

Addressing Behavioral Health Impacts

Balancing Treatment and Mission Readiness

Lt. Col. Christopher Landers, U.S. Army

The 2015 *Army Health of the Force Report* found that 17 percent of the force is medically not ready.¹ This rate includes soldiers with both physical and behavioral health concerns. Despite the significantly different challenges faced by soldiers as compared to their civilian counterparts, soldiers continue to demonstrate amazing resilience. Still, 15 percent (2014 prevalence rate) of the force has been diagnosed with a behavioral health disorder for which they require treatment.²

If the Army asked commanders in the field what they think is the greatest challenge to individual soldier fitness in recent years, many might tell the Army it is the seemingly steep rise in behavioral health-related problems, jumping from 9.4 percent diagnosed in 2007 to 15 percent in 2014.³ In a substantial number of cases, the behavioral health condition leads to an inability, at least partially, of a soldier to perform his or her wartime mission. In 2014, soldiers with behavioral health conditions totaled about eighty thousand hospital admissions and one million medical encounters.⁴ That is the equivalent of nearly an entire battalion spending three months in the hospital each year. Not included in that estimate are the thousands of patients who received a duty profile that relieves them from performing their assigned function.

The Mission Readiness Challenge

As economic, political, and global considerations drive the Army ever smaller, the challenge of maintaining combat readiness grows. A smaller force is more

vulnerable to become less combat ready due to nonavailable soldiers; the smaller the force the greater the operational impact of nonavailable soldiers.

Therefore, issues associated with behavioral health that may determine the availability of a soldier, including anxiety, posttraumatic stress disorder (PTSD), depression, and suicidal behavior have a significant and growing impact on unit readiness across the Army. More worrisome than the scale of the problem is the Army's seeming inability to protect and maintain unit readiness while still providing for the treatment needs of soldiers.

Current protocols for treatment and separation, if required, leave very little flexibility for commanders as they try to preserve readiness. Prevention, diagnosis, and treatment of behavioral health problems have received considerable, and well-needed attention, but as the Army has made strides in suicide prevention, it has created another problem: a decrease in the Army's available population for training and deployment. To deal effectively with the challenge of balancing soldier needs with unit readiness, commanders need flexibility in order to effectively treat those who need care in a way that minimizes impact on unit training and operations.

Addressing the Behavioral Health Problem

In the middle of what is now a fifteen-year war effort, the Army recognized a significant gap in its ability to diagnose and effectively treat behavioral health conditions that were resulting in a sharp increase in PTSD



and depression-related suicides. In response, the Army requested that the National Institute for Mental Health establish a team of researchers to help with the problem. Subsequently, the Army initiated the Study to Assess Risk and Resilience in Servicemembers (STARRS) program in 2009 and reported each year through 2015. Army STARRS investigators looked for factors that helped protect a soldier's mental health as well as those that put a soldier's mental health at risk.⁵ The Army STARRS research team designed and implemented five study components to analyze the problem, looking separately at each to better understand the problem and provide constructive

Staff Sgt. Jerry Majetich holds an emotional Cpl. Charles Dupree, Orlando Warrior Transition Unit, during Operation Proper Exit 16 June 2010 at Contingency Operating Station (COS) Falcon, Iraq. Dupree's unit was attacked in October 2005 in Al Dora. COS Falcon was the wounded warriors' first stop while in Iraq. (Photo by Spc. Jared Eastman, U.S. Army)

recommendations.⁶ Over the last few years, the team of researchers has produced more than thirty studies.

Concurrently, the secretary of the Army directed the vice chief of staff to "take a holistic look and identify



systemic breakdowns or concerns in the Integrated Disability Evaluation System (IDES) affecting the diagnosis and evaluation of behavioral health conditions.⁷⁷ To accomplish the task, the Army created the Army Task Force on Behavioral Health (ATFBH) in 2012, which conducted a comprehensive review and produced the *Corrective Action Plan (CAP)* to address and rectify identified breakdowns or concerns.⁸

Findings, Results, and Impacts on Readiness

The Army STARRS research project and the CAP served two key purposes. First, the Army STARRS studies sought to help prevent or predict behavioral health problems by identifying potentially at-risk soldiers and factors or conditions that may put more soldiers at risk (or increase the risk for those already identified as at risk).

According to the study, soldiers are at greatest risk if they are male, white, and junior enlisted. Not having graduated high school and recent punishment or demotion are also identified as risk factors. Being previously deployed or currently deployed also places soldiers at higher risk, especially among the female population.

Staff Sgt. Paul Bryant leads a team of service members who are recuperating from injuries in the Wounded Warrior Canoe Regatta 18 August 2013 in Honolulu, Hawaii. (Photo by Mass Communication Spc. 1st Class Daniel Barker, U.S. Navy)

Contrary to popular belief, however, the study identified a marked increase in suicide events and behavioral health disorders among never-deployed soldiers. Those at perhaps greatest risk for suicidal ideation or attempts are those with preenlistment psychiatric diagnoses. About half of all suicide cases (ideation, plans, or attempts) had preenlistment onset.⁹ This is not surprising, as across the United States, “the estimated prevalence of any DSM-IV anxiety, mood, behavior, or substance disorder in this sample was 53.1 percent. ... The vast majority of cases (91.6 percent) had onsets that were prior to expected age-of-enlistment if they were in the Army.”¹⁰

The implications of these research results are significant. Effective preenlistment screening could essentially preclude half of Army suicide-related events by preventing those with anxiety, mood, behavior, or substance

abuse disorders from enlisting. Of course, there are problems with such an undertaking. Though submission of medical records is required for initial screening if the applicant has indicated prior behavioral health treatment, how many are actually disclosing prior treatment? A quick web search reveals hundreds of prospective soldiers, sailors, airmen, and marines in online forums discussing what they should or should not disclose in order to pass screening. With that in mind, compulsory submission of insurance data and claims may reduce successful attempts at deception. Enhanced psychological screening similar to that undergone by special operations forces would almost certainly help reduce the accession of unsuitable soldiers, but the undertaking would likely be cost- and time-prohibitive on such a large scale.

The CAP focused on treatment. Better access to care (e.g., behavioral health specialists embedded with Army brigade combat teams), better understanding of the problem, and more effective and efficient IDES processes all have served to increase the overall quality of care for affected soldiers. The CAP included “24 findings and 47 recommendations to improve the behavioral health diagnosis and evaluations in the context of IDES.”¹¹

Some of the important recommendations, now implemented, include: an expanded embedded behavioral health program that aligns providers with deployable brigade-sized units; standardization of diagnosis and evaluation of soldiers with PTSD; streamlined IDES process; revision of Army Regulation (AR) 635-40, *Physical Evaluation for Retention, Retirement, or Separation*, into a single, comprehensive regulation for IDES; developed IDES performance measures that graded speed through the process and quality of care; better education for senior Army leaders on behavioral health-related issues in IDES; better training for behavioral health leadership and administration; better personnel manning related to diagnosis and treatment of behavioral health-related issues; clarification of commanders’ legal options for administrative action involving soldiers with a behavioral health condition; revised policy on the surgeon general review of all soldiers pending discharge for personality disorder; and several others.¹²

Though it is difficult to state conclusively, the implementation of the ATFBH CAP and other soldier-led prevention programs are likely to have played a major role in the recent downturn in suicides and nonfatal suicide events. Reduction in suicide events appears

to be a clear and unmistakable success. There is little doubt that soldiers are more readily diagnosed, more expertly treated and, unfortunately, more often deemed nonavailable (at least temporarily).

Overall, the Army’s response to the behavioral health crisis has been generally along two lines of effort. First, to diagnose and treat those with conditions related to military service for whom medical retirement is appropriate. Second, to screen out soldiers who cannot adapt to military life due to preexisting behavioral health conditions. The current system seems to focus more significantly on the former and may not be ideally suited to handle the latter.¹³

Recommendations to Mitigate Impacts to Unit Readiness

Above all, the Army should not change how it now identifies, diagnoses, and cares for its soldiers who suffer from behavioral health conditions that require treatment. The Army has made great strides in prevention, diagnosis, and treatment in recent years. The unintended consequence is that an increase in prevalence has caused a corresponding decrease in unit readiness. Eighty thousand hospital days per year is hard to absorb for an Army whose number one priority is readiness.¹⁴

While prevention and treatment have been the appropriate focus, more attention must be paid to maintaining unit readiness at the tactical level. Every nonavailable soldier has a significant and growing negative impact on readiness as the Army shrinks while commitments grow. Some additional actions to assist commanders in maintaining readiness are worth consideration.

First, increase the Army’s commitment to and utilization of Warrior Transition Units (WTUs) for soldiers whose behavioral health condition prevents them from serving in a productive capacity. Existing at most major installations,

A WTU closely resembles a “line” Army unit, with professional cadre

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A SIMILAR VIEWPOINT



Cpl. Kyle Click, a dog handler with 3rd Platoon, Kilo Company, 3rd Battalion, 3rd Marine Regiment, and a native of Grand Rapids, Michigan, shares a moment with Windy, an improvised-explosive-device detection dog, while waiting to resume a security patrol 27 February 2012 in Garmsir District, Helmand Province, Afghanistan. (Photo by Cpl. Reece Laddin, U.S. Marine Corps)

A Call for Research on the Impact of Dogs Deployed in Units to Reduce Posttraumatic Stress

Rebecca Segal

There is evidence that dogs should be deployed in forward-operating units to reduce the incidence and severity of posttraumatic stress disorder (PTSD). PTSD is a major medical concern for the U.S.

military, yet current therapies are of limited effectiveness, and they do not begin until weeks after a stressful event.¹ The body's response to stress actually begins on day zero and, if severe, is referred to as an acute stress

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In a related story, "A Call for Research on the Impact of Dogs Deployed in Units to Reduce Posttraumatic Stress," Rebecca Segal espouses deploying support or service dogs to combat theaters to help speed diagnosis and treatment of individuals with posttraumatic stress disorder. Like Lt. Col. Landers, Segal recognizes the significant negative effects that mental health issues such as posttraumatic stress can have on unit readiness. Segal stresses that the costs of this affliction in lost productivity, health care, and unit cohesion make this pet therapy initiative an imperative.

For online access to Segal's "A Call for Research on the Impact of Dogs Deployed in Units to Reduce Posttraumatic Stress" in the November-December 2016 issue of *Military Review*, visit: http://usacac.army.mil/CAC2/MilitaryReview/Archives/English/MilitaryReview_20161231_art015.pdf.

and integrated Army processes that build on the Army's strength of unit cohesion and teamwork so that wounded soldiers can focus on healing before transitioning back to Army or civilian status. Within a WTU, wounded, ill, and injured soldiers work with their Triad of Care—primary care manager (normally a physician), nurse case manager, and squad leader—who coordinate their care with other clinical and non-clinical professionals.¹⁵

Soldiers in WTUs are solely focused on recovery in preparation for a return to service or transition to civilian life.

Many soldiers assigned to WTUs are concurrently enrolled in the IDES process. In IDES, injured and ill soldiers receive treatment and evaluation to either return the soldier to service or render an "unfit" determination and process the soldier for transition. Like those who are physically unfit, most (there are exceptions) soldiers to be separated for being unfit due to a behavioral health condition must complete the IDES process, with a goal of 295 days from start to finish.¹⁶

Assigning a soldier to a WTU as early as possible in the evaluation process allows the soldier to continue appropriate treatment while simultaneously helping to sustain unit readiness through the replacement process. Currently, most soldiers enrolled in the IDES process for separation remain assigned to the unit as a nonavailable soldier, with obvious impacts to readiness. A challenge faced by commanders is that AR 40-58, *Warrior Care and Transition Program*, expressly prohibits admission to WTUs for the purpose of maintaining unit readiness through acquisitions. Further, admission for psychological conditions must be of a severity that the soldier poses a *substantial* risk to self or others if the soldier remains in the unit.¹⁷ Few soldiers in treatment meet this threshold (at least initially), though many receive duty-limiting profiles that are detrimental to readiness. As a result, it is not uncommon for a battalion-sized unit to have dozens of soldiers in IDES pending separation—all nonavailable for the entire 295 days (assuming the IDES timeline goal is met).

Second, the Army and the Department of Defense (DOD) should follow through with an important CAP recommendation: a statutory revision of DOD Instruction 1332.38, *Physical Disability Evaluation*, and AR 635-200, *Active Duty Enlisted Administrative*



Separations, to allow up to 365 days for detection of a preexisting behavioral health condition in soldiers who have not deployed.¹⁸ Currently, the preexisting behavioral health condition must be identified within the first 180 days, after which, discovery requires enrollment in IDES for separation. As the CAP states,

Preexisting BH [behavioral health] conditions often do not manifest in the structured and regimented periods of initial entry training. Allowing detection up to 365 days allows more time to detect an illness.¹⁹

This change would allow for a separation under chapter 5-11 (separation of personnel who did not meet procurement medical fitness standards) through a soldier's first six months at their first unit. This is especially important as over 75 percent of never-deployed soldiers who have a diagnosed disorder reported a preenlistment age of onset.²⁰ Not only do three-quarters of diagnosed disorders begin before enlistment, but they are also more powerful predictors of severe role impairment than disorders with post-enlistment onset.²¹ The pursuit of a separation under chapter 5-11 via the medical evaluation board should not be construed as a denial of care.

Spc. Gerrick Cole, Sgt. Michael Harris, and Lt. Col. Zabrina Seaymaynard practice playing the guitar in the Sounds of Acoustic Recovery (SOAR) program at the Dale Wayrynen Recreation Center, Fort Campbell, Kentucky. SOAR is an eight-week program that allows wounded soldiers to learn the basics of guitar or piano, or receive voice lessons at a beginner or intermediate level. SOAR provides therapy to help soldiers remain strong and recover from injuries in preparation for the next phase of their lives. (Photo by Lori Brenae Perkins, *Fort Campbell Courier*)

Since the CAP recommends that a soldier separated under chapter 5-11 between 181 and 365 days remain eligible for an honorable characterization of service, full VA benefits apply.

The data certainly suggests that limiting accessions of those with pre-enlistment mental disorders could help minimize the problems that materialize later in service, but diagnosis is difficult since symptoms are usually minor in adolescence and too mild to cause rejection from military service.²² Even if the prospective soldier is aware of a disqualifying diagnosis, he or she is not always going to disclose it since doing so is self-limiting.

Lastly, the Army should consider extending chapter 11, "Entry Level Performance and Conduct," to

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WE RECOMMEND

Article

Suicides in the U.S. Military: Birth Cohort Vulnerability and the All-Volunteer Force

James Griffith¹ and Craig J. Bryan¹

Abstract

This paper builds a case for examining suicide in the U.S. military relative to broad societal context, specifically, the unique experiences of birth cohorts relating to processes described by Durkheim's theory of suicide. In more recent birth cohorts, suicide rates have increased among teenagers and young adults. In addition, suicide rates of age intervals at a given time period have been reliably predicted by the size of the birth cohort and the percentage of nonmarital births—supposed indicators of Durkheim's diminished social integration and behavioral regulation. Consequences of these trends are likely more evident in the U.S. military due to having proportionally more individuals known to be at risk for suicide, that is, young males who are from nontraditional households. The all-volunteer force compared to draft force has fewer applicants to select, and proportionally more of applicants are accepted for military service. Consequently, more recruits having varied conditions now than before, perhaps including greater vulnerability to suicide, serve in the U.S. military. These points are further elaborated with supporting evidence, concluding with a call for new directions in suicide research, practice, and policy.

Keywords

military suicides, birth cohort, social integration, all-volunteer force

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Among the most challenging and puzzling issues the U.S. Army has faced among combat veterans returning from Iraq and Afghanistan since 2002 has been the unusually high number of suicides as compared to the number of such incidents associated with previous wars. In "Suicides in the U.S. Military: Birth Cohort Vulnerability and the All-Volunteer Force," originally published in *Armed Forces & Society* in 2015, authors James Griffith and Craig J. Bryan provide original research from which they develop unique and persuasive explanations for the underlying causes of the unusually high number of suicides occurring among veterans of the U.S. Army. In conjunction, they recommend mitigating solutions aimed at lowering the number of suicides.

To access their paper, visit: <http://afs.sagepub.com/content/early/2015/11/16/0095327X15614552.full.pdf+html>.

365 days. Like chapter 5-11, separation under chapter 11 (often referred to as a "failure to adapt" chapter) is limited to the first 180 days of service, essentially covering initial entry training only. Relevant to this recommendation, this separation policy applies to soldiers who "cannot or will not adapt socially or emotionally to military life, or have demonstrated character and behavior characteristics not compatible with satisfactory continued service."²³

Limiting this separation policy to 180 days is overly restrictive if commanders are really measuring a soldier's ability to adapt to military life. Like the previous recommendation regarding chapter 5-11, the regimented nature of initial enlistment training does not adequately replicate "military life," therefore successful adaptation to initial entry training does not equate to successful adaptation to the Army. The day-to-day stressors of looming deployments, field training, personal relationships, family concerns, financial management, and others are far different from the relatively straightforward life while in initial enlistment training. One could argue that a soldier has not really begun to experience military life until he or she arrives and is inculcated into his or her new unit. Only then, confronted with the aforementioned challenges, can the Army measure his or her adaptability. The impact of this recommendation lies in the fact that a statistically significant proportion of soldiers who experience a behavioral health incident (or seek treatment) report that the catalyst is the simple fact that they are in the Army and no longer wish to be. Simply put, they have not adapted and are not likely to.

The danger, of course, is in deception. Like all health treatment programs, the systems and protocols the Army uses to diagnose and treat behavioral health problems are subject to manipulation. One could argue that to a soldier who no longer wishes to serve, the allure of a speedy separation may lead him or her to manipulative behavior in order to get out of the Army. The concern certainly has merit, but there are few alternatives. In the absence of a quick separation, the soldier in question may join the twenty thousand (36 percent) newly accessed soldiers who do not complete their first term, often leaving the service after a lengthy separation for misbehavior or failure to perform.²⁴ Still worse, he or she may develop a legitimate behavioral health condition that results in roughly 295 days enrolled in IDES and potential long-term disability. The expeditious nature of this separation may outweigh the risk of manipulation by a handful of malingers.

The Army's response to the behavioral health problem, suicide specifically, has been laudable. The time, resources, and people committed to the effort have created an environment

largely absent the stigma normally assumed to be attached when seeking help. Treatment is readily available and widely relied upon. On the Army's larger installations, behavioral health professionals see several thousand unique patients annually, the vast majority of whom are treated without the knowledge of their chain of command and continue to serve effectively. Increased awareness and ample resources naturally lead to a higher prevalence of behavioral health disorder diagnoses. It is unlikely that there are more people in need of treatment; more probable is that more are being identified as needing care. The result is a sharp increase in the number of nonavailable soldiers due to behavioral health conditions.

In a fiscally constrained Army, balancing treatment and maintenance of combat readiness becomes more critical. The tools exist to identify, diagnose, and treat the soldier. Now, commanders need tools to better manage the nonavailable soldiers and maintain mission preparedness. To be clear, the recommendations set forth here are not an attempt to limit care or overrule the recommendations of behavioral health specialists in the interest of commanders' concerns. In fact, they are the result of commanders working in collaboration with embedded behavioral health and

medical staff to better balance the two lines of effort in addressing the Army's behavioral health issues.

The ability to promptly reassign all soldiers enrolled in IDES to WTUs and expeditiously separate soldiers under chapters 5-11 and 11 within the first full year of service may provide the necessary means for commanders to maintain mission readiness. Adverse effects of a growing nonavailable population are exacerbated in a downsizing force, which causes each case to have a unique impact. Moreover, nonavailable soldiers unable to perform their wartime function are collectively a distinct and distracting burden—one that draws leaders' attention from their wartime mission and the fully ready soldiers performing it. With a large and growing population of nonavailables in the Army, most commanders have made a simple observation: accomplishing the mission with fewer soldiers is easier than accomplishing it with nonavailable soldiers. ■

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