# Chapter 47

# COMBAT AND OPERATIONAL BEHAVIORAL HEALTH: FINAL THOUGHTS AND NEXT STEPS

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## INTRODUCTION

While this book has been in production, Department of Defense (DoD) behavioral healthcare delivery has improved dramatically. From the beginning of the conflicts in Afghanistan and Iraq, a robust combat stress control presence has been operating in theater. Much of the initial improvement was in the management of patients in theater and as they redeploy (return home) to the United States. Many chapters, such as those focused on patient care at Landstuhl Regional Medical Center in Germany and Walter Reed Army Medical Center in Washington, DC, have highlighted these improvements. Back in the United States, improving the reintegration of soldiers and their families is a continuous priority for leaders at all levels and for the nation.

## RECENT BEHAVIORAL HEALTH INITIATIVES

Multiple new organizations and initiatives emerged in the last few years, such as: (*a*) the Behavioral Health Proponency; (*b*) the Defense Center of Excellence; (*c*) the Comprehensive Soldier Fitness Program; and (*d*) the Behavioral and Social Health Outcomes Program at the former Center for Health Promotion and Preventive Medicine (CHPPM), now the Public Health Command (Provisional). The Army Campaign Plan for Health Promotion, Risk Reduction, and Suicide Prevention was formed in the spring of 2009. In 2010, the Army's Comprehensive Behavioral Health System of Care was implemented. The November 5, 2009, shootings at Fort Hood, Texas, spurred numerous recommendations for both the DoD and the military services. Finally, there is a new DoD–Department of Veterans Affairs Integrated Mental Health Strategy. All of these new programs and organizations have sought improved approaches to the emerging challenges facing military behavioral health.

### Behavioral Health Proponency

The Army Medical Department (AMEDD) Behavioral Health Proponency, the first of these new initiatives, was established in 2007 to coordinate all the different behavioral health functions in the AMEDD. Modeled after AMEDD's Proponency of Preventive Medicine, this organization is a multidisciplinary group, with its director located at the Office of The Surgeon General (this volume's senior editor was the first director of the Behavioral Health Proponency). A Suicide Prevention Program Office was also established in 2007 to help centralize the diverse AMEDD elements that assist with education, training, and tracking of suicide prevention efforts. However, this latter office became redundant with the Behavioral Health and Social Outcomes Program and the Army Campaign Plan for Health Promotion, Risk Reduction, and Suicide Prevention and is not currently active.

### Defense Centers of Excellence

The congressionally mandated Defense Centers of Excellence (DCoE) also started in 2007 and grew with congressional support due to a recommendation from the DoD Mental Health Task Force. The Department of Veterans Affairs and all of the military services are represented at DCoE, including the Public Health Service. The mission statement of the DCoE (available at: http://www.dcoe.health.mil/) is:

> **Mission:** The DCoE assesses, validates, oversees and facilitates prevention, resilience, identification, treatment, outreach, rehabilitation, and reintegration programs for psychological health (PH) and traumatic brain injury (TBI) to ensure the Department of Defense meets the needs of the nation's military communities, warriors and families.

### Comprehensive Soldier Fitness

The Army's chief of staff, General George W Casey, Jr, requested the establishment of the Comprehensive Soldier Fitness (CSF) program, which was begun in 2008. Under the umbrella of the G-3 (ie, the training directorate), the Army developed a comprehensive behavioral health strategy—"whole-life fitness"—that includes multiple categories of wellness (physical, emotional, social, family, and spiritual). This strategy recognizes the need to incorporate enhancement of current health (of the soldier and family), prevention of future problems, and treatment when problems arise. The strategy also emphasizes the use of standardized metrics to determine success, standardized screening and treatment modalities, and the use of evidence-based clinical guidelines. Ultimately the strategy recognizes that the Army team is successful when leadership and behavioral health professionals partner to remove any stigma associated with identifying the need for help and receiving behavioral health intervention. This strategy encompasses a holistic approach to behavioral health issues.

The "Army Strong" campaign has been a success. But mental, emotional, and spiritual strength, like physical strength, do not just "happen"—these attributes can and must be taught, practiced, and perfected. As with physical capability, everyone enters the Army

with a variable amount of strength in each of these domains, everyone has the potential to improve, and both the rate of improvement and ultimate achievement will be different for every soldier and family. At 9 years into the global war on terror, with its unrelenting operational tempo, a focus on comprehensive fitness has become an operational mandate.

The vision and mission statements of whole-life fitness (available online at: http://www.army.mil/csf/about.html) are:

> **Vision:** An Army of balanced, healthy, self-confident Soldiers, families and Army civilians whose resilience and total fitness enables them to thrive in an era of high operational tempo and persistent conflict.
>
> **Mission:** Develop and institute a holistic fitness program for Soldiers, families, and Army civilians in order to enhance performance and build resilience.

The CSF program ensures that all soldiers undergo appropriate assessment of their total fitness, encompassing all the "Army Strong" components. The results of the assessment will direct further training, intervention, or treatment as needed. This begins at accession and, like physical fitness, includes reassessment at appropriate intervals. Furthermore, the CSF office makes certain that all training, interventions, and treatments utilized have demonstrated effectiveness, applying accepted methodology and scientific rigor. They are also chartered to ensure timely reassessment, to demonstrate value added to both the soldier and the leadership.

The CSF office also ensures that the training programs, services, and interventions offered complement one another, are not duplicative, are resourced based on objective outcomes, and are standardized across the Army, including the Reserve components. Lastly, CSF is dedicated to making sure that all stakeholders, both internal (soldiers, families, leaders, and Army commands) and external (members of Congress and staff, media, and veterans' groups) understand the absolute necessity of a comprehensive, coordinated effort to enhance the fitness and resiliency of the Army, which is particularly important during this era of persistent conflict and for the foreseeable future.

**Behavioral and Social Health Outcomes Program**

A new focus on surveillance of behavioral health emerged at the former CHPPM, now the Public Health Command (Provisional). Great demand exists for such capacity, as evidenced by increasing requests from Army leadership for actionable data from population health indicators in this area. Recent Mental Health Advisory Team surveys and epidemiological consultation investigations have clearly demonstrated that no single data source is sufficient for acquiring the information necessary to perform analysis of individual, community, or military health system factors that are associated with suicides and related adverse behavioral outcomes. Timely and effective intervention requires data to be collected and reviewed in a way that allows a comprehensive understanding of both individual suicide cases and the broader community context (psychological and physical health, installation and unit factors, social ties, and other applicable factors). The former CHPPM received funding from the US Army Medical Command for the establishment of this capability, as well as funding from the Army G-1 to establish a separate "strategic analysis cell" to collect and follow data for the specific purpose of generating actionable data in the effort to mitigate suicides in the Army.

CHPPM's Behavioral and Social Health Outcomes Program (BSHOP) is a comprehensive behavioral health epidemiology and surveillance program formed to evaluate the full spectrum of psychological health and social wellness in Army communities. BSHOP's mission is to establish and operate a central behavioral health and social health outcomes epidemiologic resource for the Army and to bolster ongoing behavioral health program development and evaluation capability at CHPPM. The program is structured to analyze, interpret, and disseminate information on the status, trends, and determinants of the behavioral health and fitness of America's Army. The end objective is to provide a ready means to identify and evaluate impediments to medical readiness and establish a basis for preventive action.

In the spring of 2009, the Army's vice chief of staff established the Army Suicide Prevention Task Force (ASPTF) in response to the Army's increasing suicide rate. The ASPTF's effort has resulted in roughly 250 initiatives throughout the Army that are currently being executed, in addition to the development of the Army Campaign Plan for Health Promotion, Risk Reduction, and Suicide Prevention.

Efforts to mitigate the psychological effects of war continue. The shootings at Fort Hood led to both DoD and service-specific recommendations. The recommendations relevant to behavioral health, published in "Protecting the Force" (available at: http://www.army.mil/-news/2010/01/15/33006-protecting-the-force-lessons-learned-from-fort-hood/), emphasized caring for medical personnel and screening for violence. It is unclear at this point how well these recommendations will be implemented.

The Army's Comprehensive Behavioral Health System of Care, begun in 2010, seeks to implement best practices in optimal integration across the Army.

Begun in the Western and Pacific regions, under the leadership of Brigadier General Patricia Horoho and Brigadier General Steve Jones, it seeks to improve the reintegration process using lessons learned throughout the Army. The new DoD–Veterans Affairs Integrated Mental Health Strategy incorporates 28 strategic actions aimed at aligning the two healthcare systems. Although many of the recommendations are similar to others already made, the new program focuses on transitions from military to civilian life.

The shootings at Fort Hood have led to three major health-related efforts for the Army and DoD: (1) to seek to uncover violent tendencies in individuals; (2) to build upon the comprehensive behavioral response to the shooting; and (3) to expand provider resiliency training. There have also been concerted efforts to improve access to care by increasing the number and availability of providers and decreasing stigma. In the Army, the number of behavioral healthcare providers has increased almost 70% between 2007 and 2010.

When this chapter was written, the Army had 2,579 behavioral health providers available, with a conservative need estimate of 3,072 military, civilian, and contract behavioral healthcare providers. This represented an 84% fill, or a shortage of 493 providers. The Army is currently attempting to hire or contract the additional providers (87 psychiatrists, 146 psychologists, 222 social workers, and 38 psychiatric nurses). However, these numbers continually change, as providers are hired or leave and as new requirements are developed.

Provider hiring difficulties are not due to lack of funding; rather, the difficulties stem from a lack of civilian providers willing to practice in remote locations, compensation limitations inherent to government employment, and a national shortage of qualified providers. To address these limitations, the Army has employed selected behavioral health recruitment and retention incentives. These include

- implementing a critical skills retention bonus for master's level clinical psychologists;
- including social work officers (captains) in the critical skills retention bonus program instituted by the Army;
- establishing incentive special pay for psychiatric nurse practitioners;
- providing increases in multiyear special pay for psychiatrists
- utilizing the active duty health professions loan repayment program for both accession and retention of behavioral healthcare providers;
- making health professions scholarship program allocations available as a tool for the US Army Recruiting Command to recruit psychiatric nurse practitioners; and
- increasing the number of health professions scholarship allocations dedicated to clinical psychology and increased the seats available in the clinical psychology internship program.

## SUMMARY

This volume began with a brief look at the history of behavioral healthcare in the US military, especially the genesis of the two volumes on military psychiatry in the *Textbooks of Military Medicine* series that were published over 15 years ago. Many of the "lessons learned" described in those two volumes were based on military experiences during Vietnam. Both the military and civilian society have dramatically changed since Vietnam, but one point that remains constant is that the human ability to adapt to the horrors of combat is finite. It is through the evolution of both proactive measures to help soldiers "steel" themselves against their experiences and therapeutic interventions by the behavioral healthcare system that the best possible outcomes can be achieved for military personnel. This project has summarized the experiences of more than 150 behavioral healthcare providers, in all fields and specialties, who have given their time and words to capture these latest battlefield conditions and lessons learned.

The system of behavioral healthcare in the US military is always in flux, with numerous individuals and organizations attempting to improve it via various innovative programs. One constant theme, as demonstrated in the discussion in this chapter, is that the many attempts at both quick and comprehensive solutions only demonstrate the complexity and difficulties of the mission. Clearly the effects of the conflicts in Operation Enduring Freedom and Operation Iraqi Freedom, as well as tsunamis and other natural and manmade disasters, will continue to take their toll on US military members, their families, and the nation. It is thus a national duty to continue providing our service members the best behavioral healthcare available.