ANNEX E

INTERNMENT FACILITY SOLDIER ASSESSMENT

OPERATION IRAQI FREEDOM (OIF-II)

MENTAL HEALTH ADVISORY TEAM (MHAT-II)

30 January 2005

Chartered by:
The U.S. Army Surgeon General

This is an annex to the Operation Iraqi Freedom (OIF-II) Mental Health Advisory Team (MHAT-II) Report addressing the behavioral health services in OIF-II internment facilities. The findings were obtained from many sources to include surveys, interviews, Department of Defense- (DoD-) supported databases, and behavioral health record reviews.

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

ANNEX E

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INTRODUCTION

The Multi-National Corps-Iraq (MNC-I) requested the Mental Health Advisory Team (MHAT) to assess the behavioral health care at two Army internment facilities (Camp Bucca and Abu Ghraib), to offer recommendations to improve the current level of care, and to develop an Army Medical Department (AMEDD) behavioral health care model for detainees and Soldiers in future internment facility operations.

This report addresses Soldier behavioral health issues. The behavioral health care of detainees is addressed in Annex F.

Multi-National Corps-Iraq leadership requested an assessment of behavioral health care resources for Soldiers working at internment facilities in view of reports of custodial staff misconduct at Abu Ghraib[1] and inadequate medical resources for detainees.[2] Multi-National Corps-Iraq sought answers to the following questions:

1. Were the stressors greater for custodial staff members than for other Soldiers in Operation Iraqi Freedom (OIF-II)?

2. Was the prevalence of behavioral health disorders higher among custodial staff than for other Soldiers in OIF-II?

3. Should custodial staff and detainees share behavioral health services or should they be separate?

MISSION CONSIDERATIONS

To accomplish this assessment, the MHAT assembled a special forensic team (i.e., MHAT-FT) consisting of the Psychiatry Consultant to The Army Surgeon General, the Forensic Psychiatry Consultant to The Surgeon General, a forensic psychiatrist (who served on the MHAT 2003 mission), and a Sergeant First Class with previous correctional behavioral health experience.

When planning for this assessment, the MHAT-FT relied on previous inspection reports of Abu Ghraib and Camp Bucca for background information.[3] Soldier-related stressors identified in these reports included: heat and dust exposure, 12-hour work shifts, and low staff-to-inmate ratios.[4] Unlike Camp Bucca, Abu Ghraib faced additional stressors:

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[2] See Annex F, Appendices 1-3 for further details.

[3] A detailed overview of each internment facility can be found in Annex F.

[4] Large sub-compounds ranged in size from 200 to 300 detainees.

frequent mortar attacks, improvised explosive device ambushes, and increased public scrutiny due to alleged misconduct. The road between Abu Ghraib and the airport was notoriously dangerous due to frequent ambushes, thereby, slowing supply shipments to the camp.

Air-conditioned living quarters, internet/telephone access, and other morale, welfare, and recreation (MWR) functions offset these stressors. Likewise, improved dining facility infrastructure and food quality, and exercise facilities had improved quality of life (more details of internment facility operations appear in Annex F).

A review of the professional literature highlighted common stressors that impact correctional staff in the civilian setting: understaffing, overtime, rotating shift work, supervisor demands, role conflict, role ambiguity, threats of violence, inmate demands and manipulation, conflicts with coworkers, poor public image, and low pay.[5] Stress can result in significant problems for custodial personnel: physical illnesses,[6] burnout,[7] substance abuse,[8] excessive disability retirements,[9] and interpersonal problems with family and coworkers.[10] It is recognized that the effects of stress on civilian correctional personnel can compromise institutional safety, cost money, and create stress for other staff members.

MISSION OBJECTIVES

With these considerations in mind, MHAT-FT selected the following objectives for this assessment:

1. To determine whether current behavioral health care for Soldiers was in accordance with combat and operational stress control (COSC) doctrine.

2. To assess the behavioral health care needs of the Soldiers working at internment facilities via survey and interview techniques.

3. To make recommendations for improved Soldier behavioral health care at internment facilities.

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[5] Addressing Correctional Officer Stress: Programs and Strategies. 2000. Peter Finn. US Department of Justice.

[6] Woodruff, "Occupational Stress for Correctional Personnel"; and Cheek, F.E., and M.D. Miller, "New Look at Officers' Role Ambiguity," in Correctional Officers—Power, Pressure and Responsibility, ed. J.N. Tucker, Laurel, Maryland: American Correctional Association, 1983.

[7] Cornelius, G., Stressed Out: Strategies for Living and Working with Stress in Corrections, Laurel, Maryland: American Correctional Association, 1994.

[8] Addressing Correctional Officer Stress: Programs and Strategies. 2000. Peter Finn. US Department of Justice.

[9] Ibid.

[10] Van Fleet, F., "Correctional Officers and Their Families: Dealing with Stress," in The Effective Correctional Officer, Laurel, Maryland: American Correctional Association, 1992.

FINDINGS

Finding #1: There was no significant difference between the prevalence of behavioral health disorders among Soldiers in custodial positions and those of other Soldiers surveyed in OIF-II. Custodial staff members shared stressors in common with OIF-II peers.

The Soldier Health and Well-being Survey revealed that positive screenings for posttraumatic stress disorder (PTSD), anxiety, and depressive disorders among custodial staff members[11] were equivalent to those for other Soldier MOSs in OIF-II (see Annex A, Finding #4 and Figure 3 for further details).

In focused group interviews, custodial staff members reported comparable stressors to those of their OIF-II peers. They indicated that increased scrutiny of Army internment operations had increased their likelihood to "second guess" their decisions and felt that their hard work had been stained by the misconduct of a few. All in all, custodial staff members believed they were coping well with stressors.

Finding #2. Behavioral health care was conducted in accordance with COSC doctrine. Insufficient training in correctional behavioral health care diminished optimal support for custodial staff.

Interviews with senior behavioral health providers indicated that appropriate functional areas of COSC doctrine were implemented for Soldiers at the internment facilities. Custodial and medical staff descriptions of behavioral health services confirmed sufficient adherence to COSC doctrine and availability of services. Insufficient training in correctional behavioral healthcare delayed providers in providing support as they familiarized themselves with correction's unique stressors, procedures, philosophies, and situations.

RECOMMENDATIONS

Immediate Implementation

1. Continue behavioral health care services in accordance with COSC doctrine and MHAT-II staffing recommendations. Supplement COSC doctrine with training in specific stressors unique to corrections and in best practices to provide care to custodial staff.

While COSC doctrine provides a generic model for behavioral health care and effectively anticipates the common stressors and emotional reactions of Soldiers in military operations, further refinement is necessary to adapt it to unique needs of units

[11] Custodial staff members were military police and Soldiers with other MOSs serving in custodial positions.

and/or Soldiers. Additional training in accordance with the proposed Detainee Behavioral Health Care Program Model (see Annex F, Appendix 10, Tab D) can prepare behavioral health providers to anticipate the stressors inherent in the correctional setting, and implement the best practices to support the custodial staff. Annex B provides further behavioral health staffing guidance.

2. Consider parallel behavioral health care programs for Soldiers and detainees. If adopted, keep staff member participation in both programs at the same time to a minimum to prevent any perception of ethical conflicts.

Correctional literature advocates for independent behavioral health programs to encourage custodial personnel to access care.[12] Traditionally, custodial staff members underutilize behavioral health care when staff or services are shared.[13] Perceived conflicts in advocacy and confidentiality prevent staff members from seeking care.

Future Implementation

1. Establish a Correctional Behavioral Health Care Fellowship Training Program.

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

2. Integrate a Correctional Behavioral Health Care Track into the Force Health Protection Conference.

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

DISCUSSION

Stress and Prevalence

This analysis shows no significant difference between the prevalence of behavioral health disorders of Soldiers in custodial positions and those of Soldiers surveyed in

[12] Staffing Considerations (Chapter VI). B. Jaye Anno. Correctional Health Care: Guidelines for the Management of an Adequate Delivery System (2001). US Department of Justice.

[13] Behavioral health programs for staff members fall into one of three basic structures: in-house programs, independent contracted services, and hybrid arrangements. In-house programs offer custodial staff and inmates the same services/behavioral health as staff members. Independent contracted services offer custodial staff members a separate behavioral health team and services.

OIF-II.
In Annex A, the results of the Soldier Health and Well-being Survey revealed that a percentage of military police officers (and Soldiers in other MOSs serving as custodial staff) who screened positive for PTSD, anxiety, and depressive disorders was not statistically different from those for other Soldier MOSs in OIF-II. This analysis is fully described in Annex A (i.e., Finding #4 and Figure 3), and is not repeated here.

Custodial staff members who participated in focused group interviews reported stressors commonly shared by their OIF-II peers. Separation from family, deployment length, and lack of privacy were frequently identified as noncombat stressors. Reports of combat stressors differed between the Abu Ghraib and Camp Bucca custodial staff. By virtue of its location, Abu Ghraib presents a convenient target for insurgents, whose nightly mortar attacks have forced Soldiers to live within fortified prison cells and to wear body armor and Kevlar when outside their living quarters. In contrast, Camp Bucca's remote location has shielded it from enemy attacks.

Soldier Care Services and Resources

Interviews with senior behavioral health providers indicated that appropriate functional areas of COSC doctrine were implemented for Soldiers at the internment facilities. Custodial staff descriptions of behavioral health services confirmed sufficient adherence to COSC doctrine and availability of services. Insufficient training in correctional behavioral healthcare delayed providers in providing support as they familiarized themselves with correction's unique stressors, procedures, philosophies, and situations.

METHODS

In this assessment, the MHAT-FT relied on results from the Soldier Health and Well-being Survey and focused group interviews with military police officers, other Soldiers serving in custodial positions, and senior behavioral health providers.

Sources of Data

The MHAT-FT interviewed military police officers, other Soldiers serving in custodial positions, and senior behavioral health providers.

Data Collection

Interviews were conducted in small groups, comprised of 1 to 4 persons. Participants were asked questions relating to the following themes: 1) stressors for Soldiers at the internment facility; 2) perception of the behavioral health needs in the Soldier population; 3) stigma and barriers to behavioral health care; 4) satisfaction with behavioral health services; and 5) perception of risks to personal safety.

Interviews were conducted by 1 or 2 MHAT-FT personnel, and required approximately 1 to 1½ hours to complete. Interviewers informed participants about the purpose of this

study, and that the interview would be used in the final report. Interviewers emphasized that no statements would be attributed to a specific interviewee in the report. The MHAT-FT personnel took interview notes during the session, and these notes were later transcribed into a Microsoft Word document.

Method of Analysis

The MHAT-FT members reviewed interview documents, identified themes, and grouped similar statements together. Interview synopses are presented in this report.

RESULTS

Custodial Staff Interviews

Soldiers with custodial responsibilities were interviewed at both facilities (i.e., 4 personnel at Camp Bucca, and 8 at Abu Ghraib). These Soldiers reported being aware of behavioral health resources for themselves and for the detainee population.

Custodial staff members reported stressors commonly shared by their OIF-II peers (see Annex A, Appendix 2). Some Soldiers complained about leaders imposing seemingly arbitrary rules; "micromanagement" by leaders; and perceived busywork. Others identified separation from family, deployment length, and lack of privacy as persisting stressors.

Reports of combat-related stressors differed between Abu Ghraib and Camp Bucca custodial staff. By virtue of its location, Abu Ghraib presents a convenient target for insurgents, whose nightly mortar attacks have forced Soldiers to live within fortified prison cells and to wear body armor and Kevlar when outside their living quarters. Likewise, the risk of ambush is high for convoys coming to or leaving Abu Ghraib. In contrast, Camp Bucca's remote location has largely shielded it from enemy attacks.

Participants reported coping well with the stressors of deployment and custodial work. They felt their peers were coping equally well. All were familiar with the *buddy system* for mutual support. Morale, welfare, and recreation activities were considered key to coping with stress. Participants were aware of chaplain and COSC/behavioral health services, and felt that services had been appropriate for Soldier needs. Soldiers indicated that consultation, education, counseling, evaluations, treatment, and crisis interventions had been available through the CSC Prevention Team at Abu Ghraib, and the behavioral health team at Camp Bucca.

Nonmilitary police staff members identified additional stress from adapting to their custodial roles. These Soldiers regarded cross training as key to improving their confidence and efficiency.

Participants reported that the negative publicity of the Abu Ghraib misconduct had added to their stress level. They indicated that they were more likely to "second guess"

their decisions, and felt that their hard work had been stained by the misconduct of a few.

Behavioral Health Provider Interviews

The MHAT-FT interviewed the senior behavioral health providers at each internment facility. Each provider led their respective teams, and had arrived in Iraq only within the last 2 months.

These providers reported little to no experience in correctional settings, and indicated that their staff members were equally inexperienced. Both expressed confidence providing clinical interventions to Soldiers. They were familiar with COSC doctrine, and described services consistent with the COSC functional areas. They saw their unfamiliarity with Iraqi, Islamic, and Arabic cultures as a formidable obstacle to detainee patient care delivery.

Camp Bucca had one social work officer and one mental health specialist (91X) to provide behavioral health care to 400 Soldiers[14] and 2,600 detainees.[15] The social worker indicated that (b)(6)-2 had focused (b)(6)-2 behavioral health efforts on Soldier preventive and clinical services, and had recently initiated detainee interventions (see Annex F for details). (b)(6)-2 believed that behavioral health resources were adequate for Soldier care, but additional personnel were necessary to expand detainee services.

Abu Ghraib had a ten-person team comprised of a psychiatrist, psychologist, four nurses, and four mental health specialists (91X). Prior to the Abu Ghraib team's arrival in 2004, a combat stress control company provided Soldier care through regular visits to the camp. The psychiatrist described plans to provide parallel behavioral health services for the camp's 900 Soldiers[16] and 2,600 detainees.[17] (b)(6)-2 held the view that (b)(6)-2 team's staffing level was sufficient to satisfy Soldier care needs, but additional personnel would be necessary as detainee services expanded.

[14] This number approximates the MNC-I Soldier census on 15 Sep 2004 (derived from the MNC-I G1's Joint Personnel Statistics).

[15] Department of the Army Inspector General Detainee Operations Inspection (2004).

[16] This number approximates the MNC-I Soldier census on 15 Sep 2004 (derived from the G1's Joint Personnel Statistics).

[17] Department of the Army Inspector General Detainee Operations Inspection (2004).