

**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 (COSOC) services. The units are still referred to as CSC units; however, the services are COSOC services. The MHAT also referred to behavioral healthcare providers. Table 1 defines those military personnel considered BH care providers.

<b>AOC/MOS</b>	<b>Description</b>
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
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The team also collected data, with the help of researchers from United States Army Research Unit–Europe (USARU-E), from LRMC, 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.

- **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.

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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