

**Operation Iraqi Freedom (OIF)
Mental Health Advisory Team (MHAT)**

REPORT

16 December 2003

**Chartered by:
U.S. Army Surgeon General
& HQDA G-1**

This report is redacted to remove unit identifications, unit locations, and personal identity information in accordance with Army Regulation 25-55, *Department of the Army Freedom of Information Act Program*, and Army Regulation 340-21, *The Army Privacy Program*. Redacted information appears throughout this report blacked out, such as below.



The views expressed in this report are those of the OIF MHAT 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)
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Executive Summary

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OPERATION IRAQI FREEDOM MENTAL HEALTH ADVISORY TEAM EXECUTIVE SUMMARY

The U. S. Army Surgeon General chartered the Operation Iraqi Freedom (OIF) Mental Health Advisory Team (MHAT) in July 2003. Its mission was to assess OIF-related mental health issues, and to provide recommendations to the OIF medical and line commands. In addition to multiple small group interview sessions, the MHAT conducted surveys with 756 Soldiers—of those, 82% had engaged in combat. This is the first time in history Soldiers have been surveyed in this manner about behavioral health issues during active combat.

The MHAT conducted a comprehensive assessment of the OIF behavioral healthcare (BH) system, focusing on 1) the behavioral health services for deployed Soldiers and units; 2) the evacuation of behavioral health patients; and 3) the behavioral health services at one of the Army's projection platforms, Fort Stewart, Georgia, home of the Army's 3rd Infantry Division, and 4) the observed July 2003 increase in OIF suicides and the suicide prevention program.

FINDINGS

The MHAT found the forward elements of the OIF behavioral healthcare system demonstrated great effectiveness in helping Soldiers deal with the combat and operational stressors, benefiting both the individual Soldier and the unit. Soldiers treated forward avoided the stigma linked to evacuation for a behavioral health illness. Nevertheless, the MHAT found there was room to improve the behavioral healthcare system.

This snapshot of the behavioral health concerns of OIF Soldiers was taken at the height of summer heat, when living condition infrastructure was immature, and redeployment dates were uncertain. Although 77% of surveyed Soldiers reported experiencing no or mild stress, emotional, or family problem, 16% reported moderate and 7% reported severe levels of such stress. Additionally, 7.3% of surveyed Soldiers screened positive for anxiety, 6.9% for depression, and 15.2% for traumatic stress. Conversely, 83% of surveyed Soldiers did not meet screening criteria for behavioral health related functional impairment. Fifty-two percent (52%) of Soldiers reported low or very low personal morale and 72% reported low or very low unit morale. Soldiers who expressed a desire to receive help with mental health problems perceived barriers to receiving that assistance greater than other Soldiers surveyed.

Although forward-deployed behavioral health units enjoyed a high return to duty rate (over 95%), almost half of Soldiers surveyed reported not knowing how to obtain their services. Moreover, of those Soldiers wanting help, only one-third had received any assistance. Forward-deployed behavioral health units report greater dissatisfaction with the availability of psychotropic medications, than units located in the rear. The MHAT found there was a need for improvement in the

consistency of implementation of behavioral health services across the theater, and need for a standardized behavioral health reporting and documentation system.

Once a Soldier left the OIF theater for behavioral health reasons, very few were returned to duty. Of the 49 Soldiers evacuated to Fort Stewart, 16% failed to receive follow-up care and 76% received six or fewer follow-up visits. The top five medical-surgical reasons for evacuation demonstrated a rise in evacuation rates during the month of July 2003; this surge was not unique to behavioral health. Clinical charts were inconsistently maintained, and documentation did not reliably accompany patients through the evacuation chain.

The suicide rate for Soldiers deployed to OIF January – October 2003 was higher than recent Army historical rates (as of 5 December 2003, 15.6/100K vs. an 8-year (1995-2002) Army average of 11.9/100K). There was a high incidence of OIF suicides during July relative to other months in 2003, but it did not signify an escalating rate of suicide. Firearms were the predominant method of suicide for OIF Soldiers. Compared to historical Army suicide rates, OIF suicide rates were higher for Soldiers located in Iraq and lower for Soldiers in Kuwait; higher for Active Component Soldiers and lower for Reserve Component Soldiers; and higher for both males and females.

RECOMMENDATIONS

Immediately improve the behavioral health care system by 1) appointing a theater/area of operation behavioral health consultant, 2) providing services to Soldiers who need/want them closer to the Soldier's unit, 3) providing holding capability closer to the Soldier, and 4) improving the quality of behavioral healthcare services for Soldiers being evacuated out of the theater.

Ensure all behavioral health providers are properly trained/educated in relevant combat operational stress control (COSC) doctrine, tactics, techniques and procedures.

Improve the behavioral health support at the unit level. Develop a human resource risk management program utilizing mid-grade Soldiers to facilitate the early identification and intervention of psychosocial problems at the company level and significantly improve behavioral health support for rear-detachment commanders and Family Readiness Groups (FRG).

Adapt the existing (community-based) objectives of the Army Suicide Prevention Program (ASPP) for OIF Soldiers and units. Strategies of the ASPP can be applied to a forward deployed force through actions in the following areas: designate proponents to manage the suicide prevention program, maintain vigilance by leaders and Soldier-peers, conduct training, implement a surveillance of completed suicides and serious suicide attempts, and establish a

command climate that encourages appropriate help-seeking behavior by distressed Soldiers.

Implement the monitoring of serious suicide attempts within Army medical surveillance systems. Task the U.S. Army Center for Health Promotion and Preventive Medicine (CHPPM) and the behavioral health consultants to develop capability for monitoring serious suicide attempts at the installation, operational, and Army-wide levels.

Continue to monitor the health and well-being of OIF Soldiers via survey prior to their re-deployment to continental United States (CONUS), and after arrival at home station. Begin a systematic assessment to determine the most effective means for early intervention of Soldiers exposed to combat.

DISCUSSION

Behavioral health units had high return to duty (RTD) rates in Iraq yet there were several indicators that identified unmet needs for behavioral healthcare services: Soldiers reported barriers to getting help in theater; and the inconsistent quality of the care for Soldiers evacuated out of the theater.

The OIF suicide rate was higher than recent Army historical rates. This reminds medical planners and line leaders that strategies to minimize suicide risk are a critical component of force sustainment during combat operations. Some suicide risk factors are increased in a combat zone. Vigilance of unit leaders is necessary to identify Soldiers at risk, and to refer them for appropriate support.

OPERATION IRAQI FREEDOM MENTAL HEALTH ADVISORY TEAM REPORT

INTRODUCTION

The U. S. Army Surgeon General chartered the Operation Iraqi Freedom (OIF) Mental Health Advisory Team (MHAT) in July 2003. Its mission was to assess OIF-related mental health issues and provide recommendations to the OIF medical and line commands. In addition to multiple small group interview sessions, the MHAT conducted surveys with 756 Soldiers—of those, 82% had engaged in combat. This is the first time in history Soldiers have been surveyed in this manner about behavioral health issues during active combat.

The MHAT conducted a comprehensive assessment of the OIF behavioral healthcare (BH) system, focusing on 1) the behavioral health services for deployed Soldiers and units; 2) the evacuation of behavioral health patients; and 3) the behavioral health services at one of the Army's projection platforms, Fort Stewart, Georgia, home of the Army's 3rd Infantry Division. There were several possible negative outcomes when Soldiers experience extreme stress. The MHAT examined possible negative outcomes paying particular attention to OIF suicides. This report contains the MHAT's key findings and its recommendations.

The report consists of three major parts: 1) the OIF MHAT Executive Summary, 2) the OIF MHAT Report, and 3) the Annexes to the OIF MHAT Report. The annexes contain the assessment methodologies, results and recommendations for the behavioral healthcare system.

CONVENTIONS: The OIF MHAT referred to the behavioral healthcare system when discussing its findings. The behavioral health continuum of care encompasses not only traditional mental health care efforts, but many efforts of a primary and secondary prevention nature that have traditionally not been counted as mental health services. To avoid confusion, the MHAT will designate all of these services as behavioral healthcare services.

Also, many preventive interventions are referred to as "combat stress control" (CSC) services. Recently, the three Services (Departments of the Air Force, Army, and Navy) agreed to refer to these services as "combat and operational stress control services" (COSC). 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 behavioral healthcare providers.

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

REASON FOR THE MHAT

The Office of The Surgeon General (OTSG) established the OIF MHAT in cooperation with the Army's Deputy Chief of Staff for Personnel, or HQDA G-1, in late July 2003 to assess OIF related mental health issues, and to provide recommendations (See charter at Appendix A). Specifically, MHAT was challenged to assess potential organizational and resource-limitation factors related to 1) the July 2003 increase in OIF suicides; 2) the increased behavioral health patient flow through Landstuhl Regional Medical Center (LRMC) from OIF after May 2003; 3) the stress-related issues in the Iraqi theater; and 4) deployment-related behavioral health issues among 3rd Infantry Division Soldiers at Fort Stewart, a major deployment platform. To this end, the MHAT consulted with relevant medical commanders, line leaders, behavioral health units, behavioral health headquarters, and evacuation chain support personnel at LRMC and Fort Stewart.

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

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

THE MHAT ANALYSIS OF OBJECTIVES:

In order to consult with the behavioral health leaders in OIF and in the evacuation chain, the MHAT traveled to Kuwait, Iraq, LRMC, and Fort Stewart, Georgia. The MHAT left the CONUS Replacement Center in Fort Bliss, Texas on 25 August 2003, and stayed in Kuwait and Iraq from 27 August until 7 October 2003.

In Kuwait, the MHAT consulted with the leadership of the Coalition Forces Land Component Command (CFLCC), the [REDACTED] Medical Brigade and Combat Service Support (CSS) units (see Table 2).

Table 2: CLFCC Interviews		
Signal and Transportation Units	Engineer and Military Police Units	Medical Units
[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]

In Iraq the MHAT consulted with the leadership of the Combined Joint Task Force-7 (CJTF-7), the [REDACTED] Medical Brigade and Combat Arms (CA) units (See Table 3).

Table 3: CJTF-7 Interviews				
1 st Armored Division	4 th Infantry Division	101 st Airborne Div	3 rd ACR	[REDACTED]
[REDACTED]				

Four team members visited LRMC, Germany from 13 - 17 October. Five other team members visited Ft. Stewart, Georgia from 13 - 18 October. Both teams consulted with relevant local mental health personnel and Army Medical Department (AMEDD) leadership. (See Annex E, Appendix 2.)

The MHAT approached the mission as a rare opportunity to assess the Army behavioral healthcare system in an active combat campaign. An assessment like this has never been undertaken in an active combat environment. The MHAT used an approved Soldier and theater needs assessment tool developed by the Walter Reed Army Institute of Research (WRAIR). The OIF WRAIR Soldier Well-Being Survey (OIF SWBS) was adapted from Soldier well-being surveys used in Army military operations over the last ten years (Annex A, Appendix 2). Earlier versions have established baseline data for units in garrison, pre-deployment and

post-deployment. This was the first time the instrument was used during an active combat campaign.

The MHAT also assessed the behavioral healthcare system itself. The MHAT surveyed and interviewed behavioral health providers, primary care providers, Unit Ministry Teams, and command group's senior leaders in sampled units (see Tables 2 & 3). The MHAT assessed the OIF mental health intervention strategies, application of CSC doctrine, alternative mental health interventions and the behavioral health medical evacuation system. In addition, the MHAT studied the observed spike in OIF suicides and assessed the status of OIF suicide preventive efforts.

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

The MHAT was unanimously impressed with the professionalism and dedication of OIF leaders, Soldiers, chaplains and health care providers. It goes without saying that Iraq was an austere and very dangerous environment. In spite of high risk to themselves, they went on convoys and patrols, pulled guard duty, and performed other duties as required by the OIF mission. The medical personnel were facilitative, cooperative and extremely helpful. They performed their duties in a professional and exemplary manner. Many of our behavioral health personnel demonstrated great ingenuity and creativity in finding ways to take care of Soldiers despite severe resource limitations. Their examples taught us valuable lessons in commitment, fortitude and perseverance, and made us proud to be Soldiers.

FINDINGS

1. OIF Soldiers reported significant levels of behavioral health concerns and stress; and low levels of personal morale and unit cohesion. They expressed a desire for help with behavioral health problems, but reported barriers to receiving assistance.

This assessment showed that a minority, but significant, proportion of Soldiers deployed to OIF experienced and reported behavioral health concerns, and that there was an unmet need for behavioral services.

Distress levels and interest in receiving help. Seventy-seven percent of OIF Soldiers reported currently experiencing no or mild stress, emotional, or family problem. Sixteen percent (16%) of OIF Soldiers reported currently experiencing a moderate stress, emotional, or family problem. Seven percent (7%) reported currently having a severe stress, emotional, or family problem. Overall, 15% of Soldiers reported interest in receiving help.

Using standardized clinical scales, 83% of Soldiers indicated mild problems or minimal impact on duty performance for these problems. Seventeen (17%) of Soldiers did screen positive for traumatic stress, depression, or anxiety and reported impairment in social or occupational functioning.

Use of mental health services. Of the Soldiers who screened positive for depression, anxiety, or traumatic stress, only 27% reported receiving help at any time during the deployment from a behavioral health professional, general medical doctor, or chaplain. Of the Soldiers who reported interest in receiving help, only 32% received some form of help.

OIF Soldiers reported low Soldier morale and unit cohesion.

At the time of the Soldier health and well-being survey, OIF Soldiers reported low or very low personal and unit morale. Fifty-two percent (52%) of Soldiers reported low or very low personal morale and 72% reported low or very low unit morale. Unit cohesion was also reported to be low.

Multiple operational stressors were significantly correlated with morale, cohesion, and behavioral health problems.

The most reported combat stressors included seeing dead bodies or human remains, being attacked or ambushed, and personally knowing someone who was seriously injured or killed. The most

reported deployment stressors included uncertain re-deployment date, long deployment, separation and lack of communication with family, and lack of personal privacy. These operational stressors were significantly correlated with low morale, low cohesion, and behavioral health problems.

Barriers/obstacles impede Soldiers from obtaining behavioral health assistance.

Soldiers most in need of behavioral health care were twice as likely as other Soldiers to report concerns about accessing services. Among Soldiers who screened positive for depression, anxiety, or traumatic stress, 26% reported that it would be too difficult to get to the location of behavioral health services. Other barriers reported among those who screened positive included difficulty getting time off from work to get help (43%), not knowing where to go for help (24%), or behavioral health services not being available (24%). Perceived stigma to care was also an important concern for OIF Soldiers; Soldiers reported that they might be seen as weak (59%), that the unit leadership would treat them differently (58%), that the unit would have less confidence in them (49%), or that their leaders would blame them for the problem (46%).

2. The percentage of behavioral health patients returned to duty was highest among behavioral health units deployed forward, and was lowest among behavioral health units in the rear. Behavioral health outreach efforts were inadequate to meet the needs of Soldiers and line leaders. Although the number of behavioral health personnel in theater was sufficient to provide coverage throughout the OIF AOR, there were areas in theater that lacked behavioral health services. Forward-deployed behavioral health units reported greater dissatisfaction with the availability of psychotropic medications, than units located in the rear. Behavioral health units need a broader range of antidepressant and sleeping medications.

The percentage of behavioral health patients returned to duty was highest among behavioral health units deployed forward, and was lowest among behavioral health units in the rear.

The percentages of Soldiers who were treated for behavioral health problems and returned to duty (RTD) ranged from 97% to 4%, depending on the type of behavioral health unit that provided care. Data from the Combat and Operational Stress Control Workload and Activity Reporting System (COSC-WARS) was analyzed to calculate the Soldier RTD rate for CJTF-7 Combat Stress Control units. For Division Mental Health Sections (DMHS) and Combat Support Hospital (CSH) units, their homegrown databases were analyzed to calculate their Soldier RTD rates.

Forward-deployed behavioral health units returned to duty 97% of service members seen while only 11% of Soldiers treated in Kuwait were returned to duty and only 10 (3.6%) of behavioral health evacuees were returned to duty in OIF from LPMC. Of the evacuees whose charts were reviewed by MHAT at LPMC, 90% were treated as outpatients at LPMC.

The following factors may have contributed to the low return to duty rates: First, patients who continued in the evacuation chain may have required hospitalization for severe conditions needing long-term treatment interventions. Second, the evacuation policy promoted the evacuation of patients, not their return to duty. For many behavioral health patients, even those with transitory conditions like adjustment disorder, treatment may require more days than provided for in the CJTF-7 seven-day evacuation policy. Third, while CJTF-7's evacuation policy directed that evacuations occur "only after a good faith effort to address the issue in theater failed," there were no standing operating procedures (SOP) to guide clinicians how or when to consider returning an evacuee to duty in OIF.

In fact, several factors indicated improving behavioral health status in the evacuee population. First, the number of evacuees with high suicide risks precipitously dropped from 89 (32%) in OIF to 22 (7%) at LPMC. Second, there was a similar drop in the number of evacuees with elevated homicide risks from 25 (9%) in OIF to 7 (3%) at LPMC. Third, nearly one-third of OIF and LPMC evacuees did not require psychotropic medications, suggesting that their conditions could be adequately addressed through psychotherapeutic means only.

Behavioral health outreach efforts need to improve to better meet needs of Soldiers and line leaders.

Behavioral health personnel's perception of providing accessible care for Soldiers was different compared to the Soldiers who were surveyed. Ninety percent (90%) of the behavioral health providers surveyed agreed that Soldiers in their area of operation had good access to behavioral health services. However, only 56% of the Soldiers surveyed reported knowing how to obtain behavioral health care in theater. Twenty-six percent (26%) of Soldiers reported it would be too difficult to get to behavioral health services. Of the Soldiers who screened positive for depression, anxiety, or traumatic stress, 27% reported receiving help at any time during the deployment from a behavioral health professional, general medical

doctor, or chaplain. Of the Soldiers who reported interest in receiving help, only 32% reported receiving help during the deployment. Sixty percent (60%) of the respondents to the Soldier well being survey identified command stigma (20%), difficulties traveling (20%) and leader/Soldier lack of knowledge about behavioral health services and capabilities (20%) as the three top barriers to providing behavioral health care in theater.

Although the number of behavioral health personnel in theater was sufficient to provide coverage throughout the OIF AOR, there were areas in theater that lacked behavioral health services.

To identify the adequacy of behavioral health support, the MHAT calculated the behavioral health provider-to-Soldier population ratio for OIF and its collective areas of responsibility. The ratio was calculated by dividing the Soldier population of an area of responsibility by the number of behavioral health providers supporting that AOR.

As of September 2003, the OIF ratio was one behavioral health provider for every 851 Soldiers. In Iraq, the ratio was one provider for every 830 Soldiers; and in Kuwait, the ratio was one provider for every 986 Soldiers. The ratios by area of responsibility ranged from no providers for 4,205 Soldiers, to one provider for every 673 Soldiers.

Forward-deployed behavioral health units report greater dissatisfaction with the availability of psychotropic medications than units located in the rear.

Dissatisfaction with the availability of psychotropic medication was particularly high among Combat Stress Control units and Division Mental Health Sections (57.1 and 66.7% respectively). Unlike units at higher levels, these units do not have an integrated pharmacy to immediately dispense medication. Anecdotal reports from forward-deployed psychiatrists indicate that filling prescriptions is unnecessarily complicated by forcing Soldiers and units to arrange at least two convoys: the first convoy is for the Soldier's medication evaluation and prescription, and the second convoy is for the medication pick-up at the nearest pharmacy.

Behavioral health units need a broader range of antidepressant and sleeping medications.

Fifty percent (50%) of psychiatrists identified a need for a broader range of antidepressant medications in the current formularies, and 33% indicated that additional sleeping agents and stimulants would be helpful for treating patients.

3. There was minimal systematic training/education in the implementation of CSC doctrine. There was inconsistent communication and integration between behavioral health providers and higher medical headquarters. There were ill-defined standards across the continuum of care. There was no standardized method to collect behavioral health workload or clinical information.

Minimal CSC training in the implementation of CSC doctrine.

More than half of the behavioral health providers interviewed reported either they did not know what COSC doctrine was, or did not support it. Fifty percent (50%) percent also reported they had not received adequate training in combat stress prior to deployment. Over 50% of the behavioral health providers interviewed wanted more intense training in COSC.

There was inconsistent communication and integration between behavioral providers and higher medical headquarters.

Thirty-seven percent (37%) of behavioral health personnel reported receiving guidance and adequate supervision from their higher headquarters. Thirty-four percent (34%) reported not getting needed mission information and intelligence. There were no significant differences between the active and reserve components on this issue. Fifty-five percent (55%) of the behavioral health officers were dissatisfied with their perceived level of input into operational planning. Nineteen percent (19%) of all behavioral health personnel reported having input into the policies of their higher command.

A need for better defined standards across the continuum of care.

The MHAT found there were operational and doctrinal differences among behavioral units. Providers were divided between the medical and preventive models as means of delivering behavioral health services. The reported median time spent doing prevention activities was 39% compared to a reported median time of 60% for clinical treatment. Eighty-one percent (81%) of the psychiatrists

and psychiatric nurses reported spending less than half of their time providing prevention activities. The other behavioral health providers only reported spending 50% of their time doing prevention activities. Without instruments to assess Soldier/unit needs, behavioral health providers made assumptions about needs of the community, and relied on familiar intervention models. Providers with COSC training favored preventive strategies to promote wellness in the population – sometimes to the exclusion of needed clinical interventions. Providers with medical or clinical backgrounds resorted to the “medical model” to evaluate and treat behavioral health disorders in the population – to the exclusion of doing preventive outreach and interventions.

No standardized behavioral data collection methodology.

Each behavioral health unit in CJTF-7 was directed to enter their workload data into the COSC-WARS system and to forward this information to the [REDACTED] Medical Brigade. However, only the CSC units used COSC-WARS, the DMHSs used the disease and non-battle injury (DNBI) database, and the CSHs used “homegrown” databases. More than half (53%) of the behavioral health units contacted in theater created and maintained their own “homegrown” database systems due to the reported shortfalls within the existing databases, including COSC-WARS. These unofficial database systems were used to maintain additional caseload information and provide additional workload and Soldier/patient tracking information for the providers and also their commands.

4. There was a surge in all Army OIF evacuations during July 2003. This surge was seen in the rate of behavioral health evacuations, as well as the rates of other evacuating medical-surgical specialties. Clinical charts were inconsistently maintained, and documentation did not reliably accompany patients through the evacuation chain.

There was a surge in all Army OIF evacuations during July 2003. This surge was seen in the rates of the top five medical-surgical reasons for evacuation. The surge in evacuations was not unique to the behavioral health system.

In July 2003, the Army OIF evacuation rate per 100K troops increased 1.8 times (668 evacuees in June to 1225 in July). The top five medical-surgical reasons for evacuation demonstrated a similar rise in evacuation rates during the month of July. This surge was not unique to behavioral health. Despite this one-month surge, the proportion of behavioral health evacuations to all Army OIF evacuations remained relatively stable.

No single hypothesis adequately explained the surge in Army OIF evacuations during July 2003.

Several hypotheses attempted to explain the surge in evacuations, but each failed to provide a satisfactory answer. These hypotheses included 1) the “backlog” hypothesis, 2) the “shrinking force” hypothesis, 3) the “unknown redeployment date” hypothesis, 4) the “home front stress” hypothesis, 5) the “trivial evacuation” hypothesis, and 6) the “administrative evacuation” hypothesis.

Clinical charts were inconsistently maintained, and documentation did not reliably accompany patients through the evacuation chain. No Database adequately tracked evacuees or provided reliable clinical information

Procedures for documenting patient visits varied among the behavioral health units. Procedures fluctuated with available resources, environmental conditions, operational tempo, type of behavioral health unit (e.g. DMHS, CSC, or CSH), and unit policy. Treatment interventions were inconsistently recorded in convenience files. Even at LRMC, outpatient evacuee charts were disorganized and stapled, contained inconsistent documents, and kept in an accordion file.

Clinical documentation did not reliably arrive at the receiving facility. Although all OIF behavioral health providers claimed to send clinical documentation to the receiving facility in the evacuation chain, only 44.8% of LRMC charts actually had OIF clinical documentation within the chart. Nearly 38% of reviewed charts had neither OIF clinical documentation, nor Patient Movement Request (TRAC2ES) information. In some cases, the OIF behavioral health provider relied upon the patient to hand-deliver his/her clinical documentation to the next level of care. Evidence showed that clinical documentation was sent to the next receiving facility for 93% of all evacuees leaving LRMC.

No DoD-supported or homegrown database system adequately tracked evacuations from OIF to CONUS to home station, thereby limiting usefulness in medical planning and patient-accountability.

In lieu of receiving reliable clinical documentation from OIF, behavioral health providers have relied on TRAC2ES to make initial clinical decisions about incoming evacuees. For example, LRMC used the TRAC2ES in triage, deciding which patients needed immediate evaluation and which patients could wait until the next

duty day. However, TRAC2ES had many limitations:

- 1) TRAC2ES could only be reached via SIPRNET connection;
- 2) online TRAC2ES information was “stripped” of evacuee names and social security numbers; and 3) online TRAC2ES information only extended back 60 days.

5. Over 80% of Army OIF evacuees with behavioral health diagnoses redeployed to Ft Stewart received follow-up for their conditions—most within one week after arrival.

Although 41 (84%) of these evacuees received follow-up at Winn Army Community Hospital (WACH), the MHAT was concerned that 8 (16%) evacuees were lost to follow-up. An additional 22% had one follow-up appointment and 75% of all evacuees had six or less appointments.

Adjustment disorder was the most frequent diagnosis (33%) among evacuees returned to duty after follow-up, and among evacuees who failed to follow-up after return to home station (38%). Failure to closely monitor evacuees' follow-up at home station unnecessarily elevated the risk for a bad clinical outcome.

6. The suicide rate for Soldiers deployed to OIF January – October 2003 was higher than recent Army historical rates. There was a high incidence of OIF suicide during July when compared to other months but it did not signify an escalating rate of suicide. Not unexpected in a combat zone, firearms have been the predominant method of suicide for OIF Soldiers. Compared to historical Army suicide rates, OIF suicide rates were higher for Soldiers located in Iraq and lower for Soldiers in Kuwait; higher for Active Component Soldiers and lower for Reserve Component Soldiers; and higher for both males and females.

The suicide rate for Soldiers deployed to OIF January – October 2003 was higher than recent Army historical rates.

As of 5 December 2003, the OIF suicide rate for the period January – October 2003 was 15.6 suicides per 100,000 Soldiers per year and compares to the average annual rate of 11.9 per 100,000 for the eight-year period 1995-2002 (range 9.1 - 14.8).

There were additional Army deaths that occurred between July and the end of October 2003 for which the manner of death was pending final determination; some may later be classified as suicide.

There was a high incidence of OIF suicide during July 2003 when compared to other months, but it did not signify an escalating rate of suicide.

The July 2003 OIF suicides may be viewed as an increase when compared to the preceding and following months. There was no indication that any of the suicides served as a trigger for other suicides.

Not unexpected in a combat zone, firearms have been the predominant method of suicide for OIF Soldiers.

The frequency of OIF firearm suicide was much higher when compared to firearm suicide frequencies of the Army and the U.S. populations in previous years. The deployed force was comprised of a large number of young males who are a group with high suicide risk in the U.S. population.

Compared to historical Army suicide rates, OIF suicide rates were higher for Soldiers located in Iraq and lower for Soldiers in Kuwait; higher for Active Component Soldiers and lower for Reserve Component Soldiers; and higher for both males and females.

Compared to the average Army suicide rate of 11.9/100K Soldiers, the rates for OIF Soldiers assigned in Iraq and Active Component Soldiers were 21.2 and 17.2/100K respectively. The rates for Reserve Component Soldiers and Soldiers located in Kuwait were 9.2 and 3.0 respectively. Two of the 17 OIF suicides were female and represent an annualized rate of 19.0/100K. This rate is higher than the Army historical rate of 11.9/100K, and higher than the 4.1/100K rate of suicide among U.S. females in 2001. However, this rate is based on only two deaths, which does not establish a trend, and should not be interpreted as suggesting that there is a particular problem of suicides involving women. The annualized rate for the 15 male suicides is 15.2/100K and although higher than the historical Army rate, is lower than the rate of 17.6/100K for all U.S. males in 2001, and lower than the rate of 21.5/100K for U.S. males 20-34 years of age in 2000.

RECOMMENDATIONS

Immediate implementation.

1. Appoint a theater/Area of Operation (AOR) behavioral health consultant to advise the theater Surgeon (CJTF-7 and CFLCC Surgeons) on behavioral health issues. Immediately improve the behavioral health care system by providing services to Soldiers who need/want them closer to the Soldier's unit, providing holding capability closer to the Soldier's unit, and improving the quality of behavioral healthcare services for Soldiers being evacuated out of the theater.

Appoint a theater/Area of Operation behavioral health consultant to advise the Surgeon on behavioral health issues.

In order to better allocate behavioral health personnel and to oversee the delivery of behavioral health care in the AOR, the commander should appoint a behavioral health consultant to each theater/AOR surgeon. This officer may be already on staff, or could be requested through personnel channels if a suitable choice is not available. Example duties of the theater/AOR behavioral health consultant might include:

- Consults with the Surgeon on all behavioral health matters.
- Conducts a theater/AOR-wide behavioral health needs assessment.
- Establishes behavioral health standards and operational requirements plan.
- Recommends the behavioral health theater/AOR evacuation policy.
- Prepares the behavioral health portion of the medical operations plan.
- Reviews all command/medical policies that affect behavioral health activities.
- Evaluates the quality of behavioral health services rendered in the AOR.
- Monitors the communication among levels of care during evacuation.
- Plans for future behavioral health operations (redeployment surge, etc.).
- Coordinates joint and combined behavioral health services where necessary.
- Recommends proper distribution of behavioral health units/teams on the battlefield.
- Oversees in-theater behavioral health training.

Execute an aggressive behavioral health outreach program. Ensure that behavioral health personnel have a regular, far-forward consultation program at the small unit level.

A high percentage of Soldiers reported interest in receiving behavioral health support and/or screened positive for a behavioral health problem. However, data suggests that significant barriers are preventing Soldiers from receiving help, such as transportation constraints, knowing where to get help, behavioral health services not being perceived as available, and stigma.

Behavioral health care providers can reduce and/or eliminate many of these barriers by physically going to the Soldiers who need and/or want help. Since the data indicated that both chaplains and behavioral health professionals were accessed at a similarly low rate, both groups need to develop and execute an aggressive forward-deployed behavioral health outreach program. Establishing a predictable, regular, and visible presence at the company/battalion level is essential.

In addition to direct Soldier contacts, behavioral health personnel can partner with leaders, commanders, chaplains, and primary medical care providers to extend access to behavioral health care. Further, behavioral health personnel need to reach out particularly to leaders and other helping professionals as they often have the greatest direct and indirect behavioral health stressors

AOR behavioral health consultants need to distribute behavioral health assets appropriately.

The MHAT noted gaps in behavioral health services in theater. In particular, behavioral health personnel were not optimally distributed. To improve distribution problems, behavioral health consultants need to review their respective AORs to ensure that behavioral health personnel are optimally distributed and that the services rendered provide a consistent network of behavioral health services. Where gaps are noted, behavioral health units need to be redirected to provide the needed service.

Field a simple, standardized needs assessment tool for Soldiers and units.

The MHAT noted that few behavioral health personnel had performed a needs assessment for their AORs. Creation and distribution of a standardized needs assessment tool can provide guidance for behavioral health professionals. Such an instrument

should include symptoms, exposures, morale and cohesion, the desire for help, and barriers to care.

Train Soldiers in meeting the demands of deployment/combat related stressors.

The data suggest that training Soldiers in suicide awareness and in dealing with the stresses of deployment have many potential benefits. Standardized training materials need to be developed that teach these skills to Soldiers and leaders.

Improve the ability to hold Soldiers in theater closer to their own units. Create a behavioral health reconditioning program.

In order to facilitate behavioral health treatment and to minimize behavioral health evacuations out of theater, Soldiers with behavioral health issues should be kept in theater (Iraq or Kuwait). A properly placed, staffed, and operated reconditioning unit could successfully return to duty many Soldiers currently being evacuated for behavioral health reasons. The location should be in the rear (for those on weapons restriction), with austere conditions (to encourage return to duty), and co-located with combat support or combat service support units who could profit from the therapeutic work details the Soldiers would provide.

Another limitation to optimal behavioral health services is the theater 7-day evacuation policy, which inhibited development of CSC reconditioning programs in CJTF-7 or CFLCC. Many Soldiers evacuated with Adjustment Disorders or Combat Stress Reactions may have benefited from 1-3 weeks of reconditioning in CFLCC, allowing their units to receive replacements while other units benefit from work provided by reconditioning Soldiers.

Improve the quality of behavioral healthcare services for Soldiers during evacuation.

Improve the communication between levels of care. The flow of clinical documentation is essential for continuity of care. MHAT recommends creating the following processes to ensure proper flow of clinical documentation and information among levels of care: 1) CJTF-7 and CFLCC Surgeons should jointly establish a standard clinical documentation packet for behavioral health evacuations, 2) CJTF-7 and CFLCC Surgeons should jointly establish standard procedures for transfer of this clinical documentation packet to the receiving military treatment facility, 3) the behavioral health consultants to the CJTF-7 and CFLCC Surgeons should develop, promote, and monitor administrative and clinical communication

among levels of care in the evacuation chain to ensure adequate feedback and coordination.

Improving the data quality and utilization of TRAC2ES for tracking behavioral health patient evacuation. Among the tracking systems, TRAC2ES provides the most reliable administrative information. Until other methods for reliable transmission of clinical data are established, the MHAT recommends the following steps be taken: 1) at each MTF, PAD/MRO should establish quality improvement review procedures to minimize errors in TRAC2ES data entry. 2) The evacuating provider should provide the evacuee's DSM-IV diagnoses (in addition to ICD-9) for inclusion in the TRAC2ES narrative for greater clinical clarity. 3) To encourage utilization of TRAC2ES (and JMeWS), CJTF-7 and CFLCC Surgeons should improve behavioral health provider access to the SIPRNET. 4) Prior to deployment, all behavioral health providers should establish SIPRNET accounts. 5) CJTF-7 and CFLCC Surgeons should establish a procedure with TRAC2ES database managers at Scott Air Force Base to allow behavioral health providers access to data greater than 60 days old. 6) Behavioral Health Consultants in CJTF-7/CFLCC and BH Service/Department Chiefs should develop, maintain, and monitor feedback among MTFs about the quality, accuracy, and value of TRAC2ES information.

Maintain standards of care for patients during evacuation. The MHAT recommends the establishment of the following procedures.

Quality Improvement: 1) Monitor the quality of evacuee charts throughout the evacuation chain through a locally developed and regulated QI program. 2) Monitor implementation of evacuation policy through a locally developed and regulated QI program (i.e., to ensure that evacuees satisfy the evacuation policy requirements). 3) Jointly develop CJTF-7 and CFLCC policy on escort utilization and responsibilities, and monitor through a QI program.

Improve RTD by emphasizing treatment for evacuees: 1) Implement a behavioral health reconditioning program for CJTF-7 behavioral health evacuees with Adjustment Disorder and/or Combat Stress Reactions; 2) Implement treatment initiatives at MTFs for evacuated outpatients, particularly for Soldiers with Adjustment Disorder; 3) Develop SOPs for all MTFs in the evacuation chain to govern behavioral health evacuee evaluation, treatment, disposition, and accountability processes.

Promote treatment initiatives by extending the evacuation policy for behavioral health patients. 1) Extend CJTF-7 Evacuation Policy from 7 days to 14 days for Soldiers with Adjustment Disorders or Combat Stress Reactions; 2) MTF behavioral health chief should consider full use of available days in evacuation policy for treatment.

2. Ensure all behavioral health personnel are trained/educated in COSC doctrine, tactics, and procedures.

AOR behavioral health consultants should establish quarterly behavioral health training meetings.

Not only did a number of behavioral health personnel state they were under-trained, but battlefield execution demonstrated the need for training in COSC doctrine, tactics, and techniques. Theater behavioral health consultants should establish regular (quarterly) training conferences to ensure that doctrine is clearly disseminated and problems are addressed. Training may be centralized, regionalized, or performed via train-the-trainer. Technology may also be leveraged (VTC, telephone, videotape, and/or CD) to accomplish this. However, tapes and talk alone will not suffice without some live demonstration and periodic oversight.

Conduct COSC training for behavioral health personnel (AC/RC) preparing to deploy.

MEDCOM/OTSG and the reserve medical commands should ensure that behavioral health personnel (both active and reserve) currently alerted for deployment to theater in Spring/Summer 2004 are adequately trained. This can be accomplished by holding a predeployment conference or by holding regional training meetings. Holding a conference provides the added benefit of allowing the behavioral health personnel to meet each other and to begin to plan and network together.

Conduct COSC research in key areas to ensure that the best prevention and early intervention methodologies are established/validated.

There are several research areas that can potentially result in immediate and effective intervention of OIF Soldiers. These areas include the development of a behavioral health needs assessment and the validation of the COSC intervention methods (e.g., Critical Incident Stress Debriefing (CISD)).

3. Plan for the upcoming battle-handover.

Winter/Spring 2004 will be a major upheaval as units deploy and redeploy. Post-deployment screening will likely require some behavioral health consultation (where Soldiers screen positive on the Post Deployment Health Assessment (PDHA) behavioral health questions), some units may need debriefing sessions, reunion classes, or other behavioral health intervention. Deploying units may need stress management, anger management, communication, suicide prevention, and other classes in preparation for the battlefield.

4. Adapt the existing (community-based) objectives of the Army Suicide Prevention Program for OIF Soldiers and units.

Adapt existing community-based objectives of the Army Suicide Prevention Program (ASPP) to OIF Soldiers and units. Strategies of the ASPP can be applied to a forward deployed force through actions in the following five areas:

Designate proponents to manage the CFLCC and CJTF-7 suicide prevention programs.

Maintain vigilance by leaders and Soldier-peers to ensure Soldiers at risk for suicide receive appropriate support.

Conduct training that provides crisis intervention skills to designated Soldiers with a goal of one trained Soldier per company.

Implement surveillance of completed suicides and serious suicide attempts with standardized suicide event reporting by behavioral health personnel.

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.

Future Implementation

1. TSG ensures all behavioral health providers are properly trained/educated in relevant combat operational stress control doctrine.

Ensure all behavioral health personnel are trained/educated in COSC doctrine, tactics, and procedures.

Direct TSG behavioral health consultants to develop and implement a multidisciplinary COSC Course to teach COSC doctrine, tactics, and procedures to all behavioral health/COSC personnel.

Direct TSG behavioral health consultants to charter multidisciplinary process action teams (PAT) to develop the following key elements for inclusion in the course.

- Revise/Update COSC doctrine: organize COSC around behavioral health capabilities supporting operational requirements.
- Revise/validate the behavioral health estimate of the situation.
- Develop behavioral health standards of care for the operational environment.
- Develop and field tactics, techniques and procedures for behavioral health units and teams.
- Develop and field standardized Soldier and unit needs assessment tools.
- Develop and field a data collection methodology for behavioral health surveillance and outcome information.
- Conduct research in key COSC areas to ensure best doctrine is trained. Areas include a) behavioral health needs assessment and unit climate tool for the operational environment, b) identify the scientifically valid key leadership behaviors that facilitate Soldier morale, cohesion, and unit performance in a hostile environment, and c) determine the effectiveness of COSC intervention methods (e.g., CISD).

Direct the TSG behavioral health consultants to reorient the AMEDD officer and enlisted military education systems to integrate collective blocks of instruction in COSC, disaster behavioral health, and battlefield professional practice.

Direct CHPPM and the TSG behavioral health consultants to ensure that a COSC/ behavioral health track is incorporated into the annual Force Health Protection (FHP) Conference.

2. Develop & field a data collection methodology for behavioral health surveillance and outcome information.

MEDCOM should review the COSC Workload and Activity Reporting System (COSC-WARS) for sufficiency and then automate it.

MEDCOM should integrate COSC prevention efforts into existing and emerging theater medical databases.

3. Develop an automated evacuation tracking system.

MEDCOM 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.

4. Improve the behavioral health support at the unit level:

- a. Soldiers are far more likely to consult fellow Soldiers for support than either behavioral health providers or chaplains. Therefore, develop a peer-mentoring program utilizing mid-grade Soldiers to facilitate the early identification and intervention of psychosocial problems at the company level.
- b. Significantly improve behavioral health support for rear-detachment commanders and Family Readiness Groups.

Implement a peer-mentoring program.

Soldiers reported that they were much more willing to turn to a member of their unit for support than a chaplain or behavioral health professional. Soldiers who screened positive for behavioral health problems reported turning to other Soldiers for support (37%) much more often than they accessed care from behavioral health professionals (10%) or chaplains (12%). This suggests that developing a peer-mentoring program utilizing mid-grade NCOs within each company could facilitate the early identification and intervention of behavioral health issues at the company level.

Improve behavioral health support for rear-detachment commanders and Family Readiness Groups (FRG).

Soldiers reported being separated from the family as a major stressor (57% reported high/very high trouble or concern). Many focus groups expressed concerns that rear detachment staff and FRGs were not able to adequately support families. In the survey, 55% of married Soldiers reported not being satisfied with the rear-detachment support; 54% were not satisfied with the FRG support. This finding was also identified in prior surveys conducted among spouses of Soldiers deployed to OIF/OEF. The data suggest the Army needs to provide better support to assist families and FRGs.

During deployments, assistance should be given to brigade/ battalion rear detachments and FRGs to handle family issues. One possible solution would be to have social workers fulfill this mission.

5. Implement monitoring of serious suicide attempts within Army medical surveillance systems. Task CHPPM and the behavioral health consultants to develop capability for monitoring serious suicide attempts at the installation, operational, and Army-wide levels.

Enough precedence exists to support the strategy of reducing suicide occurrence by reducing occurrence of serious suicide attempts (leading to hospitalizations and evacuations). A critical component of this strategy would be to monitor suicide attempts as a metric for suicide prevention actions. The pilot version of the AMEDD Suicide Events Report (ASER) is a promising tool for reporting suicide attempts.

DISCUSSION

The MHAT was impressed with the commitment, dedication and professionalism of the Soldiers serving in Operation Iraqi Freedom. Many of our behavioral healthcare colleagues impressed us with their creativity and originality. Given the austere, extremely dangerous environment of Iraq, they found ways to provide behavioral healthcare services to our Soldiers with outstanding results.

With divisional DMHSs and Corps CSC units having a RTD rate in the mid to high 90% and the █ CSH in Iraq having a 69% RTD, the OIF behavioral healthcare system demonstrated great capability to help Soldiers deal with the operational and combat stressors Soldiers faced in OIF. As a result of the high RTD, both units and Soldiers benefit. Units benefit from continued force sustainment. Soldiers avoid the stigma linked to evacuation for a behavioral health illness.

Clearly, with positive results such as these, the OIF behavioral health system was working well. Nevertheless, the MHAT found room to improve the behavioral healthcare system. Several indicators identified unmet needs for behavioral healthcare services.

Twenty-three percent (23%) of Soldiers reported moderate to severe stress, emotional or family problems and 15% of Soldiers reported interest in receiving help with their problems. Seventeen percent (17%) of Soldiers screened positive for traumatic stress, depression or anxiety and reported impairment in social or occupational functioning. Of the Soldiers who reported interest in receiving help, only one-third received some form of help. Of those Soldiers who screened positive for traumatic stress, depression or anxiety, only about one-fourth reported receiving help at any time during the deployment. Soldiers reported that there were barriers to receiving help: too difficult to get to the location of behavioral health services (26%), getting time off from work (43%), not knowing where to go for help (24%), or behavioral health services not being (24%).

An aggressive COSC outreach program is the solution to overcoming these obstacles. Unlike the traditional clinical approach, COSC outreach takes the services to the Soldier's worksite. Although as a theater, OIF behavioral health providers reported spending 40% of their time in prevention activities, several units had stopped outreach programs and had set up traditional behavioral health clinics (i.e., an office-based strategy with regular office hours).

The MHAT also found RTD rates precipitously fell as patients moved through the evacuation chain. (Kuwait – 11%, LRMC – 3.6%). Given MTF de-emphasis of treatment of evacuees, a properly placed, staffed, and operated reconditioning unit may return to duty many Soldiers evacuated for transient behavioral health problems (e.g., combat stress reactions and Adjustment Disorder).

Additionally, patient documentation was inconsistently maintained and did not accompany the patient through the evacuation system. The flow of clinical documentation was essential for continuity of care. Standards for a clinical documentation packet for behavioral health evacuations and the transfer of the packet need to be established and followed immediately. Communication between levels of care is equally important and must be promoted.

The July 2003 increase in OIF suicides taught a valuable lesson: suicide awareness and prevention programs must be proactively integrated into initial planning efforts, not added later in reaction to a surge in suicides. Several suicide risk factors for Soldiers were increased in a combat zone. Vigilance of unit leaders was necessary to ensure Soldiers at risk for suicide received appropriate support.

The men and women of the U.S. Army in OIF are to be praised for their sacrifice and heroism. The MHAT's heartfelt desire is that this report will enable our colleagues to better assist Soldiers as they serve in Operation Iraqi Freedom. The conditions of an austere, hostile environment can stress Soldiers to their limits. Behavioral healthcare services on the battlefield are designed to assist commanders maintain Soldier focus on the mission, minimize distractions and help Soldiers cope with the stresses of war. This report is dedicated to that end.

APPENDIX 1 to OIF MHAT REPORT

CHARTER

21 July 2003

Consultation Proposal for Operation Iraqi Freedom (OIF)-related MH Issues

1. ESTABLISHMENT, PURPOSE AND SCOPE.

a. **ESTABLISHMENT.** The Office of The Surgeon General (OTSG) established the mental health advisory team (MHAT) for assessing and providing recommendations vice OIF-related mental health (MH) issues. This Charter delineates the OIF MHAT's purpose, membership, and specifies the scope of activities.

b. **PURPOSE.** The OIF MHAT will consult to the medical and relevant line leadership of MH treatment units and their headquarters within the OIF theater and evacuation chain to include Landstuhl Army Medical Center (LRMC) and Fort Stewart – in order to assess and provide recommendations to address potential organizational and resource-limitation factors which may be related to the recent spike in OIF-related suicides, increased MH patient flow (documented via JMEWS) thru LRMC from OIF, recent increases in media interest in stress-related issues in the Iraqi theater, as well as deployment-related mental health issues at one of our major deployment platforms-Ft. Stewart (3rd Infantry Division). As OIF continues to transition from combat to stabilization and support operations, concerns regarding the mental health services and psychological issues affecting the deployed OIF force are rapidly emerging. The recently noted increase in MH service utilization & suicides by deployed OIF Soldiers is likely primarily associated with: 1) a predictable clinical surge comprised of the backlog of MH distress cases that were on hold during the initial intense combat operational phase of OIF, 2) distress engendered by unavoidable uncertainties associated with current operational ambiguities (personal safety, redeployment dates, etc.), and 3) the renewed availability of communications of vulnerable Soldiers with distressed families at home. The MH challenges involved are surfacing from multiple levels: 1) MH casualty data, 2) deployed OIF MH providers, 3) MH providers in the patient evacuation chain at LRMC and CONUS MTFs, and 4) CONUS MH leadership receiving MH casualty data and sporadic communications from these 2 cohorts of MH colleagues. Recognizing that deployment-related mental health concerns for deployed service members and their families are not unique to the few sites delineated above, the MHAT will generalize its consultation to address service-wide policies, procedures, and resource requirements which may be constructively informed by their findings and recommendations.

c. SCOPE OF ACTIVITY.

- (1) The MHAT will assess MH challenges potentially associated with:
 - (a) Command and Control – clarity and adequacy of communication feedback to resolve emerging MH challenges.
 - (b) Communications – sufficiency of extant communications capabilities (phone, fax, e-mail) to support intra-theater referrals and conveyance of clinical information via evacuation chain for those Soldiers evacuated from theater.
 - (c) Resource Support – adequacy of: 1) psychotropic medication stocks to minimize avoidable evacuations of Soldiers requiring acute/maintenance pharmaceuticals, 2) MH patient 'holding capacity' to minimize avoidable evacuations of Soldiers who are temporarily dysfunctional for MH reasons, 3) MH provider base – specifically 3rd ID MH support, 4) geographic locations of MH clinical assets to minimize Soldier referral travel & maximize efficiency of available MH clinical assets.
 - (d) Policies – any needed changes in policies both in theater & systemically to enhance the quality of MH services provided OIF-deployed Soldiers and their families located at our deployment platform installations.

2. ORGANIZATION.

- a. The MHAT will consist of the following membership:
 - Team Leader, Behavioral Health (BH) Consultant, US Army Medical Command (MEDCOM)
 - Combat Stress Control policy staff officer, MEDCOM
 - Chief, Dept. of Psychology, Fort Hood
 - Project Officer – Operation Solace, Pentagon
 - Epidemiology support from WRAIR
 - Representative from U.S. Army Chief of Chaplains
 - Other representatives/SMEs as deemed appropriate by OTSG
- b. The MHAT team will interface and coordinate with the appropriate line and medical leadership within the OIF theater, as well as other levels of relevant line and policy leadership to accomplish the stated PURPOSE and SCOPE OF ACTIVITY above.

3. PROCEDURES.

- a. The MHAT will initiate their efforts to accomplish its PURPOSE effective the date of this CHARTER's approval, and anticipate onsite visits to Fort Stewart, LPMC, and designated appropriate sites in the OIF theater - to commence in August 2003 for the briefest duration of time necessary to accomplish its PURPOSE and SCOPE of ACTIVITY.
- b. An inbrief from the MHAT will be made available to relevant line/ medical leadership the 1st day of each site visit. An outbrief to the local line/ medical leadership describing preliminary findings and recommendations under consideration will be provided at the conclusion of each site visit.
- c. Access to locally and centrally available relevant data sources (clinical personnel, MH patient flow data, etc.) will be requested.
- d. Interviews with relevant unit/medical leadership will be requested at each site, and at higher levels of line and policy leadership as appropriate.

4. DELIVERABLES.

- a. A preliminary written report of the MHAT's findings and recommendations (after review to ensure that no classified information is inadvertently released) will be completed and submitted to OTSG NLT 15 days after the conclusion of the last site visit. The final report's submission date is contingent on completion of any relevant data analysis.
- b. Final briefings of the MHAT's findings and recommendations to all appropriate levels will occur as directed by OTSG.
- c. No media communications will occur among the MHAT members without the approval of OTSG.

KENNETH L. FARMER, JR., M.D.
Major General
Deputy Surgeon General

APPENDIX 2 (Information Paper) to OIF MHAT REPORT

17 July 2003

Subject: Mental Health (MH) Concerns & Consultant Recommendations – Operation Iraqi Freedom (OIF)

Challenges. As OIF continues to transition from combat to stabilization and support operations, concerns regarding the mental health services and psychological issues affecting the deployed OIF force are emerging. The recently noted increase in MH service utilization/suicides by deployed OIF Soldiers is associated with: 1) a predictable clinical surge comprised of the backlog of MH distress cases that were on hold during the initial intense combat operational phase, 2) distress engendered by unavoidable uncertainties associated with current operational ambiguities (personal safety, redeployment dates, etc.), and 3) the renewed availability of communications with distressed families at home. The MH challenges involved are surfacing from multiple levels: 1) MH casualty data, 2) deployed OIF MH providers, 3) MH providers in the patient evacuation chain at LPMC and CONUS MTFs, and 4) CONUS MH leadership receiving MH casualty data and sporadic communications from these 2 cohorts of MH colleagues. The data supporting these concerns are primarily anecdotal and interpolated below.

1) Command & Control – based upon reports from various deployed MH providers in the OIF theater and the experience of CONUS MH leadership, there is the perception that clear lines of authority/accountability for managing (in theater) MH issues are lacking;

2) Communications – based upon reports from deployed OIF MH providers, MH providers in the patient evacuation chain, and efforts to sustain contact by CONUS MH leadership - there is inadequate communications capability made available to OIF MH providers. Specifically, real time access to the Internet/e-mail/telephone is reportedly only episodic for many deployed MH providers, which significantly impedes clinical communications required for the safe transport of MH patients through the medical evacuation chain. Also, the MH/CSC providers often lack a directory of where the other MH providers are in the OIF theater, and how they can be contacted;

3) Resource Support – based upon ongoing anecdotal reports from deployed OIF MH providers, 3 issues are of primary concern in their attempts to deliver clinical services at some Iraq locales - inadequate: 1) psychotropic medication stocks to minimize avoidable evacuations of Soldiers requiring acute/maintenance pharmaceuticals, 2) MH patient 'holding capacity' to minimize avoidable evacuations of Soldiers who are temporarily dysfunctional for MH reasons, 3) MH provider base – specifically regarding 3rd ID MH support;

4) Leadership Concerns – based upon anecdotal reports from deployed OIF MH providers, a few leaders have purportedly withheld Red Cross notifications from their enlisted subordinates for significant periods of time after receipt - engendering anger, resentment, loss of confidence in leadership, and in some cases MH/behavioral dysfunction;

5) Expectations Management – the current lack of a well-defined theater rotation policy (recent media example from the 14 JUL03 issue of USA Today / AP – “3rd ID Soldiers get longer stay in Iraq”) is negatively impacting on the psychological status of the OIF deployed force and their family members at home with predictable deleterious MH effects on vulnerable Soldiers (particularly with challenging relationships / financial concerns back home) and their family members.

Recommendations. TSG’s MH consultants have tentatively identified (pending appropriate AMEDD/CJTF/CFLCC-command coordination and approval) a small 3-4 person MH advisory team of SMEs to travel to the OIF theater to provide time-limited advisory consultation to the medical & MH leadership for CJTF and CFLCC. The MH advisory team’s purpose is to facilitate the support and implementation of the following recommendations which parallel the issue numbers per above:

1) Command & Control:

- a. Identify a single mental health consultant in the OIF theater, whose primary responsibility is to address and manage with appropriate CJTF/CFLCC medical & line leadership approval and support - the current and future MH challenges in Iraq/OIF;
- b. Establish a routine communications feedback loop between the OIF theater MH consultant and the MH provider base dispersed throughout the Iraqi theater to support local MH mission problem identification and resolution with appropriate guidance and resources – this will likely require periodic MH unit site visits throughout Iraq;
- c. Establish routine communications between the OIF theater MH consultant and the AMEDD’s BH leadership to facilitate ongoing understanding of MH casualty trends and new initiatives (in theater, ERM, CONUS) required to minimize MH casualties and unnecessary MH evacuations from the OIF theater.

2) Communications - provide the infrastructure support and access to the Internet & software needed to maintain daily clinical communications with the patient evacuation chain in ERM and CONUS:

- a. provide a laptop PC per stand-alone MH treatment section with software (TRAC2ES and PARRTS) & Internet access;

- b. provide local MH provider training to enable utilization of available information systems (TRAC2ES and PARRTS);
- c. provide each stand-alone MH treatment unit with daily SATCOM phone access;
- d. provide a continually updated directory of MH and CSC assets and how to contact them.

3) Resource Support - reassess the adequacy and expeditiously redress identified deficiencies in the MH provider base, MH patient holding capacity, and the availability of psychotropic medications in the OIF theater:

MH provider base:

- a. cross-level MH professional/paraprofessional assets within the OIF theater to reflect clinical mission demand;
- b. assess whether current MH professional/paraprofessional assets are optimally geographically located to meet local clinical support & referral needs of soldier populations served;
- c. if additional MH professional/paraprofessional assets are required after cross-leveling & geographic repositioning - communicate same thru CoC and via MH leadership at HQ MEDCOM.

MH patient holding capacity:

- a. assess demand for temporary treatment/holding capacity needed for local & regional unit populations served;
- b. assess the appropriateness of the current geographic positioning of CSC and CSH-based MH holding capacity;
- c. maximize use of the line units themselves as the platform for distressed Soldier to rest and receive support from their leaders, teammates and chaplains, with consultation from MH or CSC "walkabouts" at the unit locations;
- d. if additional MH holding capacity is required - communicate same thru CoC and via MH leadership at HQ MEDCOM;
- e. assess OIF theater evacuation policy to insure avoidable MH A/E is minimized by maximal utilization of MH holding and treatment capabilities in theater.

Psychotropic medications availability:

- a. survey the 60Ws deployed for a focused list of those psychotropic medications needed in theater to support their Soldier populations remaining functional and meds needed to prevent avoidable evacuations;
- b. compile the list of identified psychotropic meds to provide medical logistics to assemble push packages for expedited distribution to 60Ws' with such requirements.

4) Leadership Concerns – consultation by OIF mental health consultant/medical leadership with senior OIF line leadership reemphasizing the importance of

enforcing existing policy on emergency communications from home and the primacy of leadership integrity and trust to maintain subordinate morale;

5) Expectations Management - DoD leadership rotation/redeployment policy is obviously not a MH responsibility. However, until a clearly defined policy is established for all Soldiers in the OIF theater, many of the MH issues affecting Soldiers and their families will remain unresolved.

MH Consultants HQ, USA
MEDCOM



Approved by: 