ensure continuity of BH services delivery in theater during OIF-III.

Future Implementation

1. Identify the scientifically valid key leadership behaviors that facilitate Soldier morale, cohesion, and unit performance in a hostile environment.

Leadership at the local level is critical for maintaining high Soldier morale, unit cohesion, and unit performance. Identifying and training those specific leader behaviors that have been associated with optimal Soldier and unit performance needs to be a top priority for future research efforts and leader development.

2. Develop and assess the effectiveness of training programs for Soldiers and leaders to improve coping with operational stresses, to improve understanding of MH issues, and to improve access to services. Assess the effectiveness of new

programs to reduce the stigma of MH problems. Determine the effectiveness of critical incident stress debriefing (CISD) and other interventions to prevent PTSD.

Given that a significant number of Soldiers screened positive on the PTSD scale, it is imperative that the military determine the most efficacious early intervention strategy for attenuating or preventing the onset of PTSD. This includes efforts to improve resiliency of Soldiers through new training materials, to reduce the stigma of MH care, and to improve access to services. In addition, it is important to determine the effectiveness of interventions that are being used, but do not have a strong evidence base to support their use, such as CISD. The CISD model is the most widely used methodology applied to groups exposed to traumatic events, although its effectiveness has not been proved. Walter Reed Army Institute of Research has a scientifically approved research protocol to assess the effectiveness of CISD in ameliorating the adverse MH effects of Soldiers exposed to combat.

3. Study the feasibility of developing a tactical and strategic evacuation tracking system for efficient clinical and administrative information flow.

Medical Command (MEDCOM) should establish a joint process action team (PAT) to study the feasibility of an evacuation database system capable of clinical, tracking, and analytical functions. It must be readily available, secure, and tailored to the needs of line commanders, medical personnel, medical regulating planners, and medical planners.

4. Establish a Correctional BH Care Fellowship Training Program. Integrate a Correctional BH Care Track into the Force Health Protection Conference.

- **Correctional BH Care Fellowship**

Given the paucity of Army BH providers with experience in correctional care, it is important to develop and maintain clinical and administrative program expertise as it applies to internment facility operations. The Army Medical Department (AMEDD) should consider supporting a prior proposal for a Correctional BH Care Fellowship Training Program at the U.S. Detention Barracks in Fort Leavenworth.

- **Correctional BH Care Track in the Force Health Protection Conference**

To develop a basic understanding of correctional principles and practices, Force Health Protection Conference organizers may consider adding a Correctional BH Care track to the program.

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APPENDIX 1

MENTAL HEALTH ADVISORY TEAM CHARTER

(See next three pages.)

**SUBJECT: Charter for Consultation Proposal for Operation Iraqi Freedom II
(OIF-II)-Related Behavioral Health**

Issues

1. ESTABLISHMENT, PURPOSE, MEMBERSHIP, AND SCOPE OF ACTIVITIES.

a. **ESTABLISHMENT.** At the request of the Multi-National Corps-Iraq (MNC-I) senior leadership, the Office of The Surgeon General (OTSG) established the mental health advisory team (MHAT) for assessing OIF II-related behavioral health (BH) issues and providing recommendations for improvement. This Charter delineates the OIF II MHAT's purpose, membership, and scope of activities.

b. **PURPOSE.** The OIF II MHAT will consult to the relevant medical and line leaders of BH units and their corresponding headquarters in the OIF II area of operations and in the evacuation chain, to include Landstuhl Army Medical Center. This consultation will focus its assessment and recommendations on three broad areas and the OIF II suicide prevention program:

- (1) The BH needs assessment of the OIF II area of operations;
- (2) The BH delivery system of the OIF II area of operations; and
- (3) The BH training requirements of the OIF II area of operations.

(4) Implementation of MHAT-I recommendations for the OIF II area of operation Suicide Prevention Program.

c. MEMBERSHIP.

- (1) The MHAT will consist of the following members:
 - (a) Team Leader, BH Consultant, MEDCOM
 - (b) Combat Stress Control Subject Matter Expert (SME)
 - (c) Senior Army Psychologist
 - (d) Senior Army Psychiatrist
 - (e) Senior Army Occupational Therapist
 - (f) WRAIR BH Researchers

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(g) Representative from U.S. Army Chief of Chaplains

(h) Representative from MNC-I Surgeon

(i) Other representatives/subject matter experts as deemed appropriate by

OTSG

(2) The MHAT will interface and coordinate with the appropriate line and medical leaders within the OIF II area of operations, as well as other echelons of relevant line and policy leaders to accomplish the stated Purpose and Scope of Activity above.

d. SCOPE OF ACTIVITY. The MHAT will assess BH challenges associated with:

(1) Command and Control – clarity and adequacy of communication feedback to resolve emerging BH challenges.

(2) Communications – sufficiency of extant communications capabilities (e.g. radio, phone, fax and e-mail) to support efficient and safe preventive outreach to units, to support referrals within the area of operations, and to convey adequate clinical information for Soldiers within the evacuation chain.

(3) Resource Support – adequacy of 1) BH provider base, 2) holding capacity and treatment initiatives for Soldiers in the evacuation chain, 3) geographic allocation of BH assets, and 4) psychotropic medication availability.

(4) Policies – adequacy of current OIF II and Army policies to meet the BH needs of Soldiers, units and families.

2. PROCEDURES.

a. The MHAT will initiate these efforts on the date of this Charter's approval, and will visit designated sites in the OIF II area of operations, beginning in August 2004 for a period of approximately 30 days and not to exceed 60 days in order to collect data to satisfy Purpose and Scope of Activity objectives.

b. The MHAT will conduct an in-brief to Division and echelons above Division MH units and supported units' line/medical leaders on the first day of each site visit. Likewise, the MHAT will conduct an out-brief to the local line/medical leaders at the conclusion of the site visit, and will provide preliminary findings and recommendations.

DASG-ZB

29 July 2004

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(OIF-II)-Related Behavioral Health**

c. The MHAT will request access to relevant local and central data sources (e.g. BH personnel and BH patient flow data) as needed.

d. The MHAT will conduct interviews with relevant unit/medical leaders at each site, and with line and policy leaders at higher echelons as appropriate.

e. The MHAT will conduct surveys needed to assess the morale of the troops, determine the availability and effectiveness of BH services and review significant trends as needed (i.e. suicides, MH admissions, evacuations from theater).

3. DELIVERABLES.

a. The MHAT will prepare a preliminary report of its findings and recommendations (after review to ensure that no protected information is inadvertently released) for the Commander, MNC-I and Multi-National Force-Iraq prior to departure from Iraq. The final report will be due to the Commander, MNC-I within 120 days after departure from Iraq. The final report's submission date is contingent on completion of any relevant data analyses.

b. The MHAT will conduct subsequent briefings of its final findings and recommendations to all appropriate echelons as directed by OTSG.

c. The MHAT members will not communicate with the media without approval of The Surgeon General or his designee prior to release of the MHAT report.

FOR THE SURGEON GENERAL:

//S//

JOSEPH G. WEBB, JR.
Major General
Deputy Surgeon General



ANNEX A

WALTER REED ARMY INSTITUTE OF RESEARCH (WRAIR) REPORT ON THE MENTAL HEALTH AND WELL-BEING OF SOLDIERS IN OPERATION IRAQI FREEDOM (OIF-II)

Data for this report were collected as part of the Mental Health Advisory Team (MHAT-II) Mission to Iraq and Kuwait, August through October 2004. The data were collected under an approved protocol of the Walter Reed Army Institute of Research (WRAIR), Medical Research and Materiel Command, Washington D.C.

30 January 2005

Chartered by:
The U.S. Army Surgeon General

This is an annex to the Operation Iraqi Freedom (OIF-II) MHAT-II Report addressing the mental health and well-being of Soldiers deployed to OIF-II. The findings were obtained by means of a survey (Soldier Health and Well-being Survey) and focus group interviews with junior enlisted, noncommissioned officers (NCOs), and officers conducted throughout Iraq and Kuwait.

The views expressed in this report are those of the authors and do not necessarily represent the official policy or position of the Department of Defense (DoD), the U.S. Army, or the Office of The Surgeon General (OTSG).

ANNEX A

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EXECUTIVE SUMMARY

The objective of the Soldier Survey was to assess the health and well-being of Soldiers (junior enlisted, noncommissioned officers (NCOs), and officers) deployed to Kuwait and Iraq during Operation Iraqi Freedom (OIF-II). A standardized survey instrument was administered to 2,064 Soldiers stationed at various base camps throughout Kuwait and Iraq from August through October 2004. The data from this survey were compared with data collected using a similar theatre-wide survey conducted under the same protocol during the same months in 2003 (see the Mental Health Advisory Team (MHAT) 2003 report). In addition, the survey was supplemented by focus group interviews. Initial findings from this study were provided to the Multi-National Corps-Iraq (MNC-I), Multi-National Force-Iraq (MNF-I), and Combined Forces Land Combat Command (CFLCC) leadership mid-October 2004.

Key Findings

1. Like OIF-I Soldiers, OIF-II Soldiers are experiencing numerous combat stressors. However, noncombat deployment stressors related to quality of life have shown considerable improvement since OIF-I. Deployment length remains a top concern for OIF-II Soldiers.
2. Fifty-four percent of OIF-II Soldiers reported their unit morale as low or very low. However, unit morale was significantly higher in OIF-II compared with OIF-I, when 72% of Soldiers reported low or very low unit morale.
3. Mental health and well-being improved from OIF-I to OIF-II, reflected by a lower percentage of Soldiers who screened positive for a mental health problem in OIF-II compared with OIF-I (13% vs. 18%, respectively). Acute or posttraumatic stress symptoms remain the top mental health concern, affecting at least 10% of OIF-II Soldiers.
4. Soldiers in transportation and nonmedical combat service support (CSS) National Guard and Reserve units had significantly higher rates of mental health problems and lower perceptions of combat readiness and training than Soldiers in other units.
5. Forty percent of Soldiers with mental health problems reported receiving professional help during the deployment. This was significantly higher than the 29% of Soldiers with mental health problems who received professional help in OIF-I.
6. Stigma and organizational barriers to receiving care remain concerns for Soldiers. Fifty-three percent of Soldiers with mental health problems perceived that their leaders would treat them differently, 54% that they would be seen as weak, 39% that it would be difficult getting time off work, and 20% that it was too difficult to get to the mental health specialist's location.

7. Forty-one percent of Soldiers surveyed reported that they had received adequate training in handling the stressors of deployment. This was significantly higher than the 29% percent of Soldiers who reported receiving adequate training during OIF-I.

8. Marital issues, family separation, and support of families remain top concerns for OIF Soldiers.

Key Recommendations

1. Continue to improve awareness of mental health issues, access to care, and efforts to reduce stigma. Considerations include:

a. Emphasize the role of leaders at all levels in facilitating recognition of mental health concerns, training in handling the stresses of deployment, and encouraging the use of available resources.

b. Assure that there is accessible mental health support to all units throughout the theater.

c. Where feasible, integrate mental health care with primary care in troop medical clinics/battalion aid stations so that mental health care becomes routine in these settings.

2. Develop and assess the effectiveness of standardized training modules to prepare Soldiers to handle the psychological demands of deployment and combat-related stressors throughout the deployment cycle. Train leaders and Soldiers that stress symptoms and other mental health problems are common and expected reactions to combat, that mental health interventions are best applied as early as possible, and that the Soldiers are informed early of the ways in which they can get help when they need it.

3. Continuously assess how well the behavioral health needs of families are being met in the rear. Establish clinical behavioral health support to family readiness groups (FRGs) and rear detachment commanders at least at the brigade level to address family issues and help coordinate/facilitate access to resources.

4. Reevaluate if levels of combat skills training are sufficient for transportation and support personnel from National Guard and Reserve units in the current operational environment, since confidence in combat skills likely builds resiliency to the negative effects of combat stressors.

5. Establish/maintain deployment policies that support Soldier morale and well-being across various forward operating bases (FOBs).

SURVEY METHODS

The OIF-II Soldier Health and Well-being Survey was conducted for MHAT--II under an approved protocol of the Walter Reed Army Institute of Research (WRAIR) (PIs: COL (b)(6)-2 and LTC (b)(6)-2, Walter Reed Army Institute of Research, Silver Spring, MD). The survey is part of a larger effort involving pre- and post-deployment surveys of Soldiers from XVIII ABN Corps, USASOC, and Marine Expeditionary Forces (see Hoge, et. al., New England Journal of Medicine, 2004). The survey was designed as a rapid assessment of the health and well-being of the Soldiers deployed during OIF-II. Details of the survey instrument are included in Appendix 1.

The MHAT traveled throughout Kuwait (CFLCC) and Iraq (MNC-I) and administered surveys and conducted focus groups between 27 August and 3 October 2004. In Iraq, line units from brigade combat teams (BCTs) and other units were targeted for assessment at various base camps/FOBs throughout the country. In Kuwait the survey also targeted battalion level units more likely to experience combat and operational stress, including transportation, infantry, signal, and other units. Sampling included combat arms, combat support, and CSS personnel. Combat support hospitals (CSHs) were included in both Iraq and Kuwait. Samples of approximately 20 to 25 Soldiers were drawn at the company level, based on mission availability for list of unit, locations, and types of units sampled (see Tables 1 through 3.). Signed informed consent was obtained from all participants prior to survey administration per the WRAIR protocol. Participants were briefed on the purpose of the survey and the fact that participation was voluntary. The surveys were conducted anonymously. More than 99% of the Soldiers briefed agreed to complete the survey.

Quality Control of Data

Scanning, data entry, and quality control of the data were conducted in Iraq. Data from the surveys were scanned into a database using the Scantools program. A complete quality assurance check was conducted on a random selection of approximately 5% of all surveys. Out of 2,064 surveys collected, 107 were quality checked. All 328 variables on these surveys were directly compared between the electronic database and the paper surveys (35,096 fields examined). Results revealed that there were a total of 85 errors in the 35,096 fields, in no particular pattern (overall error rate 0.2422%). Of those errors, 0.0513% were subject errors (e.g. double marks, marks too light), 0.1225% were scanner errors, and 0.0684% were hand entry errors (for fields where hand entry was required).

Comparison Populations

Cross-sectional data collected in Iraq and Kuwait during OIF-I (August-September 2003) (n=756) under the same WRAIR protocol were included for comparison (see MHAT report, 2003). Baseline data collected before deployment (n=2,530) were also included in some comparisons. These pre-deployment data were obtained from a

brigade of the (b)(2)-2 Division just prior to deployment to OIF-I (Hoge, et. al. 2004).

Study Sample

Participants were 2,064 U.S. Army Soldiers from different units serving in OIF-II (see Tables 1 through 3). The OIF-II sample was very similar to the OIF-I sample except that there was a higher proportion of National Guard and Reserve Soldiers resulting in a somewhat older sample (Table 4). The demographic distribution of the OIF-II sample differed somewhat from the demographics of the OIF theater in general (Table 4). Reserve and National Guard units and women were over-sampled, which assured adequate representation for subgroup analyses.

Sample Size/Analysis/Statistics

Based on the size of the U.S. Army population serving in OIF-II, a sample size of 2,000 is more than adequate to detect most conditions that occur at a predicted prevalence of 5-10% (for example the prevalence of screening positive for depression or posttraumatic stress disorder (PTSD). For example, 202 is the minimum number of completed surveys necessary to detect a condition with a prevalence of 5% (range no more than 2-8%) at the 95% confidence level. The 2,064 surveys, therefore, provide ample numbers to look at important subgroups within the population, for example by component (Active, Reserve, and National Guard), as well as males and females, Kuwait and Iraq, and even to a limited extent within unit types (e.g. support units compared with combat units). Analysis of data was conducted with SPSS version 12. Chi-squares and ANOVAs were used to test for significance, where relevant.

SURVEY RESULTS

FINDING #1: Like OIF-I Soldiers, OIF-II Soldiers are experiencing numerous combat stressors. However, noncombat deployment stressors related to quality of life have shown considerable improvement since OIF-I. Deployment length remains a top concern for OIF-II Soldiers.

Combat Stressors

Operation Iraqi Freedom (OIF-II) Soldiers reported experiencing numerous combat stressors. Selected experiences are shown in Figure 1. Operation Iraqi Freedom (OIF-II) Soldiers reported higher rates of incoming rocket and mortar attacks than OIF-I Soldiers. Operation Iraqi Freedom (OIF-II) Soldiers also experienced the escalation of IED attacks, a question that was not asked on the OIF-I survey. However, combat experiences thought to be more likely to be associated with mental health problems, such as seeing dead or seriously injured Americans, handling human remains, or killing an enemy combatant were all somewhat higher during the initial ground combat in OIF-I than in OIF-II. Among Soldiers who experienced firefights, the frequency was greater in

OIF-I than during OIF-II (median number of firefights during deployment that OIF-I Soldiers reported was 3 compared with 2 for OIF-II Soldiers).

Active, Reserve, and National Guard Soldiers, overall, had comparable levels of combat experiences in OIF-II. For example, during OIF-II the percent of Soldiers surveyed in Iraq who reported receiving small arms fire was 60% for Active Component Soldiers, 48% for Reserve Soldiers, and 54% for National Guard Soldiers. The percent of Soldiers surveyed in Iraq in OIF-II who reported receiving incoming rocket, artillery, or mortar fire was 93% for Active Component Soldiers, 96% for Reserve Soldiers, and 89% for National Guard Soldiers. The percent of Soldiers surveyed in Iraq in OIF-II who reported having a team member become a casualty was 57% for Active Component Soldiers, 58% for Reserve Soldiers, and 47% for National Guard Soldiers.

Noncombat Deployment Stressors/Quality of Life Measures

Many of the concerns that were endorsed at a high rate during OIF-I showed considerable reductions during OIF-II (Figure 1). In OIF-I, the most frequently reported noncombat stressor was uncertain re-deployment date, with 87% of Soldiers reporting high or very high trouble or concern. In OIF-II, this item was endorsed at that level by only 41% of Soldiers. Many quality of life concerns such as lack of privacy, lack of personal space, and difficulties communicating back home were reported much less frequently in OIF-II than in OIF-I. There was also a decrease in the percent of Soldiers reporting not having adequate equipment or repair parts. Long deployment length was the most commonly reported noncombat stressor; 52% of Soldiers reported high or very high concern about this issue, 16% reported moderate concern, and 32% reported low or very low concern. See also the section on morale, next page, for information obtained from focus groups.

FINDING #2: Fifty-four percent of OIF-II Soldiers reported their unit morale as low or very low. However, unit morale was significantly higher in OIF-II compared with OIF-I, when 72% of Soldiers reported low or very low unit morale.

Soldiers were asked to rate their personal and unit morale on a five-point scale from very low (score 1) to very high (score 5). The percent of Soldiers reporting low or very low unit morale was 54%, with 9% reporting high or very high unit morale, and the remainder reporting at the medium level; although 54% of Soldiers reported their unit morale as low or very low this was improved from the OIF-I survey, when 72% of Soldiers reported low or very low unit morale. The percent of Soldiers reporting low or very low personal morale decreased from 52% in OIF-I to 36% in OIF-II. Mean personal morale increased from 2.41 to 2.78 ($p<.001$) and unit morale increased from 1.95 to 2.32 ($p<.001$). There are very limited normative data on these morale indices for a sustained combat environment. Mean cohesion scores remained largely unchanged between OIF-I and OIF-II (2.98 and 3.10, respectively). Focus group data provided additional information relevant to Soldier and unit morale (see pages A11-A12).

FINDING #3: Mental health and well-being improved from OIF-I to OIF-II, reflected by a lower percentage of Soldiers who screened positive for a mental health

problem in OIF-II compared with OIF-I (13% vs. 18%, respectively). Acute or posttraumatic stress symptoms remain the top mental health concern, affecting at least 10% of OIF-II Soldiers.

Mental health concerns are prevalent among OIF-II Soldiers in the combat zone, particularly symptoms of acute stress/PTSD resulting from combat experiences (also see Hoge, et. al, New England J of Medicine, 2004). An encouraging finding is that OIF-II Soldiers reported a lower prevalence of mental health problems compared with OIF-I Soldiers.

In OIF-II, 17% of Soldiers reported currently experiencing a moderate or severe stress, emotional, alcohol, or family problem, compared with 23% in OIF-I ($p<.001$) and 14% ($p<.001$) in a pre-deployment sample. Overall, 11% of OIF-II Soldiers reported on the anonymous survey that they were interested in receiving help for a stress, emotional, alcohol, or family problem, compared with 15% in OIF-I and 9% pre-deployment.

Using standardized clinical screening instruments, 13% of OIF-II Soldiers screened positive for acute stress/PTSD, depression, or anxiety (Figure 1) using a clinical definition that required the subjects to meet the Diagnostic and Statistic Manual for Psychiatric Disorders (DSM)-4 criteria and report a high number of symptoms or impairment in occupational or social functioning (see Hoge, et. al., N Engl J Med 2004 for details of the study design and scales used). The 13% in OIF-II compared with 18% in OIF-I ($p<.001$). Acute stress/PTSD was the most prevalent condition (10%) compared with 15% in OIF-I ($p<.001$). Differences in rates of depression and anxiety for OIF-I and OIF-II were not statistically significant. Note that the National Center for PTSD checklist was used to measure PTSD symptoms, but in the combat zone, these symptoms would frequently be considered part of an acute stress or combat stress reaction. Overall, there were no statistically significant differences in rates of screening positive by component (Active, Reserve, or National Guard); 13% of Active Component Soldiers screened positive for a mental health problem compared with 12% of National Guard Soldiers and 15% of Reserve Soldiers. There were also no significant differences in the rates of mental health problems between male and female Soldiers (13% for males, 12% for females for any mental health problem). Soldiers in Kuwait had slightly lower rates of any mental health problem than Soldiers in Iraq (11% vs. 13% respectively). However, the distribution of diagnoses differed somewhat, with only 7% of Soldiers in Kuwait reporting acute stress/PTSD compared with 11% in Iraq, likely a reflection of the less hostile environment in Kuwait than in Iraq.

Since the OIF-I and OIF-II samples differed in terms of unit type, component, age, and the proportion of the sample that was surveyed in Kuwait, the prevalence rates of any mental health problem and acute stress/ PTSD in the OIF-II sample were adjusted to reflect the distribution of these factors seen in the OIF-I sample. Separate adjusted rates were calculated for Kuwait and Iraq, as well as both together. (No adjustment was necessary for gender, since rates of mental health problems were comparable between males and females.) This analysis showed that there were minimal effects in adjusting the rates. For example, the unadjusted prevalence of any mental health problem in the

entire OIF-II sample was 12.6%. After adjusting this to the distribution of the units sampled during OIF-I, the prevalence was 12.2%. Adjusting for age changed the rate to 12.8, and adjusting for component (Active, Reserve, National Guard) changed the rate to 13.0. Separate adjustments for Kuwait and Iraq also did not result in appreciable changes in the prevalence rates. These analyses supported the conclusion that the observed differences in the prevalence of mental health problems between OIF-I and OIF-II were not due to sampling biases.

It is not completely understood why mental health concerns showed improvement in OIF-II compared with OIF-I. Factors that may have contributed to the observed improvements in OIF-II include less frequent or intense combat experiences, markedly improved quality of life (MWR, air-conditioning, communication home, food, showers, etc.), increased access to mental health services, or improved training in handling the stresses of deployment. See discussion section of this annex for further comment on this topic.

FINDING #4: Soldiers in transportation and nonmedical CSS National Guard and Reserve units had significantly higher rates of mental health problems and lower perceptions of combat readiness and training than Soldiers in other units.

Comparisons of rates of mental health problems by the type of unit revealed some important differences (see Figure 3 for rates overall in the entire Iraq-Kuwait theater). Overall, for the entire survey sample, a higher rate of screening positive for depression, anxiety, or acute stress/PTSD was observed among the transportation and support personnel (e.g. Forward Support Battalion, Combat Support Battalion units) compared with Soldiers in combat and other units; 17% of Soldiers from transportation and support units screened positive for one of these conditions compared with 13-14% of Soldiers from combat arms units, and 8% of all other unit types ($p=.002$).

Further analysis was conducted using only the Iraq sample, which was at higher risk for combat-related mental health problems than the Kuwait sample. Overall in the Iraq sample, transportation and support units had a prevalence rate of any mental health problem of 20% compared with 13% for combat units ($p=.01$) and 9% for other unit types ($p<.001$). These differences were largely due to differences in the prevalence of acute stress/PTSD; the prevalence of acute stress/PTSD was 19% for transportation and support units compared with 11% for combat units ($p=.002$), and 7% for other unit types ($p<.001$). The higher rate of acute stress/PTSD among support units compared with other unit types was limited to National Guard and Reserve units (see Table 5). National Guard support personnel experienced twice the rate of PTSD as personnel from National Guard combat units. Reserve support personnel also had significantly higher rates than other reserve units or active component support units.

Although support and transport units had significantly higher rates of PTSD than combat arms units overall, they reported significantly lower rates of most combat experiences, suggesting that there may be differences in resilience to combat stressors among the support units. There were no significant differences in the levels of adverse childhood

experiences or non-deployment related traumatic experiences to explain the difference in prevalence rates. The survey also asked Soldiers general questions about their perceptions of combat readiness, including confidence in their unit's ability to perform the mission, whether their unit would do/did an excellent job in combat, and an assessment of level of training. An important finding was that support personnel and transporters reported significantly lower ratings in all these areas compared with other all other Soldiers in the sample. For the entire Iraq and Kuwait sample, among Soldiers from transportation and support units, 55% reported confidence in the unit's ability to perform the mission, compared with 62% of all other units ($p=.01$); 38% of Soldiers from transportation and support units agreed that their unit would do/did an excellent job in combat compared with 55% of Soldiers from other units ($p<.001$); 35% from transportation and support units agreed that the level of training was high compared with 47% from other units ($p<.001$). These differences were particularly pronounced in National Guard units in Iraq, especially for the question pertaining to perception of level of combat training (Table 6). Lower ratings of confidence, combat readiness, and training were all statistically correlated with higher rates of screening positive for mental health problems, particularly acute stress/PTSD, suggesting that perceptions of training, confidence, and combat readiness may buffer the effects of combat stressors.

FINDING #5. Forty percent of Soldiers with mental health problems reported receiving professional help during the deployment. This was significantly higher than the 29% of Soldiers with mental health problems who received professional help in OIF-I.

Among the Soldiers who screened positive for depression, anxiety, or PTSD, 40% reported receiving help at any time during the deployment from a mental health/combat stress control professional, general medical doctor, or chaplain. However, this represented an increase from OIF-I, when only 29% of Soldiers with mental health problems received treatment, and was statistically significant ($p=.03$). Increases were observed in receiving services from all types of professionals, with chaplains most frequently consulted. Twenty-two percent of Soldiers who screened positive for a mental health problem in OIF-I sought help from chaplains compared with 28% in OIF-II. The figures for a mental health/combat stress professional was 12% for OIF-I and 19% for OIF-II, GMO or medic 9% for OIF-I and 13% for OIF-II. Among those who received mental health services, 69% reported being satisfied with the treatment, and 31% reported being dissatisfied. (There was no neutral category to this question, and Soldiers who marked "NA" were excluded.)

FINDING #6: Stigma and organizational barriers to receiving care remain concerns for Soldiers; 53% of Soldiers with mental health problems perceived that they would be treated differently by their leaders and 54% that they would be seen as weak; 39% of Soldiers with mental health problems reported that it would be difficult getting time off work, and 20% that it was too difficult to get to the mental health specialist's location.

Stigma and organizational barriers to care remain a concern for Soldiers in need of mental health services. Although there was an increase in use of mental health services among Soldiers with mental health problems from OIF-I to OIF-II, there was no

evidence of changes in perceptions of stigma and other barriers among these Soldiers between OIF-I and OIF-II. Among Soldiers who screened positive for depression, anxiety, or PTSD, 53% reported that their unit leadership might treat them differently, and 54% reported that they would be seen as weak. Organizational barriers to care, which leaders can potentially influence, included concerns that it would be too difficult to get to the location of behavioral health services, reported by 20% of Soldiers with mental health problems, difficulty getting time off from work (39%), and not knowing where to go for help (22%). These findings were almost identical to findings from OIF-I.

FINDING #7. Forty-one percent of Soldiers surveyed reported that they had received adequate training in handling the stressors of deployment. However, this was significantly higher than the 29% percent of Soldiers who reported receiving adequate training during OIF-I.

Overall, 77% of Soldiers in OIF-II reported that they had received suicide prevention training in the past year, and 69% reported that they had received training in handling the stresses of deployment and/or combat. Forty-eight percent of OIF-II Soldiers surveyed reported that the training in identifying Soldiers at risk for suicide was sufficient (not different from the 45% who endorsed this in OIF-I). Although only 41% of Soldiers reported that the training in managing the stress of deployment was adequate, this rate was higher than the rate of 29% reported by OIF-I Soldiers ($p<.001$). Soldiers who indicated that they had received adequate training in handling the stresses of deployment reported significantly higher confidence in their ability to help Soldiers get assistance for a mental health problem ($p<.001$). Overall, 27% of all Soldiers surveyed in OIF-II indicated that they had helped a fellow Soldier get professional help for a mental health problem, a question that was not asked in a comparable manner during the OIF-I evaluation.

FINDING #8. Marital issues, family separation, and support of families remain top concerns for OIF Soldiers.

Nearly 50% of OIF-II Soldiers reported that being separated from family was a major stressor. Operation Iraqi Freedom (OIF-II) Soldiers who were married reported high marital satisfaction; 76-78% reported that they had a good and stable marriage; and 14% reported plans to separate or divorce, which is higher than the rate reported in a pre-deployment comparison group of 9% and the rate reported on the survey during OIF-I of 11%. Only 21% of married Soldiers reported being satisfied with the rear-detachment support of their families (compared with 18% in OIF-I); only 24% of married Soldiers reported that they were satisfied with the FRG support (vs. 15% in OIF-I).

ADDITIONAL DATA FROM FOCUS GROUPS PERTAINING TO MORALE

Focus groups provided Soldiers with an opportunity to express their views about their deployment experiences and assess if there were any areas not adequately covered on the survey. Below is a summary of the most common concerns that Soldiers identified during focus groups.

a. "Garrison" rules applied in a war zone vary across base camps/ FOBs, even within the same camps, and rules change frequently. Soldiers, who are "outside the wire" every day risking their lives, particularly resent seemingly "petty" rules when they return from patrol or criticism for things they perceive as being trivial in the context of what they have had to do on patrol or in combat. Examples include not being able to wear PT clothes to the dining facilities (DFACs) on some camps; not being able to carry small backpacks into the DFAC, despite having to walk long distances on some camps; not being allowed to wear a tiny penlight on the shirt pocket despite the convenience of this for using portable latrines at night or getting around on posts at night, etc.

b. Leadership/communication concerns exist, particularly the perception that there is poor information flow about the purpose of missions and lack of information about critical events, such as a Soldier being injured. Common complaints that Soldiers expressed included rapidly changing missions, "micromanagement" by higher leadership, frequent "pointless details" that cut into the already limited time for recovery after missions, perceived favoritism, and lack of positive feedback.

c. Soldiers also spoke frequently about the personal nature of casualties, loss of unit members, the constant threat of serious harm or death, frequent mortar attacks, the sense of anticipation, of never knowing when or where something bad would happen, feeling like "sitting ducks" on patrol "outside the wire" with frequent IED attacks, not being able to fight back at times due to rules of engagement, and the perception that there is often no clearly identified enemy.

d. Long deployment length, back-to-back deployments, and separation from family were also prominent concerns for Soldiers. Most Soldiers felt that they could comfortably manage a 6-month deployment, but the year-long deployment was very stressful. There were also concerns about back-to-back deployments for some Army units. Members of National Guard units were particularly distressed by what they perceived as an unduly long and poorly organized training period prior to deployment (up to 6 months with very limited leave time) prior to the year-long "boots on the ground."

e. High OPTEMPO, lack of down/free time, and lack of personal space were all issues that Soldiers reported commonly.

f. Some Soldiers expressed considerable anger at the Army's stop-loss policies that prevented them from leaving service at the end of their obligation, and led some to express feelings that the Army had broken its "contract" with the Soldier.

g. Some Soldiers perceived that there were unclear policies regarding family emergency leave. Some Soldiers felt that their leadership did not take sufficiently seriously some family emergencies, or that there was inequity in the decisions about which types of emergencies would result in sending a Soldier home and for how long.

h. Another concern that Soldiers voiced frequently that was not covered on the survey involved the unique factors inherent in working with and training new Iraqi security forces, including lack of equipment and supplies, communication problems, and concerns about infiltration from insurgents.

Soldiers also reported beneficial/positive aspects of deployment, including friendships, satisfaction with the job they were doing, improved confidence, cohesion, demonstrating success in missions, and pay. Many felt that improved DFACs, living conditions, MWR facilities, and R&R programs improved morale. Soldiers said they were satisfied with the lottery system that some units established to assure fairness regarding R&R trips back home.

DISCUSSION

This study of over 2,000 OIF-II Soldiers surveyed throughout Iraq and Kuwait used the same survey instruments as were used in a theater-wide assessment in OIF-I and in a study of Soldiers from combat units surveyed 3 to 4 months after returning from OIF-I reported in a prominent medical journal (see 2003 MHAT report, and Hoge, et. al. N Engl J of Med; July 1, 2004). Although the study enrollment did not use a random sampling design, the sample is very likely to be representative of most combat and support units serving in OIF-II. Operational factors largely determined which Soldiers were available to participate, and Soldiers were surveyed in their company or battalion areas at multiple FOBs throughout Iraq and Kuwait. The survey over-sampled Reserve and National Guard units, that made up about half of the sample compared to 36% of all Soldiers serving in OIF-II at the time. In addition, the survey somewhat over-sampled female Soldiers; 14% of the sample were female Soldiers compared with 10% overall in the OIF-II theater. This assured that adequate comparisons could be made by component and gender. Although the sample demographics differed somewhat from the theater at large, the comparability in rates by component and gender supports the generalizability of the survey rates to the larger theater population.

While mental health problems remain a leading health problem for Soldiers deployed to Iraq and Kuwait, there were significant decreases observed in the prevalence rates of mental health concerns between Soldiers during OIF-II compared with OIF-I. It is unlikely that differences in sampling strategy or population demographics accounted for the lower rates of mental health problems in OIF-II compared with OIF-I. These two samples were obtained at almost the identical timeframe (end of August to early October) in 2003 and 2004. The OIF-I and OIF-II samples were very similar in terms of country where surveyed (Iraq/Kuwait), gender, rank, marital status, and duration that the Soldiers had been deployed at the time of the survey. The OIF-II sample had a higher percentage of Reserve and National Guard Soldiers than the OIF-I sample, resulting in a somewhat older population. This partly mirrored the changes in the overall theater population, primarily due to National Guard infantry units serving in a much greater capacity in OIF-II than in OIF-I. Analysis showed that there were no significant differences in the rates of mental health problems by component, so the fact that the OIF-II sample had a higher proportion of National Guard Soldiers than the OIF-I sample

is not likely to account for any observed differences in prevalence rates between the OIF-I and OIF-II samples. In addition, adjusting the prevalence rates for OIF-II to the distribution of unit types seen in OIF-I or by demographic differences in the population (component and age) did not result in any appreciable changes in the reported rates, lending support to the conclusion that the differences in prevalence rates observed among OIF-I Soldiers and OIF-II Soldiers were not due to differences in the types of units or demographics of the units that were sampled.

There are several possible explanations for why the mental health prevalence rates were lower among the OIF-II Soldiers than the OIF-I Soldiers.

- a. Although there were similar rates of many combat experiences, certain experiences thought to be more closely related to PTSD symptoms (body handling, being responsible for the death of an enemy combatant) were more prevalent during OIF-I than in OIF-II and combat frequency, as measured by number of firefights was also higher in OIF-I.
- b. There have been substantial improvements made in the quality of life in theater, particularly access to air conditioned sleeping quarters, better facilities (bathrooms, showers, MWR facilities, etc.), better food and DFACs, and improved communication home through telephone and e-mail. These likely help buffer the negative effects of combat.
- c. Evidence from the survey suggests that there have been improvements in training Soldiers in handling the stresses of deployment.
- d. There have also been an increased number of mental health professionals and improved distribution of mental health professionals.

Regarding combat experiences, clearly the nature, frequency, and intensity of the combat experiences are the most important predictors of acute or posttraumatic stress disorders. There have been changes in the types of combat operations from OIF-I to OIF-II. Operation Iraqi Freedom (OIF-I) Soldiers experienced very intense sustained ground combat during the initial operations, with large numbers of Iraqi military and civilian casualties. Also, there were the constant threat of chemical or biological attack and the added stress of having to work in protective suits for extended periods during OIF-I. On the other hand, OIF-II Soldiers have had to deal with the increased rocket/mortar attacks and increased threat of improvised explosive devices (IEDs) and vehicle borne improvised explosive devices ("VBIED"), changing rules of engagement that emphasize continuous patrols in urban areas, security, and rebuilding missions, as well as a new government and increased collaboration with Iraqi security forces. Further research is needed to understand which types of combat/deployment experiences will be more predictive of long-term mental health sequelae.

Between OIF-I and OIF-II, there have been significant improvements in quality of life that likely contribute to improved morale. Compared with OIF-I Soldiers, OIF-II Soldiers

have much greater access to air-conditioned sleeping areas, food cafeterias, MWR facilities, better bathroom/shower facilities, and markedly improved communication home. Although the relationship between morale and the prevalence of mental health problems is very complex, it is highly likely that improved quality of life and improved morale buffer the effects of ongoing combat operational stressors.

Regarding training, the survey suggested that more Soldiers are receiving training in handling the stresses of deployment and that this training has a beneficial effect in building confidence and helping Soldiers get assistance when they need it. A high percentage of Soldiers reported helping a fellow Soldier access professional help. It is not fully understood what types of training programs are most effective in building resiliency to operational stress; this is an area that needs much, additional research. Key elements of any training program include information about what leaders can do to improve morale and cohesion, what leaders and Soldiers can do to better cope with stress, what types of mental health problems are most likely following combat, and how Soldiers can get help when needed.

Regarding access to mental health professionals, there are ample data collected in the other annexes of this report that shows that there have been considerable increases in the number of mental health professionals in theater and increased emphasis on outreach efforts in OIF-II compared with OIF-I. The Soldier Health and Well-being Survey confirmed that Soldiers who screened positive for a mental health problem were significantly more likely to access a chaplain or other mental health professional in OIF-II than in OIF-I. Among Soldiers who screened positive for a mental health problem, 40% reported that they had received help from a chaplain, mental health professional, or medical professional, compared with 29% of OIF-I Soldiers. While this may be because of improved mental health care delivery and outreach, it also may be related to theater maturation and greater stability of Soldiers on individual bases, or improved coordination between primary care professionals, chaplains, and mental health professionals. Among Soldiers who had returned from OIF-I deployment who screened positive for a mental health problem, 40% reported receiving help identical to the figure reported in theater in OIF-II.

Although the comparisons between prevalence rates in OIF-I and OIF-II are encouraging, it is important to bear in mind that over 12% of Soldiers in OIF-II are still experiencing significant acute or posttraumatic stress symptoms or symptoms of depression or generalized anxiety. Especially concerning is the markedly higher rate among transportation and support (FSB, CSB) personnel from National Guard and Reserve units, who are experiencing rates in excess of 20%, reflecting the fact that in the current operational environment support personnel may be just as exposed to serious combat stressors as Soldiers from combat arms units. Although preliminary, the data indicate that the high rates of mental health problems in support units are correlated with lower ratings of combat readiness, training, and confidence in their unit's ability to perform the mission. It is unclear if the perceptions that these Soldiers reported accurately reflect their levels of combat readiness, and if improved training

would adequately buffer against negative mental health outcomes, but the data suggest that further assessment of this is warranted.

RECOMMENDATIONS

1. Continue to improve awareness of mental health issues, access to care, and efforts to reduce stigma. Considerations include:

a. Emphasizing the role of leaders at all levels in facilitating recognition of mental health concerns, training in handling the stresses of deployment, and encouraging the use of available resources.

b. Assuring that there is accessible mental health support to all units throughout the theater.

c. Where feasible, integrating mental health care with primary care in troop medical clinics/battalion aid stations so that mental health care becomes routine in these settings.

Overall, more mental health professionals have been working in Iraq and Kuwait during OIF-II than in OIF-I. A significantly higher percentage of Soldiers with mental health problems in OIF-II accessed mental health services than in OIF-I, although still over half of the Soldiers who screened positive for mental health problems reported not receiving services. Challenges remain in providing services in this combat environment and reducing the stigma and barriers to care which Soldiers perceive. Considerations to reduce these barriers to care include:

a. Emphasizing the role of leaders at all levels in facilitating recognition of mental health concerns, training in handling the stresses of deployment, and encouraging access to services. Soldiers and leaders should be educated about the predictable stresses of deployment, including PTSD. Leaders have a critical role in fostering unit morale and cohesion, and assuring that Soldiers have the equipment and training needed for mission success, sufficient recovery time, and training in how to best cope with the deployment stressors. Soldiers and leaders need training in how to recognize signs of operational stress and posttraumatic stress, and how they can receive help when needed, to include buddy aid, medic, chaplain, mental health professionals, and other forms of support. Training should also include the fact that increased use of alcohol is associated with PTSD symptoms, which can lead to alcohol-related adverse behaviors. Leaders also play an important role in reducing organizational barriers to care, such as assuring that Soldiers get the needed time and have the means to get to a mental health appointment. They may also be able to effect perceptions of stigma, although there is no research yet to support this.

b. Assuring that there is accessible and visible mental health support to all units throughout the theater. This requires adequate equipment for division mental health personnel and combat stress control teams to conduct outreach, establish predictable

mental health services at battalion levels, and provide adequate supervision to mental health personnel working remotely (e.g. availability of up-armored vehicles, communication), and location of personnel to assure that Soldiers have regular and predictable access to mental health professionals.

c. Where feasible, integrating mental health care with primary care in troop medical clinics/battalion aid stations. Mental health care should become as routine as all other primary care services. Considerations to facilitate this include using the same facilities, entrances, and waiting areas that are used for routine medical care, as well as the same record keeping system that primary care providers use, limiting the details of the mental health notes to those necessary to assure continuity of clinical care and safety. It is also important to assure robust collaboration between mental health professionals, chaplains, primary care providers, and unit leaders, which is the subject of another annex of this report.

2. Develop and assess the effectiveness of standardized training modules to prepare Soldiers to handle the psychological demands of deployment and combat-related stressors throughout the deployment cycle. Train leaders and Soldiers that stress symptoms and other mental health problems are common and expected reactions to combat, that mental health interventions are best applied as early as possible, and the ways in which Soldiers can get help when they need it.

The data suggest that training Soldiers in suicide awareness and in dealing with the stresses of deployment has many potential benefits. Standardized training materials need to be further developed and applied before, during, and after deployment that teaches these skills to Soldiers and leaders. A particular emphasis should be given to educating Soldiers and leaders about the likelihood of posttraumatic stress symptoms following combat experiences, normalizing these symptoms, providing education about the benefits of earlier treatment, and the methods available, and information on how to access services if the symptoms are causing functional impairment.

3. Continuously assess how well the behavioral health needs of families are being met in the rear. Establish clinical behavioral health support to FRGs and rear detachment commanders at least at the brigade level to address family issues and help coordinate/facilitate access to resources.

The well-being of military families is essential to the health of Soldiers deployed to OIF. Many family members live on posts where there is limited availability of TRICARE

providers in the community to address their mental health needs and those of their children. At Fort Bragg, for example, much of mental health care that spouses received was through the primary care medical clinics on post, because of the lack of availability of appointments for family members at the military treatment facility or in the community. Soldiers continue to express many concerns about the ability of rear detachment commanders and FRGs to adequately support families, a finding also identified in surveys conducted among spouses of Soldiers deployed to OIF/OEF. The data suggest that the Army needs to establish permanent clinical social work support at least at the brigade level to support FRGs, to consult with rear detachment commanders, to help families cope with the deployment stressors, and to ensure families receive needed services. Leaders can assure that family problems are addressed in a timely manner.

4. Reevaluate if levels of combat skills training are sufficient for transportation and support personnel from National Guard and Reserve units in the current operational environment, since confidence in combat skills likely builds resiliency to the negative effects of combat stressors.

Data from this report show that lower perceptions of combat readiness, levels of training, and confidence in the unit's ability to perform the mission are strongly correlated with higher rates of mental health problems. While overall, National Guard and Reserve Soldiers had similar rates of mental health concerns, there were marked differences observed by unit type among National Guard and Reserve Soldiers. Soldiers in transport and support units from National Guard and Reserve units experienced increased levels of mental health problems compared with Soldiers in other units, and they reported lower levels of readiness, combat skills training, and confidence. Furthermore, in the current operational environment, these units may be at as high a risk of being attacked as combat arms units. It is unclear if these perceptions reflect accurately on actual combat skills training, or if there are other differences between support and combat arms Soldiers that could explain the findings. However, the data suggest that there should be further assessment to determine if the level of combat skills training is sufficient for transporters and support personnel in the current operational environment.

5. Establish/maintain deployment policies that support Soldier morale and well-being across various FOBs.

Focus group data consistently voiced throughout the theater provided some insight into concerns that Soldiers have that may contribute to low perceptions of unit morale. Soldiers are sensitive to perceived inequities in policies between units on the same FOB or between FOBs. Some things for leaders to consider for improved morale related to issues that Soldiers raised in focus groups include:

- a. Soldiers perceive many uniform policies in theater to be unnecessary inconveniences that do not relate to operational effectiveness, readiness, or safety. Uniform policies that are not overly restrictive, consistent, and meet the "common sense" test are important to Soldiers. Examples that Soldiers gave include allowing a

small penlight to be worn on a DCU button (very useful in portable toilets at night), sewn on names on hats, PT uniform in the DFAC, backpacks in the DFAC, pouch wallet around the neck on PT or DCU uniforms, weapons in the DFAC, etc. It is important to note that on many bases Soldiers have to walk long distances to get to locations like the DFAC or MWR facilities, and with little downtime between missions, it may be overly restrictive to have to change the uniform they are wearing or secure a backpack or weapon before eating.

b. Soldiers frequently voiced concerns about not receiving adequate information/explanation pertaining to missions (particularly when missions changed), unit policies, or critical events (such as status of wounded unit members). Soldiers also frequently complained that they received very little or no positive feedback for their efforts or lived in a climate where they often received negative feedback or threats of UCMJ action. Leaders should ensure that Soldiers are adequately informed, that policies are clearly expressed, that rumors are addressed, that Soldiers receive positive feedback, and that subordinates are allowed to seek clarification of orders or policies without their leaders responding defensively or considering the Soldier disloyal.

c. Soldiers also complained frequently about not having sufficient recovery time between missions. Leaders should emphasize the importance of not scheduling additional duties during downtime, and should assure that Soldiers get sufficient rest (generally 7 to 8 hours of sleep per 24-hour period) to maintain optimal cognitive acuity.

d. Leaders should assure that clear and consistent family emergency leave policies are communicated to Soldiers.

OPERATIONAL RESEARCH NEEDS

1. Field a unit needs assessment measure that behavioral health professionals in theater can use to assess their units and assure that Soldiers receive adequate services.

It is important for mental health professionals in theater to have the tools to conduct systematic needs assessments of their units to identify any unique needs and assure that Soldiers are receiving adequate care. This tool should include an assessment of levels of stress, mental health status, unit climate, and level of training in behavioral health issues. In addition, there should be an assessment of availability, access, and acceptability of counseling services provided according to the latest standards of care. The commander, chaplains, and mental health professionals would use the findings from this behavioral health assessment to target specific action plans, including behavioral health prevention and early intervention efforts and distribution of resources. A prototype instrument that WRAIR developed is ready for initial fielding.

2. Identify the scientifically valid key leadership behaviors that facilitate Soldier morale, cohesion, and unit performance in a hostile environment.

Leadership at the local level is critical for maintaining high Soldier moral, unit cohesion, and unit performance. Identifying and training those specific leader behaviors that have been associated with optimal Soldier and unit performance need to be top priorities for future research efforts and leader development.

3. Develop and assess the effectiveness of training programs for Soldiers and leaders to improve coping with operational stresses, understanding of mental health issues, and access to services. Assess the effectiveness of new programs to reduce the stigma of mental health problems. Determine the effectiveness of critical incident stress debriefing (CISD) and other interventions to prevent PTSD.

Given that a significant number of Soldiers screened positive on the PTSD scale, it is imperative that the military determine the most efficacious early intervention strategy for attenuating or preventing the onset of PTSD. This includes efforts to improve resiliency of Soldiers through new training materials, and efforts to reduce the stigma of mental health care and improve access to services. In addition, it is important to determine the effectiveness of interventions that are being used, but do not have a strong evidence base to support their use, such as CISD. The CISD model is the most widely used methodology applied to groups exposed to traumatic events, although its effectiveness has not been proved. The WRAIR has a scientifically approved research protocol to assess the effectiveness of CISD in ameliorating the adverse mental health effects of Soldiers exposed to combat.

TABLES AND FIGURES SUPPORTING FINDINGS

Table 1: Units Surveyed

MNC-I				
(b)(2)-2				
CFLCC				
Transporters	Combat Arms	Support	Signal	Medical
(b)(2)-2				

Table 2: Survey Locations

Location		# of Surveys	Location		# of Surveys
(b)(2)-2	Kuwait	118	(b)(2)-2	Iraq	84
(b)(2)-2	Kuwait	52	(b)(2)-2	Iraq	61
(b)(2)-2	Kuwait	79	(b)(2)-2	Iraq	53
(b)(2)-2	Kuwait	47	(b)(2)-2	Iraq	28
(b)(2)-2	Kuwait	85	(b)(2)-2	Iraq	115
(b)(2)-2	Kuwait	26	(b)(2)-2	Iraq	136
(b)(2)-2	Iraq	91	(b)(2)-2	Iraq	32
(b)(2)-2	Iraq	45	(b)(2)-2	Iraq	25
(b)(2)-2	Iraq	6	(b)(2)-2	Iraq	30
(b)(2)-2	Iraq	82	(b)(2)-2	Iraq	58
(b)(2)-2	Iraq	282	(b)(2)-2	Iraq	50
(b)(2)-2	Iraq	29	(b)(2)-2	Iraq	166
(b)(2)-2	Iraq	85	(b)(2)-2	Iraq	53
(b)(2)-2	Iraq	27	(b)(2)-2	Iraq	119
Total				2,064	

Table 3: Types of Units Surveyed

Unit Type	# (%) of Surveys OIF1	# (%) of Surveys OIF2
Combat (IN, CAV, FA, ADA, AR)	383 (51)	818 (40)
Support (FSB, CSB, Maint, etc.)	42 (6)	347 (17)
Transportation	72 (10)	131 (6)
Engineers/EOD	50 (7)	176 (9)
Military Police*	35 (5)	152 (7)
Civil Affairs	27 (4)	45 (2)
Signal	12 (2)	120 (6)
Medical from CSHs and FHs	125 (17)	245 (12)
Other/Not Listed	10 (1)	30 (2)
Total	756	2,064

* This category includes MPs and other personnel (e.g. FA Soldiers) working as MPs in Detainee Operations at Abu Ghraib and Bucca.

Table 4: Demographics of Study Populations

	OIF-I Sample, 2003 (n=756) No. (%)	OIF-II Sample, 2004 (n=2,064) No. (%)	Total OIF-II Army Population (n=99,883) 30 Sep 2004 Percent Only
Unit Location			
Iraq	577 (76)	1,595 (77)	89
Kuwait	179 (24)	469 (23)	11
Component			
AC	542 (72)	955 (47)	65
NG	58 (8)	690 (34)	21
RC*	155 (21)	410 (20)	14
Grade			
E1-E4	435 (58)	1,133 (55)	50
E5-E6	226 (30)	684 (33)	31
E7-E9	35 (5)	98 (5)	7
Officers/Warrant Officers	58 (8)	145 (7)	12
Age			
18-24	378 (50)	894 (43)	Not Available
25-29	166 (22)	440 (21)	
30-39	133 (18)	505 (25)	
40 or older	74 (10)	219 (11)	
Gender			
Male	646 (86)	1,761 (86)	90
Female	108 (14)	288 (14)	10
No. (%) Single Never Married	303 (41)	824 (41)	Not Available
No. (%) Married			
Living with spouse/geogr. apart	349 (47)	951 (47)	
Married but separated	29 (4)	104 (5)	
No. (%) Divorced	46 (6)	148 (7)	Not Available
No. (%) with Children	332 (46)	976 (48)	
Months in Theater, Median (Interquartile Range)	6 months (5-7 months)	7 months (6-7 months)	Not Available

*OIF-I RC includes 7 AGR (1%), and OIF-II RC includes 40 AGR (2%).

Figure 1. Important combat and noncombat deployment stressors, OIF-I compared with OIF-II among survey participants.

Combat:

Receiving incoming artillery, rocket, mortar

Receiving small arms fire

Knew someone seriously injured or killed

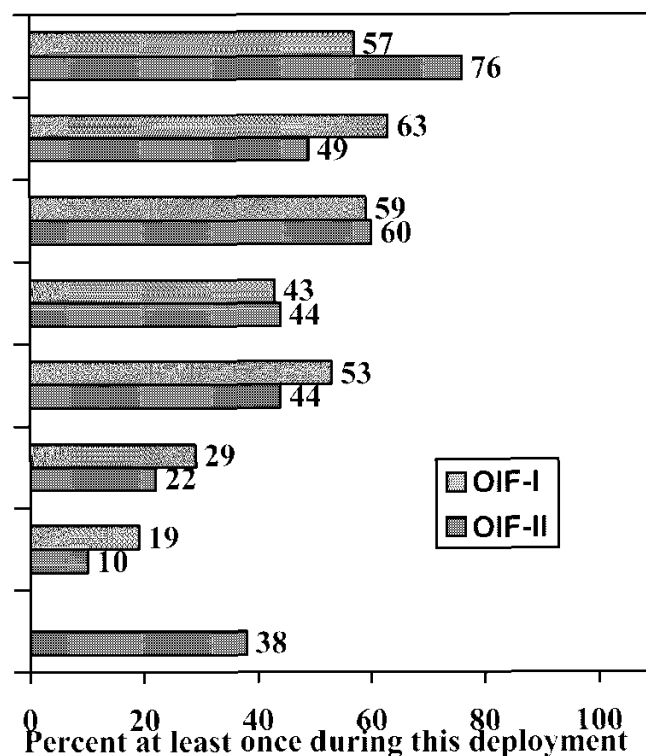
Having a member of your own unit become a casualty

Seeing dead or seriously injured Americans

Handling or uncovering human remains

Being directly responsible for the death of an enemy combatant

IED/ booby trap exploded near you



Deployment Stressors/Quality of Life Measures:

Uncertain re-deployment date

Long Deployment Length

Being separated from family

Lack of privacy or personal space

Boring or repetitive work

Difficulties communicating back home

Not having right equipment or repair parts

Lack of time off for personal time

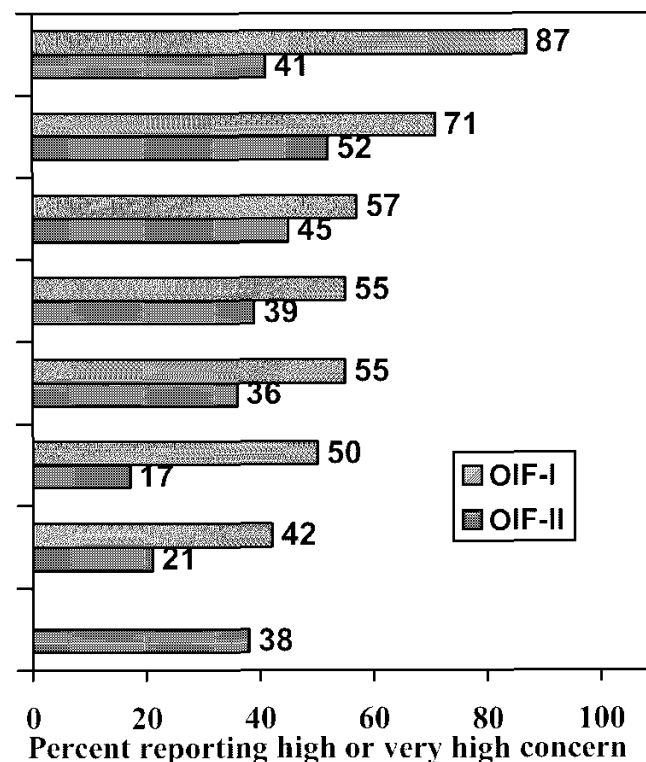


Figure 2. Graph shows percent of Soldiers who screened positive for depression, generalized anxiety, or acute stress/PTSD and endorsed high symptom severity or impairment in work/interpersonal functioning in the past month.

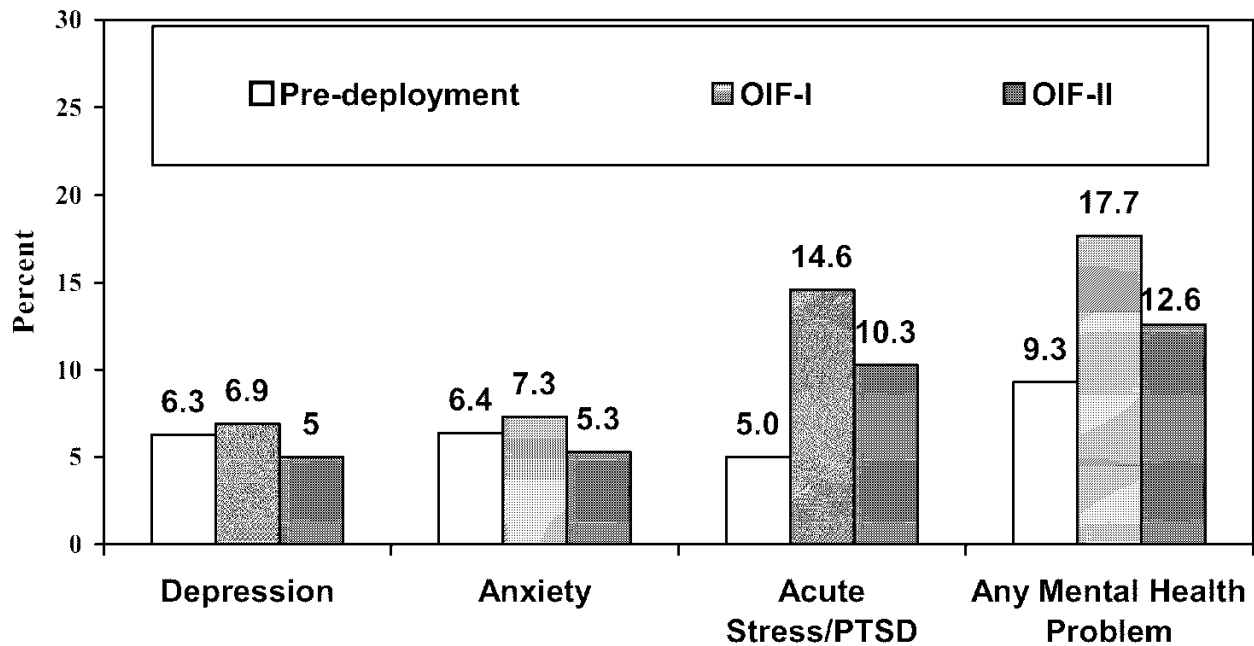


Figure 3. Prevalence of depression, anxiety, or acute stress/PTSD by unit type.

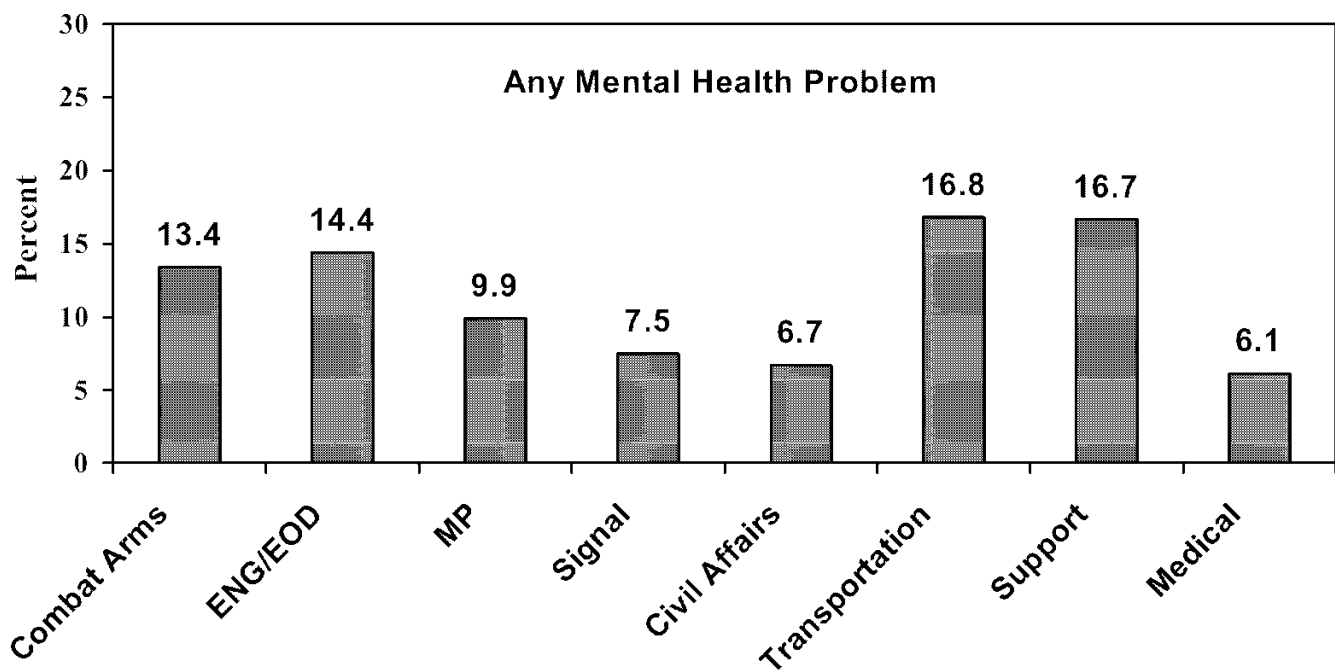


Table 5. Prevalence of Acute Stress/PTSD by Component and Unit Type

	Prevalence of Acute Stress/ PTSD	Prevalence of Any Mental Health Problem
Active Component		
Support Units	11%	13%
Combat Units	14%	16%
Other Unit Types	7%	8%
National Guard		
Support Units	20%*	22%*
Combat Units	8%	11%
Other Unit Types	7%	8%
Army Reserves		
Support Units	34%**	34%**
Other Unit Types	9%	10%

Support units include transportation, forward/combat support, maintenance, and DISCOM Soldiers. Any mental health problem includes screening positive for acute stress/PTSD, depression, or generalized anxiety.

* $p < .01$ for comparison between NG support units and NG combat units

** $p = .001$ for comparison between RC support unit and AC support unit; $p < .001$ for comparison between RC support units and RC other units

Other comparisons not significant

Table 6. Perceptions of Readiness by Component and Unit (Percent Who Agreed)

	I have real confidence in my unit's ability to perform its mission.	I think my unit would do/did an excellent job in combat.	I think the level of training is high.
Active Component			
Support Units	63%	48%*	50%
Combat Units	67%	68%	58%
Other Unit Types	68%	55%	43%
National Guard			
Support Units	55%	41%*	28%*
Combat Units	65%	62%	51%
Other Unit Types	57%	47%	33%
Army Reserves			
Support Units	54%	48%	29%
Other Unit Types	51%	44%	39%

Responses to the three statements above ranged on a 5-point scale from strongly disagree to strongly agree. "Agree" and "strongly agree" were scored as positive. Support units include transportation, forward/combat support, maintenance, and DISCOM Soldiers.

* $p < .001$ for comparison between support units and combat units within Component

APPENDIX 1

SUMMARY OF SOLDIER HEALTH AND WELL-BEING SURVEY

The Soldier Health and Well-being Survey is a specially adapted version of a questionnaire that WRAIR uses in an ongoing protocol to assess the effects of OPTEMPO, combat exposure, and mental and physical health variables on Soldiers and Marines, as well as family members. Data from other samples that WRAIR collected previously are used as comparison data in this report. The findings from scales and items in the survey that are presented in this report include:

Combat and Deployment Stressors

Combat and deployment stressors were examined using two scales.

Combat Exposure: The frequency of exposure to various combat events was examined, and participants were asked to rate the number of times they felt they were in serious danger of being injured or killed (four-point scale). Example questions include: “being attacked or ambushed,” “receiving small arms fire,” “seeing dead bodies or human remains,” “clearing/searching homes or buildings,” and “being responsible for the death of an enemy combatant.”

Deployment Stressors and Quality of Life Measures: Participants also rated their concern about various other stressors along a five-point scale. Deployment stressors included: “being separated from family,” “uncertain redeployment date,” “duration of deployment,” “lack of privacy,” “boring and repetitive work,” “difficulties communicating back home (e.g. telephone calls, e-mail, mail),” and “lack of privacy or personal space.”

Morale and Unit Cohesion

Participants were asked to rate both their personal morale and the morale in their unit on a five-point scale from “very low” to “very high.” Unit cohesion was measured as an average of participants’ agreement or disagreement to the following three questions: “The members of my unit are cooperative with each other,” “The members of my unit know that they can depend on each other,” and “The members of my unit stand up for each other.” (Castro, 2000)

Readiness

General perceptions of readiness were measured with three items that asked participants to rate on a five-point scale from “strongly disagree” to “strongly agree” their assessment that the unit would do/did an excellent job in combat, that the level of training in the unit is high, and that there is high confidence in the unit’s ability to perform its mission.

Mental Health Status

Participants were asked a number of questions about their current mental health functioning in the areas of depression, generalized anxiety, and PTSD. In order to score positive for one of these three areas, the participant had to endorse items on each scale according to established clinical guidelines at “more than half the days” (depression/anxiety scales), or “moderate” level (PTSD scale) AND endorse a high number of symptoms (PTSD scale) or mark that the problem caused functional impairment (depression and anxiety scales). The functional impairment question for depression and anxiety was based on a single question asking the respondent to rate how difficult the symptoms had made it to do his/her work or get along with other people. “Very difficult” or “extremely difficult” was scored positive. For the PTSD scale, a positive score required both meeting the DSM criteria at the moderate level and having a total score of at least 50 on a scale of 17 to 85. This established a conservative estimate of those at high risk for a possible mental disorder. (Spitzer, 1999; Blanchard, 1996; Hoge, 2004)

Stigma and Barriers to Behavioral Health Care

Stigma and barriers to receiving mental health care were assessed by asking each participant to agree or disagree (on a five-point scale) with a series of 17 questions. Organizational barrier questions included, “I don’t know where to get help,” “It is difficult to get an appointment,” and “It is too difficult to get to the location where the mental health specialist is.” Stigma questions included “I don’t trust mental health professionals,” “My leadership would treat me differently,” “My leaders would blame me for the problem,” and “I would be seen as weak.” (Hoge, et. al. 2004; Britt 2000)

Marital Satisfaction and Family Support

A number of factors were examined about marriages and how families were supported at the home station.

Marital Satisfaction: Measured by the average response to four questions (“I have a good marriage,” “My relationship with my spouse is very stable,” “My relationship with my spouse makes me happy,” and “I really feel like a part of a team with my spouse.”). In addition, participants were asked whether or not they (or their spouses) intended to separate or divorce.

Family Support During Deployment: Participants were asked to rate their satisfaction of their unit rear detachment’s support of their families, and their satisfaction with their unit FRG’s support of their families.

Mental Health Training

Soldiers were asked if they agreed on a five-point scale from “strongly disagree” to “strongly agree” if training in suicide prevention was adequate, if training for identifying Soldiers at risk for suicide was sufficient, and if training in handling the stresses of

deployment was adequate. Soldiers were also asked their confidence in their ability to identify Soldiers with depressive symptoms, at risk for suicide, and whether they had attended training in suicide prevention or stress education using “yes-no” questions.

Rating of Survey

Soldiers were asked to rate on a five-point scale (“strongly disagree” to “strongly agree”) their satisfaction with the survey in three areas: survey worthwhile, content appropriate/important, and survey covered the key/main issues. Ratings were very high. Only 16% disagreed with the statement that the survey was worthwhile, 10% disagreed that the survey content was appropriate/important, and only 9% disagreed that the survey covered the key/main issues.

APPENDIX 2

FOCUS GROUP INTERVIEWS

Seventy-three small group interviews from CFLCC AO (Kuwait) (n=8 groups) and MNC-I (Iraq) (n = 65 groups) with junior enlisted (N = 29 groups), NCOs (N =15 groups), officers (N=6 groups) and mixed officer, NCO and enlisted (N=23 groups) were conducted to obtain Soldiers' perspectives on the operational/combat stressors they encountered. A total of 177 junior enlisted Soldiers, 128 NCOs, and 28 officers were included in the groups. Of the 323 service members who were involved, 48 were women.

The Mental Health Advisory Team (MHAT) members conducted all interviews among Soldiers who had just completed the Soldier Health and Well-being Survey at the same locations throughout Kuwait and Iraq where the survey was administered.

Themes/Questions

All groups were asked the same questions. Below are the specific questions for all focus groups.

Questions: (1) Was there anything not covered on the survey that is important for us to know about your experience during the deployment? (2) What has been the most positive aspect of this deployment? (3) What has been the most negative aspect of this deployment? (4) What has been the most stressful/challenging aspect of the deployment? (5) How available are behavioral health services if you need them? (6) Please tell us about your experience with Rest and Relaxation (R & R) or the Environmental Leave (EML) program?

Procedures

All interviews began with members of the MHAT interview team introducing themselves and describing the purpose and objective of the interview. Confidentiality and anonymity were guaranteed in order to encourage candid and honest discussion. Thus, no names of any of the group members were recorded. Interviews lasted approximately 15 to 30 minutes.

Findings

The key themes identified in the focus group interviews are summarized earlier in this Annex. In addition, Soldiers were asked about whether there were any areas not well covered on the survey. In general, Soldiers were complimentary of the questionnaire. Suggestions for improvement included adding questions on leadership and chain of command (particularly officer level), questions on the impact of stop loss, and more questions specific to the medical units that were surveyed.

APPENDIX 3

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ANNEX B

BEHAVIORAL HEALTHCARE SYSTEM ASSESSMENT



Operation Iraqi Freedom (OIF-II)
Mental Health Advisory Team (MHAT-II)

30 January 2005

Chartered by:
The U.S. Army Surgeon General

This is an annex to the Operation Iraqi Freedom (OIF-II) Mental Health Advisory Team (MHAT-II) Report addressing the Behavioral Healthcare System in OIF-II, including Kuwait and Iraq. The findings were obtained via direct observation, interviews, surveys, and data calls.

The views expressed in this report are those of the authors and do not necessarily represent the official policy or position of the Department of Defense (DoD), the U.S. Army, or the Office of The Surgeon General (OTSG).

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INTRODUCTION

One objective of the Operation Iraqi Freedom (OIF-II) Mental Health Advisory Team (MHAT-II) was to conduct an assessment of the Army behavioral healthcare system in Kuwait and Iraq. The focus was to assess Army-wide policies, procedures, and resource requirements affecting behavioral health (BH) services in theater and to provide recommendations to address potential organizational and resource limitations. To accomplish this goal, MHAT-II gathered information by using three written anonymous surveys (one for behavioral healthcare providers, one for unit ministry teams (UMTs), and another for primary medical care providers), an interview schedule for behavioral healthcare providers, and a series of data calls from BH units.

Within the annex, the overall findings and recommendations for the OIF-II behavioral health system are presented first. These overall findings and recommendations draw from the findings and recommendations of the BH, primary care (PC), and UMT surveys, interviews with BH personnel, and various data calls found within the appendices.

FINDINGS

Finding #1: As reported in Annex A, Soldiers are experiencing numerous combat stressors; however, noncombat deployment stressors related to quality of life and Soldier mental health (MH) and well-being have shown improvement since OIF-I.

Although OIF-II Soldiers are experiencing numerous combat stressors and the majority (54%) rates their morale as low or very low, the noncombat deployment stressors have improved considerably since OIF-I, and the morale and MH have also improved. Mental health and well-being improved from OIF-I to OIF-II, reflected by a lower percentage of Soldiers who screened positive for a MH problem in OIF-II compared with OIF-I (13% vs. 18% respectively). In addition, 40% of Soldiers with MH problems reported receiving professional help during the OIF-II deployment, significantly higher than the 29% of Soldiers with MH problems who received professional help in OIF-I. Stigma and organizational barriers to receiving care are still problems. Fifty-three percent of Soldiers with MH problems perceived that their leaders would treat them differently, 39% reported that it would be difficult getting time off work, and 20% reported that it was too difficult to get to the location of the MH specialist (see Annex A). Other indicators of improvement include lower evacuation rates (see Annex C) and lower suicide rates (from 18 per 100,000 down to 8.5 per 100,000—see Annex D).

Finding #2: The OIF-II behavioral healthcare system is improving.

As noted in Annex G, many of the MHAT recommendations from OIF-I have been or are being implemented. Examples include the appointment of a BH consultant to the Multi-National Corps-Iraq (MNC-I) Corps Surgeons cell, the adoption of Army Suicide Event Reports (ASERs) to track data surrounding completed suicides, improvement in

Soldier access to care (from 29% to 40%), the 23% reduction in the BH evacuation rates, and the improvement of Soldier training in handling the stresses of combat/operational stress (from 29% to 41%). The following findings support the fact that the BH system is improving:

Supportive Finding #2a: Most BH personnel in theater report conducting outreach on a regular basis, despite challenges of working in the operational environment.

Sixty-nine percent of BH personnel surveyed reported that they were conducting combat and operational stress control (COSC) outreach services either weekly or several times a week, and 71% reported consulting with unit leaders once a week or more. Behavioral healthcare personnel reported they were actively involved in conducting educational classes, psychological debriefings, and suicide prevention training. They also indicated they were providing services at the Soldiers' worksites as well as their own.

In addition, COSC principles were more readily accepted in OIF-II than in OIF-I. In OIF-II, 78% of those surveyed disagreed with the statement, "Behavioral health/COSC personnel don't think preventive outreach activities are effective," and only 5% agreed with this same statement. Further, 74% disagreed with the statement that providers don't like to perform outreach. These rates show a more positive acceptance to outreach activities when compared to two questions, of a similar nature, that were asked during OIF-I. Operation Iraqi Freedom (OIF-1) providers were asked, "How relevant is COSC doctrine to current operations?" Forty-four percent of the junior enlisted, 35% of the noncommissioned officers (NCOs), and 45% of the officers agreed that it was relevant. Also, fewer people (57%) of the BH personnel in OIF-I agreed COSC was the best method of early intervention.

Supportive Finding #2b: Coordination is occurring between BH personnel, UMTs, and PC providers, and over 75% of the UMTs and PC providers reported receiving information on BH services and guidance on how to refer Soldiers to BH personnel.

Seventy-eight percent of the PC providers reported on their survey that BH personnel had given them information about where to refer Soldiers for MH problems, and 76% reported they had received information about the services offered by BH personnel for Soldiers. Many chaplains (83%) reported they had received information from BH personnel on where to refer Soldiers for MH problems, and 88% reported that they had been educated on the services provided by BH personnel for Soldiers.

Supportive Finding #2c: Behavioral health return-to-duty (RTD) rates are high and comparable to OIF-I.

All forward-deployed BH assets in OIF-II Iraq had high RTD rates. One separate brigade BH team returned 100% of the Soldiers/patients evaluated by its Division

Mental Health Section (DMHS). The two DMHS's and another separate brigade's rates were above 96%. The one combat stress control (CSC) company, while deployed at 15 forward operating bases (FOBs) throughout Iraq, returned 95% of the Soldiers it evaluated. The Air Force's two operational stress teams in Kuwait had RTD rates (97%) comparable to the Army's forward-deployed BH units. A combat support hospital (CSH) returned 80% of the psychiatric patients it evaluated and treated.

Supportive Finding #2d: Both the number of BH personnel in theater and the ratio of BH personnel to Soldiers are higher in OIF-II than in OIF-I.

Last year (OIF-I), 163 BH personnel (psychiatrists, psychologists, social workers, occupational therapists, psychiatric nurses, enlisted MH specialists, and occupational therapy (OT) technicians) provided services for an estimated 138,000 Soldiers in Kuwait and Iraq in September 2003. The overall ratio of BH personnel to Soldiers was 1/851. As of 1 October 2004, 232 BH personnel (see Table 1) are providing services to an estimated 94,500 Soldiers in Kuwait and Iraq, for a ratio of 1/407—a ratio over twice that of OIF-I. Last year's MHAT (OIF-I) concluded that the overall number of BH personnel was sufficient to provide coverage throughout the OIF Theater. However, the distribution of BH personnel was uneven; some areas lacked adequate coverage.

In Kuwait, Navy and Air Force personnel were providing most BH coverage. Other than a few Army staff members (b)(2)-2

Navy personnel performed the bulk of the primary medical care, and (b)(2)-2 Air Force combat stress teams (CSTs) performed all of the BH prevention and early intervention (See Tables 2 and 3). Based on Soldier population, there are fewer BH personnel in Kuwait (1/656 overall) than in Iraq (1/388) where the need is greater due to operational stressors.

Supportive Finding #2e: Behavioral health personnel are more evenly distributed in OIF-II than in OIF-I.

Behavioral health personnel are more evenly distributed in OIF-II than in OIF-I. The OIF-II ratios varied from 1/160 to 1/888 (with a standard deviation of 227), while the OIF-I ratio of BH personnel to Soldiers varied from zero (no BH personnel) to 1/3,292 by region (with a standard deviation of 1,038). Further, 76% of Soldiers live on FOBs where BH personnel are collocated (Note: For simplicity, "FOB" includes base camps, logistical support areas, ranges, etc., in Kuwait and Iraq). In general, as the size of the FOB population decreased, the number of BH personnel to Soldiers also decreased, and the variance in the distribution of BH personnel within each size category increased.

Forward operating bases that did not have on-site BH personnel may have received services from BH personnel at neighboring FOBs. Data from the Soldier Health and Well-being Survey showed that overall, Soldiers on smaller FOBs reported nearly identical rates of utilization of MH services as Soldiers on larger FOBs. On FOBs with Soldier populations less than or equal to 1,000 in size, 11% of Soldiers saw a MH or

CSC professional during the deployment, compared with 9% of Soldiers on FOBs that had a population of 1,001-3,000, and 11% on FOBs over 3,000.

Supportive Finding #2f: Combat stress control units, medical companies with MH sections, and CSHs can manage routine and surge period demands for holding Soldiers with BH problems.

On both routine and on an emergent basis, “holding capacity” is available at CSC units and at brigade, division, and area support medical companies (ASMCs). The CSC units have the capability to set up many more Level II cots for stress and psychiatric casualties if needed. Each CSH slice is able to admit Soldiers with BH problems on the intermediate care wards. Theater BH personnel interviewed indicated that, in general, a Soldier deemed to require an inpatient level of care is only held long enough to be stabilized, evaluated, and prepared for evacuation out of theater. All of the CSHs have partnered with CSC units to provide synergistic BH treatment and holding services.

Finding #3: The majority of OIF-I Mental Health Advisory Team recommendations has been implemented or is in the process of being implemented. Opportunities for improvement still exist in the OIF-II behavioral health system.

Examples include irregular submission of ASERs on nonlethal suicide attempts, need for a standardized unit BH needs assessment program, need for research on early psychological interventions for traumatic stress exposures, and the improved tracking systems for evacuations (see Annex C). The following findings identify areas where the BH system can improve.

Supportive Finding #3a: While coordination between BH personnel, UMTs, and PC providers is good, coordination could increase between these three professional groups.

Fifty-four percent of the BH personnel reported that they coordinated/integrated BH/COSC activities with the UMTs, and 62% of the PC providers and 61% of the chaplains (58% chaplain assistants), in turn, reported coordinating their MH activities with BH personnel. All three groups are valuable resources for each other and together represent a force multiplier for Soldiers’ support. Although the great majority of respondents indicated they were informed of where to refer Soldiers for BH care, increased coordination would further capitalize on the strengths of these three professional groups.

Supportive Finding #3b: Significant challenges remain in providing BH care.

Forty percent of the BH personnel surveyed agreed that there was inadequate transportation to conduct outreach activities, 30% agreed that there was inadequate communication between BH/COSC and supported units, and 27% reported traveling to supported units was too dangerous. Although 40% felt that arranging convoys to supported units was not difficult, 21% reported having to cancel missions due to the inability to arrange convoys.

Supportive Finding #3c: Two thirds of Soldiers reported receiving training in handling the stresses of deployment and/or combat, and less than half reported the training in managing the stress of deployment was adequate.

Sixty-nine percent of the Soldiers reported they had received training in handling the stresses of deployment and/or combat, and 41% reported that the training in managing the stress of deployment was adequate (This rate was higher than the rate of 29% reported by OIF-I Soldiers ($p < .001$)). Twenty-three percent reported not receiving suicide training in the last year. Such training is vital given that a fellow Soldier is often turned to for support. Fourteen percent of all Soldiers stated that they turned to another Soldier in their units for “counseling/MH services for a stress, emotional, alcohol, or family problem.” This percentage increased to 26% among those Soldiers who screened positive for MH symptoms (depression, anxiety, or posttraumatic stress disorder (PTSD)).

Supportive Finding #3d: Most BH personnel received pre-deployment refresher training in BH/COSC tactics, techniques, and procedures, but reported additional training is needed.

Behavioral health personnel were more confident in their training this year (OIF-II) due to the pre-deployment refresher training they received, but there were still areas of identified need. Survey and focus group data revealed four key areas that BH personnel perceive the need for further training:

- Cross-cultural (Iraqi) Evaluation and Treatment. One in five BH personnel felt confident in their ability to evaluate or treat an Iraqi individual. Given the potential to become involved in detainee or humanitarian operations, this is a vital skill that needs to be addressed.
- Combat and Operational Stress Control Workload and Reporting System (COSC-WARS). Forty-seven percent of the BH personnel reported they were confident in their ability to use this system.
- Sexual Assault Evaluation and Treatment. Sixty-three percent of BH personnel felt confident in evaluating and/or treating a victim of sexual assault.
- Substance Abuse Evaluation and Treatment. Seventy percent reported they were confident in their ability to evaluate and/or treat substance abuse disorders; 30% did not endorse confidence in this ability.

Supportive Finding #3e: Standards of care, documentation management, and statistical reporting methods were unclear to some BH personnel.

Behavioral health personnel report a lack of clarity on clinical and administrative requirements. Fifty-seven percent of the BH personnel agreed that the standards of BH care in theater were clear. Just over half (53%) agreed that COSC service standards were clear.

Documentation management in the theater was clear for less than half of the BH personnel surveyed. Of the BH personnel surveyed, 41% agreed that standards for clinical documentation were clear; 33% reported the standards for records management were clear, and 35% reported the transfer of clinical BH information between levels of care was clear.

Supportive Finding #3f: Behavioral health personnel are using multiple methods to assess the BH/COSC needs of Soldiers and units. A standardized needs assessment process, undergoing development as a result of the OIF-I Mental Health Advisory Team, needs to be implemented.

Although BH personnel report talking informally to Soldiers (92%), medical personnel (77%), unit commanders (71%), and chaplains (71%) to gather data for a needs assessment, less than half use instruments of any kind. Forty-two percent conduct focus groups or locally developed surveys. Thirty-nine percent use validated surveys/instruments. There continues to be a need to provide BH personnel with a standardized Soldier and unit needs assessment tool that can objectively quantify BH needs in order to better plan tailored BH interventions for each unit.

Supportive Finding #3g: Some BH, UMT, and PC personnel are reporting compassion fatigue and burnout.

Thirty-three percent of BH personnel reported high burnout, 27% reported low motivation, and 22% reported low morale. Fifteen percent agreed that the stressors of deployment impaired their BH job; in addition, 12% felt that their sensitivity to the needs of the Soldier had been adversely affected.

Thirty-seven percent of PC personnel reported high burnout, 35% reported low motivation, and 35% reported low morale. Fifteen percent agreed that the stressors of deployment had impaired their medical job, and 14% indicated they had become less sensitive to the needs of Soldiers during this deployment.

Sixteen percent of UMT personnel agreed or strongly agreed that the stressors of the deployment and combat impaired their job. They also reported low or very low personal energy (28%), personal motivation (23%), personal morale (18%), and high or very high personal burnout (33%). Some also reported having their mental (13%) or spiritual (15%) well-being adversely affected by combat or deployment stressors.

Table 1 presents the percentages of officers and enlisted members of the three various groups (BH, PC, and UMT) who report adverse effects of deployment and/or low morale. Primary care personnel have significantly lower morale ($p < .001$) and lower personal motivation ($p \leq .002$) than BH and UMT personnel. Primary care personnel also reported significantly less sensitivity to the needs of Soldiers than UMT personnel ($p \leq .002$). Pooled together, the officers reported significantly less adverse effects from the deployment, higher morale, and lower burnout than enlisted providers (all $p < .001$).

Table #1: Comparison of Compassion Fatigue and Burnout Among Provider Types

	% of BH	%Prim Care	% of UMT
Officers	(n = 62)	(n = 140)	(n = 89)
Ability to do job is impaired by stressors	13.1	9.5	14.6
Mental well-being adversely affected	6.6	8.7	15.7
Spiritual well-being adversely affected	9.8	13.0	7.8
Less sensitive to Soldiers' religious/spiritual needs	0	10.0	3.3
Ability to do job is impaired by listening to combat experiences	1.6	0.7	3.3
Personal morale (Low or Very Low)	14.5	24.3	11.2
Energy level (Low or Very Low)	14.5	20.7	23.5
Level of burnout (High or Very High)	26.3	26.6	26.1
Motivation (Low or Very Low)	14.5	20.1	17.1
Enlisted	(n = 74)	(n = 101)	(n = 86)
Ability to do job is impaired by stressors	15.1	21.6	16.5
Mental well-being adversely affected	11.0	22.7	10.6
Spiritual well-being adversely affected	9.6	17.5	17.7
Less sensitive to Soldiers' religious/spiritual needs	21.9	18.6	9.5
Ability to do job is impaired by listening to combat experiences	10.9	7.2	6.0
Personal morale (Low or Very Low)	25.7	48.5	24.4
Energy level (Low or Very Low)	28.4	38.6	32.5
Level of burnout (High or Very High)	38.3	53.7	41.2
Motivation (Low or Very Low)	36.9	55.6	29.1

RECOMMENDATIONS

Recommendation #1: Continue forward-deployed outreach to facilitate Soldier access to BH services.

Aggressive outreach may be one of the reasons for the increase in utilization of BH services (from 29% to 40% from OIF-I), and it should continue. Behavioral health personnel are better distributed in OIF-II than in OIF-I.

Recommendation #2: Ensure all BH personnel can provide (with supervision and medical support) the full range of BH services.

It is important to maintain strong coordination amongst the various BH personnel in theater (whether from division, CSC units, CSH, etc.) to assure that Soldiers have access to BH services when needed. Personnel who conduct outreach at the unit level or are the sole provider at a particular location should be able to provide the range of services to include clinical evaluation and treatment, triage, facilitation of restoration in local medical companies, referral to the next level of care, prevention, consultation, and education. Likewise, clinical staff at large FOBs (at CSHs, CSC restoration facilities, etc.) should be able to provide outreach routinely. While existing COSC doctrine (FM 8-51, 1998) has traditionally divided tasks into prevention, restoration, and treatment, BH personnel need to be able to do all of these functions.

Recommendation #3: Improve Soldier and leadership training in BH Issues.

Since Soldiers turn to their peers for help in crises under combat conditions, it is imperative that Soldiers and leaders be trained in how to provide support and/or refer their peers and subordinates with BH issues to BH personnel. The BH personnel in theater provide this training during outreach. It should be enhanced in officer and enlisted schools, ongoing officer and NCO development programs, and during pre-deployment and post-deployment briefings.

Recommendation #4: Develop and field an automated BH preventive and clinical documentation and reporting system for use in theater.

Theater leadership should set policy requiring a single format for documenting and reporting all BH preventive and clinical services. Assess if an existing system (such as COSC-WARS) meets the requirements and ensure that whatever system is approved is implemented theater-wide.

Recommendation #5: Complete development and fielding of a unit needs assessment program and survey tool.

Last year, the MHAT recommended that a standardized needs assessment program and tool be developed and fielded to all BH assets. This need was recognized again this year. The United States Army Medical Research and Materiel Command (USAMRMC) should be tasked to complete and field this program/tool.

Recommendation #6: Utilize an empirically derived staffing model for BH personnel allocation and distribution.

Last year's MHAT (OIF-I) concluded that the overall number of BH personnel was sufficient to provide coverage throughout the OIF Theater, providing a ratio of 1:851 BH personnel to Soldiers. However, the distribution of BH personnel was uneven; some areas lacked adequate coverage. The ratio of BH personnel to Soldiers in OIF-II is 1:407, substantially different than last year.

Future staffing decisions need to take into consideration the operational environment in theater, the overall Army operations tempo (OPTempo), and other factors. Military planners need to tailor the BH force package based on the size of the force, the distribution of the force (number of FOBs), the amount/type of services desired in theater (see Appendix 5, TAB A for full discussion of staffing model), and the availability of personnel and resources to provide this staffing level.

Utilizing the methodology in Appendix 5, TAB A, the MHAT is proposing the use of a theater-wide staffing model to improve BH personnel utilization and enhance coverage of the theater. However, regardless of the model used, it should be needs based and empirically grounded.

Recommendation #7: Finish publication of updated field manual (FM).

The 1994 CSC field manual (FM 8-51), with minor updating in 1999 for the Medical Reengineering Initiative, has not kept up with the vast shifts in doctrine since entering the Global War on Terror. Because it remains the “official” doctrine—sometimes in opposition to last year’s MHAT findings and recommendations, BH personnel in the field are confused as to which “doctrine” to follow. It is imperative that the FM be rewritten to reflect the many changes in Army and COSC practice and evolving doctrine noted in the OIF-I Mental Health Advisory Team report.

Those changes have been drafted by the MHAT for incorporation into the programmed successor to FM 8-51, FM 4-02.51. Changes noted in doctrine from this report should also be integrated into the draft and then published as quickly as possible.

Recommendation #8: Complete development of behavioral health COSC course.

As recommended by last year’s MHAT, and as part of the indoctrination and preparation of BH personnel—both active and reserve—is the creation of an “all disciplines” COSC course. This 2-week Army Medical Department Center and School (AMEDDC&S) course will serve as a foundation course for all BH disciplines in combat and battlefield BH doctrine and practice. This course should be a requirement of all new BH officers within their first year of service. Further, all BH officers should be required to attend this course upon accepting a table(s) of organization and equipment (TO&E) or Professional Filler System (PROFIS) assignment. A 1-week refresher/update course should also be created for those who have attended the basic COSC course and need an update prior to a TO&E assignment and/or deployment.

Recommendation #9: Publish a compendium of best practices.

Another OIF-I Mental Health Advisory Team recommendation that was revalidated this year is the need for a “compendium of best practices” from the field. This compendium could reside at the Center for Army Lessons Learned at the AMEDDC&S and at the United States Army Center for Health Promotion and Preventive Medicine (USACHPPM) or another appropriate site available to all BH personnel.

Recommendation #10: Web-based BH prep for deployment (OIF Newcomers Orientation Training)

Computer access in theater is improved, and most BH personnel in OIF and Operation Enduring Freedom (OEF) have access to a computer with Internet linkup. Given the disperse nature of both BH personnel in the continental United States (CONUS) prior to deployment, and the disperse nature of the teams in theater during deployment, on-demand, web-based training may be the best way to reach the vast majority of BH personnel. For those unable to access web-based training, printed materials or CD-ROM formats should also be made available. Behavioral health personnel could access Programs of instruction (POIs) throughout the entire deployment cycle (prior to

mobilization, during mobilization, during deployment, and during post-deployment and de-mobilization). Changes in doctrine, techniques, and policy could be centralized for on-demand retrieval. Further, core course work could be programmed with feedback to commanders, BH consultants, and other leadership to ensure that those officers and enlisted members under their jurisdiction have completed the courses as required. These core courses could be particularly helpful for the reserve physicians who rotate in for only 90 days. They must be able to “get up to speed” very quickly. A short hour, web-based POI would cover the medical and BH policies and procedures currently in place, familiarize them with the theater (in general, unclassified, terms), etc.

Recommendation #11: Research and implement a program for burnout and compassion fatigue.

As noted in the findings above, a third of BH, medical, and pastoral counseling personnel are experiencing burnout, compassion fatigue, and other professional impairments since being deployed. If one third of our providers are impaired, our ability to intervene early and assist Soldiers with their problems may be degraded.

In addition to studying Soldiers to better understand the products and processes of combat-induced trauma and deployment deprivation, it is vital to understand the processes of provider burnout in order to prevent and intervene in order to preserve the care in our caregivers.

Recommendation #12: Continue to appoint a BH consultant to the area of responsibility (AOR) Surgeons cell to advise the Surgeon on BH issues.

The OIF-II behavioral health consultant has been instrumental in advising the Surgeon on distribution of BH assets in theater for the delivery of BH care in the AOR; coordinating training and providing BH personnel consultation support; and consulting with the Surgeon on BH matters. Having a BH consultant to oversee the planning, coordination, and integration of BH assets in theater will help to ensure continuity of BH services delivery in theater during OIF-III.

APPENDIX 1

SUMMARY OF BEHAVIORAL HEALTH (BH) SURVEY

INTRODUCTION

The objective of the BH Survey was to gather data to assess the BH care services being rendered during OIF-II and provide recommendations based on the findings. Behavioral health personnel is defined in this section as officer and enlisted personnel who provide BH services to Soldiers.

FINDINGS

Finding #1: Standards of care for BH and COSC services and standards for documentation, records management, and transfer of clinical BH information are clear for most BH personnel. However, about one third of the BH personnel are unclear on documentation policies.

Behavioral health personnel were asked how clear the standards of BH/COSC services and documentation were to them. Fifty-seven percent agreed the standards of BH care in theater were clear, while 23% disagreed (20% were neutral). The standards of COSC services were clear for 53% and unclear for 23% of the BH personnel surveyed.

Documentation management in the theater was not clear for over one third of those surveyed. Behavioral health personnel agreed that standards for clinical documentation (41%), records management (33%), and transfer of clinical BH information between levels of care (35%) were clear. However, 33% indicated documentation standards were not clear, 39% reported records management was not clear, and 31% believed the standards for transfer of clinical BH information between levels of care in theater were not clear.

This finding indicates the need to provide training for deploying BH personnel on standards of care and documentation management. In some instances, Theater, the Army Medical Department (AMEDD), the Army, or the Department of Defense (DoD) may need to clarify policies.

Finding #2: Coordination is ongoing between BH personnel, UMTs, and PC providers.

Fifty-four percent of the BH personnel agreed they coordinated/integrated BH/COSC activities with the UMTs, and 73% coordinated/integrated their activities with PC providers. Sixty-two percent of the PC providers and 61% of the chaplains (58% chaplain assistants), in turn, reported coordinating MH activities with BH personnel. Results indicate coordination between these three groups is underutilized. All three groups are valuable resources for each other and together represent a force multiplier for Soldier support.

Seventy-eight percent of the PC providers reported on their survey that BH personnel had given them information about where to refer Soldiers for MH problems, and 76% reported they had received information about the services BH personnel had offered for Soldiers. Chaplains (83%) reported that BH personnel provided them with information on where to refer Soldiers for MH problems, and 88% had been educated on the services that BH personnel provided for Soldiers. Although the great majority of respondents indicated they were informed of where to refer Soldiers for BH care, further coordination would capitalize on the strengths of these three professional groups.

Finding #3: Many BH providers reported inadequate coordination with their higher headquarters.

Thirty-nine percent of BH personnel reported their higher headquarters (HHQ) did not encourage them to provide feedback/comments regarding theater BH/COSC policies; 34% reported their HHQ did encourage feedback. Thirty-one percent agreed their HHQ provided resources required to conduct the BH/COSC mission, while 46% disagreed.

Two questions addressed medical leadership and line leadership in support of BH/COSC activities. Seventy-six percent of respondents believed medical leadership supports BH/COSC activities; 7% disagreed. Sixty-nine percent felt the leadership of the units they worked with supported BH/COSC activities; 11% disagreed.

Finding #4: Most BH personnel in theater report conducting outreach on a regular basis, despite challenges of working in the operational environment.

Behavioral health personnel were asked how frequently they provided services listed in Table 1. Sixty-nine percent were conducting COSC outreach services either weekly or several times a week, and 71% reported consulting with unit leaders once a week or more. Behavioral health personnel reported they were actively involved in conducting educational classes, psychological debriefings, and suicide prevention training. They also indicated they were providing services at the Soldiers' worksites as well as their own.

Table 1: Provider Responses to Questions on Frequency of Service Delivery

The numbers in the columns below (1 through 7) are percentage rates of the response for each question a. through j. Below the chart is the definition key for each numeral 1-7.

BH/COSC Services		(% of Respondents)						
During this deployment, how frequently did you:		1	2	3	4	5	6	7
a. Provide COSC outreach services?		6	2	6	6	10	13	56
b. Conduct educational classes?		10	1	5	11	9	17	47
c. Consult with unit leaders?		6	3	3	7	11	22	49
d. Conduct psychological debriefings (CED/CISD)?		22	10	14	11	29	9	6
e. Conduct systematic unit needs assessments?		36	11	14	17	14	5	4
f. Conduct Suicide Prevention Training?		34	12	17	12	15	8	4
g. Provide one-to-one BH counseling with Soldiers at their worksite?		23	3	11	10	11	13	30
h. Provide one-to-one COSC services with Soldiers at their worksite?		23	5	9	8	10	14	31
i. Provide one-to-one BH counseling with Soldiers at your worksite?		9	2	4	4	5	11	65
j. Provide one-to-one COSC services with Soldiers at your worksite?		12	3	4	4	8	12	57

1 = Never; 2 = Only once; 3 = Once every 2-3 months; 4 = Once a month;

5 = Two to three times a month; 6 = Once a week; 7 = Several times a week

Seventy-eight percent of those surveyed disagreed with the statement, "Behavioral health/COSC personnel don't think preventive outreach activities are effective" while 5% agreed with this statement. Seventy-four percent disagreed with the statement that providers don't like to perform outreach. These rates show a more positive acceptance to outreach activities when compared to two questions, of a similar nature, that were asked during the MHAT-I survey. Operation Iraqi Freedom (OIF-I) providers were asked, "How relevant is COSC doctrine to current operations?" Only 44% of the junior enlisted, 35% of the NCOs, and 45% of the officers agreed that it was relevant. Also, 57% of the BH personnel in OIF-I agreed COSC was the best method of early intervention.

It is important to note that 50% of the BH personnel in OIF-I reported they had not received adequate training in COSC, prior to deploying. Driven by these findings, the combat stress control BH consultant ensured units supporting OIF-II received "just in time training," prior to their deployment. Training teams were dispatched to the units' locations for 2 to 3 days of intensive COSC instruction. A portion of this training emphasized the importance for outreach.

Significant challenges remain that impact the BH providers' ability to provide care. Forty percent of the BH personnel agreed that there was inadequate transportation to conduct outreach activities, 30% agreed that there was inadequate communication between BH/COSC and supported units, and 27% reported traveling to supported units was too dangerous. Forty percent felt that arranging convoys to supported units was not difficult; however, 21% reported having to cancel missions due to the inability to arrange convoys.

Finding #5: Behavioral health personnel are confident in their ability to treat Soldiers with combat stress, suicidal thoughts/behaviors, or PTSD. They are not as confident to treat Soldiers with substance abuse/dependence, victims of sexual assault, or Iraqi people.

Behavioral health personnel expressed varying degrees of confidence in their ability to treat the following conditions listed in Table 2. These questions began with the phrase, “I feel confident in my ability to...” followed by each of the statements listed below.

Table 2: Confidence to Treat Varying Conditions

I feel confident in my ability to:	% Who	
	Agreed	Disagreed
Help Soldiers adapt to the stressors of combat/deployment.	95%	1%
Evaluate and manage Soldiers with suicidal thoughts/behaviors.	94%	1%
Evaluate and treat Soldiers with substance abuse/dependence.	70%	9%
Evaluate and treat combat and operational stress reaction.	94%	2%
Evaluate and treat acute stress disorder/PTSD.	91%	3%
Evaluate and treat victims of sexual assault.	63%	10%
Perform clinical evaluation and treatment of Iraqi civilians.	20%	44%
Perform clinical evaluation and treatment of detainees.	23%	42%
Perform clinical evaluation and treatment of Iraqi security force personnel.	22%	61%

It is evident that further training is needed to prepare BH personnel to manage Soldiers experiencing substance abuse/dependence, PTSD, and sexual assault.

Finding #6: Psychiatric medications in OIF-II were more readily available than they were during OIF-I at each level of care, but Levels I and II continue to have limited availability of psychiatric medications for those who are credentialed to prescribe.

Seventy-seven percent of the psychiatrists and nurses who had prescriptive authority reported adequate availability of appropriate psychiatric medications. Twenty-three percent disagreed. During OIF-I, only 36% of the psychiatrists and nurses felt that there was an adequate supply of psychiatric medication, an improvement from last year. Levels I and II continue to be perceived by some as problematic. The higher the level of care, the more available the medication became as 47% reported adequate availability of psychiatric medication at Level I (the battalion aid stations (BASs)); 78% reported adequate availability at Level II (the forward support medical company (FSMC)); and 94% reported adequate availability at Level III (CSHs). Providers were asked to list the medications that Soldiers needed at each level of care; the longest list was with Level I (there were a total of 14 medications listed). Of these 14 medications, only three were repeated twice on the list, Effexor, Zyban, and Zyprexa. For the medications listed, see Table 3. Level II had eight listed with only one medication, Olanzapine, which was listed twice. Level III had only one medication listed.

Table 3: Medications Needed at Each Level of Care

Level of Care	Medications not Available to Prescribe
Level I	Ambien *, Buspar, Depakote (Extended Release), Effexor, Olanzapine, Prazosin, Remeron, Seroquel, Strattera, Trazadone* Wellbutrin XR**, Zyban, Nicoderm patch
Level II	Concerta, Lexapro, Paxil*, Prazosin, Remeron, Seroquel, Sonata, Olanzapine
Level III	Seroquel

* Approved for the medical equipment set at Level I, May 2004

** Approved for the medical equipment set at Level II, May 2004

During this past year, a process action team (PAT) of psychiatrists recommended additions to the psychiatric medication formulary in the medical equipment set's (MES's) sick call (Level I), patient holding (Level II), and the CSH pharmacy. The Directorate of Combat and Doctrine Development's (DCDD's) combat casualty care integrated concept team approved the additions in May 2004, and the MESs will be updated to incorporate these changes. Also added were Celexa at Level I and Prozac and Zoloft at Level II. Space available for basic loads of medications at Levels I and II is very limited, while special medications can be supplied on request from a CSH or through Medical Logistics. The theater BH consultants (Kuwait and Iraq) are working with the pharmacy officer in the Corps Surgeon's office on a theater-wide formulary, following data collected from providers in theater.

Finding #7: A quarter (25%) of the BH personnel surveyed reported a lack of confidence in their ability to use the COSC-WARS.

Forty-seven percent of the BH personnel reported they were confident in their ability to use the COSC-WARS. Twenty-eight percent neither agreed nor disagreed.

Finding #8: Behavioral health personnel are using multiple methods to assess the BH/COSC needs of Soldiers and units. Thirty-nine percent are using validated surveys/instruments.

Behavioral health personnel were asked how they assessed the BH/COSC needs of the units and the Soldiers they support. Ninety-two percent reported they talk informally to Soldiers; 77% talk to unit medical personnel; 72% talk with unit commanders; 71% talk to chaplains; 42% conduct focus groups; 42% use locally developed surveys; and 39% use validated surveys/instruments. These are effective methods, but there continues to be a need to provide BH personnel with a standardized Soldier and unit needs assessment tool that can objectively quantify BH needs and needs of the Commander.

Finding #9: One third of BH personnel are experiencing burnout.

Thirty-three percent of BH personnel reported high burnout, 27% reported low motivation, and 22% reported low morale. Fifteen percent agreed that the stressors of deployment impaired their BH job; in addition, 12% felt that their sensitivity to the needs of the Soldiers had been adversely affected.

BACKGROUND

Survey Methods and Procedures

The OIF-II Mental Health Advisory Team (MHAT-II) designed the BH survey. The questions were devised by consensus of the team members to gather data on a variety of topics of interest to the MHAT-II mission, such as standards of practice, provision and coordination of services, skills and training in relation to compliance and understanding of COSC doctrine, involvement in suicide prevention, perceived stigma and barriers to MH care, and resource deficits. A copy of the instrument can be found at TAB A.

The MHAT-II traveled throughout the Kuwait Combined Forces Land Combat Command (CFLCC) and the Iraq MNC-I operational theaters and administered surveys and conducted interviews with BH personnel between 28 August and 30 September 2004. All BH personnel who the MHAT-II contacted were asked to complete the survey regardless of their current work assignment or unit. Participants were briefed on the mission and informed that the survey was both anonymous and voluntary. All BH personnel asked to complete the survey chose to participate.

Quality Control of Data

The MHAT-II collected a total of 137 surveys from BH personnel throughout Kuwait and Iraq and hand-entered the data into a Microsoft (MS) Access database. A 10% quality control (QC) was performed on the dataset to check for entry errors. Each and every one of the survey fields was read aloud by one staff member, while another staff member checked the hand-entered MS Access database.

Fifteen (15) out of 137 surveys were quality checked. Each survey contained 97 fields, for a denominator of 1455. Results revealed a total of 1 error (in the comment field). The error rate for all mistakes was 1/1455 or .069%, well within the acceptable 0.2% limit.

Comparison Populations

Data from the OIF-I behavioral health survey, conducted between 29 August and 30 September 2003, are included in this report when comparisons of similar questions can be made. Most of the behavioral health OIF-II survey questions were altered to better quantify the participants' response and to also capture the changes made in the BH system between 2003 and 2004.

Study Sample

A convenience sample of 137 (59%) of the 232 (as of 1 October 2004) Iraq and Kuwait BH providers and enlisted MH specialists completed the survey at 17 locations around theater. Sixty-three percent of the survey respondents were age 30 or more. The rank distribution is as follows: junior enlisted Soldiers 28%, NCOs 27%, and officers 46%. Thirty-nine percent of all surveyed were active component, 52% Army Reserve, and 9%

National Guard. Ninety-six percent of the participants were Army, 2% were Navy, and 2% were Air Force. Sixty-five percent of the sample was male.

Participants had been deployed an average of 210 days (7 months) over the past 2 years; 25% said 1 year. Ninety-five percent of those surveyed reported currently working in their BH job. Table 4 shows the types of personnel represented in the survey.

Table 4: AOCs and MOSs Represented in the BH Survey

AOC/MOS	Description	Number	Percent of Respondents
60W	Psychiatrists	19	14%
65A	Occupational Therapists (OT)	5	4%
66C	Psychiatric Nurses	7	5%
73A	Social Workers	20	15%
73B	Clinical Psychologists	10	7%
91WN3	OT Assistants	7	5%
91X	Mental Health Specialists	62	46%
Other	Other/Did not Answer	7	4%

TAB A: Behavioral Health (BH) Survey

Behavioral Health/Combat and Operational Stress Control Personnel Survey

This survey is being conducted under the auspices of The Army Surgeon General's OIF Mental Health Advisory Team (MHAT). The purpose of this questionnaire is to gather data about the current mental well-being of Soldiers and behavioral health personnel in theater and the functioning of the mental health system in OIF/OEF. Your responses will not be linked to you as an individual.

Definitions: In this survey, Combat and Operational Stress Control (COSC) is used synonymously with preventive, educational and outreach services, and the management of combat and operational stress reactions (COSRs) as described in FM 8-51. Behavioral health (BH) is used synonymously with clinical care for behavioral health disorders (i.e., evaluation and treatment).

Today's Date: _____

Please circle the number of the category that best describes you.

A. DEMOGRAPHICS			
Age: 1 = 18-20 2 = 21-24 3 = 25-29 4 = 30-39 5 = 40 or older	Gender: 1 = Male 2 = Female	Grade/Rank: 1 = E1-E4 2 = E5-E6 3 = E7-E9 4 = O1-O3 5 = O4-O6 6 = WO1-WO5	Primary Component: 1 = Active Component 2 = Reserve (USAR) 3 = National Guard 4 = AGR 5 = Individual Ready Reserve (IRR)
MOS/AOC: 1 = Psychiatrist (60W) 2 = Occ Therapist (65A) 3 = Psych Nurse (66C) 4 = Social Worker (73A) 5 = Clin Psychologist (73B) 6 = OT Specialist (91WN3) 7 = MH Specialist (91X) 8 = Other: _____	Which region best describes where you are currently serving? 1 = Northern Iraq (Mosul area) 2 = North East Iraq (Kirkuk area) 3 = North Central Iraq (Tikrit/Balad area) 4 = Central Iraq (Baghdad area) 5 = South Central Iraq (Karbala to Nasiriyah) 6 = South Iraq (Basra area) 7 = North Kuwait (Udairi, Virginia, etc.) 8 = South Kuwait (Doha, Arifjan, etc.) 9 = Other: _____		For THIS deployment, please indicate the MONTH/YEAR you arrived in theater: How long (MONTHS) should a deployment last?
How many TOTAL DAYS have you been deployed (combat or peacekeeping) in the past 2 years?			
How many MONTHS have you been assigned to your current unit?			
How many MONTHS has your current unit been deployed to Iraq/Kuwait?			
Are you currently working in my BH/COSC job?			Yes / No

Please circle the number indicating the degree to which you agree or disagree with the statements below.
 1 = *Strongly Disagree*; 2 = *Disagree*; 3 = *Neither agree nor disagree*; 4 = *Agree*; 5 = *Strongly Agree*

B. STANDARDS	
1. The standards of BH care in this theater/Area of Operations are clear.	1 2 3 4 5
2. The standards of COSC services in this theater/Area of Operations are clear.	1 2 3 4 5
3. The standards for clinical documentation in this theater/Area of Operations are clear.	1 2 3 4 5
4. The standards for records management in this theater/Area of Operations are clear.	1 2 3 4 5
5. The standards for transfer of clinical BH information between levels of care in this theater/Area of Operations are clear.	1 2 3 4 5

C. COORDINATION	
1. My higher headquarters provides us with the resources required to conduct our BH/COSC mission.	1 2 3 4 5
2. My higher headquarters encourages us to provide feedback/comments to theater/Area of Operations BH/COSC policies.	1 2 3 4 5
3. We coordinate/integrate our BH/COSC activities with the Unit Ministry Teams in our Area of Operations.	1 2 3 4 5
4. We coordinate/integrate our BH/COSC activities with primary care medical personnel in the battalion aid stations/medical companies.	1 2 3 4 5

Please circle the number indicating the degree to which you agree or disagree with the statements below.
 1 = *Never*; 2 = *Only once*; 3 = *Once every 2-3 months*; 4 = *Once a month*;
 5 = *Two to three times a month*; 6 = *Once a week*; 7 = *Several times a week*

D. COMBAT AND OPERATIONAL STRESS CONTROL AND BEHAVIORAL HEALTH SERVICES	
1. During this deployment, how frequently did you:	
a. Provide COSC outreach services?	1 2 3 4 5 6 7
b. Conduct educational classes?	1 2 3 4 5 6 7
c. Consult with unit leaders?	1 2 3 4 5 6 7
d. Conduct psychological debriefings (CED/CISD)?	1 2 3 4 5 6 7
e. Conduct systematic unit needs assessments?	1 2 3 4 5 6 7
f. Conduct Suicide Prevention Training?	1 2 3 4 5 6 7
g. Provide one-to-one BH counseling with Soldiers at their worksite?	1 2 3 4 5 6 7
h. Provide one-to-one COSC services with Soldiers at their worksite?	1 2 3 4 5 6 7
i. Provide one-to-one BH counseling with Soldiers at the BH/COSC unit location?	1 2 3 4 5 6 7
j. Provide one-to-one COSC services with Soldiers BH/COSC unit location?	1 2 3 4 5 6 7
2. Approximately how many Soldiers does your team support?	
3. How many locations (base camps/FOBs) does your BH/COSC team support?	
4. On average, how many hours does it take to convoy to the base camps you support (including preparation time)?	

Please circle the number indicating the degree to which you agree or disagree with the statements below.
 1 = *Strongly Disagree*; 2 = *Disagree*; 3 = *Neither agree nor disagree*; 4 = *Agree*; 5 = *Strongly Agree*

E. SKILLS AND TRAINING	
1. I feel confident in my ability to:	
a. Use the COSC Workload and Activity Reporting System (COSC-WARS).	1 2 3 4 5
b. Help Soldiers adapt to the stressors of combat/deployment.	1 2 3 4 5
c. Evaluate and manage Soldiers with suicidal thoughts/behaviors.	1 2 3 4 5
d. Evaluate and treat Soldiers with substance abuse/dependence.	1 2 3 4 5
e. Evaluate and treat Combat and Operational Stress Reaction.	1 2 3 4 5
f. Evaluate and treat Acute Stress Disorder/PTSD.	1 2 3 4 5
g. Evaluate and treat victims of sexual assault.	1 2 3 4 5
h. Perform clinical evaluation and treatment of Iraqi civilians.	1 2 3 4 5
i. Perform clinical evaluation and treatment of detainees.	1 2 3 4 5
j. Perform clinical evaluation and treatment of Iraqi Security Force personnel.	1 2 3 4 5

Please circle the number indicating the degree to which you agree or disagree with the statements below.
 1 = *Strongly Disagree*; 2 = *Disagree*; 3 = *Neither agree nor disagree*; 4 = *Agree*; 5 = *Strongly Agree*

F. STIGMA AND BARRIERS TO CARE	
1. Commanders welcome back Soldiers who have received COSC services from my team.	1 2 3 4 5
2. Commanders welcome back Soldiers who have been assessed for suicidal thoughts/behaviors and returned to duty.	1 2 3 4 5
3. Commanders welcome back Soldiers who have been assessed for homicidal thoughts/behaviors and returned to duty.	1 2 3 4 5
4. Commanders welcome back Soldiers who have received other BH services from my team.	1 2 3 4 5
5. The medical leadership doesn't support BH/COSC outreach.	1 2 3 4 5
6. The supported units' leadership doesn't support BH/COSC activities.	1 2 3 4 5
7. There is inadequate transportation to conduct outreach activities.	1 2 3 4 5
8. There is inadequate communication between BH/COSC and supported units.	1 2 3 4 5
9. Soldiers feel uncomfortable talking to BH/COSC personnel about their problems.	1 2 3 4 5
10. BH/COSC personnel are unfamiliar with supported unit's leadership and Soldiers.	1 2 3 4 5
11. Traveling to supported units is too dangerous.	1 2 3 4 5
12. Arranging convoys to supported units is too difficult.	1 2 3 4 5
13. The inability to arrange convoys has led to mission cancellations.	1 2 3 4 5
14. BH/COSC personnel don't like to perform outreach services.	1 2 3 4 5
15. BH/COSC personnel aren't trained to conduct outreach services.	1 2 3 4 5
16. BH/COSC personnel are not available due to performing non-BH/COSC missions.	1 2 3 4 5
17. BH/COSC personnel don't think preventive outreach activities are effective.	1 2 3 4 5

Please circle the number indicating the degree to which you agree or disagree with the statements below.
1 = Never; 2 = Seldom; 3 = Frequently; 4 = Always

G. SOLDIER NEEDS	
1. How do you assess the BH/COSC needs of the units you support?	
a. Talk informally to the Soldiers	1 2 3 4
b. Conduct focus groups with Soldiers	1 2 3 4
c. Talk with the chaplains	1 2 3 4
d. Talk with the unit's commander	1 2 3 4
e. Talk with the unit's medical personnel	1 2 3 4
f. Use validated surveys/instruments	1 2 3 4
g. Use locally developed surveys/instruments	1 2 3 4
h. Develop a BH/COSC unit prevention and early intervention plan	1 2 3 4
i. Conduct Command Consultation	1 2 3 4

Please circle the number indicating the degree to which you agree or disagree with the statements below.
1 = Strongly Disagree; 2 = Disagree; 3 = Neither agree nor disagree; 4 = Agree; 5 = Strongly Agree

H. PERSONAL WELL-BEING	
1. My ability to do my behavioral health job is impaired by the stressors of deployment/combat.	1 2 3 4 5
2. My mental well-being has been adversely affected by the events I have witnessed on this deployment.	1 2 3 4 5
3. My spiritual well-being has been adversely affected by the events I have witnessed on this deployment.	1 2 3 4 5
4. Since this deployment, I have become less sensitive to the needs of the Soldiers I serve/support.	1 2 3 4 5
5. My ability to do my job is impaired by listening to the combat experiences of Soldiers I've talked with while performing my BH/COSC mission.	1 2 3 4 5

Please circle the number indicating the degree to which you agree or disagree with the statements below.
1 = Very low; 2 = Low; 3 = High; 4 = Very high

6. Please rate the following:	
a. Your personal morale	1 2 3 4
b. Your energy level	1 2 3 4
c. Your level of burnout	1 2 3 4
d. Your motivation	1 2 3 4

The following equipment/supplies would have improved my team's ability to complete our BH/COSC mission:

Please circle the number indicating the degree to which you agree or disagree with the statements below.

1 = *Strongly Disagree*; 2 = *Disagree*; 3 = *Neither agree nor disagree*; 4 = *Agree*; 5 = *Strongly Agree*

I. PSYCHIATRIC MEDICATION (ONLY PSYCHIATRISTS/NURSE PRACTITIONERS/PAs)	
1. The procedures for ordering/replenishing psychiatric medications in this theater/Area of Operations are clear.	1 2 3 4 5
2. In general, there has been adequate availability of appropriate psychiatric medications in the area of operations.	Yes / No
3. There has been adequate availability of appropriate psychiatric medication at these levels of care:	
a. Level I (Battalion Aid Station)	Yes / No
b. Level II (Forward Support Medical Company)	Yes / No
c. Level III (Combat Support Hospital)	Yes / No
4. What medications were needed by Soldiers during this deployment, but were not available to prescribe?	a) _____ b) _____ c) _____

Please provide any additional comments below.

Thank you for completing this survey!

APPENDIX 2

SUMMARY OF PRIMARY CARE (PC) SURVEY

INTRODUCTION

Primary care is frequently a BH referral source for Soldiers with MH problems. Some PC providers prescribe medication for mental disorders in addition to monitoring and refilling previously prescribed psychotropic medications. A part of the OIF-II Mental Health Advisory Team's (MHAT-II's) mission was to evaluate the working relationship between PC providers and BH personnel rendered in theater. The MHAT-II devised an anonymous questionnaire for primary medical care personnel. These personnel were doctors, physician assistants (PAs), nurses, and medics serving in BASs, FSMCs, and CSHs. Behavioral healthcare personnel is defined in this appendix as officer and enlisted personnel who provide BH services to Soldiers.

FINDINGS

Finding #1: Coordination is ongoing between PC personnel, BH personnel, and UMTs.

Over three quarters of the PC providers surveyed (78%) reported BH personnel had provided them information about where to refer Soldiers for MH problems, and 76% reported BH personnel had educated them on BH/COSC services available for Soldiers.

Forty-seven percent of the PC providers reported they coordinated/integrated their MH activities with UMTs, and 62% coordinated/integrated MH activities with BH personnel.

Finding #2: Primary care providers are helping Soldiers with MH problems, and they are referring Soldiers with MH problems to BH services.

Primary care providers were asked how frequently they provided services listed on the next page in Table 1. Twenty-four percent of the respondents reported helping Soldiers with MH problems either once or several times a week. Of this 24%, 14% referred Soldiers to BH personnel. While 78% of PC respondents indicated they had received information on where to refer Soldiers for MH services, 23% had not referred any Soldiers with MH problems to BH personnel; 8% had referred once; 22% had referred once every 2 to 3 months, and 47% had referred once a month or more.

Table 1: Provider Responses to Questions on Frequency of Service Delivery

The numbers in the columns below (1 through 7) are percentage rates of the response for each question in the left column. Below the chart is the definition key for each numeral 1-7.

PC Provider Provision of Mental Health Services		(% of Respondents)						
During this deployment, how frequently did you:		1	2	3	4	5	6	7
Help Soldiers for a mental health problem?		15	10	16	13	22	13	11
Conduct educational (stress management) classes?		68	11	10	6	3	1	1
Consult with unit leaders regarding mental health issues?		41	13	21	10	10	5	2
Refer Soldiers with mental health problems to the Chaplain?		40	14	22	10	10	3	2
Refer Soldiers with problems to the mental health personnel?		23	8	22	13	20	9	5

1 = Never; 2 = only once; 3 = Once every 2-3 months; 4 = Once a month; 5 = Two to three times a month; 6 = Once a week; 7 = Several times a week

Finding #3: Almost three fourths of the PC providers feel confident in their ability to help Soldiers face MH issues, but are less confident to treat Soldiers with PTSD, substance abuse, or sexual assault.

While 73% of the PC providers reported they felt confident in helping Soldiers face MH issues during this deployment, 47% were confident in treating Soldiers with substance abuse/dependence; 58% were confident in treating Soldiers with combat and operational stress reaction (COSR); 64% were confident in treating acute stress disorder/PTSD; and 39% were confident in treating victims of sexual assault.

Finding #4: Primary care personnel do not believe many commanders will welcome back their Soldiers with BH problems.

Thirty-two percent of the PC providers believed commanders would welcome back Soldiers who received MH services, 22% agreed that commanders would welcome back Soldiers who displayed suicidal thoughts/behaviors, and 18% agreed that commanders would welcome back Soldiers with homicidal thoughts/behaviors.

Finding #5: Just over one third of PC personnel are experiencing burnout.

Thirty-seven percent of PC providers reported high burnout, 35% reported low motivation, and 35% reported low morale. Fifteen percent agreed that the stressors of deployment had impaired their medical job, and 14% indicated they had become less sensitive to the needs of Soldiers during this deployment.

BACKGROUND

Survey Methods and Procedures

The MHAT-II designed the PC survey. No standardized questions were used, though most of the questions were devised by consensus of the team members. Where possible, questions were standardized across the BH, PC, and UMT surveys. The questions ranged on a variety of topics of interest to the MHAT-II mission, such as standards of practice, provision and coordination of services, skills and training in relation to compliance and understanding of BH services, perceived stigma and barriers

to MH care, and general personal well-being. A copy of the instrument can be found at TAB A.

The MHAT traveled throughout the Kuwait (CFLCC) and Iraq (MNC-I) operational theaters and administered surveys and conducted interviews with PC providers between 28 August and 30 September 2004. All PC providers who the MHAT-II contacted were asked to complete the survey regardless of their current work assignment or unit. Participants were briefed on the mission and informed that the survey was both anonymous and voluntary. All PC providers, which were asked to complete the survey, elected to participate.

Quality Control of Data

A total of 242 surveys were collected and the data entered into MS Access. A 10% QC was performed on the dataset to check for entry errors. Each and every one of the survey fields was read aloud by one staff member, while another staff member checked the hand-entered MS Access database.

Twenty-five (25) out of 242 surveys were quality checked. Each survey contained 68 fields, for a denominator of 1,700. Results revealed a total of 2 errors in 2 different fields. The error rate for all mistakes was 2/1,700 or .118%, below the accepted 0.2% error rate standard.

Study Sample

A convenience sample of 242 PC surveys was collected in 24 different locations around Iraq and Kuwait. (See Table 2 for professions represented.) Sixty-five percent of the surveyed respondents were age 30 or more. The rank distribution is as follows: junior enlisted Soldiers 20%, NCOs 22%, and officers 58%. Seventy-two percent of all surveyed were active component, 4% Army Reserve, and 23% National Guard. Ninety-five percent of the participants were Army, 4% were Navy, and 1% was Air Force. Seventy-two percent of the sample was male.

Participants had been deployed an average of 229 days (7.6 months) over the past 2 years, and 89% of those surveyed reported currently working in their PC job. Table 2 shows the types of professionals represented in the survey.

Table 2: AOCs and MOSs Represented in the PC Survey

Description	Number	Percent of Respondents
Medical Specialist 91W	85	35%
Physician Assistant	47	20%
Family Practice	28	15%
Nurse	10	4%
Emergency Medicine	9	4%
Flight Surgeon	7	3%
General Medical Officer	4	2%
Other (Internal Medicine, Surgeon, midwife, etc.)	51	21%

TAB A: Primary Care (PC) Survey

Primary Care (BAS/Medical) Personnel Survey

This survey is being conducted under the auspices of The Army Surgeon General's OIF Mental Health Advisory Team (MHAT). The purpose of this questionnaire is to gather data about the current mental well-being of Soldiers in theater and the functioning of the mental health system in OIF/OEF. Your responses will not be linked to you as an individual.

Definition: Mental health care is the clinical care of Soldiers with mental health problems or combat and operational stress reactions.

Today's Date: _____

Please circle the number of the category that best describes you.

A. DEMOGRAPHICS			
Age: 1 = 18-20 2 = 21-24 3 = 25-29 4 = 30-39 5 = 40 or older	Gender: 1 = Male 2 = Female	Grade/Rank: 1 = E1-E4 2 = E5-E6 3 = E7-E9 4 = O1-O3 5 = O4-O6 6 = WO1-WO5	Primary Component: 1 = Active Component 2 = Reserve (USAR) 3 = National Guard 4 = AGR 5 = Individual Ready Reserve (IRR)
MOS/AOC: 1 = Emerg Med (61B) 2 = Family Practice (61H) 3 = Flight Surgeon (61N) 4 = GMO (62B) 5 = PA (65D) 6 = Nurse (66B) 7 = Med Specialist (91W) 8 = Other: _____	Which region best describes where you are currently serving? 1 = Northern Iraq (Mosul area) 2 = North East Iraq (Kirkuk area) 3 = North Central Iraq (Tikrit/Balad area) 4 = Central Iraq (Baghdad area) 5 = South Central Iraq (Karbala to Nasiriyah) 6 = South Iraq (Basra area) 7 = North Kuwait (Udairi, Virginia, etc.) 8 = South Kuwait (Doha, Arifjan, etc.) 9 = Other: _____	For THIS deployment, please indicate the MONTH/YEAR you arrived in theater: How long (MONTHS) should a deployment last? 	
How many TOTAL DAYS have you been deployed (combat or peacekeeping) in the past 2 years?			
How many MONTHS have you been assigned to your current unit?			
How many MONTHS has your current unit been deployed to Iraq/Kuwait?			
Are you currently working in my medical job?			Yes/No

Please circle the number indicating the degree to which you agree or disagree with the statements below.
 1 = Strongly Disagree; 2 = Disagree; 3 = Neither agree nor disagree; 4 = Agree; 5 = Strongly Agree

B. STANDARDS	
1. The standards of medical care in this theater/Area of Operations are clear.	1 2 3 4 5
2. The standards of mental health care in this theater/Area of Operations are clear.	1 2 3 4 5
3. The standards for clinical documentation in this theater/Area of Operations are clear.	1 2 3 4 5
4. The standards for records management in this theater/Area of Operations are clear.	1 2 3 4 5
5. The standards for transfer of clinical mental health information between levels of care in this theater/Area of Operations are clear.	1 2 3 4 5

C. COORDINATION	
1. We coordinate/integrate our mental health activities with the Unit Ministry Teams in our Area of Operations.	1 2 3 4 5
2. We coordinate/integrate our mental health activities with mental health personnel in our Area of Operations.	1 2 3 4 5
3. Mental health personnel have provided us information about where to refer Soldiers for mental health problems.	1 2 3 4 5
4. Mental health personnel have provided us information about the services they provide to Soldiers.	1 2 3 4 5

Please circle the number indicating the degree to which you agree or disagree with the statements below.
 1 = Never; 2 = Only once; 3 = Once every 2-3 months; 4 = Once a month;
 5 = Two to three times a month; 6 = Once a week; 7 = Several times a week

D. COMBAT AND OPERATIONAL STRESS CONTROL AND MENTAL HEALTH SERVICES	
1. During this deployment, how frequently did you:	
a. Help Soldiers for a mental health problem?	1 2 3 4 5 6 7
b. Conduct educational (stress management) classes?	1 2 3 4 5 6 7
c. Consult with unit leaders regarding mental health issues?	1 2 3 4 5 6 7
d. Refer Soldiers with mental health problems to the Chaplain?	1 2 3 4 5 6 7
e. Refer Soldiers with problems to the mental health personnel?	1 2 3 4 5 6 7
2. Approximately how many Soldiers does your team support?	

Please circle the number indicating the degree to which you agree or disagree with the statements below.
 1 = Strongly Disagree; 2 = Disagree; 3 = Neither agree nor disagree; 4 = Agree; 5 = Strongly Agree

E. SKILLS AND TRAINING	
1. I feel confident in my ability to:	
a. Help Soldiers face mental health issues during the deployment.	1 2 3 4 5
b. Evaluate and treat Soldiers with substance abuse/dependence.	1 2 3 4 5
c. Evaluate and treat Combat and Operational Stress Reaction.	1 2 3 4 5
d. Help Soldiers face BH/COSC issues during the deployment.	1 2 3 4 5
e. Evaluate and treat Acute Stress Disorder/Posttraumatic Stress Disorder.	1 2 3 4 5
f. Evaluate and treat victims of sexual assault.	1 2 3 4 5
g. Perform clinical evaluation and treatment of Iraqi civilians.	1 2 3 4 5
h. Perform clinical evaluation and treatment of detainees.	1 2 3 4 5
i. Perform clinical evaluation and treatment of Iraqi Security Force personnel.	1 2 3 4 5

Please circle the number indicating the degree to which you agree or disagree with the statements below.
 1 = *Strongly Disagree*; 2 = *Disagree*; 3 = *Neither agree nor disagree*; 4 = *Agree*; 5 = *Strongly Agree*

F. STIGMA AND BARRIERS TO MENTAL HEALTH CARE	
1. Commanders welcome back Soldiers who have received mental health services from my team.	1 2 3 4 5
2. Commanders welcome back Soldiers who have been assessed for suicidal thoughts/behaviors and returned to duty.	1 2 3 4 5
3. Commanders welcome back Soldiers who have been assessed for homicidal thoughts/behaviors and returned to duty.	1 2 3 4 5

Please circle the number indicating the degree to which you agree or disagree with the statements below.
 1 = *Strongly Disagree*; 2 = *Disagree*; 3 = *Neither agree nor disagree*; 4 = *Agree*; 5 = *Strongly Agree*

G. PERSONAL WELL-BEING	
1. My ability to do my medical job is impaired by the stressors of deployment/combat.	1 2 3 4 5
2. My mental well-being has been adversely affected by the events I have witnessed on this deployment.	1 2 3 4 5
3. My spiritual well-being has been adversely affected by the events I have witnessed on this deployment.	1 2 3 4 5
4. Since this deployment, I have become less sensitive to the needs of the Soldiers I serve/support.	1 2 3 4 5
5. My ability to do my job is impaired by listening to the combat experiences of Soldiers I've talked with while performing my BH/COSC mission.	1 2 3 4 5

Please circle the number indicating the degree to which you agree or disagree with the statements below.
 1 = *Very low*; 2 = *Low*; 3 = *High*; 4 = *Very high*

6. Please rate the following:	
a. Your personal morale	1 2 3 4
b. Your energy level	1 2 3 4
c. Your level of burnout	1 2 3 4
d. Your motivation	1 2 3 4

The following equipment/supplies would have improved my team's ability to complete our medical mission:

Please circle the number indicating the degree to which you agree or disagree with the statements below.
 1 = *Strongly Disagree*; 2 = *Disagree*; 3 = *Neither agree nor disagree*; 4 = *Agree*; 5 = *Strongly Agree*

H. PSYCHIATRIC MEDICATION (ONLY PHYSICIANS/NURSE PRACTITIONERS/PAs)	
1. The procedures for ordering/replenishing psychiatric medications in this theater/Area of Operations are clear.	1 2 3 4 5
2. In general, there has been adequate availability of appropriate psychiatric medications in the area of operations.	Yes / No
3. There has been adequate availability of appropriate psychiatric medication at these levels of care:	
a. Level I (Battalion Aid Station)	Yes/No
b. Level II (Forward Support Medical Company)	Yes/No
c. Level III (Combat Support Hospital)	Yes/No

Please circle the number indicating the degree to which you agree or disagree with the statements below.
 1 = *Never*; 2 = *Only once*; 3 = *Once every 2-3 months*; 4 = *Once a month*;
 5 = *Two to three times a month*; 6 = *Once a week*; 7 = *Several times a week*

4. During this deployment, how frequently did you prescribe medication for:	
a. Sleep problems?	1 2 3 4 5 6 7
b. Depression?	1 2 3 4 5 6 7
c. Anxiety?	1 2 3 4 5 6 7
5. What medications did Soldiers need during this deployment, but were not available to prescribe?	a) _____ b) _____ c) _____

Please provide any additional comments below.

Thank you for completing this survey!

APPENDIX 3

SUMMARY OF UNIT MINISTRY TEAM (UMT) SURVEY

INTRODUCTION

The Unit Ministry Team (UMT) survey was administered to gather data regarding the UMT's pastoral support of deployed troops, how well they interface with BH assets during OIF-II, and to provide recommendations from the identified findings. The UMT personnel are defined as both chaplains and chaplain assistants and are included in all analyses below, except where otherwise noted.

Prior to their deployment to theater, the MHAT members constructed the survey. The UMT survey from last year's MHAT-I focused on UMTs and suicide prevention. This survey focused on combat stress and UMT's interface with the BH system in theater. Standardized questions were used in conjunction with BH and PC formats and devised by consensus of the team members. The questions covered a variety of topics of interest to the MHAT mission, such as coordination with BH assets for CSC, UMT religious and pastoral care activities, skills and training, perceived stigma and barriers to care, Soldiers' needs, personal well-being of the UMT member, and what UMT members perceive as the major issues impacting Soldiers. Space was provided for participants to make comment regarding equipment needed, and any additional comments regarding the deployment.

FINDINGS

Finding #1: Most UMT personnel are providing suicide prevention training.

Eighty-five percent of UMT personnel (91% of chaplains) report that they have conducted suicide prevention training at least once during the deployment. Just over half (51%) conduct suicide prevention training monthly or more often.

Finding #2: Most chaplains are conducting critical event debriefing (CED) sessions.

Seventy-six percent report conducting at least one CED/Critical Incident Stress Debriefing (CISD) session during the deployment; 25% conduct CED/CISDs monthly or more often.

Finding #3: Unit ministry team personnel regularly identify Soldiers at risk for battle fatigue.

Twenty-five percent of UMT personnel (82% of chaplains) report having identified at least one Soldier at risk for battle fatigue, and nearly half (49%) report identifying a Soldier once a month or more often. Fifteen percent identify a Soldier at risk once a week or more often. (Note: Army Chaplain Corps doctrine still uses the term "battle

fatigue” for what joint medical doctrine now refers to as “combat and operational stress reactions (COSRs).”)

Finding #4: Unit ministry team personnel report receiving good coordination from BH personnel. Most chaplains report coordinating/integrating their UMT religious activities with the BH/COSC team(s) and PC personnel in their Area of Operations (AO).

Eighty-three percent of UMT personnel agreed that BH personnel had provided them with information about MH services that were provided, and where to refer soldiers with MH problems. Fifty-eight percent of UMT personnel (61% of the chaplains) acknowledged coordinating/integrating their UMT activities with BH personnel. Sixty-three percent (75% of chaplains) coordinated/integrated services with PC personnel in their AO.

Finding #5: Most UMT personnel report high morale, energy, and motivation. Most also report that their mental and spiritual well-being and their ability to do their job have not been impaired by deployment/combat stressors. However, there were some UMT personnel who reported problems with burnout.

A great majority of UMT personnel indicated high levels of morale, energy, and motivation. Seventy-six percent reported that morale was high or very high. Seventy-two percent indicated that their energy level was either high or very high. Eighty-five percent reported high or very high levels of motivation. Sixty-two percent reported that their level of burnout was low or very low.

Most UMT personnel reported that their mental well-being was not adversely affected by their role as providers. Sixty-nine percent of the UMTs surveyed disagreed or strongly disagreed that their mental well-being was adversely affected by listening to the combat experiences of Soldiers. Further, 79% of UMT personnel surveyed disagreed or strongly disagreed that the stressors of deployment and combat impair their job.

Although most are doing well, 16% of UMT personnel agreed or strongly agreed that the stressors of the deployment and combat impaired their job. They also reported low or very low personal energy (28%), personal motivation (23%), personal morale (18%), and high or very high personal burnout (33%). Some also reported having their mental (13%) or spiritual (15%) well-being adversely affected by combat or deployment stressors.

RECOMMENDATIONS

Recommendation #1: Ensure UMT personnel understand COSC principles.

Field Manual (FM) 1-05 states that “the Unit Ministry Team works closely with the unit's leaders and medical personnel to care for battle fatigue cases through religious support and comfort.” Survey data revealed that UMT personnel regularly identify Soldiers with combat and operational stress and that they regularly provide CED/CISDs within their units. Working together, BH and UMT personnel can provide reinforced vigilance and intervention to Soldiers who might not otherwise seek or receive care.

Recommendation #2: Research burnout and develop/implement a program to prevent or reduce it.

Although the vast majority of chaplains and chaplain assistants are doing very well, a small, but significant portion (15-30%) are experiencing combat/deployment-induced problems that may affect their ability to care for Soldiers. Further research into the causes, effects, and mitigating factors involved in the burnout process is needed. Once these factors are better understood, prevention and/or intervention programs should be devised to assist UMT personnel.

BACKGROUND

Procedures

The MHAT traveled throughout the Kuwait (CFLCC) and Iraq (MNC-I) operational theaters, and administered surveys to UMT personnel between 29 August and 8 October 2004. Surveys were administered to combat, combat support, and combat service support units. The UMTs were surveyed as part of these units that the MHAT surveyed.

The MHAT personnel administered the surveys. All participants were briefed on the mission of the MHAT and informed that the survey was both anonymous and voluntary. All UMT personnel asked to complete the survey did so.

Quality Control of Data

Data collected from the surveys were entered into a MS Access database. A 10% quality check was performed on the first 150 surveys entered into the dataset to check for entry errors. Each and every one of the survey fields was read aloud by one staff member, while another staff member checked the hand-entered MS Access database. Fifteen out of 150 surveys were quality checked; 80 fields in each survey. Results revealed a total of 9 errors among the 1200 (80 x 15) fields checked. The error rate for all hand-entry mistakes was 0.75%.

Comparison of Data to OIF-I Mental Health Advisory Team

Due to changes in the survey, The OIF-I and OIF-II Unit Ministry Team surveys only have one question in common. The focus of the OIF-I Unit Ministry Team survey was suicide prevention, while the OIF-II UMT survey covered a wider variety of topics.

Study Sample

A convenience sample of 86 Army and 3 Air Force chaplains, and 74 Army, 2 Navy, and 4 Air Force chaplain assistants completed the survey between 29 August and 8 October 2004 at 21 locations in Kuwait and Iraq. Because UMT members were also canvassed during routine UMT training meetings in both Kuwait and Iraq, more than 21 locations are actually represented. More than 70% of the chaplains and chaplain assistants in Iraq were surveyed.

Of the commissioned chaplains, 46% were field grade officers, and of the enlisted chaplain assistants, 51% were NCOs. Of all the respondents, 57% were Active Component, 27% were National Guard, and 15% were Army Reserve Soldiers. Seventy-three percent of the chaplains were age 40 or older, while 77% of the chaplain assistants were under age 40. Two chaplains and seven chaplain assistants were female. The UMT personnel had been deployed a median 240 days in the last 2 years (may include other deployments than the current one), and 99% reported that they were performing UMT duties while in theater.

Table 1 shows the types of units the respondents supported in theater. Table 2 is a breakdown by percentage of Section C of the UMT Religious Activities that responders reported.

Table 1: Types of Units the UMT Respondents Supported

Description	Percent of Respondents
Combat Arms Units	36%
Combat Support Units	27%
Combat Service Support Units	21%
Medical	6%
Unknown or Unmarked	10%

Table 2: The UMT Religious Activities that Respondents Reported

The numbers in the columns below (1 through 7) are percentage rates of the response for each question a. through o. from Section C of the UMT survey. Below the chart is the definition key for each numeral 1-7.

BH/COSC Services	(% of Respondents)						
1. During this deployment, how frequently did you:	1	2	3	4	5	6	7
a. Provide ministry of presence?	2	1	2	4	2	6	83
b. Conduct suicide prevention training?	15	12	22	10	17	15	9
c. Conduct religious services?	6	2	1	2	4	28	58
d. Conduct memorial services?	38	22	27	6	3	2	2
e. Identify Soldiers at risk for battle fatigue?	25	8	19	16	17	8	7
f. Provide crisis intervention management?	18	10	19	17	15	12	9
g. Conduct educational classes (stress management, etc.)?	31	12	27	9	11	7	4
h. Consult with unit leaders?	4	1	4	6	12	23	51
i. Conduct psychological debriefings (CED/CISD)?	36	12	25	13	7	3	3
j. Conduct systematic unit religious needs assessments?	26	25	18	14	9	4	5
k. Conduct grief facilitation and hope counseling?	27	5	16	11	17	13	11
l. Reinforce Soldiers' faith and hope?	3	1	2	5	8	17	64
m. Provide Soldiers opportunities to discuss their combat experiences?	6	4	6	7	14	19	43
n. Provide one-to-one pastoral counseling with Soldiers at their worksite.	14	2	2	5	7	16	54
o. Provide one-to-one pastoral counseling with Soldiers at the UMT worksite?	14	1	2	5	8	12	57

1 = Never; 2 = Only once; 3 = Once every 2-3 months; 4 = Once a month; 5 = Two to three times a month; 6 = Once a week; 7 = Several times a week

TAB A: Unit Ministry Team (UMT) Survey

Unit Ministry Team (UMT) Personnel Survey

This survey is being conducted under the auspices of The Army Surgeon General's OIF Mental Health Advisory Team (MHAT). The purpose of this questionnaire is to gather data about the current mental/spiritual well-being of Soldiers and chaplains in theater and the functioning of the mental health system in OIF/OEF. Your responses will not be linked to you as an individual.

Definitions: In this survey, Combat and Operational Stress Control (COSC) is used synonymously with preventive, educational and outreach services, and the management of combat and operational stress reactions. Behavioral Health (BH) is used synonymously with clinical care for behavioral health disorders (i.e., evaluation and treatment).

Today's Date: _____

Please circle the number of the category that best describes you.

A. DEMOGRAPHICS			
Age: 1 = 18-20 2 = 21-24 3 = 25-29 4 = 30-39 5 = 40 or older	Gender: 1 = Male 2 = Female	Grade/Rank: 1 = E1-E4 2 = E5-E6 3 = E7-E9 4 = O1-O3 5 = O4-O6 6 = WO1-WO5	Primary Component: 1 = Active Component 2 = Reserve (USAR) 3 = National Guard 4 = AGR 5 = Individual Ready Reserve (IRR)
MOS/AOC: 1 = Chaplain (56A) 2 = Chaplain Assist. (56M) 3 = Other: _____	Which region best describes where you are currently serving? 1 = Northern Iraq (Mosul area) 2 = North East Iraq (Kirkuk area) 3 = North Central Iraq (Tikrit/Balad area) 4 = Central Iraq (Baghdad area) 5 = South Central Iraq (Karbala to Nasiriyah) 6 = South Iraq (Basra area) 7 = North Kuwait (Udairi, Virginia, etc.) 8 = South Kuwait (Doha, Arifjan, etc.) 9 = Other: _____		For THIS deployment, please indicate the MONTH/YEAR you arrived in theater:
What type of unit do you support? 1 = Combat (IN, AR, FA) 2 = Combat Support 3 = Combat Svc Support 4 = Medical 5 = Other: _____			How long (MONTHS) should a deployment last?
How many TOTAL DAYS have you been deployed (combat or peacekeeping) in the past 2 years?			
How many MONTHS have you been assigned to your current unit?			
How many MONTHS has your current unit been deployed to Iraq/Kuwait?			
Are you currently working in my UMT job?			Yes/No

Please circle the number indicating the degree to which you agree or disagree with the statements below.
 1 = *Strongly Disagree*; 2 = *Disagree*; 3 = *Neither agree nor disagree*; 4 = *Agree*; 5 = *Strongly Agree*

B. COORDINATION	
1. My command provides us with the resources required to conduct our UMT religious activities.	1 2 3 4 5
2. My chaplain chain of command provides us with the resources required to conduct our UMT religious activities.	1 2 3 4 5
3. We coordinate/integrate our UMT religious activities with the BH/COSC team(s) in our Area of Operations (AO).	1 2 3 4 5
4. We coordinate/integrate our UMT religious activities with primary care medical personnel in the battalion aid station(s)/medical company(s) in our AO.	1 2 3 4 5
5. Mental health personnel have provided us information about where to refer Soldiers for mental health problems.	1 2 3 4 5
6. Mental health personnel have provided us information about the services they provide to Soldiers.	1 2 3 4 5

Please circle the number indicating the degree to which you agree or disagree with the statements below.
 1 = *Never*; 2 = *Only once*; 3 = *Once every 2-3 months*; 4 = *Once a month*;
 5 = *Two to three times a month*; 6 = *Once a week*; 7 = *Several times a week*

C. UMT RELIGIOUS ACTIVITIES	
1. During this deployment, how frequently did you:	
a. Provide ministry of presence?	1 2 3 4 5 6 7
b. Conduct suicide prevention training?	1 2 3 4 5 6 7
c. Conduct religious services?	1 2 3 4 5 6 7
d. Conduct memorial services?	1 2 3 4 5 6 7
e. Identify Soldiers at risk for battle fatigue?	1 2 3 4 5 6 7
f. Provide crisis intervention management?	1 2 3 4 5 6 7
g. Conduct educational classes (stress management, etc.)?	1 2 3 4 5 6 7
h. Consult with unit leaders?	1 2 3 4 5 6 7
i. Conduct psychological debriefings (CED/CISD)?	1 2 3 4 5 6 7
j. Conduct systematic unit religious needs assessments?	1 2 3 4 5 6 7
k. Conduct grief facilitation and hope counseling?	1 2 3 4 5 6 7
l. Reinforce Soldiers' faith and hope?	1 2 3 4 5 6 7
m. Provide Soldiers opportunities to discuss their combat experiences?	1 2 3 4 5 6 7
n. Provide one-to-one pastoral counseling with Soldiers at their worksite?	1 2 3 4 5 6 7
o. Provide one-to-one pastoral counseling with Soldiers at the UMT worksite?	1 2 3 4 5 6 7
2. Approximately how many Soldiers does your team support?	
3. How many locations (base camps/FOBs) does your UMT support?	
4. On average, how many hours does it take to convoy to the base camps you support (including preparation time)?	

Please circle the number indicating the degree to which you agree or disagree with the statements below.
 1 = *Strongly Disagree*; 2 = *Disagree*; 3 = *Neither agree nor disagree*; 4 = *Agree*; 5 = *Strongly Agree*

D. SKILLS AND TRAINING					
1. I feel confident in my ability to:					
a. Conduct pastoral counseling.	1	2	3	4	5
b. Conduct suicide prevention classes/training for Soldiers.	1	2	3	4	5
c. Identify and assist Soldiers with suicidal thoughts/behaviors.	1	2	3	4	5
d. Help Soldiers adapt to the stressors of combat/deployment.	1	2	3	4	5
e. Identify Soldiers with substance abuse/dependence.	1	2	3	4	5
f. Assist Soldiers with sexual harassment issues.	1	2	3	4	5
g. Identify Soldiers with Combat and Operational Stress Reactions.	1	2	3	4	5
h. Perform clinical evaluation and treatment of detainees.	1	2	3	4	5

Please circle the number indicating the degree to which you agree or disagree with the statements below.
 1 = *Strongly Disagree*; 2 = *Disagree*; 3 = *Neither agree nor disagree*; 4 = *Agree*; 5 = *Strongly Agree*

E. STIGMA AND BARRIERS TO CARE					
1. Commanders welcome back Soldiers who have received mental health services.	1	2	3	4	5
2. Commanders welcome back Soldiers who have been assessed for suicidal thoughts/behaviors and returned to duty.	1	2	3	4	5
3. Commanders welcome back Soldiers who have been assessed for homicidal thoughts/behaviors and returned to duty.	1	2	3	4	5
4. The leadership doesn't support pastoral counseling activities.	1	2	3	4	5
5. There is inadequate transportation to conduct UMT religious activities.	1	2	3	4	5
6. Soldiers feel uncomfortable talking to UMT personnel about their problems.	1	2	3	4	5
7. Traveling to supported units is too dangerous.	1	2	3	4	5
8. Arranging convoys to supported units is too difficult.	1	2	3	4	5

Please circle the number indicating the degree to which you agree or disagree with the statements below.
 1 = *Never*; 2 = *Seldom*; 3 = *Frequently*; 4 = *Always*

F. SOLDIER NEEDS				
1. How do you assess the religious/spiritual needs of the units you support?				
a. Talk informally to the Soldiers	1	2	3	4
b. Conduct focus groups with Soldiers	1	2	3	4
c. Talk with the BH/COSC personnel	1	2	3	4
d. Talk with the unit's commander	1	2	3	4
e. Talk with the unit's medical personnel	1	2	3	4
f. Use validated surveys/instruments	1	2	3	4
g. Use locally developed surveys/instruments	1	2	3	4
h. Develop a religious support plan	1	2	3	4

Please circle the number indicating the degree to which you agree or disagree with the statements below.
 1 = *Strongly Disagree*; 2 = *Disagree*; 3 = *Neither agree nor disagree*; 4 = *Agree*; 5 = *Strongly Agree*

G. PERSONAL WELL-BEING	
1. My ability to do my UMT job is impaired by the stressors of deployment/combat.	1 2 3 4 5
2. My mental well-being has been adversely affected by the events I have witnessed on this deployment.	1 2 3 4 5
3. My spiritual well-being has been adversely affected by the events I have witnessed on this deployment.	1 2 3 4 5
4. Since this deployment, I have become less sensitive to the religious/spiritual needs of the Soldiers I serve/support.	1 2 3 4 5
5. My ability to do my job is impaired by listening to the combat experiences of Soldiers I've talked with while performing my BH/COSC mission.	1 2 3 4 5

Please circle the number indicating the degree to which you agree or disagree with the statements below.
 1 = *Very low*; 2 = *Low*; 3 = *High*; 4 = *Very high*

6. Please rate the following:	
a. Your personal morale	1 2 3 4
b. Your energy level	1 2 3 4
c. Your level of burnout	1 2 3 4
d. Your motivation	1 2 3 4

The following equipment/supplies would have improved my team's ability to complete our UMT mission:

Please provide any additional comments on the back.

Thank you for completing this survey!

APPENDIX 4

SUMMARY OF BEHAVIORAL HEALTH INTERVIEWS

INTRODUCTION

Face-to-face interviews with BH personnel in Kuwait and Iraq were conducted to obtain level of perspectives on the delivery, resources, and problems encountered providing MH/BH care in a combat operational theater. All BH specialties were represented and were the following: Psychiatrists, psychologists, social workers, occupational therapists, psychiatric clinical nurse specialists/psychiatric nurses, MH specialists, and OT assistants.

APPROACH

Face-to-Face Interviews

Members of the MHAT conducted all interviews on an interview schedule (see TAB A). Forty-two individual or group interviews were conducted at 12 different locations throughout Kuwait and Iraq with the following composition:

RANK	PARTICIPANTS	% OF TOTAL
Field Grade	20	24%
Company Grade	20	24%
NCO	15	18%
Junior Enlisted	27	34%
TOTAL	82	100%

Themes/Questions

Prior to all interviews, key themes and specific questions were determined that every MHAT interviewer would attempt to address. All individuals were asked the same questions. Interview questions were: (1) What can you tell us about your experience that we didn't ask on the survey? (2) What challenges or obstacles to providing care have you faced during the deployment? (3) What additional training would you benefit from prior to deployment, if any?

Procedures

All interviews began with a member of the MHAT introducing himself/herself and describing the purpose and objective of the interview. Confidentiality and anonymity were guaranteed in order to encourage candid and honest discussion. Thus, no names of any of the interviewees' were recorded. Interviews lasted approximately 20 to 60 minutes.

RESULTS

Behavioral Health Personnel in Kuwait

Participants were four enlisted and eight officers at three separate unit locations in Kuwait. Several issues surfaced that were not asked on the BH survey that were discussed during the interview:

- *Behavioral Health System Concerns:*

1. There were limited drug and alcohol treatment programs, but Alcoholics Anonymous (AA) was available for Soldiers.

2. Some BH personnel were assigned to do other jobs, such as psychiatric registered nurses (RNs) who were asked to work in Medicine/Surgery areas.

3. It would have been helpful to know prior to deployment what was available, and what was needed for clinical practice in theater such as reference books, because procuring equipment in theater was challenging.

4. There were limited computers and lack of private space to work with Soldiers.

5. Getting out to other FOBs was challenging due to poor roadways.

6. The concept of operations for the United States Air Force (USAF) teams was not defined regarding how much should be Army-type CSC prevention versus clinical care outreach or stationary clinic.

7. The Navy team defined its mission as solely clinical care, staffed clinics, and established an "Intensified Outpatient Program" on the Navy's model in a minimally furnished building, but then dropped the Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnoses and lumped the admissions into "combat stress reactions" and "operational stress reactions," as in Army restoration programs.

8. There was confusion about the concept of operations with an Army medical headquarters directing two USAF and one Navy team, but not defining it as a joint command.

9. It was unclear to the Air Force BH personnel what the support relationship was; they solicited essential equipment from the U.S. Air Force EMED (hospital) with whom they had no defined relationship.

- Suggested additional training that would benefit staff before deployment included:

1. Drug and Alcohol Program Adviser (DAPA)/Substance Abuse Rehabilitation Program (SARP) training and perhaps Adams classes (alcohol/substance abuse awareness) for all staff such as the Navy is doing presently.
2. Cross-training service members from sister services on cultural issues, etc.
3. Critical Incident Stress Debriefing, Cognitive Behavioral Therapy, PTSD treatment training, and Sexual Assault Victim Intervention training.

Behavioral Health Personnel in Iraq

Thirty-two officers and 38 enlisted BH personnel at ten different locations throughout Iraq shared common concerns and experiences that were not captured on the BH survey. Many of the themes below were reported more than once, but are listed only once for this report.

- The Behavioral Health System:

1. Overall, felt well prepared to perform the mission. The mutual support of providers helped tremendously.
2. Difficulty fitting in when cross-leveled to an established unit. Integrating 75% of personnel who were cross-leveled to a unit was challenging, especially with leadership and chain of command.
3. Challenges for teams to get life support when they arrive at a FOB. Need prior communication with the Area Support Groups (ASGs) to find out what units are in the FOBs and their point of contact (POC). It is best to have the CSC Detachment (or teams) collocate with an ASG and cover its area of operations. Teams may have to be tasked out and attached under operational control for support. They should send an advanced liaison to set it up. Behavioral health personnel need further training in operational details (like fragmentary orders (FRAGOs), etc.). Better coordination between outgoing and incoming BH personnel would also smooth transitions.
4. Differing tour lengths (3, 6, and 12 months) between the different services hurt BH morale. The rapid turnover of psychiatrists (60Ws) disrupted continuity of care and decreased morale of the CSC team. High personnel tempo (PERSTEMPO) may lead to reduced retention for some BH personnel—particularly among early- and mid-career personnel.
5. A road map for deployment for U.S. Army Reserves (USAR) and Army National Guard (ARNG) Soldiers would be helpful.

6. Separate (National Guard) brigades are not authorized a BH officer, and one is needed.

7. The limited range of types of patients during deployment may cause providers to lose skills. Stop-loss has been tough on professionals, especially since some professionals rotate out in 90 to 180 days.

8. Each battalion should have specified BH staff who support them as a means to assist with building relationships with the medical and UMT personnel assigned to each battalion.

9. Operating forward is essential to improving soldier access and lower stigma. Chaplain support is essential to effectiveness; developing rapport with the chaplain has really helped with BH mission accomplishment.

10. In some cases, enlisted MH personnel (91Xs) were needed to contribute to the BH mission; therefore, they were pulled away from BH work.

11. Personal stressors (long hours with no time off, trying to please everyone, time away from family, weather and heat, transition from medical center (MEDCEN) to TO&E unit) take a toll on BH personnel.

12. Tighten pre-deployment screening, for medical illness as well as mental/behavioral ones. Civilian PAs did most of the screening; they need more information about the Theater—its limited resources, the harsh environment, the consequences of decompensation, and options for deferring deployment. It would be best to assign providers who have been here to do redeployment screening. Consider pre-deployment psychological testing of Soldiers who are already on psychotropic meds in the soldier readiness processing (SRP) before going on to other screening to decrease inappropriate deployment.

- Administrative Issues:

1. Some personnel actions (promotions, etc.) are being held up because BH personnel were not correctly told to bring their personnel (201) files with them to theater.

2. Lack of replacements for the unit members sent home degrades the mission capability of the unit.

3. Training on useful military forms, unit movement, supplies, Form Flow, lessons learned, and standing operating procedures (SOPs) on administrative/logistics coordination in a “Smart Book” would be very helpful. Also knowing the administrative skills of the S1, S2, and S3 would be helpful. Training for writing an Operational Needs Assessment (with examples) and conducting one’s own unit Needs Assessment would be helpful before deploying. Know how to do command referrals/evaluations,

regulations (format, requirements on the electronic version), and when to do clinical documentation vs. COSR documentation before you deploy.

4. Be prepared to use the COSC-WARS before deploying.

5. Identify and resolve credentialing early (best before activation/mobilization).

6. Completing the continuing medical education requirement while in Theater is hard to do; this is a reason for having 6-month rotations instead of 1-year rotations. Internet education could meet some needs.

7. Have more on CSC in Command & General Staff College, Officer Candidate School (OCS), etc.

8. Have references available for military BH law, ethics, and regulations.

- Logistical/Equipment Issues:

1. Very difficult to communicate within own unit as well as with other units. For example, one unit reported having only one single-channel ground and airborne radio systems (SINCGARS) radio, but having teams at 18 locations all over Iraq. The digital nonsecure voice terminal (DNVT) phones were often down, too. Some reported no computer equipment and lack of supplies. One unit acquired Thuriya cell phones by negotiation and Iraqi commercial cell phones by purchase, in order to maintain communications and to accomplish the mission. Some unit members received training in the use and maintenance of the DNVT and other Army communication, which enabled some successful troubleshooting.

2. Limited space for work and lack of privacy in the workspace for working with Soldiers

3. Psychological testing kit materials were outdated; updated ones are needed.

4. More training was needed on how to obtain logistical support from the line units.

- Training Needs:

1. 1. Refresher training on COSC, critical incident stress management (CISM) training, mini-course for 60Ws with a CSC perspective. Teach area of concentration specifics so all staff can know each other's strengths.

2. More training for 91Xs before deployment. The 91Xs could use more clinical training since many do not work in the field in their civilian life, e.g. training on interviewing and counseling. More training on personality disorders would be helpful to the staff. One 91X reported: "My AIT had no clinical experience, and I went straight to

my division just before deployment. They let me work a little in Community MH to get my skill level up."

3. Provide clinical training for USAR and National Guard BH personnel on drill weekends with real patients (e.g. at VA, Univ. Hospital, etc.).

4. Lack of skills in dealing with real medical emergencies by many BH staff. The 91X Soldiers should also complete 91W training to prepare for combat emergencies.

5. Training on how to interact with commands; Iraq country skills. Training on awards, efficiency reports, etc.

6. Reduce unnecessary training in 91X school and devote more training time on crisis intervention, suicide prevention/intervention, COSC, anger management, battle fatigue, life saving skills, CED training, home front issues, solutions to soldier based issues, and family crisis intervention.

7. Training in pharmacological management of Soldiers in theater

8. Training in managing vicarious trauma, burnout, and compassion fatigue. Also training in team building and conflict negotiation. Important to set up help for helpers at each location—providing an outlet for providers. Awareness and buddy aid for providers. Behavioral health personnel should not skip BH-topic briefings on the assumption that they know it.

9. Updated training on the VA/DoD clinical guidelines for PTSD

10. For military training, more field and combat environment training, and more training on soldiering skills such as: convoy techniques (convoy operations training much more realistic in Kuwait than at the mobilization site in CONUS), survival skills training; battle drills; command liaison/consultation etiquette; and how to get life support in theater

TAB A: Behavioral Health Interview/Focus Group Schedule

Behavioral Health/COSC Personnel Interview/Focus Groups

"This information is anonymous and will not be linked to your unit. The information will be combined with that of other units to reflect the nature of BH/COSC units in OIF-II."

Interviewer:

Notes Taken By (if other than interviewer):

Date:

Location:

Number in Group:

Group Type (Circle): **Jr. Enlisted (E1-E4)** **NCOs (E-5 +)** **Officers**
Mixed

Ranks: ____ **E1-E4;** ____ **E5-E6;** ____ **E7-E9;** ____ **O1-O3;** ____ **O4-O6**

Gender: ____ **Males;** ____ **Females**

Unit:

1. What can you tell us about your experience that we didn't ask on the surveys?

2. What challenges have you faced during this deployment?

3. What additional training would you benefit from prior to deployment, if any?

APPENDIX 5

DISTRIBUTION OF BEHAVIORAL HEALTH SERVICES

INTRODUCTION

Assessment of staffing and distribution were key parts of the OIF-II Mental Health Advisory Team's (MHAT's) mission to evaluate the BH care in the OIF Theater. Three particular questions that were addressed were: (1) Are there enough BH personnel in theater to successfully accomplish the BH mission? (2) Are the BH personnel/units adequately distributed throughout theater to successfully execute the BH service mission? (3) What are appropriate levels of BH staffing for future similar deployments?

In order to answer these three questions, the MHAT generated a layout of the BH resources in theater (as of 1 October 2004) and examined a number of possible methods for estimating the need for and positioning of BH personnel.

The data gathered for this analysis came from reports, maps, and interviews with BH personnel, cartographers, and division/corps personnel officers. The validity of parts of this analysis is time limited due to the constant changing battlefield and concomitant shifts in personnel. For convenience, 1 October 2004 was chosen as a cross-sectional target date. Changes made after 1 October 2004 are not reflected in this analysis. Although there are no data to support this, a key assumption is that on-site BH personnel will help to reduce barriers to BH care.

This analysis only includes Army Soldier populations, Army BH personnel, and those Navy and Air Force BH personnel who are primarily serving Army Soldiers. Special Forces personnel and FOBs with a population of less than 25 U.S. Army Soldiers were also excluded from this analysis.

FINDINGS

Finding #1: The ratio of BH personnel to Soldiers is greater this year (OIF-II) than last year (OIF-I).

Last year (OIF-I), 163 BH personnel (psychiatrists, psychologists, social workers, occupational therapists, psychiatric nurses, enlisted MH specialists, and OT technicians) provided services for an estimated 138,000 Soldiers in Kuwait and Iraq in September 2003. The overall ratio of BH personnel to Soldiers was 1/851. As of 1 October 2004, 232 BH personnel (see Table 1) are providing services to an estimated 94,500 Soldiers in Kuwait and Iraq, for a ratio of 1/407—a ratio over twice that of OIF-I. Last year's MHAT (OIF-I) concluded that the overall number of BH personnel was sufficient to provide coverage throughout the OIF Theater. However, the distribution of BH personnel was uneven; some areas lacked adequate coverage.

In Kuwait, Navy and Air Force personnel were providing most BH coverage. Other than a few Army staff members (b)(2)-2 the bulk of the primary medical care was performed by Navy personnel, and all of the BH prevention and early intervention was performed by (b)(2) Air Force Operational Stress Teams (OSTs) (See Tables 2 and 3). Based on Soldier population, there are fewer BH personnel in Kuwait (1/656 overall) than in Iraq (1/388) where the need is greater due to operational stressors.

Finding #2: Behavioral health personnel are more evenly distributed in OIF-II than in OIF-I.

The OIF-II ratios varied from 1/160 to 1/888 (with a standard deviation of 227). The OIF-I ratio of BH personnel to Soldiers varied from zero (no BH personnel) to 1/3,292 by region (with a standard deviation of 1,038).

Finding #3: Forward operating bases with higher Soldier populations tend to have more on-site BH personnel. There were some FOBs in all size categories without on-site BH personnel located on them. These FOBs may receive BH services from neighboring FOBs.

Seventy-six percent (76%) of Soldiers live on FOBs where BH personnel are collocated. (NOTE: For simplicity, “FOB” includes base camps, logistical support areas, ranges, etc., in Kuwait and Iraq). In general, as the size of the FOB population decreased, the number of BH personnel to Soldiers also decreased, and the variance in the distribution of BH personnel within each size category increased (see Table 4). Almost all FOBs with more than 1,000 Soldiers had a BH professional on site. One FOB in Iraq with over 3,000 Soldiers and two FOBs with 1,000-3,000 Soldiers had no on-site BH personnel.

The MHAT visits to, and interviews with, PC and UMT personnel at some sites without on-site BH personnel indicated that BH personnel were not regularly visiting some of these FOBs. However, data from the Soldier Health and Well-being Survey showed that Soldiers on smaller FOBs reported nearly identical rates of utilization of MH services as Soldiers on larger FOBs. On FOBs with Soldier populations less than or equal to 1,000 in size, 11% of Soldiers saw a MH or CSC professional during the deployment, compared with 9% of Soldiers on FOBs that had a population of 1,001-3,000, and 11% on FOBs over 3,000.

Finding #4: Psychiatrists, psychiatric nurses, and occupational therapists—who specialize in medical management and restoration/reconstitution services—were generally located at larger FOBs, while social workers and clinical psychologists were located farther forward (smaller FOBs) to provide more outreach services.

Table 5 shows the distribution of BH specialties by FOB size.

Finding #5: There is adequate BH holding capacity in theater.

On an emergent basis, "holding capacity" is available at CSC units, medical companies, and at CSHs. The CSC units have the capability to set up many more Level II cots for stress and psychiatric casualties if needed. Each of the CSH slices are able to admit Soldiers with BH problems; however, none of the Army CSH slices in theater is staffed to host a psychiatric treatment ward which is appropriate given the current theater evacuation policy (see Table 6).

Theater BH personnel interviewed indicated that, in general, a Soldier deemed to require an inpatient level of care is only held long enough to be stabilized, evaluated, and prepared for evacuation out of theater. All of the CSHs have partnered with CSC units to provide BH treatment services (see Finding #6 below).

Finding #6: The CSC restoration programs are located near CSH slices and often share resources.

Like last year's MHAT, the MHAT this year noted that the four CSC restoration programs are located on the same FOBs as the CSHs (see Table 7). Collocating the CSC fitness teams with the CSHs has been implemented in various ways, often synergistically. The (b)(2)-2 provides the classes and treatment services to those psychiatrically admitted to the (b)(2)-2. Patients sleep on the ward in the CSH at night, but are transported to the CSC for a day treatment program. At both (b)(2)-2 psychiatrists assigned to the CSC teams have admitting privileges and provide the needed BH specialty services at the local CSH.

Finding #7: There is one CSC reconditioning program in theater.

In addition to a restoration program, the CSC company element in Baghdad has a structured program for holding Soldiers with psychiatric mental disorders and good prognosis for RTD for up to 3 weeks. The program combines milieu therapy, OT, psychotherapy, and medication (as needed).

RECOMMENDATIONS

Recommendation #1: Use an empirically derived staffing model for BH personnel allocation and distribution.

Last year's MHAT (OIF-I) concluded that the overall number of BH personnel was sufficient to provide coverage throughout the OIF Theater, providing a ratio of 1:851 BH personnel to Soldiers. However, the distribution of BH personnel was uneven; some areas lacked adequate coverage. The ratio of BH personnel to Soldiers in OIF-II is 1:407, substantially different than last year.

Future staffing decisions for OIF and similar stability/support operations need to take into consideration the operational environment in theater, the OPTEMPO,

and other factors. Military planners need to tailor the BH force package based on the size of the force, the distribution of the force (number of FOBs), the amount/type of services desired in theater (see TAB A for a full discussion of a staffing model), and the availability of personnel and resources to provide this staffing level.

Based on the BH consultants to The Army Surgeon General, Human Resources Command, and MEDCOM Operations, there are significant concerns about being able to sustain current staffing levels of BH assets in theater with the existing AMEDD infrastructure. In addition, there are no data that demonstrate what the optimal number of BH professionals in theater should be. For many BH issues, leadership, training, unit cohesion, morale, and quality of life are probably as important as the number of BH personnel available.

The methodology in TAB A of this appendix provides a general model for determining staffing levels. It is intended to be a guide, not the definitive answer on what the optimal staffing level should be. Any model that is used should be needs based, empirical, and driven by operational requirements and Army doctrine.

Recommendation #2: Continue forward-deployed outreach to ensure Soldiers can access BH services.

Recommendation #3: Ensure all BH personnel can provide (with supervision and medical support) the full range of BH services.

It is important to maintain strong coordination amongst the various BH personnel in theater (whether from division, CSC, CSH, etc.) to assure that Soldiers have access to BH services when needed. Personnel who conduct outreach at the unit level or are the sole provider at a particular location should be able to provide the full range of services to include clinical evaluation and treatment, triage, referral, prevention, consultation, and education. Likewise, clinical staff at large FOBs (at CSHs, restoration units, etc.) should be able to provide outreach routinely.

Recommendation #4: Develop and implement a plan to assure that there will be adequate BH resources to sustain the BH mission over the next several years.

The current BH infrastructure was not designed for the OPTEMPO of the Global War on Terrorism. The increase in PERSTEMPO is leading to high levels of attrition of BH personnel and impacting other healthcare and professional training missions. Medical operation and military personnel planners should develop and coordinate a plan to allocate resources based on desired service levels and ensure that there are enough personnel to sustain current and future operations.

Table 1: Behavioral Health Personnel Ratios in OIF-I and OIF-II

REGION	OIF-I (SEP 2003)			OIF-II (SEP 2004)		
	BH	SOLDIERS	RATIO	BH	SOLDIERS	RATIO
(b)(2)-2						
IRAQ TOTAL	140	116000	830	215	83200	387
(b)(2)-2						
KUWAIT TOTAL	23	22000	943	17	11250	662
GRAND TOTAL	163	138000	851	232	94450	407

Note: Number of Soldiers is rounded for Operations Security (OPSEC).

Table 2: OIF-II Behavioral Health Personnel by Service

Specialty	TOTAL	Army	Navy	USAF
Psychiatrist	18	15	1	2
OT	8	8		
Psych Nurse	14	12	2	
Soc Work	30	27		3
Psychologist	19	17		2
Medic	5	5		
OT Tech	8	8		
MH Specialist	130	120	3	7
TOTAL	232	212	6	14

Table 3: OIF-II Behavioral Health Personnel by Unit and Unit Type

Unit	Unit Total	Ψiatry	OT	Ψ Nurse	Soc Wk	Ψology	OT Tech	MH Spec
(b)(2)-2								
(b)(2)-2								
(b)(2)-2								
(b)(2)-2								

Table 4: Behavioral Health Personnel Ratios By Forward Operating Base Size

AOR	FOB Size	TOTAL				WITH BH PERSONNEL				W/O BH P
		# of FOBS	# of Soldiers	# of BH	Ratio (1:X)	# of FOBS with BH	# of Soldiers	# of BH	Ratio (1:X)	# of FOBS w/o BH
IRAQ	(b)(2)-2									
	<i>All Iraq</i>	<i>64</i>	<i>83350</i>	<i>215</i>	<i>388</i>	<i>28</i>	<i>65650</i>	<i>215</i>	<i>305</i>	<i>36</i>
KUWAIT	(b)(2)-2									
	<i>All Kuwait</i>	<i>10</i>	<i>11150</i>	<i>17</i>	<i>656</i>	<i>2</i>	<i>6150</i>	<i>17</i>	<i>362</i>	<i>8</i>
THEATER	<i>All Theater</i>	<i>74</i>	<i>94500</i>	<i>232</i>	<i>407</i>	<i>30</i>	<i>71800</i>	<i>232</i>	<i>309</i>	<i>44</i>

Note: Number of Soldiers is rounded for OPSEC.

Table 5: Behavioral Health MOS by Forward Operating Base Size

AOR	FOB Size	# of FOBS	Total # of BH	# of Psychia- trists	# of Psychol- ogists	# of Soc Workers	# of OTs	# of Psych Nurses	# of MH EMs	# of OT EMs
IRAQ	(b)(2)-2									
	<i>All Iraq</i>	<i>64</i>	<i>215</i>	<i>15</i>	<i>19</i>	<i>26</i>	<i>8</i>	<i>13</i>	<i>126</i>	<i>8</i>
KUWAIT	(b)(2)-2									
	<i>All Kuwait</i>	<i>10</i>	<i>17</i>	<i>3</i>	<i>0</i>	<i>4</i>	<i>0</i>	<i>2</i>	<i>8</i>	<i>0</i>
THEATER	<i>All Theater</i>	<i>74</i>	<i>232</i>	<i>18</i>	<i>19</i>	<i>30</i>	<i>8</i>	<i>15</i>	<i>134</i>	<i>8</i>

Table 6: Disposition of Inpatient MH Assets as of 1 October 2004

AOR	FOB	UNIT	Total Staff	Psychiatrists	Psych Nurses	Psychologists	Social Workers	MH EMs
IRAQ	(b)(2)-2							
KUWAIT	(b)(2)-2							

Table 7: Disposition of Restoration Assets as of 1 October 2004

AOR	FOB	UNIT
IRAQ	(b)(2)-2	
KUWAIT	(b)(2)-2	

TAB A: Behavioral Healthcare Staffing Model

Last year's MHAT Report (Office of The U.S. Army Surgeon General, 2003) discussed several methods for evaluating BH personnel strength in OIF-I (Kuwait and Iraq). Those methods included Unit Basis of Allocation (in accordance with FM 8-55) and BH personnel to Soldier ratios. Last year's MHAT concluded that a ratio of one BH personnel for every 851 Soldiers was sufficient to provide needed coverage. This year, the ratio has increased to one to 407 Soldiers because of an increase in BH personnel in theater and an overall decrease in the Soldier population.

This analysis includes only Army Soldier populations, Army BH personnel, and those Navy and Air Force BH personnel who are primarily serving Army Soldiers.

Staffing Models

Faulkner and Goldman (1997) posited five approaches to estimating the number of BH personnel needed to staff a civilian MH system. Most of these look at the existing number of BH personnel and try to determine if they can meet the needs of the service population. However, as Elisha, Levinson, and Grinshpoon (2004) point out, approaches that are based on the existing number of BH personnel "tend to perpetuate distortions in staffing patterns, give little weight to clients' needs, and lack a conceptual rational" (p. 325).

One of Faulkner and Goldman's (1997) approaches begins with an estimate of the population needs and demands. Calculations are based on three variables:

1. The number of individuals who need services as determined by a population-based psychiatric morbidity survey.
2. The percent of individuals likely to demand BH services as determined by records or estimates of service utilization.
3. The amount of time/effort BH providers have to put forth to provide the services needed as determined by workload efficiency data.

In addition to these three variables, Faulkner (2003) and Elisha, et al. (2004) parse the need into those tasks that a psychiatrist must perform, and those any other MH professional can perform. For this analysis, we will parse the need into officers and enlisted, assuming that a further analysis will need to take place amongst the officer corps to determine the appropriate mix of areas of concentration (AOCs) in theater.

Staffing Model Assumptions

This analysis makes a number of assumptions that may not remain valid under differing circumstances in the theater of operation. Any use of this model requires careful analysis of each assumption, and the overall product must be weighed against

METT-TC (Mission, Enemy, Terrain and weather, Troops and support available, Time available, Civil considerations).

For this report, the following assumptions have been made:

1. Approximately 11% of the population will receive BH care during the course of the deployment. This is based on multiple sources of data. As noted above, we examined three variables: those who want help, those who need help, and those who usually use help.

a. Want help. On the OIF-II survey, 11% of all Soldiers reported a desire to get help for a stress, emotional, alcohol, or family problem (see Annex A).

b. Need help. Regarding estimated treatment need, 13% of OIF-II Soldiers who were surveyed screened positive for depression, anxiety, or PTSD.

c. Normally use help. Data from the Walter Reed Army Institute of Research (WRAIR) Land Combat Study indicated that 7-11% of Soldiers surveyed 3-4 months after returning from OIF-I used BH services in the past year (this includes the deployed period). In the current OIF-II survey, 9% of Soldiers reported that they had seen a BH provider at least once during the deployment. (Soldiers were surveyed on average 7 months into the deployment, but this cannot be directly extrapolated to a year deployment since Soldiers do not seek care uniformly throughout the year.) These rates are very similar to Army-wide ambulatory BH service utilization. Overall, eight percent of the Soldiers reported that they had seen a MH professional within the last year according to the most recent DoD Survey of Health Related Behaviors Among Military Personnel (Bray et al., 2003).

2. Soldiers who receive BH care will have, on average, three clinical visits. Available DoD healthcare utilization data indicate that the median number of visits is 2; however, high utilizers may drive the mean higher than this. Therefore, we chose a conservative estimate of three visits per Soldier receiving care.

3. On average, BH providers will be able to provide individual outpatient clinical support to up to six Soldier visits a day, 6 days a week (or 36 visits/week/provider). These numbers include both initial appointment and follow-up visits; they also include both diagnosed patients and Soldiers who are experiencing combat and operational stress symptoms and require intervention. The MHAT members determined the ratio (36/week/provider) based on their collective clinical experience and observations in theater.

4. All FOBs with Soldier populations over 1,000 will need a BH officer. Although there may be FOBs with over 1,000 Soldiers who can be adequately covered by neighboring FOBs, or staffed by BH NCOs instead of officers, for this planning model, we assumed the need for a BH officer at each FOB over 1,000. For each FOB over 1,000 Soldiers, there would be at least 1 officer and 1 MH specialist (91X) providing clinical services

and outreach (see #5 below). Larger FOBs would require additional BH professionals to provide clinical and/or outreach to the additional population. (b)(2)-2

(b)(2)-2

(b)(2)-2

5. Behavioral health outreach, consultation, prevention, and education services provided at the unit-level will require approximately 8 hours (1 duty-day) per battalion-size unit per week. This time allows for travel time and coordination. It is expected that some battalions will require substantially more time than this (e.g. travel time/waiting for convoys, etc), while others that are collocated on the same FOB with the BH professionals will require less time for these services. For planning purposes, BH enlisted Soldiers provide these services under the supervision of the officer on the same FOB, although they may switch responsibilities as needed.

6. The average restoration unit will hold about 4 Soldiers at a time; the reconditioning units will hold about 8. Based on observations from OIF-I and OIF-II, the MHAT noted that the restoration units in theater rarely held more than 4 Soldiers at a time. Calculations on the number of BH personnel needed for these missions are based on Tables 3 and 4, below.

7. Combat Support Hospitals (CSHs) will deploy with their doctrinal 4 BH personnel (2 officers and 2 enlisted). The BH personnel are included in the calculations as providing basic clinical support on large FOBs.

8. Behavioral health officers have differing capabilities, but can provide a full range of care, given proper supervision and consultation. Although communication types and sophistication levels vary from FOB to FOB, in general, communications have improved significantly since last year (OIF-I). Given the improvement in the telephone and e-mail systems, and the availability of psychotropic medication support from a PC physician/PA, most BH officers should be able to provide the full range of BH services 24/7. In addition, enlisted BH personnel can provide BH services given proper consultation, staffing, and supervision. For purposes of this analysis, all officer specialties are assumed to be interchangeable. Further analysis is required to differentiate which specific specialties are needed for a given operation.

9. Some BH personnel are required to fill command, control, and staff functions in addition to those needed for clinical and outreach services. Because BH officers and NCOs hold staff positions within medical brigades, and command and leadership positions within CSC units and other units, additional time (resources) must be factored into the model. For this model, we have chosen a ratio of one leader/staff officer for every fifteen BH personnel (1:15). This ratio would provide the equivalent of three fulltime leadership personnel in a CSC unit.

Further Discussion of Assumptions Underlying the Model

The nature of combat and the combat environment requires staffing redundancy and flexibility not needed in CONUS, peacetime, or civilian staffing models. These intangible factors include efforts to secure basic life support and supplies, efforts to arrange for and conduct convoy operations to remote locations, personnel surges on the battlefield (due to unit rotations or local battle concentrations), mass casualty events, and possible loss of BH personnel due to casualties, emergency leave, etc.

As critical events and battle concentrations occur in differing areas, additional BH personnel may be temporarily needed to augment certain areas/units. Whether sent as individuals or "quick reaction teams," the flexibility to surge BH personnel from one battlefield area to another requires sufficient resources be in theater to continue universal minimal services while staffing such missions.

To address these considerations, this staffing model builds in flexibility to allow the BH care system to respond to these types of factors.

1. The total number of BH care visits among Soldiers who access care was assumed to be 3, whereas the average, based on all available data, is 2. Thus, estimated actual clinic utilization is likely to be lower than predicted by the model.

2. Outreach at the battalion level is assumed to take 1 entire day for each battalion, visited once every week. Some battalions may need more time than this, particularly given the difficulties with travel. However, some battalions may need to be visited less frequently, based on the outcome of an individualized unit needs assessment. It may not take an entire day to conduct outreach to a battalion collocated with the BH professional.

3. All bases with more than 1,000 Soldiers were assumed to have at least 1 BH officer and 1 BH enlisted professional on-site, whereas Soldiers on the smaller bases (b)(2)-2 are assumed to receive services either through BH outreach at the battalion level (staffed for the whole theater) or through Soldiers traveling to the location of the BH professionals (also staffed for the whole theater).

4. Behavioral health professionals could work more than 6 days a week if necessary. Also, they may provide one-on-one BH care to more than six Soldiers per day.

5. Personnel at the CSHs are not considered in the calculations. This provides, on average, 2 additional BH personnel on each of the FOBs where a CSH slice is located. These individuals can provide some of the FOB outpatient clinical work or they can be used for outreach to units on the local FOB, contingent on the workload at the CSH.

6. The current staffing is based on calculations for the entire theater with the same level of staffing for Kuwait as in Iraq. Based on the data from the Soldier Health and Well-being Survey, the MH care needs are greater in Iraq than in Kuwait. While theoretically resources from Kuwait could be shifted to support Iraq bases, in practice this is problematic given the different commands.

In addition, it is assumed that there will be flexible utilization of BH personnel. For planning purposes for this model, BH officers were identified as the primary professionals (as credentialed professionals) responsible for clinical care and enlisted BH personnel as the primary personnel for conducting outreach services. However, in practice this is highly flexible, with officers frequently providing outreach and education and enlisted personnel providing clinical services. The staffing model is designed to allow for this flexibility. The model only generates an estimate of the total number of personnel that may be needed in theater. Operational and medical leaders, guided by the tactical/operational situation and Army doctrine, determine how these personnel are allocated and used.

Behavioral health personnel are currently assigned to, and deploy with, Division/Brigade Mental Health Sections, CSC units, CSHs, Area Support Medical Battalions (ASMBs), Area Support Medical Companies (ASMCs), etc. Nothing in this staffing model is meant to detract from the current organization tables or methods of personnel deployment; however, medical planners may use this staffing model to determine how many units or unit slices to deploy. This model provides an estimate of the number of BH personnel needed to provide care, outreach, etc.; it does not assume or restrict where that support should come from (Division Mental Health Sections, CSC units, or individual augmentees).

Staffing Model Calculations

Using these assumptions, we calculated three increasing “components” of care, each built upon the previous one. These components can be stacked up as need, command support, and resources allow.

The first of these is a clinical services component. It provides for clinic-based outpatient care on all FOBs with a Soldier population larger than 1,000. It also provides some inpatient care capability by using CSH behavioral health assets. The calculations for this component are based on population estimates of psychiatric morbidity (need), desire for care, and past patterns of utilization.

The second service component provides unit outreach. These additional BH personnel extend the clinical mission by adding preventive counseling, command consultation, unit needs assessment, Soldier classes, coordination with UMTs and PC providers, etc. The calculations for this component are based on the number of battalion-size units needing outreach, and the frequency of that need. With this model, officer and enlisted staff members located on each FOB could switch off duties as needed to provide clinical and outreach services.

The third service component adds additional personnel to staff regional restoration units that provide a location and up to a 3-day program as an intermediate care facility. This component also provides for a reconditioning unit in theater to provide longer-term restoration and reconditioning services (up to 21 days) to Soldiers from all over theater. These calculations are based on a new restoration/reconditioning unit staffing model found at the end of this TAB.

Table 1 presents an estimate of the BH staffing levels for each component of care based on OIF-II data as of 1 October 2004. In addition to the number of officers and enlisted for each component, the table shows the “running totals” and “running ratios” (ratio of 1 BH personnel to the number of Soldiers). The data used for this table will likely change for OIF-III and thus require a new staffing calculation.

**Table 1: Operation Iraqi Freedom Behavioral Health Functional Components Staffing Model
(Based on OIF-II Soldier Population of 95000, 1 October 2004)**

BASIC COMPONENTS	Off	Enl	Ldrs	TOTAL	Running Total	Running Ratio (1:X)
Clinical Services (FOBs >1000)	32	32	4	68	68	1386
Unit Outreach	0	32	2	34	102	929
3 Rest/1 Recond Units (Avg 4-8 pts)	10	10	1	21	123	770
TOTAL	42	74	7	123		

Using the assumptions noted in the sections above, the staffing projection for the OIF (Kuwait and Iraq) population (as of 1 October 2004) is 123 BH personnel (42 officers, 74 enlisted, and 7 leaders—a mix of officers and senior NCOs). This would provide one BH personnel for every 770 Soldiers in theater—a ratio in between the current level of staffing, and that of OIF-I.

The model allows for differing assumptions. For example, it may not be reasonable to lump Iraq and Kuwait together since they have different needs and different command structures. If one wishes to only look at Iraq (assume Iraq data is that of 1 October 2004—see Annex B, Table 4), wants to ensure that there are 2 officer providers on each FOB larger than 1,000 (plus additional enlisted BH staff), and thinks that outreach to each battalion-sized unit will take 2 days on average instead of 1 day, then new staffing levels can be calculated. These new parameters would result in 183 BH personnel (58 officers, 114 enlisted, and 11 leaders—a mix of officers and senior NCOs). This would provide one BH personnel for every 456 Soldiers in Iraq (see Table 2).

**Table 2: Operation Iraqi Freedom Behavioral Health Functional Components Staffing Model
(Based on Iraq-Only Soldier Population of 84,000, 1 October 2004, Two Providers on
FOBs >1000, and 2 Outreach Days per Week per Battalion)**

BASIC COMPONENTS	Off	Enl	Ldrs	TOTAL	Running Total	Running Ratio (1:X)
Clinical Services (FOBs >1000)	48	48	6	102	102	815
Unit Outreach	0	56	4	60	162	515
3 Rest / 1 Recond Units (Avg 4-8 pts)	10	10	1	21	183	456
TOTAL	58	114	11	183		

The model can thus be used for a range of situations, depending on the facts one has and the assumptions one makes at the time of the estimate. If further redundancy is desired, the planner may choose to increment the numbers by an additional percentage (add a “fudge factor”).

Additional Information on Staffing Model Calculations

Clinical Services Component

1. The estimated number of Soldiers needing help was determined by multiplying the Soldier population by the average of the percent of Soldiers wanting help (11%), needing help (13%), and usually using help (10%). The result was 10,500.

$$[\text{SoldiersServe}] = [\text{Soldier population}] * ([\% \text{WantHelp}] + [\% \text{NeedHelp}] + [\text{UseHelp}]) / 3$$

2. The estimated total number of visits for a deployment year is 31,500 (10,500 times the number of visits per Soldier, 3).

$$[\text{TotalVisits}] = [\text{SoldiersServe}] * 3$$

3. 31,500 visits require 17 officer providers seeing six Soldiers per day, 6 days a week.

$$[\text{Providers}] = ([\text{TotalVisits}] / (365 * 6 / 7)) / 6$$

4. However, 17 providers will not provide adequate coverage for all 23 FOBs with populations >1,000 Soldiers. Therefore, one must have at least 23 (one for each FOB) plus an additional 9 for FOBs with large populations (over 3,500) in order to cover the required clinical workload. This results in a total of 32 clinical providers. This was increased for Table 2, above, to assure at least 2 officers (and two enlisted) could be placed on each FOB over 1,000.

$$[\text{ClinProviders}] = \text{The Greater of } ([\text{Providers}] \text{ OR } ([\text{NumFOBs} > 1000] + [\text{NumFOBs} > 3500]))$$

5. To support and extend the clinical mission, 32 enlisted soldiers (one for each officer provider) will deploy as well. This results in a total of 64 BH personnel to provide clinical

coverage at the 23 FOBs throughout theater with Soldier populations greater than 1,000 (see Table 1, above).

[Enlisted] = [ClinProviders]

6. In addition to clinical providers, for every 15 BH personnel, one additional person (or “full time equivalent”) is added to the model to allow for command, control, and staff functions. This adds 4 additional personnel (could be any combination of additional officers or senior enlisted personnel), for a total of 68 BH personnel.

[Total] = [ClinProviders] + [Enlisted] + (([ClinProviders] + [Enlisted]) / 15)

Unit Outreach Component

7. Outreach staffing numbers are based upon a BH officer or enlisted member spending 1 day each week with each battalion-sized element in theater. This time can be used doing need assessments, command consultation, liaison with chaplains and PC providers, providing on-the-spot interventions, classes, setting up and training the battalions’ Soldiers in a train-the-trainer mode, etc. We did not have the exact number of battalions in theater, but estimated it by taking the total Soldier population and dividing it by 500 (approximately 500 Soldiers in a battalion). This resulted in the need for 189 person-days per week. This was divided by 6 (the number of work days per week), resulting in the need for 32 additional personnel. For our analysis, we assumed that this work could be done in large part by 91Xs under the supervision of the BH officer at the FOB or on a nearby FOB. This resulted in the need for 32 additional enlisted BH personnel. For Table 2 this was changed to assume that it would take 2 days for each battalion.

[OutreachPeople] = ([NumBNs] * [NumDaysOutreachPerBN]) / 6

8. The additional personnel also require one leader for every 15 personnel, so 2 additional leaders are needed.

[Total] = [OutreachPeople] + ([OutreachPeople] / 15)

Regional Restoration and Theater Reconditioning Component

9. The number of personnel needed to staff a regional restoration program or a theater-wide reconditioning program was drawn from the Staffing Model below. We assumed that restoration programs in OIF and comparable scenarios would not hold more than 4 Soldiers on average, and that a reconditioning program would not hold more than 8 Soldiers on average. Restoration programs required 2 officers and 2 enlisted staff to serve a 1:4 ratio. Since there are three regional restoration programs, this resulted in 6 additional officers and 6 additional enlisted personnel.

10. From the staffing guidelines below, a reconditioning program needs 4 officers and 4 enlisted personnel to support a 1:8 ratio.

11. Adding these together results in the need for 10 more officers and 10 more enlisted personnel to support 3 regional restoration programs and one theater-reconditioning program.

12. Finally, one must add one additional leader (or “full time equivalent”) for the 20 BH personnel performing restoration/reconditioning services; this results in a total of 21 BH personnel to conduct restoration and reconditioning in theater.

Combat Stress Control Restoration and Reconstitution Staff Models

The MHAT noted that some CSC restoration programs had more personnel than they needed to care for the Soldiers being referred to them. The theater BH consultant stated that some of these personnel are used as rapid reaction teams for surges and psychological mass casualties (MASCALs). Current base tables of organization and equipment (BTOEs) implies incorrectly that a restoration or fitness section works as (and only as) a single entity. However, current teaching and the rewritten draft COSC field manual clearly state that all CSC teams, and especially fitness teams, must routinely split into smaller, dispersed elements, as needed to fulfill specific missions. The Army Transformation CSC unit will be composed of 3-person mobile teams that can provide outreach services or can be assembled to provide restoration or reconditioning. This will provide planners and leaders with more flexibility and freedom to adapt to mission requirements. As noted above, certain specialties (like OT) are needed at restoration units. However, any persons and/or time not fully used in providing restoration/reconditioning care should be shifted to provide preventive outreach to units on the local FOB.

Behavioral health inpatient wards have developed staffing-to-patient models, but restoration units and prevention teams have not yet identified such models. In actual practice, the independent capability level of any particular BH team or unit is based on two critical aspects: (1) The licensure/regulatory limitations imposed and the experience of the team members, and (2) The capability/capacity of the BH team/unit to hold and treat Soldiers/patients. Behavioral health teams with the appropriate capability ratings should be matched (and not over-matched) with mission needs.

Table 3 describes the various capability levels that a BH provider or team may assume based on the specialized capabilities of its member(s). Table 4 describes the levels each BH provider or unit may assume based on ability to provide holding capacity.

Using Table 4, each proposed restoration program should be able to gauge the appropriate number and mix of personnel needed to care for a given number of Soldiers. For example, if a unit is providing care for 1 to 4 Soldiers, they will need two full-time 91Xs, an OT or OT technician, and a social work or clinical psychology officer. If the number of Soldiers in restoration is increased to eight, the unit would need 3 fulltime 91Xs, 2 OTs or OT technicians, and one social work or clinical psychology officer. These tables and ratios are meant to be guidelines; leaders must take into

consideration operational and environmental factors when staffing units on the battlefield.

Table 3: Combat and Operational Stress Control Specialty Capability Levels

Specialty Care	Enlisted 91X	BH Officer	BH Officer w/Cmd-Directed Eval Capability IAW DoD 6490.1	BH Officer w/ Prescribing Privileges
Program Content	Outreach; Consultation; Basic Assessment; Soldier Coaching	+ Full Assessment; Outpt management; Outpt treatment	+ Self-contained evaluations of command-directed evaluations in non-emergent environs	+ On-site medication management
Specialty Support	Lone 91Xs should be NCOs. Junior enlisted may be used if senior (E7) 91X or BH officer telephone/email support is available 24/7.	OT officers may be used if a licensed BH clinician's telephone/e-mail support is available 24/7.	Non-PhD BH officers can evaluate Cmd-directed cases in emergent conditions. They can evaluate routine Cmd-directed cases if PhD-level BH clinician telephone/e-mail support is available 24/7 and the case is reviewed and countersigned when a PhD provider is available.	Non-prescribing BH officers should use available PA/physician support for basic medical management. Poly-pharm and/or potentially complicated medical management cases must have available psychiatrist telephone/e-mail support 24/7.
Documentation	• COSC-WARS • Outpt cases – BH chart notes; BH note in pt outpt records	• COSC-WARS • Outpt cases – BH chart notes; BH note in pt outpt records	• COSC-WARS • Outpt cases – BH chart notes; BH note in pt outpt records • Cmd-directed cases — cmd-directed forms	• COSC-WARS • Outpt cases – BH chart notes; BH note in pt outpt records • Cmd-directed cases -cmd-directed forms

Table 4: Holding Capability Levels

CAP	2a Unit Holding	2b Medical Holding	2c Restoration	2d Reconditioning	2e Inpatient Ward
Unit	Soldier's or nearby supporting unit	Non-BH Medical Unit	BH/CSC Unit	BH/CSC Unit	BH Inpatient Ward
Program Content	Rest, reassure, replenish, and restore confidence (4Rs)	• 4Rs; Monitoring; Stabilization	2b + OT Assessment	2c + OT Program	• Secure environment • Stabilization • Medication Management
Program Length	As needed	1-3 days	1-3 days	4+ Days	As needed
Specialty Care	91X + supervision	91X + supervision	CAP 1b + OT/91WN3	CAP 1d + OT + PN	CAP 1d + PN
Personnel Requirements	Unit members provide watch as needed.	• 91X – 1:4 • 91W – per med unit's staffing SOP • Medical officer supervision – per med unit's staffing SOP	• 91X – 1 + 1:4 • OT/91WN3 – 1:6 • CAP 1b Off – 1:12	• 91X – 1 + 1:4 • 91WN3 – 1:6 • OT – 1:12 • PN – 1:12 • CAP 1b Off – 1:12 • CAP 1d Off – 1:30	Based on BH inpatient ward staffing model used by the particular hospital, augmented if necessary by CSC unit
Milieu	w/unit and peers	w/other med patients	Occ Milieu	Psych/Occ Milieu	Psychiatric Milieu
Identification	Soldier at Rest	Soldier in Holding	Soldier in Holding	Soldier in Recovery	Patient
Documentation	• COSC-WARS • Brief BH note in outpt record	• COSC-WARS • Brief BH note in outpt record	• COSC-WARS • Brief BH summary in outpt record	• COSC-WARS • Full notes in BH chart • Summary BH note in outpt record	• Full inpt medical chart • Admission and disposition notes in outpt chart

Note: 91X = Enlisted Mental Health Specialist; 91WN3= Enlisted Occupational Therapy Technicians; OT = Occupational Therapist; PN = Psychiatric Nurse; SOP = Standing Operating Procedures

APPENDIX 6

BEHAVIORAL HEALTH RETURN-TO-DUTY AND WORKLOAD DATA

INTRODUCTION

As part of the MHAT mission, electronic workload, evacuation, and RTD data were collected from various BH units. These units included: CSC detachments; a CSC company; division, brigade and area support medical company MH sections; CSH psychiatric sections; and USAF teams that supported primarily U.S. Army troop populations. Many units did not respond to the data call, and in other cases, the data received were difficult to standardize for comparison. However, the usable data provided by some units allowed us to arrive at some findings and recommendations.

FINDINGS

Finding #1: Behavioral health assets had high RTD rates.

All forward-deployed BH assets in OIF-II Iraq had high RTD rates (See Table 1). One separate brigade BH team with two each organic officers and 91Xs returned 100% of the Soldiers/patients that its DMHS evaluated. The two DMHS's and another separate brigade's rates were above 96%. The one CSC Company, deployed for a time at 15 separate FOBs throughout Iraq, returned 95% of the Soldiers provided 1-on-1 preclinical or clinical care. The Air Force's (b)(2)-2 operational stress teams in Kuwait had RTD rates (97%) comparable to the Army's forward-deployed BH units.

Table 1: OIF-I and OIF-II Return to Duty By Type of BH Team/Unit

Type of Unit	Dates	% RTD	
		OIF-II	OIF-I
Division MH Sections	Apr-Aug 04	97%	97%
Separate Brigade MH Sections*	Apr-Aug 04	99%	---
Combat Stress Control Unit	Aug-Sep 04	95%	96%
USAF Combat Stress Teams	Jun-Aug 04	97%	96%
CSH (with CSC R/R)**	Apr-Aug 04	80%	69%
CSH (Psych Inpatients only)*	Apr-Aug 04	4%	---
Regional Medical Center (Germany)	Mar-Sep 04	3% ***	4%

* No data from a comparable unit in MHAT-I Report

** R/R = Restoration/Reconditioning Program

*** LPMC OIF-II RTD was 0% for inpatients, 3.7% for outpatients.

Soldiers returned to duty from divisions, separate brigades, and CSC units included both non-inpatient "psychiatric" and "combat/operational stress reactions." Non-inpatient RTD rates in the high nineties suggest that forward-deployed BH personnel are retuning almost all Soldiers they help/treat for both stress and mental problems immediately to their units.

The CSC reconditioning program treats selected Soldiers with diagnosed mental disorders who have not responded to outpatient treatment or a 3-day restoration program, but who were still judged to have worthwhile RTD potential. Since many units (particularly reserve units) do not receive replacements during the 1-year deployment, a program that can treat Soldiers and return them to duty is a force multiplier. The program's RTD rate from reconditioning could not be reliably calculated from the records available to the MHAT-II. Continual analysis is required to judge whether the BH personnel involved in treating the reconditioning cases would have greater impact on overall combat effectiveness and soldier well-being if they were employed further forward for outreach and outpatient interventions.

The OIF-I combat support hospital had its own small psychiatric ward and additional staff. The OIF-II combat support hospital could only admit psychiatric casualties on an intermediate medical care ward. However, the OIF-II combat support hospital worked closely with the CSC unit's restoration/reconditioning program. Soldiers admitted to one unit were often treated and/or quartered by the other. In general, Soldiers were seen at the CSHs in either an outpatient or inpatient mode. Soldiers seen as outpatients (including those who were temporary residents in the neighboring CSC unit restoration program) had a much higher RTD rate (80%) than did those Soldiers who were admitted as inpatients to the intermediate care ward (4.3%). This lower 4.3% RTD rate reflects the severity and poor prognosis of their conditions in the psychiatrist's clinical judgment. Less severe cases with better prognosis were admitted to the nearby CSC facility, which also has psychiatry, psychiatric nursing, and OT capabilities focused on RTD.

Finding #2: A tracking system for CSC preventive and preclinical individual contact activities has not yet been universally implemented in the OIF Theater.

The attempt to gather and compare data from various units in OIF-II clearly demonstrated a need to both standardize and enforce mandatory reporting of common data. Although the CSC/BH units under the Medical Brigade and the two divisions in OIF-II use the COSC-WARS summary report, some units use it differently. Some users made variations in the line formats or misinterpreted what data to enter into certain fields, thus making comprehensive compilation and analysis impossible.

The CHPPM's automated version of COSC-WARS is one option that AMEDD Combat Developments is using as the test-bed for developing contract specifications for the COSC functional area in the Theater Medical Information Program (TMIP). Automated COSC-WARS is developing the capability to capture the data at the single-event level, generate summary reports, enable temporary archiving in theater for local use, and permanently archive the initial data and reports in CHPPM's secure, searchable surveillance database, which can respond to inquiries from Theater. The program operates on laptops and handheld and desktop computers, with electronic synchronization and transmission. Coordination has begun to add COSC-WARS capabilities to the medical communications for combat casualty care (MC4) system.

Further assessment and coordination is needed to ensure that the existing system (COSC-WARS) meets BH and theater requirements.

Finding #3: Combat Stress Control (CSC) units contribute to outreach efforts.

Table 2 demonstrates the types and quantity of outreach and early intervention that one CSC Company accomplished in a 7-month timeframe. This workload represents the equivalent of 52 debriefings, 198 classes, 1,160 unit visits, and 274 command consultations per month. Organic BH assets also do outreach, but through augmentation, CSC behavioral health personnel can greatly assist organic outreach (and other BH service) efforts. TAB A contains definitions for workload categories noted in Table 2.

Table 2: Preventive Outreach Activities of a CSC Unit in OIF-II, March–September 2004 (Summing Weekly COSC-SRs)*

Activities	Total Number
Critical Event Debriefings	364
# Critical Events	178
# Participants	2587
Other Debriefings	91
# Participants	1746
Health Protection Classes	1097
# Participants	8405
Mission-focused Classes	290
# Participants	5295
Unit Surveys	29
# Questionnaires Received	1122
Command Consults (Not case related)	1921

*The company had approximately 80 personnel to conduct preventive activities, about 68 of them clinically trained. From March to June, the summary reports (SRs) came weekly to the CSC Company HQ from

(b)(2)-2

(b)(2)-2

Based on these statistics, the CSC Company provided an average of two CED sessions for each critical event they responded to, with an average 7 Soldiers in each debriefing. This is consistent with training guidelines. There were fewer “Other debriefings;” these averaged 19 participants per session.

Approximately 8 Soldiers attended the health protection classes on average. Examples of these classes included individual Soldiers attending anger management or tobacco cessation classes. Mission focused classes, on the other hand, averaged 18 participants per session; most likely these were coordinated with specific units for members of that unit.

Finding #4: Behavioral health providers rated “relational factors” as the predominant contributing factor to Soldiers’ chief complaint.

Table 3, below, reports what BH personnel in a DMHS recorded as the primary stressors or contributing factors in the COSR and psychiatric cases they interviewed and aided/treated. Their evaluations integrated the chief complaints of the individual Soldiers with their own knowledge and experience in the etiology of emotional distress and mental disorders. They perceived relational issues as the major factor in the majority of cases (58%). Of these relational issues, problems in relationships on the home front were considered the most common, followed by problems with peers in the unit, then leadership conflicts. Individual causes were perceived as the next highest contributor to the symptoms (26%); these causes included preexisting disorders, “conditional” (“I’ll get better only if you send me home”), and character traits. Operational exposures, including traumatic events, were perceived as primary causes in 11%. See TAB B for definitions of the below contributing factors.

***Table 3: Contributing Factors to Soldiers’ Stress Reactions
(From a DMHS’ Weekly COSC-SR; Jan - Aug 2004)***

Contributing Factors	Number	Percent
Operational Exposures	252	11%
Combat Exposure	125	5%
Noncombat Critical Event	127	5%
Relational Factors	1345	58%
Peer/Unit	460	20%
Leadership	312	13%
Home Front	575	25%
Environmental Exposures	129	6%
Physical/Environmental	45	2%
Mission Requirements	84	4%
Individual Causes	607	26%
Characterological Factors	244	10%
Conditional	72	3%
Preexisting Condition	301	13%

Number of Soldier Visits = 1,575.

Behavioral health personnel could record up to 3 factors/case.

RECOMMENDATIONS

Recommendation #1: All BH/CSC personnel use a single standard format for documenting preventive encounters and interventions.

Theater BH assets should use an identical format for recording their COSC-type activities and cases. The teams may use different portions of the format, and report only what higher headquarters specifies in the SOP. The documentation must merge within the BH/CSC teams to produce the unit’s weekly summary, and by higher headquarters to combine the summary reports across units and over time for ongoing trend analysis, resource redistribution, and follow-up assessment.

The CHPPM's automated version of COSC-WARS is one option. The AMEDD Combat Developments is using COSC-WARS as the test bed for developing contract specifications for the COSC functional area in the TMIP. Automated COSC-WARS has the baseline capability to capture the data at the single-event level, generate summary reports, enable temporary archiving in theater for local use, and permanently archive the initial data and reports in CHPPM's secure, searchable surveillance database, which can respond to inquiries from theater. The program operates on laptops and handheld and desktop computers, with electronic synchronization and transmission.

Recommendation #2: Cooperation and synchronization of effort between organic MH sections and augmenting CSC teams should be fostered through task organization and clear command and control relationships.

The advent of the CSC units in 1993 added BH personnel to the deployed force, but experience has found that organic (division and brigade) and augmenting CSC personnel, teams, and units often have difficulty integrating within a single area of operations. Because CSC units (and their BH personnel) are corps-level assets, the corps medical brigade usually controls them. Further, the corps medical brigade commander may or may not be the Corps Surgeon, creating distinct chains of command for divisional BH personnel and CSC personnel. This split can result in different reporting formats, differential service standards, and most apparently, in overlaps and gaps in BH services in theater.

Logistics support of CSC units is another noted problem that has been raised through BH interviews and focus groups in both OIF-I and OIF-II. Because CSC units are a corps asset and often (as small teams) lack inherent supply, communication, and other necessary survival capabilities, coordination must be done when placed in a forward location to ensure adequate logistical support.

BACKGROUND

Study Sample

The units for which adequate workload and RTD data were obtained in time for this report are listed in Table 5. Some units provided data that were incomplete, inconsistent, or difficult to interpret. These units are also listed in Table 5.

Table 5: Units Contributing Data to the Data Call Appendix

Unit Data Used in Analyses	Unit Data Not Included in Analyses*
(b)(2)-2	

* Data not used because data was inconsistent, incomplete, or difficult to interpret within the time available

Procedures

All major BH units and sections were queried via telephone and e-mail and/or in person between 9 September and 9 October 2004. Although some small, forward-located teams were not canvassed, their parent organizations were. A data matrix was e-mailed to the major units in September 2004 and again to non-responders a week or so later. Additionally, COSC-WARS summary reports compiled over time were received from (b)(2)-2

(b)(2)-2 Kuwait.

The electronic data call form is at TAB C. The standard data fields (numbered lines) of the manually recorded COSC-WARS Summary Report that the (b)(2)-2 Med Bde used is at TAB D. The MHAT archived the electronic data from the forms and of the e-messages related to the data used in this appendix in the Department of Military Psychiatry, Walter Reed Army Institute of Research (WRAIR), Silver Spring, MD.

TAB A: Definition of COSC-WARS Preventive Outreach and Intervention Terms

of Critical Event Debriefing (CED)* Sessions

Number of debriefing sessions for Soldiers, leaders, others who were part of a critical incident

A Critical Event Debriefing (CED) is a form of psychological debriefing conducted by BH/COSC personnel at the request of units following a critical event (CE) for the purpose of clarifying the event, facilitating the team members' support for each other, and regaining unit cohesion and readiness for further action.

Total # of Attending CEDs

The total number of participants in all of the CEDs performed during the reporting period

of Critical Events**

This is the number of all critical (combat and noncombat) events that has occurred within the reporting unit's area of responsibility during the time covered by the report.

A CE is an event that involves death, injury, or imminent risk thereof, and has high potential to produce emotions/cognitions of intense fear, horror, helplessness/hopelessness, guilt, etc., in some survivors and rescuers.

of Other Debriefing Sessions

The number of debriefing sessions for Soldiers for reasons other than the aftermath of a critical event (for example, end of tour debriefings)

of Force Health Protection (FHP) Classes

The number of classes given on FHP topics that are not related to a current deployment or deployment-phase. For example, FHP classes would include smoking cessation, anger management, stress management, suicide prevention, etc. Reunion classes are FHP classes if given generically, and not as part of a current deployment.

Total # of Attending FHP Classes

Total number of participants attending all FHP classes lead by the reporting unit during the reporting timeframe

of Mission-Focused Classes

Mission-focused classes include those classes, courses, and briefings related to a current or pending deployment/mission. Pre-deployment briefings and re-deployment briefings (to Soldiers and/or family members, etc.) are mission-focused classes. Other examples include classes on: Continuous Operations; Psychological Aspects of Nuclear, Biological, and Chemical (NBC) Operations; Peacekeeping Operations, etc.

Consultations to Command or Other Med Pros

The number of nonclinical (i.e., not about an individual) command consultations or consultations to other medical professionals

TAB B: Definitions of Contributing Factors to Soldiers' Stress Reactions

of Combat Exposure

The number of COSC contacts where the primary problem was attributed to direct combat exposure (lethal weapons used with deadly intent in the immediate vicinity, direct exposure to casualties, front-line action, etc.)

NonCombat Severe Event

The number of COSC contacts where the primary problem was attributed to a critical incident other than direct combat (suicide in unit, fatal accident, exposure to mass suffering or dead bodies, great danger, etc.)

Peer/Unit

The number of COSC contacts where the primary problem was attributed to a conflict with the unit or with a peer in the unit

Leadership

The number of COSC contacts where the primary problem was attributed to a conflict with or between leaders in the unit or to perceived poor leadership within the unit or at higher echelons of command

Home Front

The number of COSC contacts where the primary problem was attributed to an issue at home, conflict with family member, etc.

Environmental Factors*

The number of COSC contacts where the primary problem was attributed to environmental causes (living conditions, specific mission requirements, high operations tempo (OPTEMPO), sleep loss, continuous operations, mission-oriented protective posture (MOPP), resupply delay, etc.)

#Other Individual Factors*

The number of COSC contacts where the primary problem was attributed to individual causes (personality, malingering, expectation of secondary gain, etc.)

* The COSC-WARS Summary Report format (See TAB D) provided data entry fields for dividing Environmental Factors into two subcategories and Other Individual Factors into three subcategories.

TAB C: Electronic Data Matrix

Please complete these steps.

Step 1: Save this Microsoft Excel document to your hard drive using this naming system: "MHAT(your unit designation, date)."

For example, MHAT (b)(2)-2 01Sep 04).

Step 2: Complete the worksheets:

Workload
Supported Units
Personnel
Miscellaneous
Evacuations

Any questions regarding this information worksheet may be addressed to LTC (b)(6)-2 (see e-mail address below).

Step 3: Return this completed document to LTC (b)(6)-2 by 10 Sep 04.

Please send to (b)(6)-2

1. Please enter the number that best reflects your unit's workload by month during the period, 1 April through 30 August 2004.

	April	May	June	July	August	Total
New Patients*						0
All Patient Visits						0
New COSC One-on-One Contacts**						0
All COSC One-on-One Contact Visits						0
Soldiers with Suicidal Thoughts or Behaviors						0
Completed Suicides						0
Soldiers with Homicidal Thoughts or Behaviors						0
Evacuations						0
Soldiers Receiving Restoration						0
Soldiers Returned to Duty From Restoration						0
Soldiers Receiving Reconditioning						0
Soldiers Returned to Duty From Reconditioning						0

* "New Patients" are clinical in nature (i.e., the Soldier is evaluated and treated through traditional behavioral health care). This category accounts for distinct individuals seen by your unit.

** "New COSC One-on-One Contacts" are nonclinical in nature (i.e., the Soldier is managed through COSC interventions). This category accounts for distinct individuals seen by your unit.

2. What source did you use for this data (e.g., COSC-WARS)?

3. Do you track workload using another database (e.g., a homegrown Excel or Access database)?

4. List the units that you support and the corresponding distance and travel time from you.

[illegible]

6. On the average, how many person-hours are lost to non-COSC/BH taskings per week?	
7. How many teams does your unit have?	
8. How many clinicians are in your unit?	
9. How many clinicians are on your unit's modification table of organization and equipment (MTOE)?	
10. How many vehicles are on your unit's MTOE?	
11. How many vehicles does your unit have in its possession?	
12. How many vehicles could your unit dependably borrow if needed?	
13. How many armored vehicles does your unit have?	
14. How many working SINCGARs does your unit have?	
15. What is the medical holding capacity of your unit?	
16. Does your unit have SAWs for use on convoys?	
17. Does your unit have access to a DNVF phone?	
18. Does your unit have access to a secure internet?	
19. Does your unit have access to the nonsecure internet?	
20. Does your unit have access to Motorola Walkie-Talkies?	
21. Does your unit have access to cell phones?	
22. Does your unit have access to satellite phones?	

23. Did you bring psychotropic medication for the purpose of distributing to Soldiers/patients?		Yes or No
24. How far away is the nearest pharmacy to refill your medication supplies?		In miles
25. How many psychological tests have been performed from 1 April to 30 August 2004?		Number
26. How do you order laboratory tests?		Text
27. How do you get laboratory test results?		Text
28. Are you satisfied with laboratory support?		Yes or No
29. Which currently unavailable laboratory tests are needed to adequately care for patients?		Text List
30. What medications have you requisitioned (or otherwise acquired) that are otherwise not available in the pharmacy formulary?		Text List
31. Do you have a Behavioral Health Casualty Estimate Model? <i>If yes, please attach a copy to this completed worksheet.</i>		Yes or No

With this information, the MHAT will follow Soldiers and the development of their behavioral health problems as they move through the evacuation chain. Study results will help medical planners improve the efficiency of the evacuation system and the quality of care at each step in the evacuation chain.

[illegible]

TAB D: Standard COSC-WARS Summary Report (SR) Data Fields

The COSC-WARS, as a data collection system for COSC surveillance and monitoring, has three standard data entry formats: one for summarizing aspects of each preventive contact; one for summarizing aspects of each individual preclinical or clinical contact; and one periodic summary report of selected, rolled-up data from both the preventive and individual contacts. The original Prevention Contacts and Individual Contact forms were not used in OIF-II.

In field operations without COSC-WARS being automated, it is often impractical to fill out each prevention and individual contact form, then transcribe the data from each event sheet into a computer, and do the computations to produce the summary report. Therefore, the COSC-Summary Report form was also designed to be a data collection worksheet for recording and summing the Summary Report data. Immediately after each event, the provider puts a tick mark or Arabic numeral in the space in the row to the right of each relevant data field title. At the end of each reporting period, the tick marks or numerals are summed to give the totals in the far right columns, and the totals for each line (row) from all the providers are summed to give the unit's totals at the end of each reporting period. As with automated roll-down menus in an automated system, only the rows (data fields) that are relevant to the event are used.

The Summary Report form, beginning on the next page, is the one that all (b)(2) Medical Brigade units in OIF-II used. It is the form that (b)(2)-2 Medical Brigade was using at the end of OIF-I, in which they had added 7 lines regarding degrees of suicidal and homicidal behaviors to the original 52-line version. The mental health sections of the Corp's divisions and brigades received the original 52-line version, but some then added or deleted data fields without preserving the original line sequence.

COSC-SUMMARY REPORT– (COSC-SR) – MODIFIED

CONTACT FORM FOR THE SURVEILLANCE OF COMBAT & OPERATIONAL STRESS REACTIONS

1	Unit and Team(s):			
2	Report Dates:	From:		
		Thru:		
3	Location (and/or BCT Supported):			
PRIMARY PREVENTION				
4	# of Critical Event Debriefing Sessions			
5	Total # Attending CEDs			
6	# of Critical Events			
7	# of Other Debriefing Sessions			
8	Total # Attending Other Debriefings			
9	# of Preventive Educational Classes	Enter Sum from Line 10 and Line 12		
10	# of Force Health Protection (FHP) Classes			
11	Total # Attending FHP Classes			
12	# of Mission-Focused Classes			
13	Total # Attending Mission Classes			
SURVEILLANCE ACTIVITIES				
14	# Sensing Sessions/Walkabouts/Focus Groups			
15	Total # Participants/Contributors			
16	# Unit Surveys (Different Units Surveyed)			
17	# Questionnaires (Total Returned in Unit Surveys)			
18	# of Individuals Screened for Pre-/Post-Deployment			
19	# of Individuals Further Screened in Person			
20	# of Individuals Requiring Further Intervention			
21	# Consultations to Command or Other Med Pros			
SECONDARY PREVENTION				
22	Total # of COSR Contacts	Enter Sum from Line 23 and Line 24		
23	# of New Cases (First-time Contacts)			
24	# of Follow-Up Contacts			
25	Operational Causes	# Combat Exposure		
26		# NonCombat Critical Event		
27	Relational Causes	# Peer/Unit		
28		# Leadership		
29		# Home Front		
30	Environmental Factors	# Physical/Environmental Exposure		
		# Other Mission Requirements		
31	Other Individual Causes	# Characterological Factors		
		# Conditional		
		# Preexisting Condition		

APPENDIX 7

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ANNEX C

EVACUATION ASSESSMENT

OPERATION IRAQI FREEDOM (OIF-II)

MENTAL HEALTH ADVISORY TEAM (MHAT-II)

30 January 2005

Chartered by
The U.S. Army Surgeon General

This is an annex to the Operation Iraqi Freedom (OIF-II) Mental Health Advisory Team (MHAT-II) Report addressing the behavioral health evacuation system in OIF-II (including Kuwait and Iraq). The findings were obtained from many sources to include interviews, record reviews, and Department of Defense- (DoD-) supported databases.

The views expressed in this report are those of the authors and do not necessarily represent the official policy or position of the Department of Defense (DoD), the U.S. Army, or the Office of The Surgeon General (OTSG).

ANNEX C

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NOTE: For the purpose of brevity, the following acronyms may be used (instead of spelling out the words) in this Table of Contents.

- *LRMC: Landstuhl Regional Medical Center*
- *MHAT: Mental Health Advisory Team*
- *OIF: Operation Iraqi Freedom*
- *TRAC2ES: Transportation Command Regulating Command and Control Evacuation System (TRAC2ES)*

INTRODUCTION

The Mental Health Advisory Team (MHAT-II) charter called for an examination of Army behavioral health (BH) evacuations from Operation Iraqi Freedom (OIF-II). This report focuses on the relative evacuation rates for medical-surgical specialties, evacuee demographics and diagnoses, and clinical/administrative procedures. These findings are compared with those identified in the MHAT-I report.

In keeping with the MHAT-II charter, this report focuses on BH relevant aspects of the medical evacuation process. It does not explore other clinical, logistical, or administrative issues (e.g., delays in evacuation; standing operating procedures (SOPs) by tactical and strategic medical evacuation flight teams; and clinical services in flight).

FINDINGS

- 1. For the same 7-month period (1 March—30 September), 25% fewer Soldiers were evacuated for BH problems in 2004 than those evacuated in 2003. Similarly, evacuations for all medical-surgical problems fell 12.1% in the same time frame.**

Table 1: Comparison of Army Evacuations/100,000 Soldiers			
Evacuation Source	# of Evacuations	Evacuations/ 100K Soldiers	% Difference from Year Before
OIF-I Evacuations (2003)	7415	4877	-
OIF-II Evacuations (2004)	4152	4288	-12.1%
OIF-I Behavioral Health Evacuations (2003)	527	347	-
OIF-II Behavioral Health Evacuations (2004)	251	260	-25%

Behavioral health accounted for only 6.0% of all OIF-II Army medical-surgical evacuations, falling from 7.1% from OIF-I. When compared with other medical-surgical specialties, BH was the fourth leading evacuator from OIF-II, falling from third in the year before.

Put into a historical perspective, the percentage of OIF-II behavioral health to all evacuations fell within the parameters of past military operations (see Table 2).

Table 2: Behavioral Health Evacuation Rates in Previous Military Operations*		
Military Operation	Behavioral Health Evacuations/ All Evacuations	%
Desert Storm/Desert Shield	215/6316	3.4%
Somalia	22/538	4.1%
OIF-II (Mar-Sep 04)	251/4152	6.0%
OIF-I (Mar-Sep 03)	527/7415	7.1%
Afghanistan (2003)	10/119	8.4%
Kosovo/Bosnia**	60/253	23.7%
* Provided by the AMEDD Center & School, Directorate of Combat and Doctrine Development.		
** The number of physical battle injuries requiring evacuation markedly impacts the percentage of behavioral health evacuations/all evacuations. A peacekeeping mission is likely to have few battle injuries; thereby, behavioral health's representation is increased.		

2. Evacuation procedures and policies have matured as evidenced by written SOPs, increased accountability, efficient information tracking, and improved transmission of clinical information between levels of care.

Landstuhl Regional Medical Center (LRMC) has made marked improvements in the evacuation procedures since MHAT-I's visit. The Deployed Warrior Medical Management Center (DWMMC) has completed its critical SOPs. Transmission of clinical information from OIF-II to LRMC substantially improved from OIF-I (83.5% v. 44.8%). Landstuhl Regional Medical Center BH records were assembled in accordance with hospital SOPs. Landstuhl Regional Medical Center clinical documentation was forwarded to the next level of care in 92.7% of cases. Interviews with evacuees indicated that they were very satisfied with their care during the evacuation process. The Office of The Surgeon General (OTSG) Evacuation database sufficiently tracked patients evacuated from theater. Landstuhl Regional Medical Center's BH providers report that Transportation Command Regulating Command and Control Evacuation System (TRAC2ES)/Patient Movement Record's (PMR's) clinical utility continues to improve.

RECOMMENDATIONS

Immediate Implementation

- 1. Develop performance improvement data entry procedures to improve the clinical utility of TRAC2ES/PMR.**

Future Implementation

- 1. Study the feasibility of developing a tactical and strategic evacuation tracking system for efficient clinical and administrative information flow.**

Medical Command (MEDCOM) should establish a joint process action team (PAT) to study the feasibility of an evacuation database system capable of clinical, tracking, and analytical functions. It must be readily available, secure, and tailored to the needs of line commanders, medical personnel, medical regulating planners, and medical planners.

METHODS

I. Evacuation Rates

Source of Data: As in the MHAT-I analysis, MHAT-II relied on the OTSG Evacuation database,¹ which combined information from other Department of Defense (DoD) databases: TRAC2ES, PARRTS, and Medical Occupational Data System (MODS) (see Appendix 1 for further details on each database).

Inclusion Criteria for OIF-II Army Evacuations: To prepare the OTSG Evacuation database for analysis, MHAT-II subjected all entries to specific inclusion criteria. To be included in the OIF-II Army Evacuation database, entries had to satisfy the following inclusion criteria: 1) must have Army as the branch designator; 2) must have Iraq as the operational event designator; and 3) must have a date between 1 March and 26 September 2004 as the date designator. The MHAT-II eliminated any updated entries that did not satisfy the inclusion criteria. Remaining blank entries were assumed to fulfill the inclusion criteria. The final database contained all OIF-II Army Evacuations from 1 March to 26 September 2004.

Inclusion Criteria for Behavioral Health Evacuations: To prepare the OIF-II Army Evacuee database for BH evacuation analysis, MHAT-II subjected all entries to inclusion criteria. To be included in the OIF-II Army Behavioral Health Evacuee database, all entries must have satisfied either of the following inclusion criteria: 1) must have psychiatry as the medical-surgical specialty designator; or 2) must have a history highlighting BH reasons for evacuation (e.g., intentionally self-inflicted wounds, overdose, or psychiatric diagnosis). The MHAT-II members reviewed the histories of those entries without a psychiatry medical-surgical designator for inclusion in the database. The MHAT-II reviewed all entries with a psychiatry designator, and included only those with a history consistent with a BH condition. The final database contained all Army OIF-II Behavioral Health Evacuees between 1 March and 26 September 2004.

Evacuation Rate per 100,000 Soldiers: To determine the evacuation rate per 100,000 Soldiers, the number of evacuations was divided by the average force population in OIF-II from 1 March to 30 September 2004, and then multiplied by 100,000.

¹ MHAT-II considered using Deployed Warrior Medical Management Center's Patient Information Application (PIA). However, it followed only LPMC OIF-II evacuees, unlike the OTSG database, which tracked all evacuees regardless of their destination. MHAT-II also considered using TRAC2ES database itself, but opted for the OTSG Evacuation database given that it contained TRAC2ES data as well as information from other medical databases (e.g. PARRTS and MODS).

To determine the evacuation rate per 100,000 Soldiers by month, evacuations with known dates were sorted by month, divided by the force population during that respective month, and then multiplied by 100,000.

Because evacuees were not systematically given a Reserve Component (RC) or Active Component (AC) in the database, it was not possible to compare the rates of these two groups.

II. Evacuee Chart Review

Source of Data: The MHAT –II developed a plan for evacuee chart review at LRMC (see Appendix 1 for details). The LRMC team consisted of three researchers from WRAIR (Europe) and the former psychology consultant to The Surgeon General (TSG). This team conducted the protocol over a 1-week period, and submitted data to MHAT-II for use in this report.

The MHAT-II used the OTSG evacuee database to identify Army BH evacuees who were transferred from OIF-II to LRMC from 1 March to 30 September 2004. For each identified evacuee, MHAT requested his/her patient records for review. The LRMC team reviewed the charts for information identified in the research protocol and entered this information into a Microsoft Access file or Word document.

Method of Analysis: Analysis of the LRMC Chart Review database used tools in Microsoft Access and Excel. Sorting results were compared to the total number of database entries for the purpose of generating a ratio or percent value.

III. Behavioral Health Interviews

Instrument Development: The MHAT-II developed interview instruments for BH providers and BH evacuees at LRMC. Questions focused on evacuation procedures, clinical services, and command and control. The interview questions for BH providers are available for review in Appendix 2; questions for evacuees are in Appendix 3.

Unstructured interviews were conducted with Multi-National Corps-Iraq (MNC-I) and Combined Forces Land Combat Command (CFLCC) surgeons and their staffs to elicit information regarding evacuation policies and procedures.

Interview Method: Structured interviews were conducted in small groups, comprised of three to five BH personnel. The former psychology consultant to TSG conducted the interviews. Interviews required approximately 1 to 1½ hours to complete. Limits of confidentiality were reviewed with interview participants. Interview notes were taken during the session, and later these notes were entered into a database for analysis.

Analysis of Surveys and Interviews: Tool in Microsoft Access was used to analyze the surveys and interview database. Results were compared to the raw number of database entries for the purpose of generating a ratio or percent value.

RESULTS

I. Evacuation Rates

Total Army OIF-II Evacuations: The Army OIF-II Evacuee database contained entries for 4,152 Soldiers evacuated from OIF-II from 1 March to 26 September 2004 (210 days; approximately 7 months). On the average, 19.8 evacuees were evacuated per day, and 593 evacuees were evacuated per month.

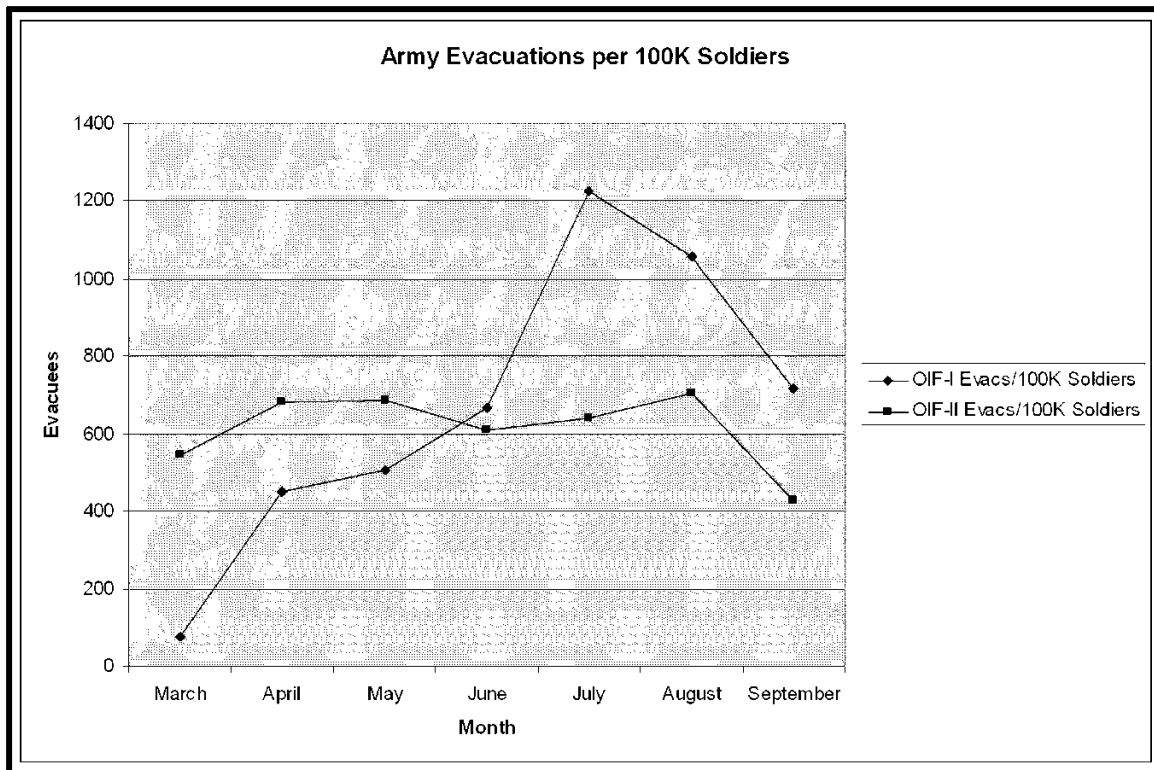
In comparison with OIF-I, evacuation rates were 12.1% lower in OIF-II. Table 3 compares total number of evacuations, average monthly and daily evacuations, and evacuations per 100,000 Soldiers.

Table 3: Total Army OIF-II Evacuations				
	Total Evacuations	Average Evacuations per Month	Average Evacuations per Day	Evacuations per 100,000 Soldiers
OIF-I (1 Mar – 30 Sep 03)	7415	1059	34.6	4877
OIF-II (1 Mar – 26 Sep 04)	4152	593.1	19.8	4288

Table 4 compares Army evacuations per 100,000 Soldier by month (March through September) for OIF-I and OIF-II. Chart 1 shows this same information graphically.

Table 4: Army Evacuations per 100,000 Soldiers by Month (March-September)							
	Mar	Apr	May	Jun	Jul	Aug	Sep
OIF-I	76	452	506	668	1225	1057	717
OIF-II	546	684	687	612	639	705	425

Chart 1: Army Evacuations per 100,000 Soldiers



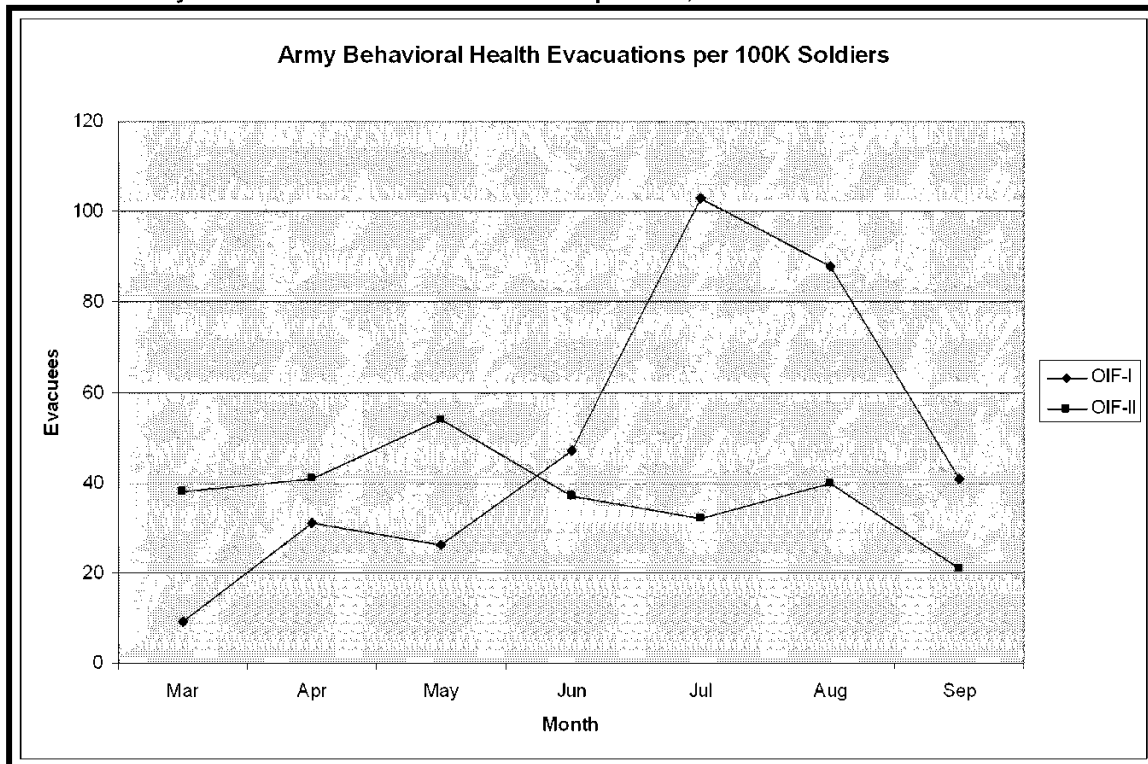
Behavioral Health Evacuations: There were 251 Army OIF-II behavioral health evacuations from 1 March to 26 September 2004 (210 days; approximately 7 months). On the average, 19.8 evacuees were evacuated per day, and 593 evacuees were evacuated per month. The rate of BH evacuations per 100,000 Soldiers was 260.2. Table 5 compares BH evacuations in OIF-I with OIF-II.

	Behavioral Health Evacuations	Average Evacuations per Month	Average Evacuations per Day	Evacuations per 100,000 Soldiers
OIF-I (1 Mar – 30 Sep 03)	527	75	2.5	346.6
OIF-II (1 Mar – 26 Sep 04)	251	36	1.2	260.2

Table 6 compares BH evacuations per 100,000 Soldiers by month (March through September) for OIF-I and OIF-II. Chart 2 shows this same information graphically.

Table 6: Army Evacuations per 100,000 Soldiers by Month (March-September)							
	Mar	Apr	May	Jun	Jul	Aug	Sep
OIF-I	9	31	26	47	103	88	41
OIF-II	36	42	54	38	26	35	21

Chart 2: Army Behavioral Health Evacuations per 100,000 Soldiers



Of all Army OIF-II behavioral health evacuations, 232 Soldiers were designated as *psychiatry* evacuations (i.e., entries with the psychiatry medical-surgical specialty designator). Of the 232 psychiatry evacuations, 3 were eliminated because their histories were not consistent with a BH issue. Review of the history fields from the 3,920 medical-surgical specialty-designated evacuations revealed that 22 entries were related to BH issues (see Table 7); these entries were included in the final dataset, bringing the total number of entries to 251.

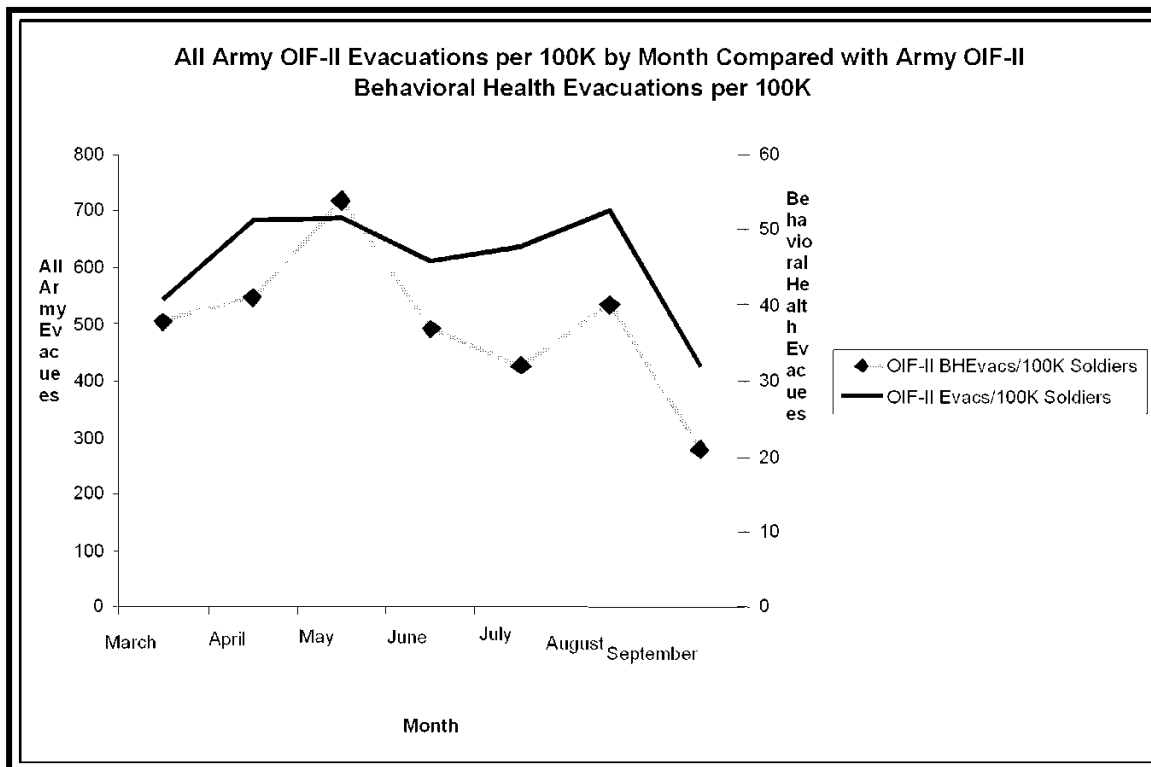
Table 7: Behavioral Health Evacuees Given A Non-Psychiatry Designator		
Medical-Surgical Specialty	Behavioral Health Issue	Number of Evacuations
Gastrointestinal	Adjustment Disorder	1
	Depression	1
General Surgery	Depression	1
	Self-inflicted Gun Shot Wound	5
Neurology	Various psychiatric disorders	6
Neurosurgery	Overdose	1
	Psychological factors	1
Orthopedic	Psychosis	1
	PTSD/Alcohol Dependence	1
Podiatry	Self-Inflicted Gunshot Wound	1
Pulmonary	Overdose	1
	Adjustment Disorder	1
	Panic Attack	1
Total		22

Comparisons of evacuations by medical-surgical specialty are shown in Table 8. In comparison with 1 March-30 September 2003, BH moved from the third leading evacuating medical-surgical specialty to fourth in 1 March-26 September 2004. Neurosurgery rose from the fifth to third leading evacuating specialty; however, its evacuations only exceed BH by one. Of note, general surgery experienced the greatest increase in evacuations (60%) when compared to other specialties.

Table 8: Evacuations by Medical-Surgical Specialty (1 March-26 September 2004)				
Medical-Surgical Specialty	# Evacuations	% of All OIF-II Evacuations	OIF-II Evacuations per 100,000 Soldiers	% Change from OIF-I Evacuations per 100,000 Soldiers
General Surgery	1066	25.7%	1101	60%
Orthopedic	969	23.3%	1001	-24%
Neurosurgery	253	6.1%	261	15%
Psychiatry (Behavioral Health)	232 (251)	5.6% (6.0%)	240 (260)	-29% (-25%)
Cardiac	224	5.4%	231	18%
Internal Medicine	221	5.3%	228	29%
Urology	186	4.5%	192	6%
Neurology	175	4.2%	181	-44%
Ear Nose Throat	120	2.9%	124	-12%
Gastrointestinal	97	2.3%	100	-36%
Ophthalmology	96	2.3%	99	-12%
Pulmonary	96	2.3%	99	-40%
GYN	85	2.0%	88	-56%
Oncology	53	1.3%	55	-14%
Dermatology	45	1.1%	46	-63%
Burn Surgery	42	1.0%	43	-26%
Oral Surgery	35	0.8%	36	96%
Renal	24	0.6%	25	-35%
Infectious Disease	21	0.5%	22	-52%
Obstetrics	19	0.5%	20	-74%
Podiatry	19	0.5%	20	-32%
Endocrine	14	0.3%	14	-57%
Rheumatology	14	0.3%	14	-37%
Dental	9	0.2%	9	-66%
Thoracic	9	0.2%	9	102%
Maxofacial Surgery	8	0.2%	8	-10%
Audiology	7	0.2%	7	-65%
Hematology	7	0.2%	7	-61%
Vascular Surgery	4	0.1%	4	0%
Metabolic	1	0.0%	1	-98%
Unknown	1	0.0%	1	-93%
Total Evacuation	4152	100.0%	4288	-12.1%

Chart 3 compares Army OIF-II evacuations per 100,000 Soldiers by month with BH evacuations per 100,000 Soldiers during 1 March-26 September 2004. This chart shows the relationship between the two curves graphically. As all evacuations rise or fall, BH evacuations reflect these changes as well.

Chart 3: All Army OIF-II Evacuations per 100,000 Soldiers by Month Compared with Behavioral Health Evacuations per 100,000 Soldiers



II. Evacuee Chart Review

Landstuhl Regional Medical Center Chart Review: Landstuhl Regional Medical Center provided 273 OIF-II evacuee BH charts for review (82 inpatient; 189 outpatient; and 2 both in- and outpatient charts). Thirty-five of these charts (13%) belonged to evacuees who were originally transferred out of OIF-II for nonbehavioral health reasons.

The Behavioral Health Service maintained Landstuhl Regional Medical Center's charts. Each record was comprised of various administrative and clinical documents, and maintained like those of other patients.

Tables 9, 10, and 11 summarize the demographic characteristics; diagnosed BH disorders in OIF-II; and diagnosed BH disorder at discharge from LPMC. Operation Iraqi Freedom (OIF-II) demographics were comparable to OIF-I. Table 12 shows that the percentage of Adjustment Disorders diagnosed at LPMC fell nearly 14% (i.e., from 39.43 in OIF-I to 25.64% in OIF-II).

Table 9: Demographics		
Category	#	%
Enlisted	196	90.5%
Officer	12	4.4%
Warrant Officer	8	2.9%
Unknown	6	2.2%
Male	237	86.8%
Female	36	13.2%
Active Component	167	61.2%
Reserve Component	99	36.3%
Unknown Component	7	2.6%

Table 10: Behavioral Health Disorders in OIF-II

Category	#	%
Mood Disorders	88	32.23%
Unknown	66	24.18%
Anxiety Disorders	42	15.38%
Adjustment Disorders	37	13.55%
Psychotic Disorders	13	4.76%
Other	11	4.03%
Personality Disorders	8	2.93%
Substance Abuse Disorders	7	2.56%
V Codes	1	0.37%
No Diagnosis	0	0.00%

Table 11: Behavioral Health Disorders at Discharge from LRMC

Category	#	%
Mood Disorders	81	29.67%
Adjustment Disorders	70	25.64%
Anxiety Disorders	59	21.61%
Unknown	22	8.06%
Psychotic Disorders	11	4.03%
Personality Disorders	10	3.66%
Other	9	3.30%
Substance Abuse Disorders	9	3.30%
V Codes	2	0.73%
No Diagnosis	0	0.00%

Table 12: % Change in Diagnoses from OIF-I to OIF-II

Disorder Category	OIF-I	OIF-II	% Change
Adjustment Disorders	39.43%	25.64%	-13.79%
Other	5.02%	3.30%	-1.72%
No Diagnosis	1.43%	0.00%	-1.43%
Personality Disorders	4.66%	3.66%	-1.00%
V Codes	0.72%	0.73%	0.01%
Substance Abuse Disorders	1.08%	3.30%	2.22%
Psychotic Disorders	1.79%	4.03%	2.24%
Anxiety Disorders	19.35%	21.61%	2.26%
Mood Disorders	25.09%	29.67%	4.58%
Unknown	1.43%	8.06%	6.63%

Table 13 reveals many diagnoses in OIF-II did not change by time of discharge at LRMC. Over 80% of Adjustment Disorders diagnosed in theater remained the same by the time the evacuees left LRMC.

Table 13: OIF-II Diagnoses Remaining Unchanged at LRMC			
Category	# OIF Dx	# OIF-II Dx Unchanged at LRMC	% Unchanged
Adjustment Disorders	37	31	83.78%
Substance Abuse Disorders	7	6	85.71%
Anxiety Disorders	42	34	80.95%
Mood Disorders	88	58	65.91%
Psychotic Disorders	13	8	61.54%
Personality Disorders	11	6	54.55%
Other	8	2	25.00%
V Codes	1	0	0.00%

Table 14 shows all BH diagnoses given at LRMC and their corresponding percentages.

Table 14: Expanded List of Behavioral Health Disorders		
Diagnosis	#	%
Adjustment Disorders	70	25.64%
Mood Disorders	81	29.67%
Bipolar Disorder	(19)	(6.96%)
Depressive Disorder NOS	(17)	(6.23%)
Dysthymic Disorder	(1)	(0.37%)
Major Depressive Disorder	(42)	(15.38%)
Mood Disorder NOS	(2)	(0.73%)
Anxiety Disorders	55	20.15%
Acute Stress Disorder	(19)	(6.96%)
Anxiety Disorder NOS	(9)	(3.30%)
Generalized Anxiety Disorder	(6)	(2.20%)
OCD	(2)	(0.73%)
Panic Disorder	(5)	(1.83%)
PTSD	(13)	(4.76%)
Simple Phobia	(1)	(.037%)
Other Disorders	10	3.66%
ADHD	(1)	(0.37%)
Cognitive Disorder NOS	(1)	(0.37%)
Conversion Disorder	(3)	(1.10%)
Dissociative Disorder	(1)	(0.37%)
Intermittent Explosive Disorder	(1)	(0.37%)
Sleep Disorder NOS	(1)	(0.37%)
Somatoform Disorder NOS	(2)	(0.73%)
Personality Disorders	12	4.40%
Psychotic Disorders	6	4.03%
Brief Psychotic Disorder	(3)	(1.10%)
Psychotic Disorder NOS	(6)	(2.20%)
Schizoaffective Disorder	(1)	(0.37%)
Schizophreniform Disorder	(1)	(0.37%)
Substance Disorders	9	3.30%
Alcohol Dependence	(4)	(1.47%)
Benzodiazepine Abuse	(1)	(0.37%)
Inhalant Abuse	(1)	(0.37%)
Substance Abuse	(3)	(1.10%)
Unknown	23	8.42%
V Code	2	0.73%
Total	273	100.00%

Table 15 indicates how many evacuees were prescribed psychotropic medications in OIF-II and at LRMC. In comparison with OIF-I, OIF-II saw a 21% increase in evacuees who were prescribed medication (39.07% to 60.44%). Evacuees who received medication throughout evacuation increased from 29.39% in OIF-I (82 evacuees out of 279) to 58.57% in OIF-II (147 evacuees out of 251).

Those evacuees not receiving any medication during their evacuation dropped from 25.8 % in OIF-I (i.e., 72 evacuees without prescriptions out of 279) to 10.7% in OIF-II (i.e., 27 evacuees without prescriptions out of 251).

Table 15: Medication Prescribed in OIF-II and LRMC						
			LRMC			
			Yes	No	Unknown	#
OIF-II	Yes	147	17	1	165	60.44%
	No	21	27	2	50	18.32%
	Unknown	16	4	6	26	9.52%
# LRMC			184	48	9	273
% LRMC			67.40%	17.58%	3.30%	

Table 16 shows the return-to-duty rates from LRM to OIF-II by inpatient/outpatient status, and by diagnosis. Only 7 (2.56%) evacuees were returned to duty from 1 March to 30 September 2004. In contrast, OIF-I returned 10 (3.58%) evacuees to duty from 1 March to 30 September 2003.

Table 16: Return-to-Duty Rates			
Patient Status	#	# Returned to Duty in OIF-II	%
Inpatient Only	82	0	0%
Outpatient Only	189	7	3.70%
Both	2	0	0%
Total	273	7	2.56%
Diagnosis	#	# Returned to Duty in OIF-II	%
Adjustment Disorder	70	1	1.43%
Alcohol Dependence	4	1	25.00%
Depressive DO NOS	17	1	5.88%
Mood DO NOS	2	1	50.00%
Personality DO	12	1	8.33%
Unknown	23	2	8.70%

Table 17 shows the documentation found on evacuee BH inpatient and outpatient charts at LRM. Transmission of OIF-II clinical documentation increased from 44.8% in OIF-I (125 charts out of 279) to 83.5% in OIF-II (228 charts out of 251). Either OIF-II clinical or TRAC2ES documentation was on 96.4% of LRM charts.

Table 17: Documentation in LRM Charts		
OIF-II Clinical Documentation	#	%
Yes	228	83.5%
No	19	7.0%
Unknown	26	9.5%
LRM Clinical Documentation Forwarded to Next Level of Care		
Yes	253	92.7%
No	5	1.8%
Unknown	14	5.1%
Patient Movement Request (or TRAC2ES)		
Yes	192	70.3%
No	55	20.1%
Unknown	25	9.2%
OIF-II Clinical Documentation and TRAC2ES		
Either present	243	96.4%
Neither present	4	1.5%

III. Evacuation Policy

Evacuation Policy of CFLCC and MNC-I: Discussions with Corps Surgeons at CFLCC and MNC-I revealed that there was no change in the evacuation policy of 7 days. An extended evacuation policy was considered impractical because it would require additional medical assets in theater. Instead, BH cases were given the flexibility to extend beyond the 7-day window, based on the clinician's assessment of return-to-duty potential.

During the Combat and Operational Stress Control Conference held in September 2004, BH providers reported adherence to the theater evacuation policy. Evacuations out of theater were made only after 1) a good faith effort to address the issue in theater failed; 2) if Soldiers were unable to adequately contribute to the mission; or 3) if they were dangerous to self or others. Behavioral health providers indicated that they kept patients in theater beyond the 7-day evacuation window on a case-by-case basis, and reported that this arrangement had worked well.

IV. Landstuhl Regional Medical Center Behavioral Health Interviews and Evacuation Procedures

Arrival: All evacuees arrive at Ramstein Air Force Base (AFB) in accordance with the United States Air Force (USAF) medical evacuation procedures. Ambulatory evacuees are transported by bus or ambulance as required. All evacuees arrive at the emergency room or, based on their condition, may go directly to the appropriate ward. During duty hours, personnel evacuated due to a BH issue are directed to report to the Outpatient Psychiatry Service, Division of Behavioral Health, where an initial assessment is conducted within 1 to 2 hours of arrival based on the number of evacuees. Operation Iraqi Freedom (OIF-II) evacuees have first priority in the walk-in clinic. After duty hours, the BH provider on-call is contacted and comes to the emergency room to conduct the assessment.

Triage: All evacuees are triaged and evaluated by the doctoral-level behavioral healthcare provider. The criteria for hospitalization are identical to those applied to all BH assessments. These criteria hinge on the degree of dangerousness to self or others. Additional criteria are employed on a case-by-case basis such as any unique medical issues requiring inpatient management. Admission procedures for the BH evacuee are essentially identical to those for other admissions. As with all patients who exhibit suicidal or homicidal behavior, the OIF-II evacuee who exhibits these behaviors is hospitalized and evacuated consistent with USAF regulations for patients in this status.

Duration of Stay: Hospital stays vary from 4 to 6 days based on the availability of evacuation aircraft.

Outpatient: Outpatient evacuees are housed at Kleber Kaserne, located approximately 30 minutes from LRMCC. The facility is a converted administrative and housing unit with a maximum capacity of 400 persons. The census is usually 200 to 250. The population consists of all ambulatory evacuees to include those with psychiatric diagnoses.

Command and control consists of a detachment commander, first sergeant, and operations noncommissioned officer (NCO). Daily formations are at 0600, and Soldiers are required to have a pass to proceed outside the immediate Kaiserslautern/Landstuhl area.

Additional control measures include the use of unit liaisons. These are individuals from the evacuees' unit who meet the arriving bus and are responsible along with the Deployed Warrior Medical Management Center (DWMMC) for monitoring the evacuee's progress through the medical system.

Overall responsibility for the Kleber facility and monitoring all evacuees is the DWMMC. The DWMMC maintains the Patient Information Application (PIA) database, which tracks the evacuee from date of arrival to date of departure, and provides status updates to the command while the evacuee is at LRMC. The PIA is accessible by providers, DWMMC personnel, and unit liaisons on the LRMC intranet.

All BH outpatient evacuees receive a memorandum (attached) from the Chief, Department of Psychiatry, providing instructions concerning contacting their unit liaison, leave requirements, and the prohibition of the consumption of alcoholic beverages.

Standards of Care: In all areas, the evacuee standards of care are identical to those provided to non-OIF-II patients. With respect to access to care, the OIF-II evacuees' access is superior in that they receive immediate attention upon arrival and are not appointed for a later date. Evacuee charts are subject to existing quality improvement SOPs and are not evaluated separately.

Treatment Initiatives: The relative brief stay of most evacuees (4-6 days) does not permit the development of initiatives requiring extensive follow-up. However, three areas of care are subject to immediate intervention and monitoring. Patient safety issues are assessed immediately following arrival at LRMC, and a determination of inpatient versus outpatient status is made. In addition, patients often arrive with sleep disturbance and anxiety symptoms. Immediate medical management has been highly effective in the amelioration of these symptoms.

Evacuee Accountability: The DWMMC has responsibility for all patient evaluation, treatment, disposition, and accountability while at LRMC. The DWMMC also maintains a PIA on the LRMC intranet. This PIA provides a wealth of data on each patient to include date of arrival, current medical status, and projected departure date.

Documentation from OIF-II: The evacuees arrive with a TRAC2ES/PMR, which details the circumstances that prompted the evacuation. Although the majority of these reports are thorough, there have been occasions where patients arrived with little or no information. Because of this lack of information, it is difficult to provide feedback to these providers.

Although not strictly medical information, the PMR is very helpful to have information from the Soldier's command concerning his performance and expectations concerning return to duty. Also e-mail addresses and other access points for the referring provider are helpful in planning dispositions and providing any requested feedback from the referring provider.

Feedback is not routinely provided to the referring provider due to lack of contact information.

According to LPMC staff, the clinical utility of TRAC2ES/PMR data is improving, and this facilitates disposition of an evacuee. The range for both inpatients and outpatients is 4 to 6 days.

In the absence of clinical documentation from the referring unit, an effort is made to contact the unit and determine the reason for evacuation. Without this information, the information provided by the evacuee determines the management. In cases where it is considered that no psychiatric condition is present which warrants evacuation, the recommendation is that the Soldier returns to duty. These cases without psychiatric documentation usually occur in patients evacuated due to medical reasons other than psychiatric.

Command Notification of Evacuation Progress: The unit liaison is aware of disposition, and where contact information exists, both the CONUS receiving facility and the OIF-II referring facility are notified. Behavioral health does not provide disposition back to the OIF-II command.

Suicides and Uniform Code of Military Justice (UCMJ) Issues: No evacuee has committed suicide and no assaults have been reported. One BH evacuee is under investigation for violation of the no movement policies and other possible UCMJ actions.

Alcohol Use by Evacuees: All BH evacuees are directed via memorandum from the Chief, Department of Psychiatry, to abstain from the use of alcohol. Incidents of misuse or abuse are reported to the Soldier's command and addressed clinically as required.

LPMC Recommendations for Improved Evacuations: LPMC personnel proposed making changes in two areas that might enhance the quality of care for evacuees.

Unstructured interviews with LPMC Command, BH providers, medical personnel, and chaplains indicated that Landstuhl Regional Medical Center personnel were directly impacted by the ongoing care demands of OIF-II evacuees. Landstuhl Regional Medical Center Command considers this issue important and requests that the MHAT-II consider the following recommendations.

- 1) Provide two BH providers with specialized expertise in the care and management of healthcare provider stress.

LRMC Rationale for 1). The LRMC staff is comprised of both active and United States Army Reserve (USAR) component personnel. These individuals provide care for many seriously injured personnel from all services. Interviews with BH providers, medical/surgical providers, chaplains, and LRMC leadership confirm the stress attendant to these duties. Landstuhl Regional Medical Center receives three to six buses of injured service members each day. Implementation of a “therapy by walking around” model, as was accomplished by Operation Solace, could assist the providers in managing this stressful duty. Additionally, these augmentees could enhance the Department of Psychiatry consultation liaison services for the intensive care unit (ICU) and medical and surgical patients.

- 2) Recommend that MHAT-II address this need for increased psychiatric inpatient capacity at LRMC.

LRMC Rationale for 2). LRMC serves a catchment area of 400,000 beneficiaries. It has an 18-bed inpatient psychiatry capacity. A proposed increase to a 26-bed unit is pending funding by MEDCOM. As active duty admissions surge due to periodic OIF-II requirements, care for family members becomes an issue as these beneficiaries must be hospitalized in German medical treatment facilities (MTFs).

V. Landstuhl Regional Medical Center Evacuee Interviews

Two BH evacuees were interviewed. One was an inpatient who had arrived on the day of this interview. The other was an outpatient who had arrived two days prior to this interview. Responses to the specific questions are summarized below. Although the interviews were conducted separately, the responses are consolidated for the purpose of this report. Both evacuees were informed concerning the purpose of this interview, the MHAT-II charter, and right to decline participation. Each evacuee was assured that only his/her responses to the questions and no identifying information would be included in the report. Both evacuees were cooperative and freely participated in the interviews.

Both evacuees described their care as excellent during all stages of their evacuation. Each complimented the care received through combat stress control (CSC) units. The evacuees described themselves as reluctant to leave the theater, but described their care in positive terms.

Both described support from caregivers and their duty units during the initial stages of the evaluation. One evacuee noted that his battalion commander came to the CSC unit to check on him prior to evacuation. They both noted that medical personnel ensured accountability for all ambulatory evacuees throughout the process.

Neither evacuee had any recommendations to improve his experience. However, one did note somewhat humorously that a “hot in-flight meal” would have been preferable to a meal-ready-to-eat (MRE).

One evacuee returned with an escort. This evacuee described the escort as very helpful. Both evacuees described the reception processing at Ramstein and LRMC as efficient. Neither required specialized medical care. However, one stated that had it been necessary, she was confident that it would have been provided. This evacuee stated that, throughout the flight, nursing staff regularly checked on their status and offered assistance.

APPENDIX 1

DESCRIPTION OF DEPARTMENT OF DEFENSE-SUPPORTED DATABASES

Transportation Command Regulating Command and Control Evacuation System (TRAC2ES)

Transportation Command Regulating Command and Control Evacuation System (TRAC2ES) is a web tool that tracks and manages casualty evacuations and patient movement. The present system was deployed nearly 2 years ago to monitor the movement of casualties out of a combat zone. The Transportation Command took over the responsibility for TRAC2ES in 1993; the casualty-evacuation management software was developed in response to widespread complaints following the 1991 Persian Gulf War that it was difficult to track and locate wounded service members being treated at military care centers and hospitals. Typical scenarios for the applicability for TRAC2ES, commanders on the ground determine that casualties need to be evacuated and transported to a medical facility. The command will contact the so-called "patient movement requirement center," a facility set up to support a specific conflict. The center, in turn, will request the aircraft and crews to transport those patients.

Although TRAC2ES was designed to track evacuees like cargo shipments, healthcare providers have relied on its clinical data entries whenever medical/BH records did not accompany the evacuee.

Patient Accounting and Reporting Real-Time Tracking System (PARRTS)

The purpose of the PARRTS is to report special interest patients as required by MEDCOM Regulation 40-7, Reporting of Special Interest Personnel. It is an interactive web-based data entry system used by Army MTFs and deployed medical assets. Manually, data are inputted via the U. S. Army Patient Administration Systems and Biostatistics Activity (PASBA) Restricted Web Site. Users of the PARRTS are senior staff members of the OTSG and MEDCOM, patient administration personnel at MTFs, and PASBA Input Sections.

Medical Occupational Data System (MODS)

The Medical Occupational Data System (MODS) is a database that helps personnel managers, special pay clerks, Professional Filler System (PROFIS) managers, manpower managers, and medical readiness managers make operational data simpler. The MODS provides Army Medical Department (AMEDD) human resource and soldier readiness processing (SRP) site managers with a responsive and reliable information management data system for all categories of military and Department of Army (DA) civilian medical support personnel. The data that are the basis for MODS are pulled from 18 different major Army and DoD databases.

APPENDIX 2

THE MENTAL HEALTH ADVISORY TEAM (MHAT-II) LANDSTUHL REGIONAL MEDICAL CENTER (LRMC) VISIT

Purpose

To provide structure and method to collect LRMC's Army Operation Iraqi Freedom (OIF-II) behavioral health (BH) evacuation data for the MHAT-II report.

Personnel

The MHAT-II, that will collect BH evacuation data at LRMC, is comprised of the following two sub-teams:

- Sub-team 1, consisting of one senior Army BH clinician, will conduct the Behavioral Health Provider Interviews and Behavioral Health Evacuee Interviews, and will request Miscellaneous Evacuation-Related Records. The Sub-team 1 leader is also designated as the Senior Team Leader and will oversee the MHAT-II Landstuhl Regional Medical Center visit.
- Sub-team 2, consisting of three U.S. Army Research Unit-Europe (USAMRU-E) personnel, will conduct the Behavioral Health Evacuee Record Review.

Command and Control

Each sub-team has a designated team leader who reports to the Senior Team Leader. The designated Senior Team Leader oversees the MHAT-II visit, liaisons with LRMC leadership, and reports to Colonel [b)(6)-2] through daily situation reports (SITREPs).

Instruments to be used during the collection of LRMC's Army OIF-II behavioral health data are:

- The Europe Regional Medical Command (ERMC) Clinician:
 - Behavioral Health Provider Interview (TAB A).
 - Behavioral Health Evacuee Interview (TAB B).
 - Request for Miscellaneous Evacuation Related Records.
- The MHAT-II In-Brief PowerPoint Presentation (TAB C).
- The Behavioral Health Evacuee Record Review (see TAB C, slide 8).
- The Operation Iraqi Freedom (OIF-II) MHAT-II Charter (Appendix 1 to Report).

Method

- **Step 1: Preparation for the MHAT-II Visit**

- Colonel (b)(6)-2 will contact the LRMC command to arrange visit date, time, and place. In this contact, team membership, method of data collection, sources of data, and logistical support are identified (see Visit Preparation Worksheet). Specifically, Colonel (b)(6)-2 will arrange the following events and corresponding details:

- **In-Brief:** Date, time, place, and point of contact for the Senior Team Leader's in-brief with the LRMC Commander, DCCS, DCA, DCN, and other key personnel designated by the Commander. Estimated duration: 1 hour

- **Behavioral Health Provider Interviews:** Date, time, place, and point of contact for Sub-team 1's individual interviews or group interview—depending on staff availability—with the following BH personnel:

- Chief, Department of Psychiatry.
- Chief, Psychology Service.
- Chief, Social Work Service.
- Chief, Patient Administration Division.
- Chief, In-Patient Psychiatry.
- Chief, Outpatient Psychiatry.
- Chief, Deployed Warrior Medical Management Center.

Estimated duration: 1-1/2 hour per interview

- **Behavioral Health Evacuee Interviews:** Date, time, place, and point of contact for Sub-Team 1's individual interviews with two Army OIF-II behavioral health evacuees. Estimated duration: 30 minutes per interview

- **Behavioral Health Evacuee Record Review**

- Point(s) of contact (POCs) for collection of BH inpatient and outpatient records

- Identification and collection of all Army OIF-II behavioral health inpatient and outpatient records from 1 March through 30 September 2004 for review

- Point of contact for space/computer/telephone logistical support
 - Date, times, and place for Sub-team 2's Army OIF-II behavioral health patient record review. Estimated duration: 5 days

- **Miscellaneous Evacuation Records**

- The POC for the DWMMC and an electronic copy of its standing operating procedures (SOPs). Estimated duration: 30 minutes

- Point(s) of contact for BH evacuee tracking databases unique to LPMC, and electronic copies (if available). Estimated duration: 30 minutes

- **Out-Brief:** Date, time, place, and point of contact for the Senior Team Leader's in-brief with the LPMC Commander, DCCS, DCA, DCN, and other key personnel designated by the Commander. Estimated duration: 1 hour

- Colonel (b)(6)-2 will provide LPMC leaders copies of MHAT's Patient Record Review instruments, Behavioral Health Provider Interview instruments, and Behavioral Health Evacuee Interview instruments on request.

- Colonel (b)(6)-2 will provide the completed Visit Preparation Worksheet to the Senior Team Leader prior to the visit.

- The Senior Team Leader will confirm arrangements with points of contact prior to the team's arrival date.

- **Step 2: In-Brief**

- The Senior Team Leader will meet with the LPMC Commander, DCCS, DCA, DCN, and other key personnel designated by the Commander. Other MHAT-II members may be present at the discretion of the Senior Team Leader.

- In the briefing, the Senior Team Leader will discuss the MHAT-II's charter; proponent; purpose for visiting LPMC; team membership; requested data sources; each sub-team's data collection methods; use of data to develop the MHAT-II report for the OTSG; visit timeline; team contact numbers; and request to out-brief LPMC leadership at the mission's completion (see TAB C, MHAT-II In-Brief PowerPoint presentation).

- **Step 3: Sub-Team Tasks**

- **Sub-Team 1**

- **Behavioral Health Provider Interviews**

- Sub-team 1 will meet with BH providers as previously arranged. Individual and/or group interviews are permitted.

- Before asking questions from the Behavioral Health Provider Interview Worksheet, the interviewer will review the following information with the interviewee: MHAT-II's charter; proponent; purpose for visiting LPMC; purpose of the interview; limits of confidentiality regarding information; use of interview data to

develop the MHAT-II report for the OTSG; and the right to refuse participation in the interview.

- Interview questions are listed in the Behavioral Health Provider Interview Worksheet (see TAB A). Interviewers should write interviewee responses verbatim, whenever possible, in the space provided on the worksheet.

- After the interview, written responses will be typed into the electronic Behavioral Health Provider Interview Worksheet. A completed electronic copy will be given to the Senior Team Leader for final transmission to

Colonel (b)(6)-2

- **Behavioral Health Evacuee Interviews**

- Sub-team 1 will meet with BH evacuees as previously arranged. To maintain privacy, only individual interviews are permitted.

- Before asking questions from the Behavioral Health Evacuee Interview Worksheet, the interviewer will review the following information with the interviewee: MHAT-II's charter; proponent; purpose for visiting LRMC; purpose of the interview; lack of confidentiality regarding information provided by interviewee (note: no patient identifying data will be documented); use of interview data to develop the MHAT-II report for the OTSG; and the right to refuse participation in the interview.

- Interview questions are listed in the Behavioral Health Evacuee Interview Worksheet (see TAB B). Interviewers should write interviewee responses verbatim, whenever possible, in the space provided on the worksheet.

- After the interview, written responses will be typed into the electronic Behavioral Health Evacuee Interview Worksheet. A completed electronic copy will be given to the Senior Team Leader for final transmission to Colonel Patterson.

- **Miscellaneous Evacuation Records**

- Sub-team 1 will coordinate with the point of contact of the DWMMC and will collect an electronic copy of its SOPs. This electronic copy will be given to the Senior Team Leader for final transmission to Colonel (b)(6)-2

- Sub-team 1 will coordinate with the POC(s) for any BH evacuee tracking databases unique to LRMC, and will collect an electronic copy of the databases. Electronic copies will be given to the Senior Team Leader for final transmission to Colonel (b)(6)-2

- **Sub-Team 2**

- **Behavioral Health Evacuee Record Review**

- Sub-team 2 will confirm arrangements with the point(s) of contact for patient record collection and with the point of contact for space/computer/telephone logistical support after the In-Brief.

- Sub-team 2 members will use the Microsoft Access file, LPMC Evacuee Record Review, to record data collected from each BH evacuee's inpatient and/or outpatient record (see TAB C, slide 8, for LPMC Database Fields).

- Each Sub-team 2 member will have a copy of this Microsoft Access file saved on his/her laptop computer. The copy will be named in accordance with this format: "Name of reviewer – LPMC Evacuee Record Review – Date." For example: "Leavitt – LPMC Evacuee Record Review – 30 Sep 04."

- After completing the record review, an electronic copy of each reviewer's Microsoft Access file will be given to the Senior Team Leader for final transmission to Colonel (b)(6)-2

- **Step 4: Out-Brief**

- The Senior Team Leader will discuss preliminary findings and observations with Colonel (b)(6)-2 prior to the out-brief. All collected electronic files and documents will be forwarded to Colonel (b)(6)-2 for review. Out-briefing content will be coordinated with Colonel (b)(6)-2

- The Senior Team Leader will meet with the LPMC Commander, DCCS, DCA, DCN, and other key personnel designated by the Commander. Other MHAT-II members may be present at the discretion of the Senior Team Leader.

- In the briefing, the Senior Team Leader will thank LPMC leadership support for the MHAT-II mission; discuss preliminary findings in accordance with Colonel (b)(6)-2 guidance; provide contact information to follow up with team members and/or Colonel (b)(6)-2; and answer questions.

TAB A: THE Mental Health Advisory Team (MHAT-II) Landstuhl Regional Medical Center (LRMC) Visit Behavioral Health Provider Interview Questions Handout

LRMC Behavioral Health Provider Interview Questions

Date: Location: Interviewer:

Interviewee(s):

Group Number:

Positions/Titles:

AOCs:

I. EVACUEE ARRIVAL

1. Where do evacuees arrive in Germany? When do they typically arrive? How do they arrive (e.g., bus, ambulance, or other)?

2. How are evacuees transported to LRMC? Who transports them?

3. When is the initial BH assessment conducted? How many hours after the evacuees' arrival? Who conducts the assessment? How long does a typical assessment last? Where is the assessment conducted?

4. How is inpatient and outpatient status determined? What are the criteria? Who makes this decision?

5. Do the procedures for admitting a BH evacuee differ from a "routine" BH admission? How soon after admission is a treatment plan developed?

6. Where are outpatient evacuees housed? How are they monitored? Who supervises them? Are there any safety considerations for these outpatients? For example, is access to alcohol limited; is their movement controlled, etc.? How is accountability maintained?

7. What medical records should arrive with the OIF-II evacuee? Are the medical records or documentation arriving with the patient from the OIF-II Theater?

8. What medical information is helpful in managing your mental health patient?

9. Is the evacuee's clinical documentation valuable to you during the evaluation phase?

10. Do you provide input and feedback to the sending BH provider regarding the value, accuracy, and integrity and transported clinical documentation?

11. Is the evacuee's TRAC2ES documentation valuable to you during the evaluation phase?

II. PATIENT CARE

1. What is the typical length of stay for inpatients? Outpatients? Who decides how long these patients stay at LPMC?

2. When an OIF-II patient escalates with suicidal and/or homicidal behavior, how does that impact the management of the patient throughout the evacuation process?

3. Has any evacuee in LPMC's care committed suicide, assaulted others, or broken the law?

4. How do you manage patients who do not have a clear reason for evacuation (e.g., no clinical documentation, no Axis I diagnosis, malingering)?

5. Who alerts the OIF-II command about the disposition plan? How is the patient notified? Do you alert the next higher level of care?

6. What types of behavior have occurred that have warranted the Uniform Code of Military Justice (UCMJ)? Who has administrative control of the evacuees and is it enforced?

7. What additional resources or staffing do you need to provide care to evacuees?

8. Do the outpatient evacuee standards of care approximate those of partial or outpatient in general?

9. How many BH providers deliver care to the OIF evacuees?

10. How do you know if your treatment initiatives for OIF-II evacuees are effective? What are the measurable outcomes for these findings?

11. What criteria are used to determine if evacuation to a higher level of care is needed? Who makes the decision?

12. Are there specific treatment initiatives for evacuees? Inpatients? Outpatients?

13. Are there SOPs for BH evacuee evaluation, treatment, disposition, and accountability processes?

14. What is the policy concerning alcohol use? How has it compromised clinical status of OIF-II evacuees?

15. How is the final evacuation disposition determined?

16. How do you determine whether an evacuee should return to OIF-II? Do you have a SOP or policy? If so, may we receive an electronic copy?

III. EVACUEE DEPARTURE

1. Has LRMC developed any specific forms to be used for evaluation and treatment of OIF evacuees? If so, may we receive an electronic copy of these forms?
2. How do you decide where to evacuate a patient? Who decides this?
3. How is the evacuee sent from LRMC to CONUS/OCONUS? Who manages the administrative process? Who manages the medical process? From where does the evacuee depart?
4. What medical records should be sent with the patient upon further evacuation from LRMC?
5. Do you have e-mail addresses and telephone numbers for points of contact for BH providers in OIF-II? OCONUS? CONUS? If so, may we receive a copy of your list(s)?
6. Do you notify the rear detachment before initiating the patient's evacuation to the next level of care? The final MTF destination? Deployment Cycle Support care managers?
7. Do you provide input to the receiving BH provider regarding the value, accuracy, and integrity of the patient's transported clinical documentation?

IV. TRAC2ES

1. Has the PAD established a quality improvement process to minimize errors in TRAC2ES data entry?
2. Do you monitor the quality, accuracy, and value of TRAC2ES information?
3. Is there a quality improvement program for evacuee charts? If so, may we have a copy of the SOP?
4. Is there a quality improvement program for the implementation of LRMC evacuee policy and procedures? If so, may we have a copy of the SOP?
5. What information in TRAC2ES needs to be included for it to be useful?
6. What factors lead you to this conclusion about TRAC2ES documentation?
7. How would you rate the value and quality of the documents accompanying OIF-II evacuees?
8. What factors lead you to this conclusion about evacuee documentation?

V. ESCORTS

1. How are escorts managed (e.g., fed, housed, accounted for) once they arrive at LRMC? Are/is there a policy and/or SOP governing escort management at LRMC?
2. How is it decided whether or not to send an escort? How are escorts selected? What training is provided to the escorts (specifically regarding safety)?
3. What do escorts do if there is a problem (e.g., who are their POCs if a problem arises)? What accommodations are escorts given?
4. Are there problems with the escort system? Do you have a SOP that is applied to the responsibility of escorts; if so, may we have a copy of the SOP?

TAB B: The Mental Health Advisory Team (MHAT-II) Landstuhl Regional Medical Center (LRMC) Visit Behavioral Health Evacuee Interview Questions Handout

LRMC Army OIF-II Behavioral Health Evacuee Interview Questions

Date:

Location:

Interviewer:

Interviewee(s):

Group Number:

Positions/Titles:

AOCs:

Customer Satisfaction:

1. Were you satisfied with the care received during the evacuation process (at origin, during travel, at destination)?
2. What factors led you to this conclusion?
3. What would have made your experience better?
4. What kinds of treatment did you receive during the evacuation process?

TAB C: THE Mental Health Advisory Team (MHAT-II) In-Brief PowerPoint Presentation

ANNEX D



ASSESSMENT OF SOLDIER SUICIDE PREVENTION PROGRAM
AND
REPORT ON COMPLETED SUICIDES
IN
OPERATION IRAQI FREEDOM (OIF-II)
MENTAL HEALTH ADVISORY TEAM (MHAT-II)

30 January 2005

Chartered by:
The U.S. Army Surgeon General

This is an annex to the Operation Iraqi Freedom (OIF-II) Mental Health Advisory Team (MHAT-II) Report addressing suicide prevention activities and suicides among soldiers deployed to OIF, including Kuwait and Iraq.

The views expressed in this report are those of the authors and do not necessarily represent the official policy or position of the Department of Defense (DoD), the U.S. Army, or the Office of The Surgeon General (OTSG).

ANNEX D

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INTRODUCTION

As part of its charter, the Operation Iraqi Freedom (OIF-I) Mental Health Advisory Team (MHAT-I) was directed to determine whether the July 2003 suicides represented a burgeoning suicide rate among OIF soldiers. The MHAT-II's charter included an assessment of implementation of the MHAT-I recommendation for a Suicide Prevention Program in OIF II. In addition to suicide prevention activities, a comparison of suicide rates for calendar year (CY) 2003 and CY 2004 for the OIF theater was conducted and is reported in this annex.

This report provides an analysis of Army suicides occurring in Iraq and Kuwait between January and December 2003 and January 2004 and December 2004 by male and female Active and Reserve Component (RC) soldiers. The OIF suicide rates for 2003 and 2004 were compared to other relevant suicide rates, and the characteristics of OIF suicides were studied to determine whether there are increased risks for suicide associated with OIF deployment. Findings and recommendations are presented first, followed by discussion, tables, summary of methods, and references.

FINDINGS

FINDING #1: The community-based Army Suicide Prevention Program (ASPP) objectives have been adapted and a unit Suicide Prevention Program is evident at all OIF major commands of the combat units in Iraq as recommended.

All major commands of the combat units surveyed in Iraq indicated that they have designated proponent(s) to manage the Suicide Prevention Program. All major commands of the combat units surveyed indicated that they had leader and soldier suicide awareness training in the past year.

FINDING #2: Surveillance of completed suicides with use of the standardized suicide event reporting has been implemented.

Army Suicide Event Reports (ASERs) for completed suicides for OIF-II have been submitted as required, according to the ASER program manager.

FINDING #3: The January-December 2003 suicide rate for soldiers deployed in OIF was 18.0 per 100,000 soldiers. The January-December 2004 suicide rate for soldiers deployed in OIF was 8.5 per 100,000 which is lower than 2003 and recent Army historical rates.

Although in July and November 2003 OIF suicides rose to 5 each month, there was no confirmed trend of rising suicides in OIF in 2003 and the rate for other months remained lower at 2 each month, which is consistent with Army historical rates. The OIF 2004 confirmed suicide rate was 8.5 per 100,000 soldiers for suicides occurring between January-December 2004. This rate is lower than the 2003 OIF rate of 18.0 per 100,000

and the average annual rate of 12 per 100,000 for the 9-year period 1995-2003 (range 9.1 - 14.8).

RECOMMENDATIONS

- 1. Continue existing (community-based) objectives of the ASPP for OIF soldiers and units during pre-deployment, deployment, and re-deployment.***
- 2. Continue monitoring and reporting of completed suicides and serious suicide attempts with the ASER.***
- 3. Develop and implement an assessment process to track suicide prevention training for all soldiers in accordance with AR 600-63 and DA PAM 600-24 during pre-deployment, deployment, and re-deployment.***

DISCUSSION

FINDING #1: The community-based ASPP objectives have been adapted and a unit Suicide Prevention Program is evident at all OIF major commands of the combat units in Iraq as recommended.

All major commands of the combat units surveyed in Iraq indicated that they have a designated proponent to manage the Suicide Prevention Program. All major commands of the combat units surveyed indicated that they had leader and soldier suicide awareness training in the past year.

Two BCT brigades of the combat units indicated they have had key unit personnel trained in providing crisis intervention (e.g. Applied Suicide Intervention Skills Training (ASIST)). Mental Health Advisory Team (OIF-II) member contacts with Unit Ministry Teams (UMTs) and commands confirm the above and indicate most UMTs have had ASIST.

There is evidence of a command climate that encourages appropriate help-seeking behavior by distressed soldiers. The Soldier Health and Well-being Survey responses indicated that 77% of soldiers surveyed reported they received suicide prevention training in the past year, and 59% of soldiers surveyed indicated they felt confident in their ability to identify Soldiers at risk for suicide. Ninety percent of UMTs surveyed reported that they provided suicide prevention training in the past year ranging from 2 to 3 times per month to several times a week to their various units.

FINDING #2: Surveillance of completed suicides with use of the standardized suicide event reporting has been implemented.

Army Suicide Event Reports for completed suicides for OIF-II have been submitted as required, according to the ASER program manager. Data have been compiled and

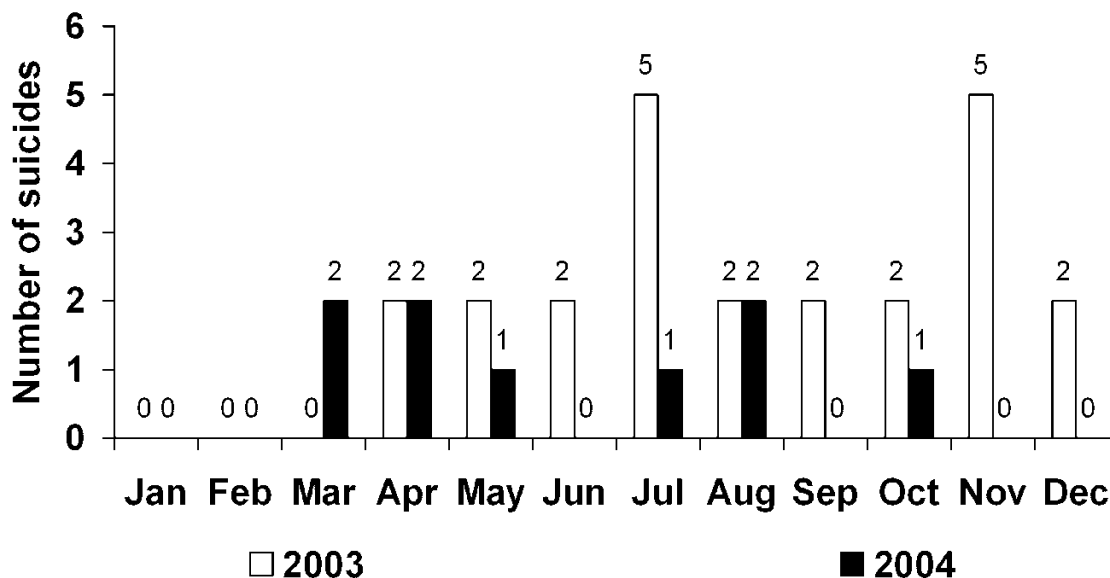
distributed on these cases. However, ASERs on nonlethal, serious suicide attempts have not been submitted consistently. This requires improved compliance to make the ASER Program a viable data source for future study.

FINDING #3: The January-December 2003 suicide rate for soldiers deployed in OIF was 18.0 per 100,000 soldiers. The January-December 2004 suicide rate for soldiers deployed in OIF was 8.5 per 100,000, which is lower than CY 2003 and recent Army historical rates.

Although in July and November 2003 OIF suicides rose to 5 each month, there was no confirmed trend of rising suicide in OIF in 2003 and the number of suicides for other months remained lower at 2 each month, which is consistent with Army historical rates. The OIF 2004 confirmed suicide rate was 8.5 per 100,000 soldiers. This rate is lower than the 2003 OIF rate of 18.0 per 100,000. The average annual rate for the 9-year period 1995-2003 was 12 per 100,000 (range 9.1 - 14.8) (Appendix 1, Tab A). The rate of 8.5 per 100,000 was based on 9 January-December 2004 Army deaths occurring within Iraq or Kuwait that the Office of the Armed Forces Medical Examiner (OAFME) classified as suicides (Appendix 1, Tab D).

Table 1 displays monthly OIF suicides for 2003 and 2004. When comparing numbers of suicides each month in 2003 and 2004, there were increases in suicides in July and November 2003. There were no spikes in the number of suicides in 2004 and no indication that any of the suicides were related to each other. There were no suicides in OIF in January, February, June, September, November, and December 2004; two suicides in March, April, and August 2004; and one suicide in May, July, and October 2004.

Table 1: Monthly OIF Suicides for 2003-2004



Firearms were the only confirmed method of suicide for OIF soldiers in 2003 and 2004 with the exception of one drug overdose case in 2003. Suicides were committed predominately by young males, a group that is typically high risk for suicide. The frequency of firearm suicide during OIF was much higher when compared to firearm suicide for the Army and U.S. populations in previous years. The deployed force is comprised of a large number of young males who are a group with high suicide risk in the U.S. population.

Table 2 compares demographic characteristics of CY 2003 and CY 2004 OIF Soldier-suicides to Army suicides in 2003. The OIF suicide cohort is comprised of young males (a group that is high risk for suicide in the U.S. population with twice the national rate of suicide in 2002 (ages 25-34)). The OIF 2003 and 2004 cohort is more junior in rank to the 2003 Army suicides with no females in 2004 and fewer minorities in 2004 than 2003.

Table 2: Summary of Demographics on OIF 2003, OIF 2004, and Army 2003 Suicides

<i>As of 12 Dec 2004</i>	2004 Army OIF Suicides	2003 Army OIF Suicides	2003 Army Suicides
Suicide by firearm/gunshot	100%	96%	71%
Male	100%	92%	94%
Age 30 or younger	89%	79%	72%
E-4 or below	78%	71%	56%
Married	11%	38%	53%
Minority (non-white)	22%	42%	22%

RECOMMENDATION #1: Continue existing (community-based) objectives of the ASPP for OIF soldiers and units during pre-deployment, deployment, and re-deployment.

Strategies of the ASPP should be applied to the OIF force through actions in the following five areas: proponentcy, awareness, training, surveillance, and help-seeking behavior. See the MHAT-I report for detailed descriptions of these five areas.

RECOMMENDATION #2: Insure monitoring of serious suicide attempts with the ASER.

Enough precedence exists to support the strategy of reducing suicide occurrence by reducing the occurrence of serious suicide attempts (leading to hospitalizations and evacuations). A critical component of this strategy is the monitoring of suicide attempts as an outcome metric for suicide prevention actions. Serious suicide attempts (that result in hospitalizations or evacuations) should be included as reportable medical

events analogous to communicable disease and other reportable events. See the MHAT-I report for rationale for use of the ASER as a means of data collection.

RECOMMENDATION #3. Develop and implement an assessment process to track suicide prevention training for all soldiers in accordance with AR 600-63 and DA PAM 600-24 during pre-deployment, deployment, and re-deployment.

Limited data were available on suicide prevention training during pre-deployment, deployment, and re-deployment.

APPENDIX 1

TABLES

TAB A: U.S. Army Suicide Rates: 1995-2004

Calendar Year	Rate per 100,000
1995	14.8
1996	12.4
1997	10.6
1998	12.0
1999	13.1
2000	12.1
2001	9.1
2002	11.1
2003	12.8
2004	9.5
Average 1995-2003	12

TAB B: OIF Suicides: 2003-2004

SUICIDE UPDATE	2003	2004
OIF Confirmed	24	9
OIF Pending	0	3
OIF Confirmed Rate	18.0	8.5 (As of EOM: Dec 2004)

TAB C: Profile of Confirmed OIF 2003 Suicides

Date of Suicide	Age	Rank	MOS	Comp	Gender	Race/Ethnicity	Married	Method
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TAB D: Profile of Confirmed OIF 2004 Suicides (as of 12 December 2004)

Date of Suicide	Age	Rank	MOS	Comp	Gender	Race/Ethnicity	Married	Method
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(b)(6)-2

APPENDIX 2

METHODS AND PROCEDURES

1. Operation Iraqi Freedom suicides were defined as those Army Active or RC deaths for which the fatal self-inflicted injury occurred in Iraq or Kuwait between 1 January 2003 and 31 December 2004, and for which the OAFME determined the manner of death to be suicide.
2. Information about the soldiers from the suicide cohort was obtained from casualty reports, personnel records, CID reports, and the medical examiner records. There were no psychological autopsies or other reports from behavioral health personnel for the suicides occurring in Iraq or Kuwait.
3. Suicide rates are reported by convention as the number of suicides per 100,000 persons. Monthly suicide rates were calculated by multiplying the number of suicides each month by 100,000 and dividing by the number of soldiers in the OIF theater. The denominators used were force strength numbers at the end of each month, January 2003 through December 2004, for male and female active and RC soldiers assigned to Kuwait and Iraq.

APPENDIX 3

REFERENCES

1. Mental Health Advisory Team (MHAT-I) Report from Operation Iraqi Freedom, chartered by The U.S. Army Surgeon General and HQDA G-1, December 16, 2003, available on www.armymedicine.army.mil
2. Crow, BC. Ft. Lewis Suicide Prevention 1998-2003, the Quest for Best Practices. 6th Annual Force Health Protection Conference, Albuquerque, New Mexico, 14 August 2003, sponsored by the U.S. Army Center for Health Promotion and Preventive Medicine, Edgewood, MD.
3. Other Military References:
 - DA PAM 600-24, Suicide Prevention and Psychological Autopsy
 - AR 600-63, Army Health Promotion
 - Army Suicide Prevention: A Guide for Installations and Units (Draft)
 - AR 600-5, Health Promotion
 - AR 190-40, Serious Incident Reporting
 - DoD Suicide Prevention and Risk Reduction Committee Charter

ANNEX E



INTERMENT FACILITY SOLDIER ASSESSMENT

OPERATION IRAQI FREEDOM (OIF-II)

MENTAL HEALTH ADVISORY TEAM (MHAT-II)

30 January 2005

Chartered by:
The U.S. Army Surgeon General

This is an annex to the Operation Iraqi Freedom (OIF-II) Mental Health Advisory Team (MHAT-II) Report addressing the behavioral health services in OIF-II internment facilities. The findings were obtained from many sources to include surveys, interviews, Department of Defense- (DoD-) supported databases, and behavioral health record reviews.

The views expressed in this report are those of the authors and do not necessarily represent the official policy or position of the Department of Defense (DoD), the U.S. Army, or the Office of The Surgeon General (OTSG).

ANNEX E

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INTRODUCTION

The Multi-National Corps-Iraq (MNC-I) requested the Mental Health Advisory Team (MHAT) to assess the behavioral health care at two Army internment facilities (Camp Bucca and Abu Ghraib), to offer recommendations to improve the current level of care, and to develop an Army Medical Department (AMEDD) behavioral health care model for detainees and Soldiers in future internment facility operations.

This report addresses Soldier behavioral health issues. The behavioral health care of detainees is addressed in Annex F.

Multi-National Corps-Iraq leadership requested an assessment of behavioral health care resources for Soldiers working at internment facilities in view of reports of custodial staff misconduct at Abu Ghraib¹ and inadequate medical resources for detainees.² Multi-National Corps-Iraq sought answers to the following questions:

1. Were the stressors greater for custodial staff members than for other Soldiers in Operation Iraqi Freedom (OIF-II)?
2. Was the prevalence of behavioral health disorders higher among custodial staff than for other Soldiers in OIF-II?
3. Should custodial staff and detainees share behavioral health services or should they be separate?

MISSION CONSIDERATIONS

To accomplish this assessment, the MHAT assembled a special forensic team (i.e., MHAT-FT) consisting of the Psychiatry Consultant to The Army Surgeon General, the Forensic Psychiatry Consultant to The Surgeon General, a forensic psychiatrist (who served on the MHAT 2003 mission), and a Sergeant First Class with previous correctional behavioral health experience.

When planning for this assessment, the MHAT-FT relied on previous inspection reports of Abu Ghraib and Camp Bucca for background information.³ Soldier-related stressors identified in these reports included: heat and dust exposure, 12-hour work shifts, and low staff-to-inmate ratios.⁴ Unlike Camp Bucca, Abu Ghraib faced additional stressors:

(b)(2)-2

² See Annex F, Appendices 1-3 for further details.

³ A detailed overview of each internment facility can be found in Annex F.

⁴ Large sub-compounds ranged in size from 200 to 300 detainees.

frequent mortar attacks, improvised explosive device ambushes, and increased public scrutiny due to alleged misconduct. The road between Abu Ghraib and the airport was notoriously dangerous due to frequent ambushes, thereby, slowing supply shipments to the camp.

Air-conditioned living quarters, internet/telephone access, and other morale, welfare, and recreation (MWR) functions offset these stressors. Likewise, improved dining facility infrastructure and food quality, and exercise facilities had improved quality of life (more details of internment facility operations appear in Annex F).

A review of the professional literature highlighted common stressors that impact correctional staff in the civilian setting: understaffing, overtime, rotating shift work, supervisor demands, role conflict, role ambiguity, threats of violence, inmate demands and manipulation, conflicts with coworkers, poor public image, and low pay.⁵ Stress can result in significant problems for custodial personnel: physical illnesses,⁶ burnout,⁷ substance abuse,⁸ excessive disability retirements,⁹ and interpersonal problems with family and coworkers.¹⁰ It is recognized that the effects of stress on civilian correctional personnel can compromise institutional safety, cost money, and create stress for other staff members.

MISSION OBJECTIVES

With these considerations in mind, MHAT-FT selected the following objectives for this assessment:

1. To determine whether current behavioral health care for Soldiers was in accordance with combat and operational stress control (COSC) doctrine.
2. To assess the behavioral health care needs of the Soldiers working at internment facilities via survey and interview techniques.
3. To make recommendations for improved Soldier behavioral health care at internment facilities.

⁵ Addressing Correctional Officer Stress: Programs and Strategies. 2000. Peter Finn. US Department of Justice.

⁶ Woodruff, "Occupational Stress for Correctional Personnel"; and Cheek, F.E., and M.D. Miller, "New Look at Officers' Role Ambiguity," in *Correctional Officers—Power, Pressure and Responsibility*, ed. J.N. Tucker, Laurel, Maryland: American Correctional Association, 1983.

⁷ Cornelius, G., *Stressed Out: Strategies for Living and Working with Stress in Corrections*, Laurel, Maryland: American Correctional Association, 1994.

⁸ Addressing Correctional Officer Stress: Programs and Strategies. 2000. Peter Finn. US Department of Justice.

⁹ Ibid.

¹⁰ Van Fleet, F., "Correctional Officers and Their Families: Dealing with Stress," in *The Effective Correctional Officer*, Laurel, Maryland: American Correctional Association, 1992.

FINDINGS

Finding #1: There was no significant difference between the prevalence of behavioral health disorders among Soldiers in custodial positions and those of other Soldiers surveyed in OIF-II. Custodial staff members shared stressors in common with OIF-II peers.

The Soldier Health and Well-being Survey revealed that positive screenings for posttraumatic stress disorder (PTSD), anxiety, and depressive disorders among custodial staff members¹¹ were equivalent to those for other Soldier MOSs in OIF-II (see Annex A, Finding #4 and Figure 3 for further details).

In focused group interviews, custodial staff members reported comparable stressors to those of their OIF-II peers. They indicated that increased scrutiny of Army internment operations had increased their likelihood to “second guess” their decisions and felt that their hard work had been stained by the misconduct of a few. All in all, custodial staff members believed they were coping well with stressors.

Finding #2. Behavioral health care was conducted in accordance with COSC doctrine. Insufficient training in correctional behavioral health care diminished optimal support for custodial staff.

Interviews with senior behavioral health providers indicated that appropriate functional areas of COSC doctrine were implemented for Soldiers at the internment facilities. Custodial and medical staff descriptions of behavioral health services confirmed sufficient adherence to COSC doctrine and availability of services. Insufficient training in correctional behavioral healthcare delayed providers in providing support as they familiarized themselves with correction’s unique stressors, procedures, philosophies, and situations.

RECOMMENDATIONS

Immediate Implementation

1. Continue behavioral health care services in accordance with COSC doctrine and MHAT-II staffing recommendations. Supplement COSC doctrine with training in specific stressors unique to corrections and in best practices to provide care to custodial staff.

While COSC doctrine provides a generic model for behavioral health care and effectively anticipates the common stressors and emotional reactions of Soldiers in military operations, further refinement is necessary to adapt it to unique needs of units

¹¹ Custodial staff members were military police and Soldiers with other MOSs serving in custodial positions.

and/or Soldiers. Additional training in accordance with the proposed Detainee Behavioral Health Care Program Model (see Annex F, Appendix 10, Tab D) can prepare behavioral health providers to anticipate the stressors inherent in the correctional setting, and implement the best practices to support the custodial staff. Annex B provides further behavioral health staffing guidance.

2. Consider parallel behavioral health care programs for Soldiers and detainees. If adopted, keep staff member participation in both programs at the same time to a minimum to prevent any perception of ethical conflicts.

Correctional literature advocates for independent behavioral health programs to encourage custodial personnel to access care.¹² Traditionally, custodial staff members underutilize behavioral health care when staff or services are shared.¹³ Perceived conflicts in advocacy and confidentiality prevent staff members from seeking care.

Future Implementation

1. Establish a Correctional Behavioral Health Care Fellowship Training Program.

Given the paucity of Army behavioral health providers with experience in correctional care, it is important to develop and maintain clinical and administrative program expertise as it applies to internment facility operations. The AMEDD should consider supporting a prior proposal for a Correctional Behavioral Health Care Fellowship Training Program at the U.S. Detention Barracks in Fort Leavenworth.

2. Integrate a Correctional Behavioral Health Care Track into the Force Health Protection Conference.

To develop a basic understanding of correctional principles and practices, Force Health Protection Conference organizers may consider adding a Correctional Behavioral Health Care track to the program.

DISCUSSION

Stress and Prevalence

This analysis shows no significant difference between the prevalence of behavioral health disorders of Soldiers in custodial positions and those of Soldiers surveyed in

¹² Staffing Considerations (Chapter VI). B. Jaye Anno. Correctional Health Care: Guidelines for the Management of an Adequate Delivery System (2001). US Department of Justice.

¹³ Behavioral health programs for staff members fall into one of three basic structures: in-house programs, independent contracted services, and hybrid arrangements. In-house programs offer custodial staff and inmates the same services/behavioral health as staff members. Independent contracted services offer custodial staff members a separate behavioral health team and services.

OIF-II.

In Annex A, the results of the Soldier Health and Well-being Survey revealed that a percentage of military police officers (and Soldiers in other MOSs serving as custodial staff) who screened positive for PTSD, anxiety, and depressive disorders was not statistically different from those for other Soldier MOSs in OIF-II. This analysis is fully described in Annex A (i.e., Finding #4 and Figure 3), and is not repeated here.

Custodial staff members who participated in focused group interviews reported stressors commonly shared by their OIF-II peers. Separation from family, deployment length, and lack of privacy were frequently identified as noncombat stressors. Reports of combat stressors differed between the Abu Ghraib and Camp Bucca custodial staff. By virtue of its location, Abu Ghraib presents a convenient target for insurgents, whose nightly mortar attacks have forced Soldiers to live within fortified prison cells and to wear body armor and Kevlar when outside their living quarters. In contrast, Camp Bucca's remote location has shielded it from enemy attacks.

Soldier Care Services and Resources

Interviews with senior behavioral health providers indicated that appropriate functional areas of COSC doctrine were implemented for Soldiers at the internment facilities. Custodial staff descriptions of behavioral health services confirmed sufficient adherence to COSC doctrine and availability of services. Insufficient training in correctional behavioral healthcare delayed providers in providing support as they familiarized themselves with correction's unique stressors, procedures, philosophies, and situations.

METHODS

In this assessment, the MHAT-FT relied on results from the Soldier Health and Well-being Survey and focused group interviews with military police officers, other Soldiers serving in custodial positions, and senior behavioral health providers.

Sources of Data

The MHAT-FT interviewed military police officers, other Soldiers serving in custodial positions, and senior behavioral health providers.

Data Collection

Interviews were conducted in small groups, comprised of 1 to 4 persons. Participants were asked questions relating to the following themes: 1) stressors for Soldiers at the internment facility; 2) perception of the behavioral health needs in the Soldier population; 3) stigma and barriers to behavioral health care; 4) satisfaction with behavioral health services; and 5) perception of risks to personal safety.

Interviews were conducted by 1 or 2 MHAT-FT personnel, and required approximately 1 to 1½ hours to complete. Interviewers informed participants about the purpose of this

study, and that the interview would be used in the final report. Interviewers emphasized that no statements would be attributed to a specific interviewee in the report. The MHAT-FT personnel took interview notes during the session, and these notes were later transcribed into a Microsoft Word document.

Method of Analysis

The MHAT-FT members reviewed interview documents, identified themes, and grouped similar statements together. Interview synopses are presented in this report.

RESULTS

Custodial Staff Interviews

Soldiers with custodial responsibilities were interviewed at both facilities (i.e., 4 personnel at Camp Bucca, and 8 at Abu Ghraib). These Soldiers reported being aware of behavioral health resources for themselves and for the detainee population.

Custodial staff members reported stressors commonly shared by their OIF-II peers (see Annex A, Appendix 2). Some Soldiers complained about leaders imposing seemingly arbitrary rules; “micromanagement” by leaders; and perceived busywork. Others identified separation from family, deployment length, and lack of privacy as persisting stressors.

Reports of combat-related stressors differed between Abu Ghraib and Camp Bucca custodial staff. By virtue of its location, Abu Ghraib presents a convenient target for insurgents, whose nightly mortar attacks have forced Soldiers to live within fortified prison cells and to wear body armor and Kevlar when outside their living quarters. Likewise, the risk of ambush is high for convoys coming to or leaving Abu Ghraib. In contrast, Camp Bucca’s remote location has largely shielded it from enemy attacks.

Participants reported coping well with the stressors of deployment and custodial work. They felt their peers were coping equally well. All were familiar with the *buddy system* for mutual support. Morale, welfare, and recreation activities were considered key to coping with stress. Participants were aware of chaplain and COSC/behavioral health services, and felt that services had been appropriate for Soldier needs. Soldiers indicated that consultation, education, counseling, evaluations, treatment, and crisis interventions had been available through the CSC Prevention Team at Abu Ghraib, and the behavioral health team at Camp Bucca.

Nonmilitary police staff members identified additional stress from adapting to their custodial roles. These Soldiers regarded cross training as key to improving their confidence and efficiency.

Participants reported that the negative publicity of the Abu Ghraib misconduct had added to their stress level. They indicated that they were more likely to “second guess”

their decisions, and felt that their hard work had been stained by the misconduct of a few.

Behavioral Health Provider Interviews

The MHAT-FT interviewed the senior behavioral health providers at each internment facility. Each provider led their respective teams, and had arrived in Iraq only within the last 2 months.

These providers reported little to no experience in correctional settings, and indicated that their staff members were equally inexperienced. Both expressed confidence providing clinical interventions to Soldiers. They were familiar with COSC doctrine, and described services consistent with the COSC functional areas. They saw their unfamiliarity with Iraqi, Islamic, and Arabic cultures as a formidable obstacle to detainee patient care delivery.

Camp Bucca had one social work officer and one mental health specialist (91X) to provide behavioral health care to 400 Soldiers¹⁴ and 2,600 detainees.¹⁵ The social worker indicated that (b)(6)-(2) had focused (b)(6)-(2) behavioral health efforts on Soldier preventive and clinical services, and had recently initiated detainee interventions (see Annex F for details). (b)(6)-(2) believed that behavioral health resources were adequate for Soldier care, but additional personnel were necessary to expand detainee services.

Abu Ghraib had a ten-person team comprised of a psychiatrist, psychologist, four nurses, and four mental health specialists (91X). Prior to the Abu Ghraib team's arrival in 2004, a combat stress control company provided Soldier care through regular visits to the camp. The psychiatrist described plans to provide parallel behavioral health services for the camp's 900 Soldiers¹⁶ and 2,600 detainees.¹⁷ (b)(6)-(2) held the view that (b)(6)-(2) team's staffing level was sufficient to satisfy Soldier care needs, but additional personnel would be necessary as detainee services expanded.

¹⁴ This number approximates the MNC-I Soldier census on 15 Sep 2004 (derived from the MNC-I G1's Joint Personnel Statistics).

¹⁵ Department of the Army Inspector General Detainee Operations Inspection (2004).

¹⁶ This number approximates the MNC-I Soldier census on 15 Sep 2004 (derived from the G1's Joint Personnel Statistics).

¹⁷ Department of the Army Inspector General Detainee Operations Inspection (2004).

ANNEX G



CURRENT STATUS
OF
MENTAL HEALTH ADVISORY TEAM (MHAT-I)
ISSUES
AND
RECOMMENDATIONS

OPERATION IRAQI FREEDOM (OIF-II)

MENTAL HEALTH ADVISORY TEAM (MHAT-II)

30 January 2005

Chartered by:
The U.S. Army Surgeon General

This is an annex to the Operation Iraqi Freedom (OIF-II) Mental Health Advisory Team (MHAT-II) Report addressing the Behavioral Healthcare System in the OIF Theater of Operation (Kuwait and Iraq). The findings were obtained via direct observation, interviews, surveys, and data calls.

The views expressed in this report are those of the authors and do not necessarily represent the official policy or position of the Department of Defense (DoD), the U.S. Army, or the Office of The Surgeon General (OTSG).

ANNEX G

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INTRODUCTION

In December 2003, The Army Surgeon General's Mental Health Advisory Team (MHAT-I) identified a number of issues to improve behavioral health (BH) services throughout the Operation Iraqi Freedom (OIF-I) Theater. In August-October 2004, the MHAT-II collected data to evaluate the progress being made in addressing the OIF-I MHAT issues—both within the OIF Theater and in Germany/continental United States (CONUS). The MHAT-I recommendations are the starting point for discussing the issues, but this is not intended as an assessment of "compliance." The decision makers in OIF-II may have implemented other actions to fix an identified problem.

The data supporting the findings that follow this page were garnished from the OIF-I MHAT Report, portions of this (OIF-II MHAT) report, or were collected during the months of August through December 2004. Findings are summarized on the following pages. Sources of data for each finding listed below are located in various annexes of the MHAT-II Report. Status of MHAT-I issues as of December 2004 is described as GREEN, AMBER, or RED. GREEN indicates that substantial progress or completion has been achieved in addressing this issue based on data collected in MHAT-II. AMBER indicates that some significant progress has been achieved in addressing this issue. RED indicates that little or no progress has been made on this issue. Some issues were described as "Future"; therefore, it may be premature to expect progress to be made in only 1 year.

FINDINGS

OIF-I MHAT ISSUES	STATUS	OIF-II MHAT FINDING
1. A. Appoint a Theater/Area of Operation BH consultant to advise the Surgeon on BH issues.	GREEN	Colonel (b)(6)-2 was appointed the OIF Theater/Area of Operation BH consultant and arrived in theater in April 2004.
1. B. Execute an aggressive BH outreach program. Ensure that BH personnel have a regular, far-forward consultation program at the small-unit level.	GREEN	Most Soldiers in the OIF-II Theater have access to BH resources, and 79% of BH professionals indicate they provided combat and operational stress control (COSC) outreach services once each week or more. Seventy-six percent of OIF-II Soldiers live on a Forward Operating Base (FOB) that has resident BH care. There are presently 232 BH personnel either present on site or visiting FOBs and sites where Soldiers are serving. Suggest continued evaluation of placement of resources in order to best meet the BH needs of the Soldiers in theater.
1. C. Area of responsibility (AOR) BH consultants need to distribute BH assets appropriately.	AMBER	Seventy-six percent of OIF-II Soldiers live on a FOB that has resident BH care. Some FOBs had no resident BH services but may be provided services presently by BH professionals from other FOBs. Some gaps remain. Operation Iraqi Freedom (OIF-II) BH planners implemented and are widely advertising a "Help 4 U" web site and a 24 hours/day telephone point of contact through which any leader or service member can learn how to contact the nearest providers to coordinate access.
1. D. Field a simple, standardized needs assessment tool for Soldiers and units.	AMBER	Walter Reed Army Institute of Research (WRAIR) has developed a needs assessment tool for use by BH personnel in theater that is ready for initial fielding. While BH personnel in theater conduct needs assessments, recommendation remains to field a standardized tool to allow for research opportunities, better communications between providers, etc.

OIF-I MHAT ISSUES	STATUS	OIF-II MHAT FINDING
1. E. Train Soldiers in meeting the demands of deployment/combat-related stressors.	AMBER	The MHAT-II Soldier Health and Well-being Survey data indicate Soldiers reported higher levels of training in handling the stresses of deployment compared with Soldiers in OIF-I. The Center for Health Promotion and Preventive Medicine (CHPPM) and MHAT developed five Tip Cards that were distributed by Multi-National Corps-Iraq (MNC-I) in October 2004 in spite of logistical problems. Efforts are underway to provide these cards and instructions to units for internal training before they leave CONUS or while in staging areas in Kuwait. Additional work needs to be done to standardize, implement, and assess training materials.
1. F. Improve the ability to hold Soldiers in theater closer to their own units. Create a BH Reconditioning Program.	GREEN	Operation Iraqi Freedom (OIF-II) Theater BH has increased the ability to hold Soldiers in theater and provide BH fitness teams to further assess patients. Restoration programs were found in (b)(2)-2. Soldier and staff reports and return-to-duty rates are favorable on these programs. There is no shortage of combat stress control (CSC) and medical company cots to hold Soldiers in theater during Restoration or Reconditioning. The table(s) of organization and equipment (TOE) capabilities of the CSC fitness teams now deployed were designed for stress casualty rates predicted in a major theater with possible use of weapons of mass destruction.
1. G. Improve the quality of behavioral healthcare services for Soldiers during evacuation.	GREEN	The quality of behavioral healthcare services for Soldiers during evacuation has improved based on revised standing operating procedures (SOPs), better command and control, and better transmission of clinical data from theater to Lanstuhl and from Lanstuhl to other medical treatment facilities (MTFs). In spite of these improvements, no specific BH initiatives have been developed.
2. A. Area of responsibility BH consultants should establish quarterly BH training meetings.	GREEN	Area of responsibility BH Consultant, Colonel (b)(6)-2 established a quarterly BH training meeting schedule; meetings took place 6 June 2004 and 15 September 2004. Attendance has been excellent with representatives of MNC-I staff, Multi-National Force-Iraq (MNF-I) staff, combat brigades, combat support hospitals (CSHs), CSC units, and division mental health (MH) staff.

OIF-I MHAT ISSUES	STATUS	OIF-II MHAT FINDING
2. B. Conduct COSC training for BH personnel, both Active Component/Reserve Component (AC/RC), preparing to deploy.	GREEN	Training was conducted for all deploying CSC units during Calendar Year (CY) 2004. A team of COSC specialists from Medical Command (MEDCOM), Army Academy of Health Sciences (AHS), and Walter Reed Army Medical Center (WRAMC) provided COSC training to (b)(2)-2 CSC personnel during (b)(2)-2 at (b)(2)-2 to (b)(2)-2 CSC personnel during (b)(2)-2 to (b)(2)-2 CSC personnel in (b)(2)-2 and to pre-deploying Army National Guard (ARNG) MH personnel in (b)(2)-2. Future training for deploying units will be scheduled as units are alerted and preparing to deploy and COSC subject matter experts (SMEs) have been recruited to conduct training sessions as requirements are identified. Medical Command staff members are coordinating this effort presently.
2. C. Conduct COSC research in key areas to ensure that the best prevention and early intervention methodologies are established/validated.	AMBER	Walter Reed Army Institute of Research (WRAIR) has an approved research protocol to assess the validity of COSC critical event debriefing (CED) intervention methods. Implementation is scheduled for 2005. As of 26 October 2004, the Deputy Assistant Secretary of Defense for Clinical and Program Policy tasked the Armed Forces Epidemiological Board to explore further OIF mental health issues and support research activities. There was an initial planning session on 30 November and 1 December 2004 to examine future research questions involving all of the armed services. A multi-service cooperative effort should develop to further study combat stress issues.
3. Plan for the upcoming battle-handover.	GREEN	Planning sessions did take place at MEDCOM, and BH services and personnel were expanded in OIF-II to meet growing demands and OPTEMPO. Operation Iraqi Freedom (OIF-III) and -IV planning sessions took place at MEDCOM in November and December 2004. All redeploying and deploying division psychiatrists are in e-mail contact to improve turnover. (b)(2)-2

OIF-I MHAT ISSUES	STATUS	OIF-II MHAT FINDING
4. A. Designate proponents to manage the Coalition Forces Land Component Command (CFLCC) and Coalition Joint Task Force-7 (CJTF-7) Suicide Prevention Programs.	AMBER	The existing community-based Army Suicide Prevention Program has been adapted to OIF Soldiers and units. A survey of the brigades in theater revealed that all brigades identified a suicide prevention program in their AOR. They all indicated that they have a designated proponent to manage the suicide prevention program. MHAT-II learned that most Unit Ministry Teams (UMTs) have completed Applied Suicide Intervention Skills Training (ASIST), but more effort is required to ensure the Suicide Prevention Program is fully implemented during pre-deployment, deployment, and post- deployment.
4. B. Maintain vigilance by leaders and Soldier-peers to ensure Soldiers at risk for suicide receive appropriate support.	GREEN	Soldiers who indicated they received adequate training in handling the stresses of deployment and/or combat in OIF-II reported significantly higher confidence in their ability to help Soldiers get assistance for a MH problem. Twenty-seven percent indicated they actually helped a fellow Soldier get professional help for a MH problem. Suicide rates in OIF-II are significantly lower than in OIF-I.
4. C. Conduct training that provides crisis intervention skills to designated Soldiers with a goal of one trained Soldier per company.	AMBER	Soldiers in OIF-II reported higher levels of training in handling the stresses of deployment compared with Soldiers in OIF-I. Crisis intervention skill training was conducted in the (b)(2)-2. The (b)(2)-2 CSC Unit began "in theater" training in October 2004. Plans to expand the training throughout theater are being explored. Response by combat divisions to the crisis intervention skills training thus far has been very positive.
4. D. Implement surveillance of completed suicides and serious suicide attempts with standardized suicide event reporting by BH personnel.	AMBER	The AMEDD Suicide Events Report (ASER) reporting process implemented with submissions on completed suicides for 2004. Serious suicide attempts reporting is not occurring consistently in theater presently. This requires emphasis by Office of The Surgeon General (OTSG) and Army Medical Department (AMEDD) commanders and staff.

OIF-I MHAT ISSUES	STATUS	OIF-II MHAT FINDING
4. E. Establish a command climate that encourages appropriate help-seeking behavior by distressed Soldiers. Behavioral health care should be delivered as far forward as possible to maximize the likelihood of successfully returning Soldiers to duty. <u>Future Implementation</u> 1. A. Direct The Surgeon General (TSG) BH consultants to develop and implement a multidisciplinary COSC course to teach COSC doctrine, tactics, and procedures to all BH/COSC personnel. 1. B. Direct TSG behavioral health consultants to charter multidisciplinary PATs to develop the key elements for inclusion in the course. 1. C. Direct TSG behavioral health consultants to reorient the AMEDD officer and enlisted military education systems to integrate collective blocks of instruction in COSC, disaster BH, and battlefield professional practice. 1. D. Direct CHPPM and TSG behavioral health consultants to ensure that a COSC/BH track is incorporated into the annual Force Health Protection (FHP) Conference.	AMBER AMBER AMBER AMBER GREEN	The MHAT-II Soldier Health and Well-being Survey found that the percent of Soldiers with MH problems that accessed professional services increased from 29% in OIF-I to 40% in OIF-II. However, there were no appreciable differences between the perceptions that OIF-I Soldiers had compared with OIF-II Soldiers that they would be stigmatized by their unit or leadership if they received help. A review of BH staff located in theater indicated providers were far forward in most instances and the return-to-duty rate for those seen far forward was over 95% and over 90% by the division and brigade BH teams. Behavioral health consultants are developing a proposal for a CSC course presently that will provide training for all BH specialties with priority for those in COSC duty positions. Behavioral health consultants are developing a proposal for a CSC course presently. Behavioral health consultants are developing a proposal for a CSC course presently. A BH track was incorporated in the annual FHP Conference during 2003 and 2004 and is planned for 2005.

OIF-I MHAT ISSUES	STATUS	OIF-II MHAT FINDING
2. A. Medical Command should review the COSC Workload and Activity Reporting System (COSC-WARS) for sufficiency and then automate it.	AMBER	The MH teams under MNC-I and the medical units under the Medical Brigade used the COSC-WARS Summary Report (SR), with hand entry of data. Problems were identified with standardization, training, and written instructions. The SR format needs to record additional variables. The COSC-WARS Preventive Contacts (PC) and Individual Contacts (IC) data entry formats (never used for routine manual entry) have been automated by CHPPM for data entry into handheld and laptop computers. A pre-pilot, debugging trial of the software and hardware began in October 2004 in two CSC units in Iraq. The CHPPM is incorporating lessons learned. Combat stress control units and MH sections mobilizing for OIF-III are receiving the software and training. With Command approval, a pilot test could be conducted in OIF-III.
2. B. Medical Command should integrate COSC prevention efforts into existing and emerging theater medical databases.	AMBER	The automated PC and IC programs will generate the periodic SRs, and can be programmed to generate the Disease/Nonbattle Injury (DNBI) Report and other report formats. The Army Medical Department Center and School (AMEDDC&S) and potential users are evaluating the integration of COSC-WARS and the Medical Communications for Combat Casualty Care (MC4) system. The COSC-WARS is the AMEDD Combat Developments and CHPPM test-bed for developing precise contract requirements for the COSC component of the totally automated Theater Medical Information Program of the Future Force.
3. Medical Command should establish a joint process action committee to work on an evacuation database system capable of clinical, tracking, and analytical functions. It must be readily available, secure, and tailored to the needs of line commanders, medical personnel, medical regulating planners, and medical planners.	RED	No effort to change the evacuation database has been put forth as of this time.

OIF-I MHAT ISSUES	STATUS	OIF-II MHAT FINDING
4. A. Develop a peer-mentoring program using mid-grade Soldiers to facilitate the early identification and intervention of psychosocial problems at the company level.	AMBER	The WRAIR behavioral health staff has a proposal for this program and has presented it to the Deployment Cycle Support Program Manager and WRAIR for consideration and implementation. It has similarity to the British model focused on traumatic risk assessment and management. The (b)(2)-2 in OIF-II is testing an adaptation of the British Traumatic Risk Management (TRM) Program. A peer-mentoring training program, taught to noncommissioned officers (NCOs), has also been developed, and the (b)(2)-2 CSC Unit in Iraq is field testing it presently. No officially sanctioned peer-mentoring program has been approved or fielded as of now. Additional training for medics, battalion and company commanders, first sergeants (1SGs), and platoon leaders in stress management training and BH issues is recommended, with COSC personnel among the trainers. This will shore up the existing infrastructure rather than introduce a new program that line or medical leadership may not support.
4. B. Improve BH support for rear-detachment commanders and Family Readiness Groups (FRGs). One possible solution would be to have social workers fulfill this mission.	AMBER	Some AR, ARNG, and Army AC commands are now using Army Community Service (ACS) family program coordinators or social workers and in some cases activated Behavioral Health Officers (e.g. (b)(2)-2 Regional Readiness Command (RRC)) to assist families during pre-deployment, deployment, and post-deployment. In addition, Army One Source has been established to assist Soldiers or family members by referring them to local resources to address issues of concern and paying for six counseling sessions to help resolve issues of concern. The following other resources have been established to address BH support for rear-detachment commanders and FRGs: • Care Manager Program. • Disabled Soldiers Support System (DS3). • Extended TRICARE Benefits. The Army Deployment Cycle Support Program managers (DCSPER-G-1 staff) are presently exploring alternatives to ensure the referral and availability of needed services for Soldiers and family members. Medical Command will be involved in ensuring the successful implementation of BH support and was solicited in November 2004 to provide input to the DCSPER-G-1 staff to design the programs.

OIF-I MHAT ISSUES	STATUS	OIF-II MHAT FINDING
5. Implement monitoring of serious suicide attempts within Army medical surveillance systems. Task CHPPM and the BH consultants to develop capability for monitoring serious suicide attempts at the installation, operational, and Army-wide levels. The pilot version of the ASER is a promising tool for reporting suicide attempts.	AMBER	The ASERs for completed suicides for OIF have been submitted as required, and data have been compiled and distributed on these cases. The ASERs on suicide behaviors resulting in hospitalization and evacuation, but not death, have not been submitted consistently. Behavioral health leadership in theater must continue to emphasize submission to improve data collection rates.

DRAFT

DISCUSSION

As is evident from the report above, many of the MHAT-I recommendations have been implemented in the past 12 months. More BH staff is present in theater in OIF-II. The overall ratio of BH personnel to Soldiers has increased from 1:846 in OIF-I to 1:407 in OIF-II. The number of BH personnel in theater now is sufficient to provide coverage throughout the OIF area of responsibility, a very great accomplishment.

As far as the 16 immediate recommendations from MHAT-I, there is evidence that 8, or 50%, have been fully implemented presently and that 8, or 50%, are at a minimum partially completed. Overall, 100% of MHAT-I recommendations have either been implemented fully or at least partially as of October 2004. This is a substantial step in meeting the needs of Soldiers in theater, and for this, staff should be commended.

As far as the 10 future recommendations from MHAT-I, 1 is fully implemented and 8 are partially implemented giving a total of 9 of 10 or 90% in place or in process. The other long-term recommendation should be the focus of efforts now in order to ensure the very best of care and outcomes for our Soldiers and their families in the future. Recommendations for action plans are developed in this report and will be emphasized to leadership. Without doubt, our Soldiers and their families will be well-served due to the extensive commitment and actions of BH staff and their actions on behalf of our force. All involved should be commended for their actions, and leadership should also be commended for their willingness to explore BH needs and the actions that have followed MHAT-I activities.

ANNEX H



MENTAL HEALTH ADVISORY TEAM (MHAT-II) SUPPORTING DOCUMENTS

**Operation Iraqi Freedom (OIF-II)
Mental Health Advisory Team (MHAT-II)**

30 January 2005

**Chartered by:
The U.S. Army Surgeon General**

This is an annex to the Operation Iraqi Freedom (OIF-II) Mental Health Advisory Team (MHAT-II) Report providing supporting documentation for the MHAT mission.

The views expressed in this report are those of the authors and do not necessarily represent the official policy or position of the Department of Defense (DoD), the U.S. Army, or the Office of The Surgeon General.

ANNEX H

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APPENDIX 1

MENTAL HEALTH ADVISORY TEAM (MHAT-II) MEMBERSHIP

COL (b)(6)-2 DSW: (b)(6)-2
(b)(6)-2 Social Work Consultant to
the Surgeon General; MHAT Team Chief.

COL (b)(6)-2 MD: Combat Stress Control Program officer, (b)(6)-2
(b)(6)-2

COL (b)(6)-2 MA, MSS, OTR: (b)(6)-2
(b)(6)-2 Occupational Therapy Consultant to the
Surgeon General.

COL (b)(6)-2 Ph. D.: Reserve Component Psychology Consultant,
Department of Psychology (b)(6)-2

COL (b)(6)-2 M.D., Chief, Department of Psychiatry and Behavioral
Sciences, (b)(6)-2

COL (b)(6)-2 M.D., Psychiatry Consultant to The Surgeon General,
(b)(6)-2

COL (b)(6)-2 Psychiatric Nurse Consultant to The Surgeon General,
Behavioral Health Consultant to OIF, Baghdad, Iraq

LTC (b)(6)-2 Forensic Psychiatric Consultant to The Surgeon General,
(b)(6)-2

LTC (b)(6)-2 M.D.: Chief, Operation Solace, Pentagon Stress
Management Team, (b)(6)-2
(b)(6)-2

CH (LTC) (b)(6)-2 Soldier Well-being Branch, (b)(6)-2
(b)(6)-2

MAJ (b)(6)-2 M.S.W.: Social Work Officer, (b)(6)-2
(b)(6)-2

SFC (b)(6)-2 NCOIC, Soldier & Family Support Branch, (b)(6)-2
(b)(6)-2

SFC (b)(6)-2 NCOIC, Dept of Psychology, (b)(6)-2
(b)(6)-2

SPC (b)(6)-2 Mental Health Specialists, Department of Psychiatry and
Behavioral Sciences, (b)(6)-2

APPENDIX 2

MENTAL HEALTH ADVISORY TEAM (MHAT-II) ITINERARY

July 2004: MHAT-II mission defined and tasked to U.S. Army MEDCOM

July 2004: MHAT-II team formed

July—August 2004: Initial MHAT-II planning via audio conferences

6-12 August 2004: MHAT-II meets at the U.S. Army Force Health Protection Conference, Albuquerque, New Mexico.

22-27 August 2004: MHAT-II is at the CONUS Replacement Center (CRC), Ft. Bliss, Texas.

28 August—3 September, 22-26 September 2004: MHAT-II activities in Kuwait

3 September—9 October 2004: MHAT-II Activities in Iraq

MHAT-II exit briefed (b)(2)
2 Med Bde, MNC-I, and MNF-I leadership on 6, 7, and 9 October 2004.

9-18 October 2004: MHAT-II Activities in Kuwait. MHAT exit briefed (b)(2)
2 Med Bde and CFLCC leadership on 13 October 2004.

19-21 October 2004: MHAT-II at CRC, Ft. Bliss, Texas

22 October—5 December 2004: MHAT-II analyzes data and writes draft report.

6–17 December 2004: MHAT-II meets at WRAIR, Washington, D.C. to finalize drafts of report.

30 January 2005: MHAT-II report submitted to OTSG, CENTCOM, MNC-I, and MNF-I for final review.

APPENDIX 3

GLOSSARY OF TERMS **USED BY THE MENTAL HEALTH ADVISORY TEAM (MHAT-II)**

DoD Dictionary of Military Terms

As amended through 5 June 2003

<http://www.dtic.mil/doctrine/jel/doddict/>

accident

An unplanned event that results in injury (including death) or occupational illness to person(s) and/or damage to property, exclusive of injury and/or damage caused by action of an enemy or hostile force. (AR 310-5)

brigade

(DoD) A unit usually smaller than a division to which are attached groups and/or battalions and smaller units tailored to meet anticipated requirements. Also called BDE and bde.

combat and operational stress

(DoD) The expected and predictable emotional, intellectual, physical, and/or behavioral reactions of Service members who have been exposed to stressful events in war or military operations other than war. Combat stress reactions vary in quality and severity as a function of operational conditions, such as intensity, duration, rules of engagement, leadership, effective communication, unit morale, unit cohesion, and perceived importance of the mission.

combat service support

(DoD) The essential capabilities, functions, activities, and tasks necessary to sustain all elements of operating forces in theater at all levels of war. Within the national and theater logistic systems, it includes but is not limited to that support rendered by service forces in ensuring the aspects of supply, maintenance, transportation, health services, and other services required by aviation and ground combat troops to permit those units to accomplish their missions in combat. Combat service support encompasses those activities at all levels of war that produce sustainment to all operating forces on the battlefield. Also called CSS. See also combat support.

combat support

(DoD) Fire support and operational assistance provided to combat elements. Also called CS. See also combat service support.

communications zone

(DoD) Rear part of a theater of war or theater of operations (behind but contiguous to the combat zone) which contains the lines of communications, establishments for supply and evacuation, and other agencies required for the immediate support and maintenance of the field forces. Also called COMMZ. See also combat zone; line of communications; rear area; theater of operations; theater of war.

concept plan

(DoD) An operation plan in concept format. Also called CONPLAN. See also operation plan.

division

(DoD, NATO) 1. A tactical unit/formation as follows: a. A major administrative and tactical unit/formation which combines in itself the necessary arms and services required for sustained combat, larger than a regiment/brigade and smaller than a corps. b. A number of naval vessels of similar type grouped together for operational and administrative command, or a tactical unit of a naval aircraft squadron, consisting of two or more sections. c. An air division is an air combat organization normally consisting of two or more wings with appropriate service units. The combat wings of an air division will normally contain similar type units. 2. An organizational part of a headquarters that handles military matters of a particular nature, such as personnel, intelligence, plans, and training, or supply and evacuation. 3. (DoD only) A number of personnel of a ship's complement grouped together for tactical and administrative control.

evacuation

(DoD) 1. The process of moving any person who is wounded, injured, or ill to and/or between medical treatment facilities. 2. The clearance of personnel, animals, or materiel from a given locality. 3. The controlled process of collecting, classifying, and shipping unserviceable or abandoned materiel, U.S. or foreign, to appropriate reclamation, maintenance, technical intelligence, or disposal facilities. 4. The ordered or authorized departure of noncombatants from a specific area by Department of State, Department of Defense, or appropriate military commander. This refers to the movement from one area to another in the same or different countries. The evacuation is caused by unusual or emergency circumstances and applies equally to command or non-command sponsored family members. See also evacuee; noncombatant evacuation operations.

evacuation policy

(DoD) 1. Command decision establishing the maximum number of days that patients may be held within the command for treatment. Patients who, in the opinion of responsible medical officers, cannot be returned to a duty status within the period prescribed are evacuated by the first available means, provided the travel involved will not aggravate their disabilities. 2. A command decision concerning the movement of

civilians from the proximity of military operations for security and safety reasons and involving the need to arrange for movement, reception, care, and control of such individuals. 3. Command policy concerning the evacuation of unserviceable or abandoned materiel and including designation of channels and destinations for evacuated materiel, the establishment of controls and procedures, and the dissemination of condition standards and disposition instructions. See also evacuation; patient.

medical treatment facility

(DoD) A facility established for the purpose of furnishing medical and/or dental care to eligible individuals.

morale

The state of the spirits of a person or group as exhibited by confidence, cheerfulness, discipline, and willingness to perform assigned tasks. (The American Heritage[®] Dictionary of the English Language: Fourth Edition. 2000.)

operation plan

(DoD) Any plan, except for the Single Integrated Operational Plan: for the conduct of military operations. Plans are prepared by combatant commanders in response to requirements established by the Chairman of the Joint Chiefs of Staff and by commanders of subordinate commands in response to requirements tasked by the establishing unified commander. Operation plans are prepared in either a complete format (OPLAN) or as a concept plan (CONPLAN). The CONPLAN can be published with or without a time-phased force and deployment data (TPFDD) file. a. OPLAN—An operation plan for the conduct of joint operations that can be used as a basis for development of an operation order (OPORD). An OPLAN identifies the forces and supplies required to execute the combatant commander's strategic concept and a movement schedule of these resources to the theater of operations. The forces and supplies are identified in TPFDD files. OPLANs will include all phases of the tasked operation. The plan is prepared with the appropriate annexes, appendixes, and TPFDD files as described in the Joint Operation Planning and Execution System manuals containing planning policies, procedures, and formats. Also called OPLAN. b. CONPLAN—An operation plan in an abbreviated format that would require considerable expansion or alteration to convert it into an OPLAN or OPORD. A CONPLAN contains the combatant commander's strategic concept and those annexes and appendixes deemed necessary by the combatant commander to complete planning. Generally, detailed support requirements are not calculated and TPFDD files are not prepared. c. CONPLAN with TPFDD—A CONPLAN with TPFDD is the same as a CONPLAN except that it requires more detailed planning for phased deployment of forces. Also called CONPLAN. See also operation order; time-phased force and deployment data.

squadron

(DoD) 1. An organization consisting of two or more divisions of ships, or two or more divisions (Navy) or flights of aircraft. It is normally but not necessarily composed of ships or aircraft of the same type. 2. The basic administrative aviation unit of the Army, Navy, Marine Corps, and Air Force. 3. Battalion-sized ground or aviation units in U.S. Army cavalry regiments.

suicide

1 a: the act or an instance of taking one's own life voluntarily and intentionally especially by a person of years of discretion and of sound mind **b:** ruin of one's own interests <political *suicide*>

2: one that commits or attempts suicide. (Merriam-Webster's Online Dictionary)

Joint Acronyms and Abbreviations

http://www.dtic.mil/doctrine/jel/doddict/acronym_index.html

AFME Armed Forces medical examiner

ASIST Applied Suicide Intervention Skills Training

ASMC Area Support Medical Company

BAMC Brooke Army Medical Center

CONPLAN Concept Of Operation Plan

CONPLAN Contingency Plan

CSH combat support hospital

DMHS Division Mental Health Section

EAMC Eisenhower Army Medical Center

FSMC Forward Support Medical Company

LRMC Landstuhl Regional Medical Center

LRMC Landstuhl Regional Medical Center (U.S. Army)

MODS Major Operations Data System

MODS Medical Occupational Data System

MTF medical treatment facility

NIPRNET Non-Secure Internet Protocol Router Network

OTSG Office of The Surgeon General

PARRTS Patient Accounting and Reporting Real-Time Tracking System

SIPRNET Secure Internet Protocol Router Network

TRACZES TRANSCOM Regulating And Command and Control Evacuation System

Additional Acronyms and Abbreviations

AC Active Component

ACA American Correctional Association

ADHA attention deficit hyperactivity disorder

AFB Air Force Base

AMEDD Army Medical Department

AOC area of concentration

AOR area of responsibility

APA American Psychiatry Association

AR Army regulation

ASD acute stress disorder

ASER Army Suicide Event Report

ASPP Army Suicide Prevention Program

ASR acute stress reaction

BATS Biometric Automatic Toolset System

BH behavioral health

CFLCC Coalition Forces Land Component Command

CI civilian internee

CONUS continental United States

CP collection point

CSC/COSC combat stress control/ combat and operational stress control

CY calendar year

DA Department of the Army

DAIG Department of the Army Inspector General

DCA Deputy Commander for Administration

DCCS Deputy Commander for Clinical Services

DCN Deputy Commander for Nursing

DCS deployment cycle support

DNA deoxyribonucleic acid

DNBI disease and non-battle injury

DO disorder

DWMMC Deployed Warrior Medical Management Center

EPW enemy prisoner of war

ERMC European Regional Medical Command

FOB forward operating base

GC Geneva Convention

GPW Geneva Convention Relative to the Treatment of Prisoners of War (Also known as Geneva Convention III (GC III))

GTMO Guantanamo Bay U.S. Naval Base, Cuba

GYN gynecology

HIV human immunodeficiency virus

HQDA Headquarters, Department of the Army

ICRC International Committee of the Red Cross

ICU intensive care unit

I/R internment/retention

ISN internment serial number

MEDCOM U.S. Army Medical Command

METL mission essential task list

MH mental health

MHAT-FT Mental Health Advisory Team—Forensic Team

MNC-I Multi-National Corps-Iraq

MNF-I Multi-National Force-Iraq

MP military police

MRE meals, ready-to-eat

NCO/NCOIC noncommissioned officer/Noncommissioned officer in charge

NDRS National Detainee Reporting System

NIC National Institute of Corrections

NOS not otherwise specified

OCD obsessive-compulsive disorder

OEF Operation Enduring Freedom

OT occupational therapist

PA physician assistant

PAT process action team

PCP primary care provider

PIA patient information application

PIES proximity, immediacy, expectancy, and simplicity

PIR priority intelligence requirements

PMR patient movement record

PROFIS professional filler system

PTSD posttraumatic stress disorder

PWIC Prisoner of War Information Center

RC Reserve Component

RP retained personnel

SEIU Service Employees International Union

SF **881600** Special Form 881600

SITREP situation report

SOP standing operating procedures

TSG The Surgeon General

UCMJ Uniform Code of Military Justice

UMT Unit Ministry Team

UN United Nations

USAF United States Air Force

USAMRU-E U.S. Army Research Unit–Europe

WRAIR Walter Reed Army Institute of Research

91X enlisted MOS code for Mental Health Specialists