Mental Health Advisory Team (MHAT) V

Operation Iraqi Freedom 06-08: Iraq

Operation Enduring Freedom 8: Afghanistan

14 February 2008

Office of the Surgeon
Multi-National Force-Iraq

and

Office of the Command Surgeon

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Office of The Surgeon General
United States Army Medical Command

The results and opinions presented in this report are those of the Mental Health Advisory Team V members and do not necessarily represent the official policy or position of the Department of Defense, the United States Army, or the Office of The Surgeon General.

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1. OVERVIEW

1.1 Introduction

The fifth Mental Health Advisory Team (MHAT) V was established by the Office of the U.S. Army Surgeon General. Historically, teams have been formed to support requests from the Commanding General, Multi-National Force-Iraq (MNF-I); however, for MHAT V the request from MNFI-I was augmented by a request from the Service Chief, Army Central Command (ARCENT) to examine Soldiers in Afghanistan and Kuwait. Therefore, unlike previous years, the current MHAT report contains two separate reports – one for Operation Iraqi Freedom (OIF) which includes a section on Soldiers in Kuwait, and one for Operation Enduring Freedom (OEF).

The OIF and OEF reports are independent and designed to be stand-alone documents. At the same time, there was close coordination between the OIF and OEF teams. Both teams were staffed primarily with personnel from the Walter Reed Army Institute of Research (WRAIR) and its subordinate unit, the US Army Medical Research Unit – Europe (USAMRU-E). Both teams used virtually identical assessment tools; similar analytic strategies, and collaborated in the writing. For these reasons, there is also a great deal of similarity in the two reports.

One key outcome of the coordination between teams was that the OEF report uses OIF data to help interpret and draw inferences from the data collected in Afghanistan. This was done because OEF had only one previous MHAT data collection (in 2005), and many of the responses on the surveys need to be interpreted in a broader context – comparing OEF to OIF provided this context. Readers of both reports may occasionally note small discrepancies in the values reported for OIF 2007 between the OIF and OEF reports. These differences reflect the fact that it was often necessary to adjust values for demographic and other sample differences in order to clearly delineate findings. For example, Soldiers in the OEF sample had deployed an average of 7.7 months while Soldiers in the OIF sample had deployed an average of 9.4 months. To help compare combat experiences in the two theaters, it was therefore necessary to normalize time and provide adjusted values as though both groups had comparable deployment lengths (9 months).

To illustrate how the adjustments may have changed values, note that in the OIF report the raw value for receiving small arms fire was 57.7% (Appendix C: OIF Report) while the adjusted rate in the OIF report was 59.3% (Table 5: OIF Report). In contrast, the adjusted rate in the OEF report for OIF Soldiers receiving small arms fire was 59.7% (Table 8: OEF Report). The differences in adjusted OIF rates in the two reports (59.3% versus 59.7%) reflect that the adjustments were based on different samples – the OIF report adjusted OIF 2007 relative to the 2006 OIF data, and the OEF report adjusted OIF 2007 relative to the OEF 2007 data. As authors, we felt that the potential confusion of reporting values with minor differences (e.g., 59.3% versus 59.7%) was offset by being able to adjust for demographic differences in the samples that could otherwise obscure substantive differences. Readers should note that great care was taken to provide accurate numbers. Specifically, all reported values in both reports were run in the statistical language R (R Core Development Team, 2007), and replicated by a second member of the research team using the Statistical Package for the Social Sciences (SPSS).

1.2 Combined Findings and Recommendations

Both of the reports have executive summaries providing key findings and recommendations specific to OIF and OEF. Many of the theater-specific recommendations were immediately implemented based on in-theater outbriefs to the medical and operational leaders. For instance, in OEF the distribution of Behavioral Health assets was completely changed based on recommendations from the OEF team. The following summary provides key background, findings and non-theater specific recommendations from the larger reports.

1.2.1 *Background*

During October and November of 2007, MHAT personnel deployed to Iraq and Afghanistan to assess the mental health status of Soldiers. Recommendations are based on:

- 2,295 Soldier well-being surveys from Operation Iraqi Freedom (OIF)
- 699 Soldier well-being surveys from Operation Enduring Freedom (OEF)
- Focus group interviews with Soldiers
- Surveys and interviews with behavioral health, primary care and unit ministry team personnel.

1.2.2 Central Findings from OIF

a. Mental Health and Morale. The percent of Soldiers screening positive for mental health problems is similar to previous years (17.9% for a combined measure of acute stress, depression or anxiety). Reports of unit morale showed a significant increase from 2006.

b. Combat Exposure. Reported levels of combat exposure varied significantly among units; however, there was an overall decline in reports of combat. The decline was most pronounced among Soldiers deployed 6 months or less.

c. Behavioral Health Care Delivery. Compared to 2006, Soldiers reported more difficulty accessing behavioral health services, but lower stigma associated with seeking care. Behavioral health personnel reported a shortage of behavioral health assets and higher burnout.

d. Role of Behavioral Health Officers. Behavioral health personnel reported significant increases in advising commanders about Soldier mental health issues.

e. Deployment Length. Reports of work-related problems due to stress, mental health problems and marital separations generally increased with each subsequent month of the deployment. Reports of mental health problems declined in the last third of the deployment likely due to redeployment optimism.

f. Multiple Deployers. Soldiers on their third or fourth deployment were at significantly higher risk than Soldiers on their first or second deployment for mental health problems and work-related problems.

g. Concussions. In all, 11.2% of Soldiers met the screening criteria for mild traumatic brain injuries. Less than half of these (45.9%) reported being evaluated for a concussion.

h. Battlemind Training. Soldiers who received pre-deployment Battlemind training reported fewer mental health problems.

i. Suicide. Suicide rates continue to be elevated relative to historic Army rates. Most suicides involve failed relationships with spouses or intimate partners.

1.2.3 Central Findings from OEF

a. Mental Health. Soldiers in OEF reported rates of mental health problems (acute stress, depression, anxiety) similar to rates observed in OIF MHAT missions.

b. Combat Exposure. Brigade Combat Team (BCT) Soldiers in OEF reported levels of combat exposure similar to or higher than levels reported by BCTs in Iraq.

c. Barriers to Care. Soldiers reported significant barriers to mental health care, and behavioral health personnel reported difficulties getting to Soldiers.

d. Role of Leadership. Soldiers who report high combat experiences and poor leadership report very high levels of mental health problems. Findings replicate using OIF data.

e. Suicide. Suicide rates were elevated relative to historic Army rates.

1.2.4 Key Recommendations (non-theater specific)

Increase in-theater behavioral health assets

- Develop a mechanism to allow GS or contracted psychiatrists, psychologists, and social workers to fill select behavioral health positions in theater to augment military personnel.
- Create and fill Behavioral Health Officer and NCO positions in Aviation Brigades.
- Mandate all combat medics receive Battlemind Warrior Resiliency (formerly Battlemind First Aid) Training before deploying OEF or OIF to augment behavioral health personnel.

Change the mTOE to maximize the impact of organic behavioral health assets.

- Move Division Psychiatrist position from Sustainment Brigade to Division Surgeon cell.
- Move Brigade Behavioral Health Officer and NCO positions from Brigade Support Battalions (BSB) to the Brigade Surgeon cell.

Mitigate multiple deployment effects

- Provide Soldiers who have deployed multiple times priority for TDA assignments.
- Ensure adequate dwell-time between deployments.

Strategies to reduce suicide risk

- Amend TRICARE rules to cover marital and family counseling as a medical benefit.
- Tailor suicide prevention training packages to focus on phase of deployment and aimed at building psychological resiliency.

Training

- Continue emphasis on Battlemind Training for Soldiers and Families.
- Enhance training for NCOs at Warrior Leader Course, BNCOC and ANCOC on their role in maintaining Soldier resiliency through counseling & mentorship training.
- Develop and implement senior leader Battlemind training.
- Continued emphasis on ethics training.

Concussion

- Develop consistent policies for evaluating Soldiers after a concussive event.

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2. EXECUTIVE SUMMARY

2.1 Introduction

The Mental Health Advisory Team (MHAT) V was established by the Office of the U.S. Army Surgeon General at the request of the Commanding General, Multi-National Force-Iraq (MNF-I). The mission of MHAT V was to:

1. Assess Soldier mental health and well-being
2. Examine the delivery of behavioral health care in Operation Iraqi Freedom (OIF)
3. Provide recommendations for sustainment and improvement to command.

In the period of 2 SEP to 23 OCT, 2,279 OIF Soldiers completed an anonymous survey. In addition, 350 anonymous surveys were completed by behavioral health, primary care and unit ministry team members.

During the period of 15 OCT to 15 NOV the MHAT V team (a) processed and analyzed survey data, (b) examined secondary data sources, and (c) conducted focus group interviews with Soldiers, behavioral health personnel, and medical personnel. The MHAT V team report and recommendations are based on these data sources.

2.2 Central Findings: Soldiers

Findings are listed in terms of outcomes, risk factors, and protective factors.

2.2.1 Morale, Mental Health, Performance and Ethical Behavior Outcomes

1. The percent of Soldiers who reported high or very high unit morale was significantly higher in 2007 than 2006.

2. The percentage of Soldiers screening positive for mental health problems was similar to 2006 and other years.

3. Soldiers' reports of the degree to which their work performance was impaired by stress or emotional problems were significantly lower in 2007 than in 2006.

4. 11.2% of Soldiers met the screening criteria for concussion (also called mild Traumatic Brain Injury – mTBI). Less than half of these were evaluated by a medical professional.

5. Soldiers' reports of engaging in unethical behaviors were largely unchanged relative to 2006; however, they did report a significant decline in "modifying" the rules of engagement.

6. Soldiers who screened positive for mental health problems were significantly more likely to report engaging in unethical behaviors.

2.2.2 *Risk Factors: Soldiers*

1. Normalizing data for months deployed, Soldiers reported a significant decline in exposure to a wide range of combat experiences relative to 2006. The decline was particularly pronounced for Soldiers in theater for six months or less.

2. On an unadjusted basis, Soldiers reported high exposure to a variety of intense combat events. In particular, 72.1% of Soldiers reporting knowing someone seriously injured or killed.

3. There was considerable variability across units in terms of combat exposure.

4. On a normalized basis, relative to 2006 Soldiers reported a significant decline in deployment concerns such as being separated from family. On an unadjusted basis, Soldiers' top concerns were deployment length and being separated from family.

5. Deployment length was a risk factor for most outcomes. A number of outcomes (morale, mental health, alcohol use, and unethical behaviors) show improvements in the last 4 months of the deployment.

6. Even with an improvement in reports of mental health in the last months of the deployment, nearly three times as many Soldiers would be expected to report mental health problems at month 15 than would be expected to report problems at month one.

7. Soldiers on multiple deployments report low morale, more mental health problems, and more stress-related work problems. Soldiers on their third/fourth deployment are at particular risk of reporting mental health problems.

8. Soldiers reported an average of 5.6 hours of sleep per day which is significantly less than what is needed to maintain optimal performance. Reports of sleep deprivation are a significant risk factor for reporting mental health problem and work-related problems.

9. Officers appeared to underestimate the degree to which sleep deprivation negatively impacts performance.

2.2.3 *Protective Factors: Soldiers*

1. Soldiers' ratings of their social climate (leadership, cohesion and readiness) were significantly higher in 2007 than 2006.

2. Soldiers perceptions of the stigma associated with mental health care were significantly lower in 2007 than 2006.

3. In contrast to stigma, Soldiers' perceptions of several barriers to care increased. Increases were likely driven by Soldiers at command outposts who had trouble accessing mental health.

4. Soldiers' perceptions of their marital quality did not change from 2006.

5. Soldiers reported either no change or a decrease in their willingness to report a unit member for engaging in unethical behaviors relative to 2006.

6. Soldiers reported significant increases in training adequacy for managing the stress of deployments and for identifying Soldiers at risk for suicide.

7. Soldiers who received pre-deployment Battlemind training reported lower mental health problems.

8. Soldiers reported a significant increase in the adequacy of ethics training.

2.3 Summary of Behavioral Health Personnel Findings

1. Behavioral Health personnel in 2007 are conducting significantly more command consultations than personnel in 2006.

2. Behavioral Health personnel report significantly more shortages in personnel than did Behavioral Health personnel in 2006.

3. Behavioral Health personnel in 2007 report significantly more burnout than personnel in 2006.

4. The ratio of Behavioral Health personnel to total Army strength is 1:734. This ratio is the highest since OIF 1 where it was 1:836.

2.4 Summary of Primary Care Personnel Findings

1. Primary Care personnel in 2007 report significant increases in helping Service Members with mental health problems and referring Service Members to mental health services relative to 2006.

2. Primary Care personnel report significant increases in the number of medications prescribed for sleep, depression, and anxiety relative to 2006.

2.5 Summary of Unit Ministry Team Personnel Findings

1. Unit Ministry Team members in 2007 report talking more to commanders and with unit medical personnel than members in 2006.

2.6 Summary of Suicide Assessment

Since the beginning of OIF (March 2003), there have been 113 confirmed Army suicides in Iraq. The MNF-I has an active Suicide Prevention Committee, chaired by the Chief of Clinical Operations for the Command Surgeon. This has recently been augmented by an MNCI-I Suicide Prevention Board Chaired by the Corps Chief of Staff. The current suicide training program is being revamped into a more robust program, which will require further review once established to gauge effectiveness. The Automated Suicide Event Report (ASER) is being widely used in the theater by behavioral health care providers, but only for suicides/suicidal gestures by Army personnel. Although there are numerous service-specific mental health tracking systems, there is no single, joint tracking system capable of monitoring suicides, mental

health evacuations, and use of mental health/combat stress control services in a combat environment.

2.7 Key Recommendations

2.7.1 Sustainment of Soldier Resilience

1. Continue emphasis on Battlemind training across the deployment cycle.

2. Continue targeting behavioral health based on time in theater

    a. Time-driven Battlemind debriefing after 6 months in theater for high combat exposure units.
    b. Unit Behavioral Health Needs Assessments after 6 months in theater.

3. Provide NCOs who have deployed multiple times priority for TDA assignments.

4. Provide adequate dwell-time for Soldiers. Research indicates that one-year may not be sufficient time to reset mental health.

2.7.2 Leaders

1. Develop and monitor work cycle programs that provide adequate sleep time using the Combined Arms Doctrine Directorate (CADD) on Sleep Management and encourage Soldiers to seek treatment for sleep problems.

2. Encourage BN and CO leaders to read material such as the NATO leader's guide to "A Leader's Guide to Psychological Support Across the Deployment Cycle."

2.7.3 Training

1. Enhance training for NCOs at Warrior Leader Course, BNCOC and ANCOC on their role in reducing Soldier Stigma through counseling & mentorship training.

2. Enhance and validate ethics training.

2.7.4 Suicide Prevention

1. Synchronize Behavioral Health with Deployment Cycle Support System

2. Tailor suicide prevention training packages focused on phase of deployment and aimed at building psychological resiliency.

2.7.5 Strengthen Families

1. Amend TRICARE rules to cover Marital and Family Counseling as a medical benefit under TRICARE Prime.

2. Increase the number of Family Life providers in CONUS to work with Spouses and Families.

2.7.6 Delivery of Behavioral Health Care in Theater

1. Ensure the Theater Behavioral Health Consultant and senior Mental Health NCOIC are assigned to the MNC/F -I Surgeon's office to have theater oversight.

2. Appoint a Behavioral Health Consultant within each MND to work with the theater Behavioral Health consultant.

2.7.7 Increase the Number of Behavioral Health Personnel

1. Place Behavioral Health Officer and Behavioral Health NCO in Aviation Brigades.

2. Develop mechanism to fill CSC teams with GS or contracted psychologists or social workers.

3. Cross-train select 68W to allow them to augment 68X using training such as Battlemind First-Aid.

3. BACKGROUND AND LIMITATIONS

3.1 Background

This report presents findings from the fifth annual Mental Health Advisory Team (MHAT V). The MHAT deployed to Iraq in support of Operation Iraqi Freedom (OIF) in October and November of 2007. The mission and scope of activities of the MHAT V were approved by the Commanding General (CG), Multi-National Forces – Iraq (MNF-I) (see Appendix A for an unclassified version of the MHAT V Fragmentary Order – FRAGO). The MHAT V members were assigned to the MNF-I and worked directly under the supervision and control of the Command Surgeon, MNF-I who also serviced as the Command Surgeon, MNC-I.

3.1.1 MHAT Mission

The MHAT mission is to assess Soldier mental health and well-being; examine the delivery of behavioral health care in OIF, and provide recommendations for sustainment and improvement to command.

3.1.2 MHAT Scope of Activities

The MHAT is designed to:

1. Assess the mental health and well-being of the deployed force, and identify trends by comparing findings to previous MHAT data.

2. Reassess ethical issues faced by Soldiers to enhance future battlefield ethics training. This activity was included in the previous MHAT (MHAT IV) at the specific request of the CG, MNF-I.

3. Review behavioral health policies, programs, and structure to ensure optimal integration/utilization.

4. Review suicide prevention efforts.

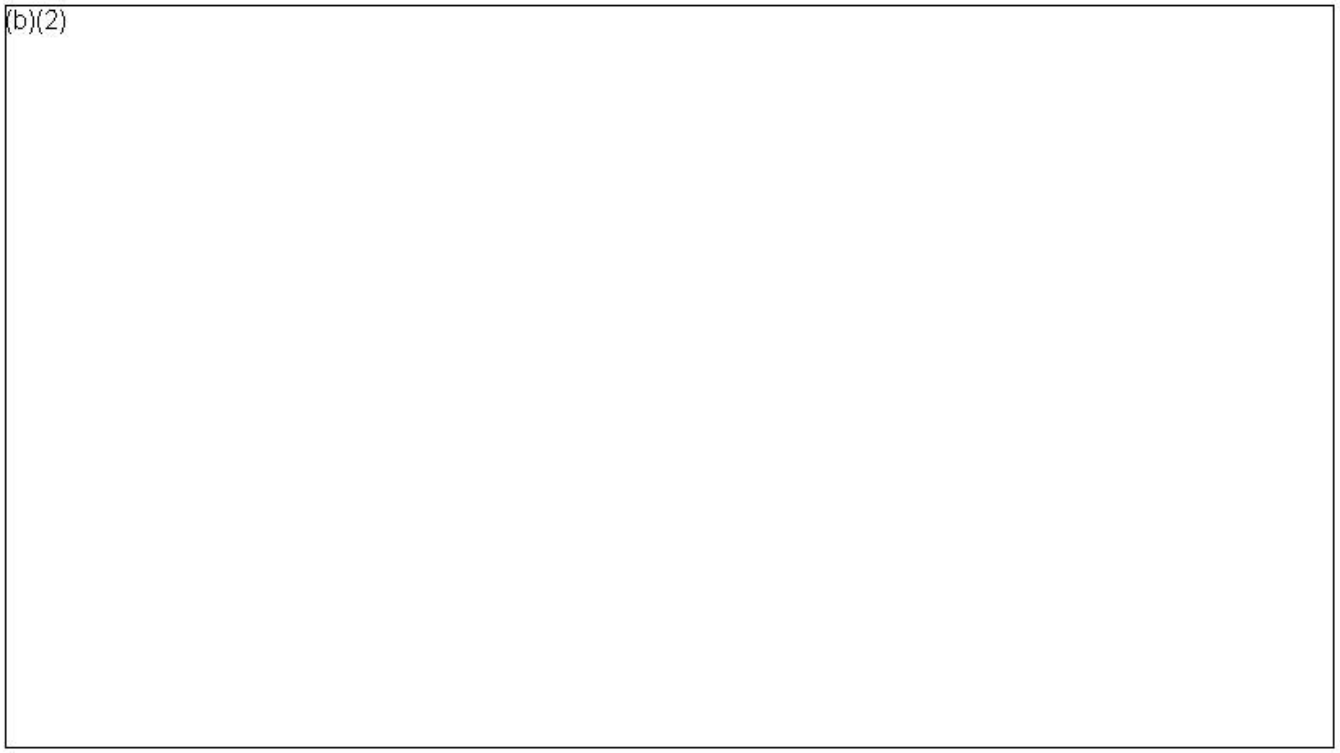
5. Review the status of the implementation of recommendations of previous MHATs.

3.2 Limitations

MHAT recommendations are based upon many sources of information to include survey data from Soldiers and providers, records review and focus groups. One of the primary sources of data, however, comes from the anonymous Soldier Well-Being surveys collected as part of the effort. Soldier survey data are valuable because they provide a way to summarize responses from a large number of Soldiers and examine trends and patterns that would otherwise be impossible to detect. Despite these strengths, there are two limitations associated with the Soldier survey data that need to be highlighted – issues related to the validity of certain scales and the sampling scheme used to collect the data.

3.2.1 Scale Validity

Many of the constructs assessed in the survey are measured using validated scales. For instance, the items used to assess Post-Traumatic Stress Disorder (PTSD) are widely used in civilian and veteran settings and have been subsequently validated in active-duty Army



Brigade Combat Teams and Task Forces represented in the assessment are listed in Table 1. These units had Soldiers complete the Soldier Well-Being survey and provided individuals to complete the behavior health (BH), primary care (PC) or unit ministry team (UMT) surveys. In addition, selected units also provided Soldiers for focus group interviews.

Table 1. Task Forces in OEF

27.3 Demographics and Comparison with MHAT OEF 2005 and OIF 2007

In the analyses detailed in this report, Soldier responses to the OEF 2007 survey (n=699) are compared to responses to the OEF 2005 survey (n=610) and the OIF 2007 survey (n=2195). For each of these assessments, the sampling strategy was virtually identical; nonetheless, there