U.S. Army Center for Health Promotion and Preventive Medicine

USACHPPM REPORT NO. 23-KG-0BS6-09
EVALUATION OF A PILOT SOCIAL WORK OUTREACH PROGRAM
USING COMBAT AND OPERATIONAL STRESS CONTROL
PRINCIPLES IN GARRISON
FORT SILL, OKLAHOMA
JUNE–SEPTEMBER 2009

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14. ABSTRACT
The Outreach Program (OP) at Fort Sill, Oklahoma provides continual behavioral health (BH) education and counseling awareness services to Soldiers using the principles of Combat and Operational Stress Control (COSC) in garrison. OP requested a program evaluation from the U.S. Army Center for Health Promotion and Preventive Medicine (USACHPPM) to describe the programs activities, the process of implementation, the programs effect on Soldiers access to BH services, and the programs impact on Soldiers BH outcomes for those who access services. USACHPPM based the findings on data previously gathered by OP staff and on existing Army epidemiological databases. In addition, USACHPPM conducted interviews with key OP staff to capture the implementation process and lessons learned. Over the course of the program, OP activities have reached more than 17,000 Soldiers, Unit Leaders, and Family Readiness Group (FRG) members at Fort Sill. These groups report high satisfaction with program activities. Soldiers and Unit Leaders who attended OP activities cited differential treatment by leadership as the largest barrier to seeking BH care. Overall, perceptions of barriers to BH care were lower in this group than those reported in the published literature. During program implementation, hospitalizations at Reynolds Army Community Hospital (RACH) for ICD-9 mental health diagnoses stabilized while ambulatory visits increased. This may be associated with the programs ability to intervene early and encourage Soldiers use of BH services for routine issues before they become emergencies. The OP is a valued and well received BH program which has the capability to affect a positive impact on Soldiers BH. The results of this evaluation support the continuation and expansion of the program at Fort Sill while also warranting further prospective investigation of social work outreach programs in garrison and their effect on Soldiers general wellbeing and mission readiness.

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EXECUTIVE SUMMARY
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1. PURPOSE. The U.S. Army Center for Health Promotion and Preventive Medicine (USACHPPM) conducted an evaluation of a pilot social work outreach program (OP) in garrison at Fort Sill, Oklahoma using both quantitative and qualitative data. The goal of this evaluation was threefold: (1) to describe the OP's activities and the process of implementation, (2) to determine the OP's effect on Soldiers' access to behavioral health (BH) services, and (3) to measure the OP's impact on Soldiers' BH outcomes for those who access services.

2. CONCLUSIONS. Overall, the OP is a valued and well-received BH program which has the capability to affect a positive impact on Soldiers' wellbeing. Conclusions specifically relating to OP process, impact, and outcome measures are described below.

a. The primary mission of the OP is to provide continual BH education and counseling awareness services to Soldiers at Fort Sill. The intent is to bridge the gap between Soldiers and BH services. The OP's focus on proactive activities, including trainings, screenings, and sensing sessions, increases the visibility of BH in Soldiers' work areas. This may develop trust in BH professionals and decrease stigma.

b. Since February 2007, the OP has made contact with over 17,000 Soldiers, Unit Leaders and Family Readiness Group (FRG) members through trainings, formal sensing sessions, and consultations. Each contact is an opportunity to create awareness of BH programs and detect and respond to BH issues before they affect overall readiness.

c. Soldiers, Unit Leaders, and FRG members who have had contact with the OP report high satisfaction with the services received. The program is particularly appealing because of its "boots on the ground" approach, its flexibility in scheduling program activities, and its reputation for consistent follow through.

d. Soldiers and Unit Leaders who were surveyed by the OP were most concerned about being treated differently by their leadership, losing confidence from members of their unit, and being perceived as weak. Among those surveyed by the OP, perceptions of barriers to BH care were generally low.

e. While causality cannot be established at this time, this evaluation suggests a positive impact of the OP on Soldiers' BH utilization. Stabilization in hospitalizations and an increase in ambulatory visits for mental health diagnoses at Reynolds Army Community Hospital during OP implementation may be associated with the program's ability to intervene early and encourage Soldiers' use of BH services for routine issues before they become emergencies.

f. Soldiers treated through the OP are on average experiencing a mild level of dysfunction similar to those treated through Social Work Services for self-identified relationship issues. This indicates that OP staff is identifying Soldiers who need assistance but may not be seeking BH services for reasons other than the severity of their problem.

3. RECOMMENDATIONS. The results of this evaluation support the continuation and expansion of the program at Fort Sill while also warranting further investigation of social work OPs in garrison and their effect on Soldiers' general wellbeing and mission readiness. Recommendations to strengthen the body of evidence for the effectiveness of OPs in garrison are outlined below.

a. Fort Sill's Outreach Program.

(1) Incorporate a long-term evaluation plan into standing operating procedures (SOPs) to include: (1) program goals and objectives; (2) a conceptual framework; (3) process, impact and outcome indicators; (4) a data collection and analysis plan; and (5) a plan for dissemination of future evaluation results.

(2) Begin collection of OP-outcome data such as pre- and post-knowledge of topics covered during trainings and outcomes for Soldiers who received outreach services.

(3) Modify current and develop new program activities to address Soldiers' commonly cited barriers to BH care. Evaluate new initiatives for effectiveness with regard to reducing stigma, building resiliency, and increasing wellbeing.

(4) Increase staffing of Licensed Clinical Social Workers and Social Work Assistants to strengthen the presence of the OP among the units in garrison and reduce the potential for compassion fatigue among staff.

b. Replication and Evaluation Studies.

(1) Replicate social work Ops at other installations. Fort Sill's OP was developed to meet the needs of that particular post. In addition, the success of the program appears dependent on the quality of the staffing. It is important to determine the feasibility of implementing this program in different environments with different populations and unit structure. Replication studies would be especially valuable for units with organic BH assets. Coordination between OP

staff and organic BH assets allow for improved transition of the OP mission from garrison to theater and return to garrison. The importance of this continuity cannot be understated.

(2) Include an evaluation plan in SOP for any replication study. At a minimum, the evaluation plan should include a protocol for collecting data on program activities and on expected program outcomes before, during, and following full program implementation. The ability to compare expected program outcomes before and after implementation strengthens evidence to gauge program effectiveness.

(3) Identify a lead organization and point of contact to coordinate evaluation studies of OP's at other installations. This will ensure similar methods of data collection to facilitate the comparison of outcomes across programs and installations.

(4) Develop and disseminate best practices for OP implementation using evidence based upon the findings from multiple evaluation studies and sites.

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1. REFERENCES. See Appendix A for a listing of references used in this report.

2. PURPOSE. The U.S. Army Center for Health Promotion and Preventive Medicine (USACHPPM) conducted an evaluation of a pilot social work outreach program (OP) in garrison at Fort Sill, Oklahoma using both quantitative and qualitative data. The goal of this evaluation was threefold: (1) to describe the OP's activities and the process of implementation, (2) to determine the OP's effect on Soldiers' access to behavioral health (BH) services, and (3) to measure the OP's impact on Soldiers' BH outcomes for those who access services.

3. AUTHORITY. Website request from Ms. Cheryl Kottke, Outreach Services Coordinator, Fort Sill's Outreach Program, 5 May 2009, subject: Program Evaluation of Fort Sill's Outreach Program[1].

4. BACKGROUND.

a. Project Personnel. Dr. Jennifer Piver-Renna, a public health researcher with the USACHPPM Public Health Assessment Program, performed an evaluation of the pilot OP at Fort Sill, Oklahoma from June 2009–September 2009.

b. Literature Review. A review of the published literature on BH OPs indicates the value of such programs, especially following traumatic events[2]. A *Cochrane* review found that participants receiving outreach were significantly more likely to stay in contact with BH services and were significantly less likely to be admitted to a hospital than those receiving standard community care[3]. Implementation of a behavioral outreach worker program for adolescents in need of BH services resulted in shorter waiting times for initial BH visits and increased access to mental health intervention services[4]. In addition, a review of studies on BH service engagement concluded that the model of service delivery was more important than patient factors when predicting engagement with BH services and that outreach models including flexible hours, short waiting times, and frequent contact with a single worker can maximize engagement[5].

c. Outreach Program Description.

(1) Organization. Fort Sill's OP is assigned to the Social Work Services (SWS) clinic within Reynolds Army Community Hospital (RACH) in Oklahoma. The OP was formally initiated in October 2006 and began implementing program activities in February 2007. Appendix B shows the conceptual framework of the OP[6].

(2) Mission. The mission of the Soldier-centric OP is to plan, conduct, and provide continual education and counseling awareness services in support of Active Duty personnel as well as National Guard and Reserve units during deployment phases while assigned to Fort Sill. It conducts this mission using the Combat and Operational Stress Control (COSC) principles of prevention, detection, assessment, normalization, support, and referral[7]. The COSC interventions are commonly implemented in deployed environments; however, Fort Sill's OP is unique in its application of these principles in garrison.

(3) Staffing. Table 1 shows current staff positions allocated for the OP and their primary responsibilities.

Table 1. Outreach Program Staffing Levels and Responsibilities

Title	Number	Status	Primary Responsibilities
Outreach Program Coordinator (Licensed Clinical Social Worker (LCSW))	1	Filled	- Coordinates OP - Performs social work services - Receives guidance and direction from Chief of SWS - Reviews program objectives with regard to adherence to Army-wide goals and professional social work principles
Outreach LCSW	2	Filled	- Assists Program Coordinator with OP implementation - Adheres to guidance and direction from Program Coordinator - Assists in implementing program objectives and Soldier Readiness Processing (SRP) duties
Outreach Social Work Assistant (SWA)	2	Filled	- Adheres to guidance and direction from Program Coordinator - Renders services to Fort Sill community covering a range of social service functions - Assesses, researches, and assists in developing programs for military and families

(4) Funding. In September 2008, OP staff was converted from Other Contingency Operations-funded positions (formally, Global War on Terrorism) to permanent General Service positions supported by RACH.

(5) Utilization Measures. A system of codes to accurately document OP activities in Armed Forces Health Longitudinal Technology (AHLTA) is still being developed. In addition to AHLTA, OP is using a modified version of the Combat and Operational Stress Control Workload and Reporting System (COSC-WARS) to track their numbers for RACH

accountability. This system was developed to capture COSC interventions in theater and has been adapted to reflect the program's use in garrison. Relative Value Units (RVU) are generated during Soldier screenings and assessments most often at SRP events and during short-term brief supportive counseling sessions with Soldiers.

d. Outreach Program Services.

(1) Primary Prevention. The OP staff delivers trainings for Soldiers in group settings to raise awareness of BH issues and increase Soldiers' ability to identify problematic symptoms in themselves and others. Training topics include COSC reactions, suicide prevention, anger management, stress management, and sleep hygiene. These trainings are incorporated into the reintegration cycle (1 day and 90/120 days post-deployment) but can also be delivered upon request of the Unit Leader.

(2) Secondary Prevention. The OP offers several services to detect existing BH issues among Soldiers. These include—

(a) SRP Screenings. The LCSWs from OP attend all SRP and Reverse-SRP (R-SRP) events to screen and assess Soldiers for potential BH issues. Soldiers are referred to the LCSW at the SRP site based on their responses to the Post-Deployment Health Assessment (PDHA) or Post-Deployment Health Reassessmentment (PDHA or PDHRA) questionnaire. The LCSW normalizes the behavior or refers the Soldier to other services as appropriate.

(b) Consultations. The OP consults with Unit Leaders and Chaplains to identify BH needs within the unit and to discuss courses of action for Soldiers with specific issues.

(c) Formal Sensing Sessions. The OP staff administers a short survey to Soldiers to measure the Unit's overall welfare in the areas of morale, unit conflict, sleep quality, personal conflict, and substance use/abuse. The survey can usually be administered, analyzed, and the results reported back to Unit Leaders within a week. See Appendix C for a copy of the unit morale survey.

(d) Informal Sensing Sessions. An OP team consisting of one LCSW and one SWA travels to various work areas on post and engages Soldiers in informal conversations about BH issues and other relevant topics. These sessions provide Soldiers with an opportunity to become familiar with BH services and build trust among OP staff, thereby, helping to reduce stigma for seeking help. During these sessions, the OP staff is discreet, yet attentive, to any request for assistance. The OP staff seeks permission from Unit Leaders before speaking with Soldiers and ensures that there is minimal impact on the Unit's operations during their visit.

(3) Tertiary Prevention. The OP staff has protocols in place to assist Soldiers who need assistance or treatment with BH issues. These include—

(a) Referrals. Patient referral services are provided during walk-ins, appointments, or crisis situations and include referrals back to OP or to Command, Primary Care, BH, Emergency Department, or Chaplain.

(b) Short-term Supportive Counseling. Soldiers referred back to OP receive short-term counseling sessions from LCSWs. Soldiers who need extended treatment are referred to other BH clinics as appropriate.

(c) Traumatic Event Management and Crisis Intervention. The OP staff collaborates with other appropriate services as necessary to stabilize Soldiers in crisis and debrief following critical events (CEs).

5. METHODS.

a. Study Design. This is a retrospective evaluation of an OP program that was implemented in October 2006. The USACHPPM used a mixed-methods design basing findings on both quantitative and qualitative data. Each data source is described below.

b. Data Sources.

(1) Program Activities Data. The OP staff has collected data on program activities since October 2006. Data include the number of OP activities provided per month, the number of Soldiers reached and referred byOP activities, and Soldiers' disposition after referral.

(2) Questionnaires.

(a) Satisfaction Survey. The OP staff developed an 8-item survey to measure program satisfaction among Soldiers, Unit Leaders, and the Family Readiness Group (FRG). Surveys were distributed to attendees after most program activities from January through September 2009. Respondents rated their experience with OP staff on a 5-point Likert scale and were also able to write in suggestions for program improvement. See Appendix D for the Soldiers' satisfaction survey.

(b) Barriers to Care/Stigma Survey. In September 2009, the OP staff attached a 13-item survey to the back of the satisfaction survey measuring barriers (including stigma) to accessing BH services. The USACHPPM adapted the barrier/stigma survey from the survey used during previous Mental Health Advisory Team assignments. The OP administered the survey to

Soldiers and Unit Leaders after most program activities. See Appendix E for the barriers to care/stigma survey.

(c) BH Outcomes Data. The Outcome Questionnaire (OQ®-45) is a 45-item self-report questionnaire that measures Soldiers' functional level on three dimensions: symptom distress, interpersonal functioning, and social role[8]. It can be used to track the progress of patients during therapy and is administered at the beginning of each counseling session in all Department of Behavioral Health (DBH) clinics at RACH including OP. The USACHPPM compared initial OQ®-45 scores for Soldiers seeking counseling through SWS and through OP since incorporation of the OQ®-45 into clinical practice. Effective provision of appropriate referrals for care by the OP staff would be evidenced by a decrease in the OP's initial OQ®-45 scores over time. (The OQ®-45 is a registered trademark of OQ Measures, LLC).

c. Key Informant Interviews. The USACHPPM conducted five interviews during August 2009 with current or former staff in DBH at RACH who had extensive knowledge of OP. The OP staff provided contact information for initial informants. The USACHPPM sought contact information for additional informants from each informant after the interview. See Appendix F for the key informant interview question protocol.

d. Epidemiological Behavioral Health Data.

(1) Through the Defense Medical Epidemiology Database (DMED) of the Armed Forces Health Surveillance Center (AFHSC), USACHPPM obtained data on hospitalizations and ambulatory visits for Soldiers seen at RACH with an International Classification of Diseases, 9th Revision (ICD-9) primary diagnosis of mental disorder from 1999 to 2008. Effective facilitation of early intervention would be evidenced by a decrease in hospitalizations.

(2) Through the TRICARE Operations Center (TOC), USACHPPM obtained data on number of appointments, appointment status, and appointment type by clinic for BH services at RACH from October 2006 July 2009. Effective facilitation of early intervention would be evidenced by a decrease in acute BH visits and an increase in routine BH appointments.

e. Data Limitations. The USACHPPM conducted this evaluation retrospectively nearly 3 years after program inception. As such, the results of this evaluation are largely based on self-report surveys, process data available from program staff, or health outcome data from large military databases. The ability to make meaningful comparisons to outcomes before OP was implemented or to outcomes from similar programs is limited. These limitations temper the strength of the conclusions that can be drawn from the data with regard to program effectiveness and impact.

f. Data Analysis. The Statistical Package for the Social Sciences (SPSS®), Version 16.0, was used for statistical analysis. Descriptive statistics (i.e., frequencies, distributions, and means) were calculated for questions on the satisfaction survey and barriers/stigma survey. *T*-tests were used to compare initial mean OQ®-45 scores between OP and SWS. (SPSS® is a registered trademark of SPSS Corporation).

6. FINDINGS.

a. Program Activity Data.

(1) The complete data set showing the number of OP activities per month, the number of contacts reached (i.e., Soldiers, Leaders, and FRG members) for each activity per month, and the average number of contacts reached for each activity since program activities began in February 2007 is available in Appendix G.

(2) Figure 1 shows the average number of contacts for each formal sensing session per month. From February 2007 to July 2009, an average of 63.28 contacts completed the unit morale survey per month.

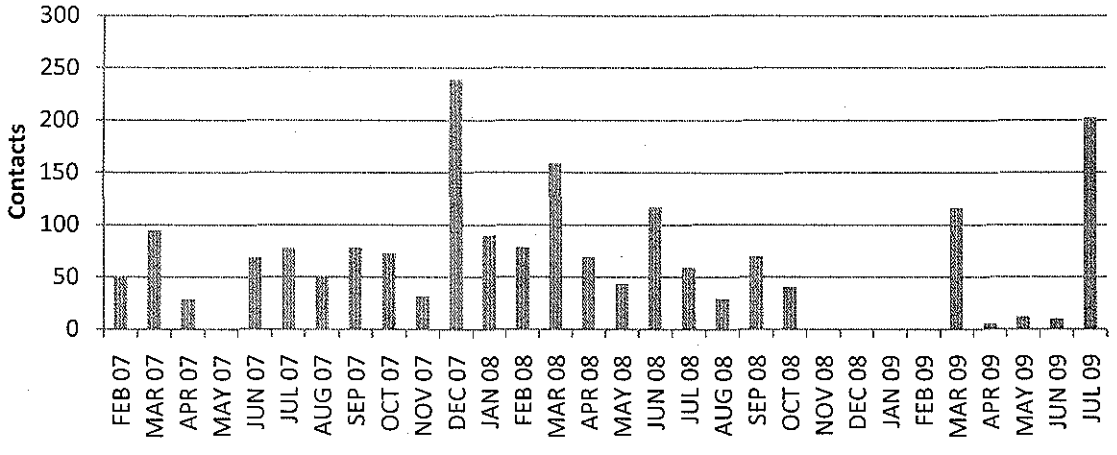


Figure 1. Average Number of Contacts Per Morale Survey Event

(3) Figure 2 shows the number of Unit Leader and Soldier consultations per month. From February 2007 to July 2009, OP staff conducted an average of 3.53 Unit Leader consultations and 14.93 Soldier consultations each month.

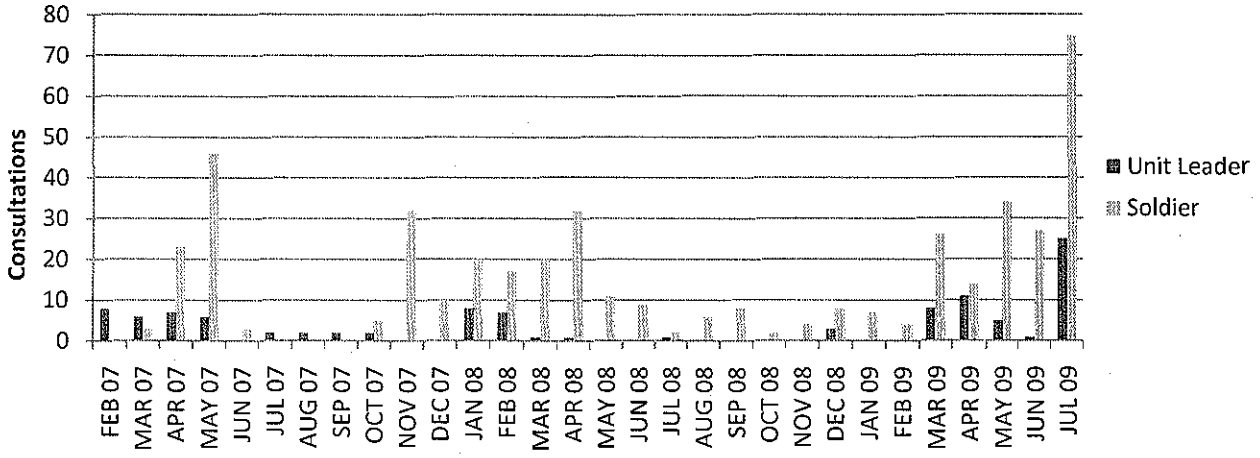


Figure 2. Unit Leader and Soldier Consultations Per Month

(4) Figure 3 shows Soldiers' dispositions after consultation with OP staff. Sixty-three percent of Soldiers ($n = 288$) returned to duty with no restrictions.

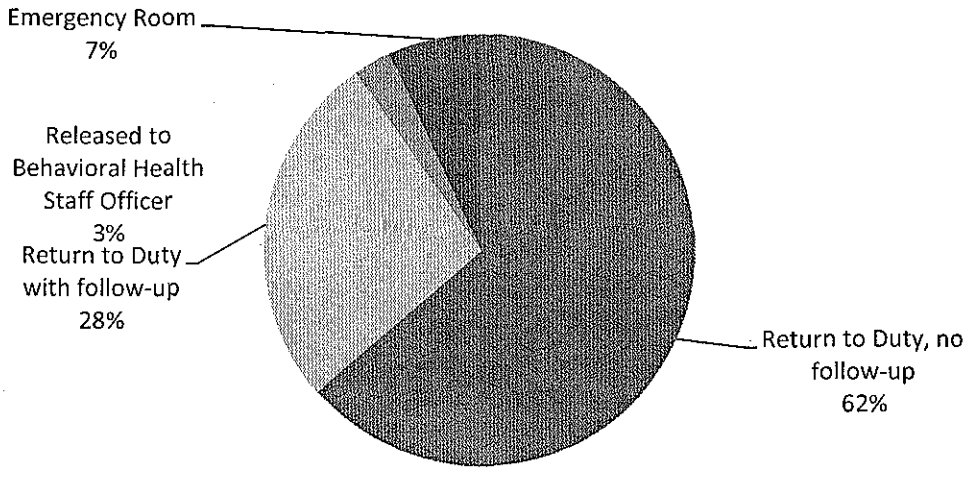


Figure 3. Soldier Disposition after OP Consultation ($n = 468$)

(5) Figure 4 shows the number and type of Soldier referrals given by OP staff. Most Soldiers were referred to either a primary care manager (n = 148, 36.10%) or to Social Work Services (n = 147, 35.85%).

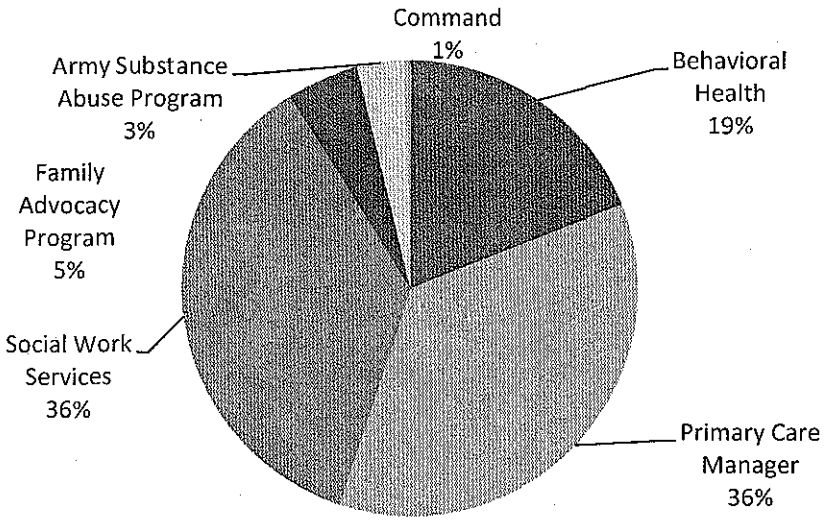


Figure 4. Soldier Referrals from OP (n = 410)

(6) Figure 5 shows the average number of contacts attending each preventive educational training session per month. From February 2007 to July 2009, an average of 43.71 contacts attended each training session.

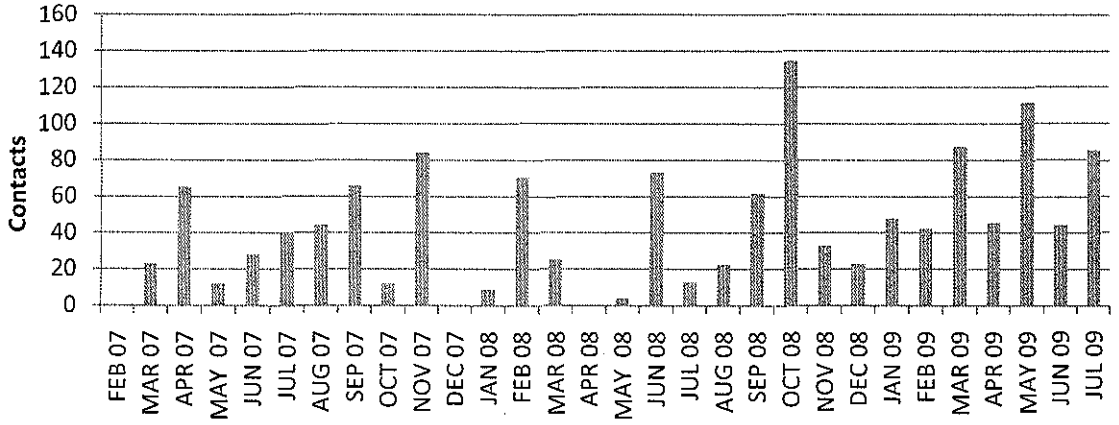


Figure 5. Average Number of Contacts Per Training

(7) Table 2 shows the number of Soldiers screened, assessed, and briefed by OP staff at SRP events pre- and post-deployment each fiscal year.

Table 2. Number of Soldiers Assessed and Briefed at SRP and R-SRP Events

Date	Pre-Deployment SRP	Post-Deployment R-SRP
FY 07: October 2006 to September 2007	476	1009
FY 08: October 2007 to September 2008	4489	630
Partial FY 09: October 2008 to July 2009	6600	1235
Total	**11565**	**2874**

b. Satisfaction Survey.

(1) The OP staff administered satisfaction surveys to 185 contacts. Of those, 80 percent ($n = 147$) provided information about their experiences with OP. Seventy-one percent ($n = 105$) of respondents were Soldiers, 19 percent ($n = 28$) were Unit Leaders, and 10 percent ($n = 14$) were FRG members.

(2) Table 3 shows the mean response for each question on the satisfaction survey. The response set for each question ranged from 1 (worst possible) to 5 (best possible). There were no significant differences in self-reported program satisfaction among groups (Soldiers, Unit Leaders, and FRG).

Table 3. Mean Response to Satisfaction Survey Items (n = 147)

Question	Mean Response
How would you rate your overall experience with FSOP?	4.52
Please rate the FSOP staff's efforts to treat you with courtesy and respect.	4.31
How helpful was the FSOP team or team member you encountered?	4.69
How well did the FSOP team or team member listen to you?	4.53
How well did the FSOP team or team member address your concerns?	4.46
How well did the FSOP team or team member meet the needs of your unit?	4.48

(3) The satisfaction survey also asked respondents to list ways in which the program could be improved. Table 4 shows the major themes of the comments and examples in each category.

Table 4. Comments from Satisfaction Survey (n = 81)

Theme	Percent of Responses	Examples
Praise	51	"Very helpful, friendly, and wanting to make things better for the Soldier." "We intend to fully utilize the many services and training support FSOP offers!" "Very happy to have this available." "Kept Soldiers engaged and it was very interesting."
Additional information	23	"More information on stress relief." "More scenarios, maybe role play." "Make the curriculum more scenario-driven." "Address timeline of symptoms and improvements."
Additional activities/resources	19	"More counselors would better help us serve our Soldiers." "Provide more one-on-one courses." "Schedule more classes at different times so Soldiers out training can attend." "Have this service briefed before and after deployment."
Awareness	7	"Advertise services offered through flyers." "Put the program out there more through brigade and battalion commanders." "Better public awareness." "Didn't know Fort Sill had program."

c. Barrier to Care/Stigma Survey.

(1) The OP staff administered a survey to measure barriers to care, including stigma, to 61 contacts during September 2009. Of those, 74 percent ($n = 45$) were Soldiers and 26 percent ($n = 16$) were Unit Leaders.

(2) Table 5 shows the mean response for the each statement on the survey ordered from highest rated to lowest rated barrier. The response set for each question ranged from 1 (strongly disagree) to 5 (strongly agree). There were no significant differences in self-reported barriers to care between Soldiers and Unit Leaders.

Table 5. Mean Response to Barriers to Care Survey Items ($n = 61$)

Question	Mean Response
Leadership might treat me differently.	2.59
Members of my unit might have less confidence in me.	2.51
I would be seen as weak.	2.48
It would harm my career.	2.28
I don't trust mental health professionals.	2.23
It would be too embarrassing.	2.16
My leaders would blame me for the problem.	2.10
There would be difficulty getting time off work for treatment.	2.08
It is difficult to schedule an appointment.	2.00
Mental health care doesn't work.	1.90
Mental health care costs too much money.	1.75
I don't know where to get help.	1.44
I don't have adequate transportation.	1.30

d. Hospitalizations. Figure 6 shows the rate of hospitalization at RACH for Soldiers with a primary diagnosis of mental disorder per ICD-9 coding criteria from 1999 to 2008. Overall, the rate of hospitalization has increased from 4.08 hospitalizations per 1,000 Soldiers in 1999 to 17.83 hospitalizations per 1,000 Soldiers in 2008. The rate of hospitalizations stabilized during the two years of OP implementation with 17.76 hospitalizations per 1,000 Soldiers in 2007 and 17.83 hospitalizations per 1,000 Soldiers in 2008.

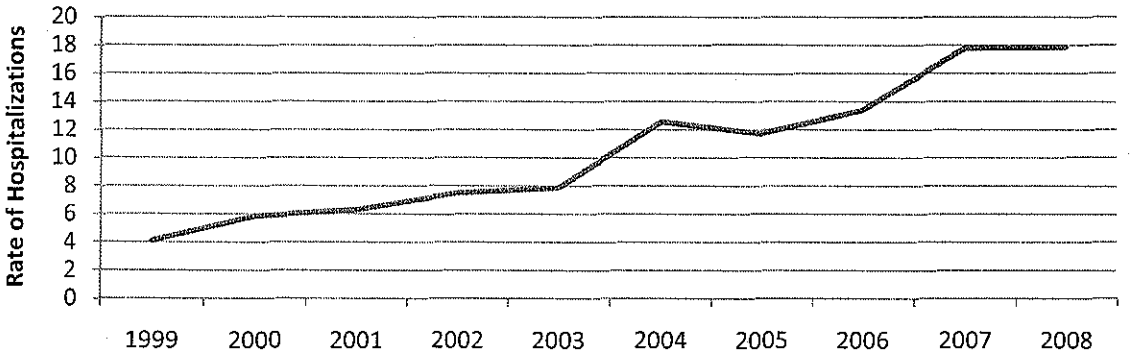


Figure 6. Rate of Soldier Hospitalizations with an ICD-9 Primary Diagnosis of Mental Disorder

e. Ambulatory Care. Figure 7 shows the rate of ambulatory visits at RACH for Soldiers with a primary diagnosis of mental disorder per ICD-9 coding criteria from 1999 to 2008. Overall, the rate of ambulatory visits has increased from 389.28 visits per 1,000 Soldiers in 1999 to 1230.28 visits per 1,000 Soldiers in 2008. The rate of ambulatory visits increased during the two years of OP implementation with 823.01 visits per 1,000 Soldiers in 2007 to 1230.28 visits per 1,000 Soldiers in 2008.

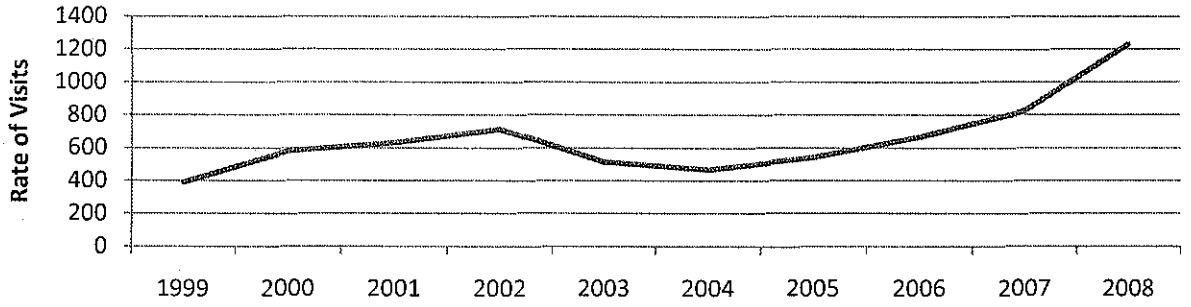
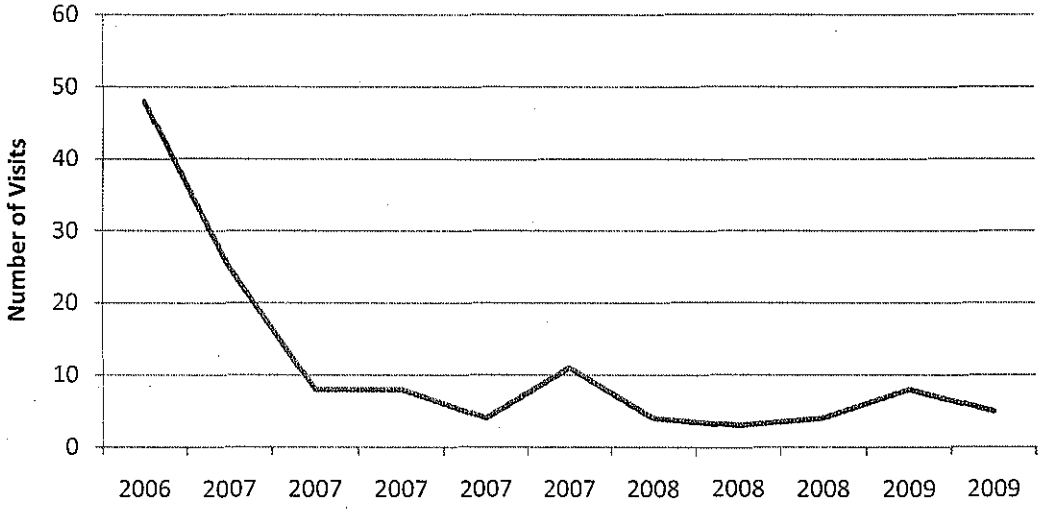


Figure 7. Rate of Soldier Ambulatory Visits with an ICD-9 Primary Diagnosis of Mental Disorder

f. Behavioral Health Visits.

(1) Figure 8 shows the number of Soldiers' acute BH visits at RACH from 4th quarter 2006 to 2nd quarter 2009. The data are aggregated into quarters due to small numbers. Overall, the number of Soldiers' acute BH visits decreased from 48 visits in 4th Quarter 2006 to 5 in 2nd quarter 2009.



*Note: Q2 of 2007 only includes data from the months of April and June due to missing data for May.

Figure 8. Number of Acute Behavioral Health Visits

(2) Figure 9 shows the number of routine, specialty and wellness (non-acute) BH visits at RACH from 4th quarter 2006 to 2nd quarter 2009. The data are aggregated into quarters due to small numbers. Overall, the number of Soldiers' non-acute BH visits also decreased from 5683 visits in 4th quarter 2006 to 2341 visits in 2nd quarter 2009.

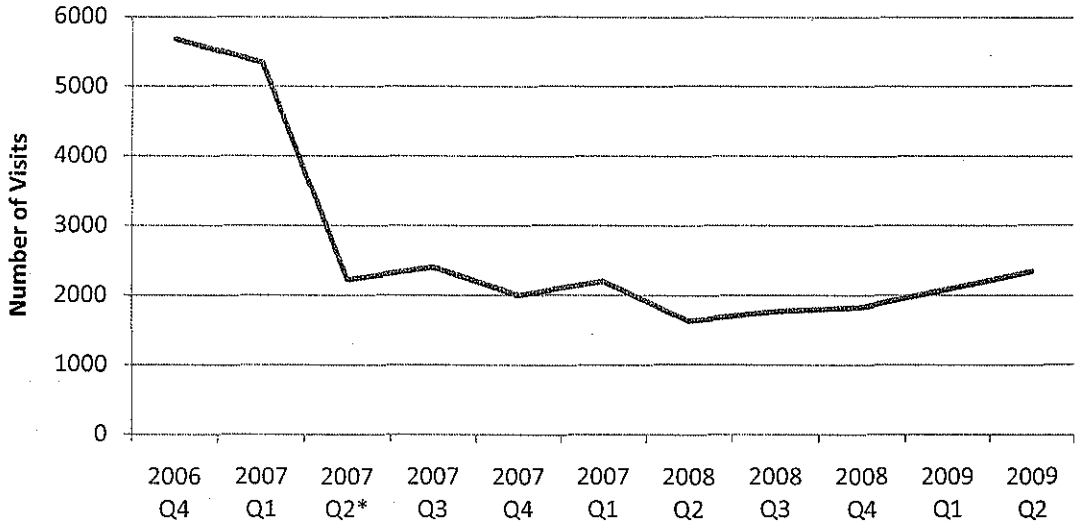


Figure 9. Number of Non-Acute Behavioral Health Visits

g. Behavioral Health Outcomes. The OQ-45 scores for individual Soldiers were not available at the time of this report. Therefore, trends in scores over time controlling for time in treatment could not be determined. However, OQ-45 scores at initial visits with SWS and OP were available. Figure 10 shows the average OQ-45 scores for Soldiers during their first visit with OP or SWS. The scoring manual states that scores above 63 indicate dysfunction[8]. On average, OQ-45 scores for Soldiers seen at OP and SWS were not significantly different ($t(8) = 1.80$, *n.s.*).

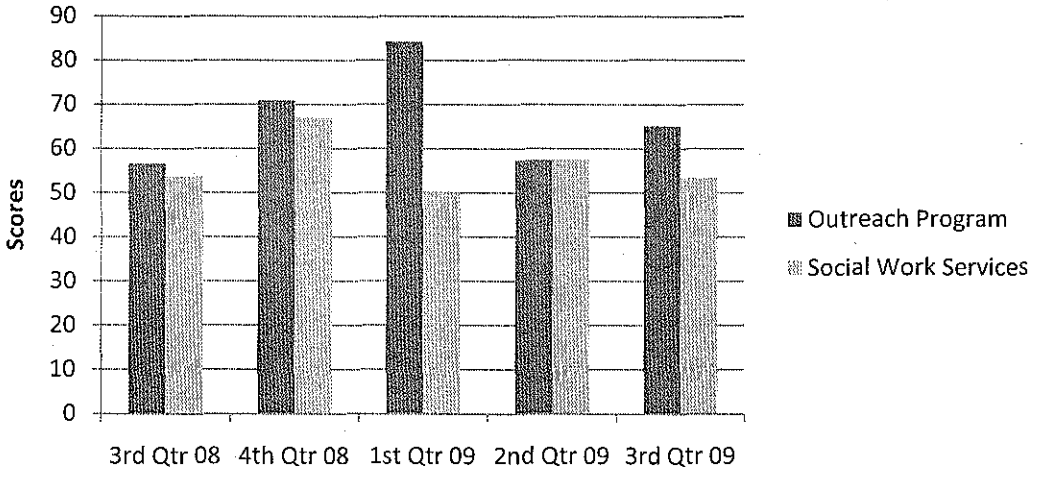


Figure 10. OQ-45 Scores for OP and SWS

h. Program Implementation Experiences. During key informant interviews, RACH OP and DBH staff identified several barriers, facilitators, and lessons learned of program implementation. Table 6 identifies major themes in each category and supporting quotes.

Table 6. Lessons Learned from OP Implementation

Theme	Quotes
Barriers	
Accountability system	"Trying to merge OP with the military treatment facility (MTF) accountability system is like putting a round object in a square hole." "The bean counters were having a tough time wrapping their heads around the idea that they have clinical social workers who weren't being clinical per se." "When you throw the MTF in and the responsibilities it has to accountability, I think then that adjusts the people in the leadership positions' viewpoints because they become uncomfortable with [the unstructured pieces of the program]."
Executing mission	"Getting out in front of things instead of always being reactive." "Civilians in my experience are very uncomfortable at first with the whole nuanced thing of walking down [into the units]." "There is pressure to become more clinical."
Facilitators	

Table 6. Lessons Learned from OP Implementation (continued)

Theme	Quotes
Program champions	"Not only did [the program manager] kick down the door but what that created was static—a lot of static—among the brigade commander to motivate the MTF to continue the program." "They said, 'Do you want to try and make this thing work?' and [Chief, SWS] said 'I have to have it my way and y'all need to leave me alone and let me just do it'." "The program manager got the vision early and is self-motivated."
Perceived benefit	"The program increases workload in some ways and decreases workload in other ways. Overall, however, it maximizes care for behavioral health issues." "When we do referrals to behavioral health they are more appropriate, more legitimate." "It takes behavioral health out of the ivory tower." "You are down at the smallest group level facilitating improvement and communications within behavioral health services."
Flexibility	"If you are going to go out there and work with the Soldiers and the command team you have to be there on their time, not on your time." "It's flexible. It works with the unit. It's not rigid like a clinic—you open, you close." "You are going to have to have some people who are flexible, willing to sometimes go above and beyond, and who truly love doing community social work."
Lessons learned	
Follow through	"If you promise something, you better deliver it." "We are showing them that our word is our bond." "If we've kept through to our word then we get the respect of the command team and they will use us." "The minute we start not following through and take shortcuts we are going to end up flat on our face."
Be effective	"Start small, earn respect, and be effective." "Everybody is getting the word out that if they want something done, you call and ask us to help." "There is a trust with us. They realize that what they said meant something and we did what they asked and so they come back [from deployment] and ask specifically for us."
Find the right staff	"Staff drives the direction of the program and can make it or break it." "It is a special kind of person to stay with this and not get discouraged." "It is a necessity to find personnel with very good clinical boundaries." "The best possible combination would be a social work officer with COSC experience and their civilian counterpart who has a community mindset."

7. CONCLUSIONS. Overall, the OP is a valued and well-received BH program which has the capability to affect a positive impact on Soldiers' wellbeing. Conclusions specifically relating to OP process, impact, and outcome measures are described below.

a. The primary mission of the OP is to provide continual BH education and counseling awareness services to Soldiers at Fort Sill. The intent is to bridge the gap between Soldiers and BH services. The OP's focus on proactive activities, including trainings, screenings, and sensing

sessions, increases the visibility of BH in Soldiers' work areas. This increased presence was addressed directly by Lieutenant General Schoomaker as one action Leaders could take to address barriers to wellness, especially stigma, that may impact mission readiness[9].

b. Since February 2007, the OP has made contact with over 17,000 Soldiers, Unit Leaders and FRG members through trainings, formal sensing sessions, and consultations. Each contact is an opportunity to create awareness of BH programs and detect and respond to BH issues before they affect overall readiness

c. Soldiers, Unit Leaders, and FRG members who have had contact with the OP report high satisfaction with the services received. The program is particularly appealing because of its "boots on the ground" approach, its flexibility in scheduling program activities, and its reputation for consistent follow through.

d. Soldiers and Unit Leaders who were surveyed by the OP were most concerned about being treated differently by their Leadership, losing confidence from members of their unit, and being perceived as weak. However, the perception of barriers among Soldiers surveyed by OP were much lower than perceptions measured in other published literature of previously deployed infantry units[10, 11] and spouses of deployed service members[12].

e. While causality cannot be established at this time, this evaluation suggests a positive impact of the OP on Soldiers' BH utilization. Stabilization in hospitalizations and an increase in ambulatory visits for mental health diagnoses at RACH during OP implementation may be associated with the program's ability to intervene early and encourage Soldiers' use of BH services for routine issues before they become emergencies. During the same time frame, hospitalizations for all ICD-9 diagnoses showed a similar pattern of stabilization while ambulatory rates for all ICD-9 diagnoses decreased. However, the data do not account for other unknown or known factors, such as operational tempo, service availability, or other health care programs that may also affect these rates.

f. Although acute BH visits decreased as expected, non-acute (i.e., routine, specialty, and wellness) BH visits also decreased over time contrary to the pattern expected. For both acute and non-acute visits, rates of Soldiers' visits were not available and counts were presented instead. The data, therefore, are more likely to be influenced by deployment cycle and may not be representative of actual BH service utilization.

g. Although trends in OQ-45 scores over time were not available, the data did show that Soldiers treated through OP are on average experiencing a mild level of dysfunction similar to those treated through SWS for self-identified relationship issues. This indicates that OP staff are identifying Soldiers who need assistance but may not be seeking BH care for reasons other than severity of their problem.

8. RECOMMENDATIONS. The results of this evaluation support the continuation and expansion of the program at Fort Sill while also warranting further investigation of social work OPs in garrison and their effect on Soldiers' general wellbeing and mission readiness. Recommendations to strengthen the body of evidence for the effectiveness of OPs in garrison are outlined below.

a. Fort Sill's Outreach Program.

(1) Incorporate a long-term evaluation plan into SOPs to include: (1) program goals and objectives; (2) a conceptual framework; (3) process, impact and outcome indicators; (4) a data collection and analysis plan; and (5) a plan for dissemination of future evaluation results.

(2) Begin collection of OP outcome data, such as pre- and post-knowledge of topics covered during trainings and outcomes for Soldiers who received outreach services. See Appendix H for a list of suggested metrics and measures.

(3) Modify current and develop new program activities to address Soldiers' commonly cited barriers to BH care. Evaluate new initiatives for effectiveness with regard to reducing stigma, building resiliency, and increasing wellbeing.

(4) Increase staffing LCSW and SWAs to strengthen the presence of the OP among the units in garrison and reduce the potential for compassion fatigue among staff.

b. Replication and Evaluation Studies.

(1) Replicate social work OPs at other installations. Fort Sill's OP was developed to meet the needs of that particular post. In addition, the success of the program appears dependent on the quality of the staffing. It is important to determine the feasibility of implementing this program in different environments with different populations and unit structure. Replication studies would be especially valuable for units with organic BH assets. Coordination between OP staff and organic BH assets allow for improved transition of the OP mission from garrison to theater and return to garrison. The importance of this continuity cannot be understated.

(2) Include an evaluation plan in SOP for any replication study. At a minimum, the evaluation plan should include a protocol for collecting data on program activities and on expected program outcomes before, during, and following full program implementation. The ability to compare expected program outcomes before and after implementation strengthens evidence to gauge program effectiveness.

(3) Identify a lead organization and point of contact to coordinate evaluation studies of OP's at other installations. This will ensure similar methods of data collection to facilitate the comparison of outcomes across programs and installations.

(4) Develop and disseminate best practices for OP implementation using evidence based upon the findings from multiple evaluation studies and sites.

9. POINT OF CONTACT. Dr. Jennifer Piver-Renna, the principal investigator, is the point of contact for this project. She may be reached at 410-436-9283 (commercial) or 584-9283 (DSN) or by email at jennifer.piverrenna@us.army.mil.

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APPENDIX A

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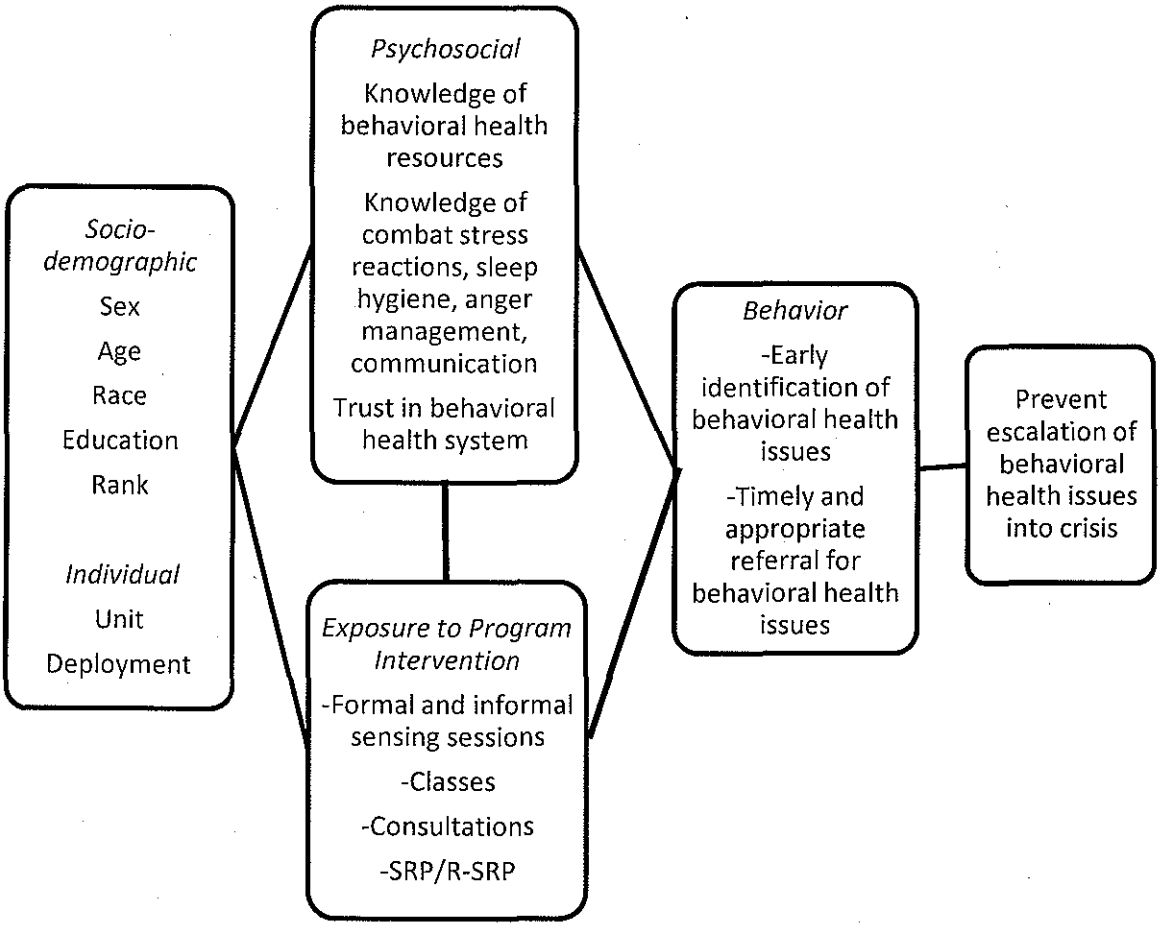
APPENDIX B

CONCEPTUAL FRAMEWORK OF FORT SILL'S OUTREACH PROGRAM



APPENDIX C

UNIT MORALE SURVEY

UNIT SURVEY

UNIT: _____ Length of last deployment: _____ Rank (check) ◯ Junior Enlisted

Date: _____ Number of deployments: _____ ◯ NCO or Officer

- The following questions relate to unit climate and will remain anonymous.
- Sections 1 & 2 : Tell us how much you agree or disagree with the statements.
- Section 3 : Decide how much those statements apply to you.

0 = Never 1 = Seldom 2 = Sometimes 3 = Often 4 = Always

My unit strongly considers my goals and values	0	1	2	3	4
My unit really cares about my well-being	0	1	2	3	4
My unit shows little concern for me	0	1	2	3	4
My unit would forgive an honest mistake on my part	0	1	2	3	4
My unit cares about my opinion	0	1	2	3	4
If given the opportunity, my unit would take advantage of me	0	1	2	3	4
Help is available from my unit when I have a problem	0	1	2	3	4
My unit is willing to help me when I need a favor	0	1	2	3	4

Total Score Section 1

How often do people in your unit get into arguments with each other at work ?	0	1	2	3	4
How often do people in your unit yell at each other at work ?	0	1	2	3	4
How often are people in your unit rude to each other at work ?	0	1	2	3	4
How often do people in your unit do bad things to each other at work ?	0	1	2	3	4

Total Score Section 2

Section 3 scale: 0 = Not at All 1 = Some 2 = Moderate 3 = Quite a bit 4 = Extreme

Since returning from deployment I have been verbally and / or physically aggressive with people that are important to me. 0 1 2 3 4

Since my last deployment my use of alcohol has gone up by "How many" drinks a day more than before I deployed.

None = 0 1 to 2 = 1 3 to 4 = 2 4 to 5 = 3 5+ = 4

Since this last deployment I have averaged "How many" hours of sleep each night.

0 – 2 hours = 1 3 – 4 hours = 2 5 – 7 hours = 3 8+ hours = 4

On the reverse side, please indicate: What has been most helpful and / or harmful to your morale recently

APPENDIX D

SOLDIER SATISFACTION SURVEY

The purpose of this survey is to collect information about your experience with the Fort Sill Outreach Program (FSOP). Your responses will be confidential. The information you provide will be used to improve the care and other services we provide. Thank you for your assistance.

Date: _____

1) Circle your Unit: 75th 214th 434th 428th 479th USMC FA Det.

Please answer the following questions by circling the number that best corresponds to your assessment of the FSOP, where 1 is the worst possible and 5 is the best possible.

2) How would you rate your overall experience with the FSOP?

   1 (worst possible) 2 3 4 5 (best possible)

3) Please rate the FSOP staff's efforts to treat you with courtesy and respect.

   1 (worst possible) 2 3 4 5 (best possible)

4) How helpful was the FSOP team or the team member you encountered?

   1 (worst possible) 2 3 4 5 (best possible)

5) How well did the FSOP team or team member listen to you?

   1 (worst possible) 2 3 4 5 (best possible)

6) How well did the FSOP team or team member address your concerns?

   1 (worst possible) 2 3 4 5 (best possible)

7) How well did the FSOP team or team member meet the needs of your unit?

   1 (worst possible) 2 3 4 5 (best possible)

8) How could we improve our services?

   _____

   _____

   _____

   _____

APPENDIX E

BARRIER TO CARE/STIGMA SURVEY

Please rate each of the following factors that might affect your decision to receive behavioral health counseling or services if you ever had a problem on a scale from STRONGLY DISAGREE to STRONGLY AGREE.

	Strongly Disagree	**Disagree**	**Neither Agree nor Disagree**	**Agree**	**Strongly Agree**
I don't trust mental health professionals.	1	2	3	4	5
I don't know where to get help.	1	2	3	4	5
I don't have adequate transportation.	1	2	3	4	5
It is difficult to schedule an appointment.	1	2	3	4	5
There would be difficulty getting time off work for treatment.	1	2	3	4	5
Mental health care costs too much money.	1	2	3	4	5
It would be too embarrassing.	1	2	3	4	5
It would harm my career.	1	2	3	4	5
Members of my unit might have less confidence in me.	1	2	3	4	5
My unit leadership might treat me differently.	1	2	3	4	5
My leaders would blame me for the problem.	1	2	3	4	5
I would be seen as weak.	1	2	3	4	5
Mental health care doesn't work.	1	2	3	4	5

APPENDIX F

KEY INFORMANT INTERVIEW QUESTION PROTOCOL

1. What is your role in the Fort Sill Outreach Program?

2. Could you describe the Fort Sill Outreach Program?
   - ☐ Organization within RACH?
   - ☐ Program activities?
   - ☐ Staffing?
   - ☐ Counseling/consultations?
   - ☐ Referrals?
   - ☐ Follow-up procedures with patient?
   - ☐ Funding/financial support?

3. How long have you been involved in the program?

4. What were some of the driving factors that led the implementation of this program?

5. How has the program changed over time since you became involved?

6. What role, if any, did your experience as/with Soldiers play in your awareness of or decision to implement the outreach program?

7. What do you consider some of the benefits of the outreach program?
   - ☐ To RACH?
   - ☐ To Soldiers?
   - ☐ To Big Army?

8. What was the goal of this program? Has that goal been reached?

9. What were some concerns or problems that the hospital anticipated when implementing the outreach program?
   - ☐ Effectiveness of intervention in garrison conditions?
   - ☐ Ease of use?
   - ☐ Acceptability by staff?
   - ☐ Acceptability by Soldiers?
   - ☐ Adequacy of existing infrastructure and human resources?

10. What factors have supported the continued implementation of the outreach program?
    - ☐ Influence of a program champion?
    - ☐ Sufficient financial resources?
    - ☐ Well planned implementation approach?
    - ☐ Involvement of end users in implementation planning and execution?
    - ☐ Fit with other organizational goals and programs?

11. What challenges arose in implementing the outreach program?
    - ☐ Poor acceptability by staff?
    - ☐ Poor acceptability by Soldiers?
    - ☐ Insufficient financial resources?
    - ☐ Inadequate infrastructure?
    - ☐ Incompatibility with other organizational goals and programs?

12. What consequences, good or bad, has RACH experienced from implementing this outreach program?
    - ☐ Consequences for Soldiers?
    - ☐ Consequences for staff?
    - ☐ Consequences for hospital as a whole?

13. Did you learn any important lessons from the implementation of the outreach program?

14. Would you recommend this program at other installations? Why or why not?

15. Is there anything else I ought to know about how the hospital implemented the outreach program? Did I miss anything?

Thank you for your time.

APPENDIX G

TABLE OF PROGRAM ACTIVITIES

Date	Unit Surveys		Trainings		Unit Leader Consultation	Soldier Consultation
	Events	Contacts	Events	Contacts		
FEB 07	4	200	0	0	8	0
MAR 07	5	473	1	23	6	3
APR 07	1	29	3	196	7	23
MAY 07	0	0	7	85	6	46
JUN 07	9	618	4	114	0	3
JUL 07	1	78	1	40	2	0
AUG 07	3	153	2	89	2	0
SEP 07	9	706	3	198	2	0
OCT 07	1	73	1	12	2	5
NOV 07	1	32	4	337	0	32
DEC 07	1	239	0	0	0	10
JAN 08	10	901	2	18	8	20
FEB 08	9	707	4	282	7	17
MAR 08	8	1270	1	25	1	20
APR 08	13	907	0	0	1	32
MAY 08	1	44	1	4	0	11
JUN 08	11	1290	2	147	0	9
JUL 08	7	416	1	13	1	2
AUG 08	7	206	3	68	0	6
SEP 08	13	911	10	618	0	8
OCT 08	1	41	3	404	0	2
NOV 08	0	0	2	66	0	4
DEC 08	0	0	4	92	3	8
JAN 09	0	0	4	192	0	7
FEB 09	0	0	2	85	0	4
MAR 09	2	233	8	699	8	26
APR 09	1	5	4	182	11	14
MAY 09	2	24	8	895	5	34
JUN 09	1	10	13	579	1	27
JUL 09	3	608	10	856	25	75
Total to Date	**124**	**10174**	**108**	**6319**	**106**	**448**
Average/month	**4.13**	**339.13**	**3.60**	**210.63**	**3.53**	**14.93**

APPENDIX H

SUGGESTED METRICS FOR OUTREACH PROGRAM EVALUATIONS

Process Evaluation: How well and to what extent is the Outreach Program being implemented?

Metrics	**How Measured?**
Prevention	
Number of outreach services provided to Soldiers per year	Program records
Number of Soldiers contacted through each outreach service per year	Program records
Number of each type of referral resulting from outreach services per year	Program records
Soldier disposition after individual consultation	Program records
Soldiers' satisfaction with survey	Satisfaction survey
Implementation	
Detailed description of program activities	Policy/protocol Interviews with program staff
Detailed description of program staffing levels and responsibilities	SOP/policy Interviews with program staff
Detailed description of how program is incorporated into MTF	SOP/policy Interviews with program staff
Detailed description of program funding and revenue	SOP/policy AHLTA

Intermediate Outcome Evaluation: Has the Outreach Program met its objectives?

Indicator	How Measured?
*Knowledge: COSC**	
Soldier can identify signs/symptoms of combat stress reactions	Survey before and after briefings
Soldier can identify available health and welfare resources	Survey before and after briefings
Soldier can describe self-care methods	Survey before and after briefings
Behavior – Help-seeking	
Number of commander referrals	Program data
Commander support	Surveys with commanders
Number of Soldier walk-ins per outreach activity	Tracking cards distributed during outreach Additional intake question
Barriers to mental health	Barriers survey
Number of Soldiers who access services of number referred	PDHA/PDHRA AHLTA Chart review

* Knowledge pre-/post-survey can be adapted/interchangeable based on the content of briefings (anger, sleep, communication, stress, etc.)

Impact Outcome Evaluation: Can changes in the Soldier community be attributed to the Outreach Program?

Indicator	How Measured?
Prevention	
Number of Soldiers in crisis	OQ-45 scores
Timeliness	
Soldier referred to appropriate service	Survey
Amount of time between referral and access to appropriate service	PDHA/PDHRA AHLTA Chart review
Long-term	
Soldier attrition rates of those seeking behavioral health services	Defense Medical Surveillance System