

**Mental Health Advisory Team (MHAT) V  
Operation Iraqi Freedom 06-08: Iraq  
Operation Enduring Freedom 8: Afghanistan**

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Office of the Surgeon  
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and

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and

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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.