Mental Health Advisory Team (MHAT) 6
Operation Enduring Freedom 2009
Afghanistan

6 November 2009

Office of the Command Surgeon
US Forces Afghanistan (USFOR-A)

and

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 6 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.

The MHAT 6 team would like to acknowledge the active involvement and in-theater support provided by the CJTF 101 Psychiatrist and the 30th MEDCOM Behavioral Health Consultant. It was through their initiative and effort that the current report was able to examine a large sample of Service Members from maneuver and support and sustainment units.

1. EXECUTIVE SUMMARY

1.1 Introduction

Mental Health Advisory Team 6 OEF was established by the Office of the U.S. Army Surgeon General at the request of the Commanding General, US Forces Afghanistan (USFOR-A). The purpose of MHAT 6 OEF was to:

1. Assess Service Member behavioral health
2. Examine the delivery of behavioral health care in Operation Enduring Freedom (OEF)
3. Provide recommendations for sustainment and improvement to command.

From April 2009 to June 2009, OEF Service Members at the operational level completed the anonymous MHAT 6 OEF survey. In total, 638 surveys were collected from 27 maneuver unit platoons, and 722 were collected from 25 support and sustainment platoons. Additionally, 126 surveys were collected from Soldiers in TF (b)(2) (b)(2) and 63 surveys were collected from Service Members serving at (b)(2) Thirty-one surveys were collected from behavioral health personnel in the Afghanistan Theater of Operations (ATO). From 07 May to 24 June, the MHAT 6 OEF team (a) processed and analyzed survey data, (b) examined secondary data sources, (c) conducted focus group interviews with Soldiers and behavioral health personnel, and (d) wrote the technical briefing and draft report.

MHAT 6 OEF differs from previous MHATs in three ways.

1. Pre-selected platoons were randomly selected to complete surveys.
2. Two distinct samples were collected – a sample of platoons within maneuver battalions of Brigade Combat Teams (BCTs) (maneuver unit sample), and a sample of platoons from support and sustainment units (support and sustainment sample).
3. Trends where examined across the three years of MHATs conducted in OEF (2005, 2007, and 2009).

1.2 Central Findings

1.2.1 *Outcomes: Behavioral Health and Relationships*

1. Morale: Individual morale rates in OEF 2009 were similar to rates reported in 2005 and 2007. However, unit morale rates in OEF 2009 were significantly lower than in 2005 or 2007.

2. Psychological Problems: Rates of psychological problems (any combination of acute stress, depression, or anxiety) in OEF 2009 were similar to OEF 2007 rates but were significantly higher than OEF 2005 rates.

3. Marital Problems: Junior enlisted Service Members reported significantly more marital problems (divorce intentions from either Service Member or spouse or infidelity concerns) than NCOs. Service Members in support and sustainment units reported significantly more marital problems than Service Members in maneuver units.

1.2.2 *Risk Factors*

1. Combat Exposures: Combat exposure rates in OEF 2009 were significantly higher than rates in OEF 2005 and similar to rates in OEF 2007. Support and sustainment units reported significantly fewer combat exposures than maneuver units.

2. Deployment Length: Maneuver unit Service Members in OEF 2009 reported significantly lower unit morale in the last 6 months of their deployment. OEF 2009 support and sustainment Service Members' morale remained constant across the length of the deployment.

3. Deployment Length: Support and sustainment unit Service Members reported significantly more marital problems in the last 6 months of their deployment compared to maneuver unit Service Members.

4. Multiple Deployments: Service Members on their third/fourth deployment report significantly more acute stress, psychological problems, and among married Service Members, report significantly more marital problems compared to Soldiers on their first or second deployment.

5. Multiple Deployments: Service Members on their third/fourth deployment also reported using medications for psychological or combat stress problems at a significantly higher rate than Service Members on their first deployment.

1.2.3 *Resilience Factors*

1. Barriers to Care: Barriers to receiving behavioral healthcare were significantly higher in OEF 2009 compared to 2005. This may reflect the high troop dispersion through the Afghanistan Theater of Operations (ATO) but also may be a result of a change in sampling design in OEF 2009 improving the distribution of surveys throughout the ATO.

2. Barriers to Care: Barriers to care in support and sustainment units were significantly lower than in maneuver units.

3. Stigma: In maneuver units, stigma rates about receiving behavioral health care held constant across 2005, 2007, and 2009. No differences in stigma rates were found between maneuver and support and sustainment units.

4. Coping behaviors: The amount of time Service Members engaged in individual coping behaviors during their off time (such as surfing the net and video gaming) was associated with a decrease in psychological problems when done in moderation (no more than 2 to 4 hours). However, the association reversed itself if Service Members spent more than 3 or 4 hours per day engaged in these activities. The exception to this curvilinear trend was with physical training (PT). Physical training was associated with decreased psychological problems regardless of how much time is spent doing PT.

5. Behavioral Health Training: OEF 2009 Service Members reported increases in the frequency and adequacy of several different types of behavioral health training (deployment stress, Battlemind, and suicide prevention) compared to OEF 2005 and 2007.

1.3 ATO Behavioral Healthcare System Assessment

1. The Afghanistan Theater of Operations (ATO) is currently understaffed in behavioral healthcare personnel based on combat and operational stress doctrine (Combat and Operational Stress Control Planning Model).

2. Physical security policies and procedures were a concern among behavioral healthcare providers interviewed in the wake of the (b)(2) (Iraq) homicides.

1.4 ATO Suicide Assessment

1. There were seven confirmed suicides in calendar year 2008.

2. There have been five confirmed 2009 suicides as of 31 May 2009..

3. Ninety-five percent (95%) of Service Members reported receiving suicide prevention training within the last year.

1.5 (b)(2) Assessment

1. Rates of psychological problems were higher than other support and sustainment units.

2. (b)(2) personnel whose primary military occupational specialty (MOS) was Military Police (MP) reported fewer psychological problems than personnel whose primary MOS was not MP.

3. ATO Behavioral healthcare providers expressed concern about (b)(6) personnel's psychological well-being.

1.6 Task Force (b)(2) Assessment

1. Rates of psychological problems were lower than other maneuver units although rates of combat exposure were comparable.

2. Demographically, TF (b)(2) Soldiers are older, higher in rank, and have more military experience.

3. The OEF 2009 TF (b)(2) findings replicate findings of previous MHATs with military transition team personnel.

1.7 Key In-Theater Recommendations

1. Increase behavioral health personnel staffing in accordance with the combat and operational stress control doctrine of one behavioral health asset per 700 Soldiers.

2. Maintain the 1:700 staffing ratio through the surge in forces and ensure that the end-state ratio supports the final end-state force strength. Directly related to this, MHAT 6 OEF recommends:

(b)(2),(b)(5)

3. Once the staffing ratio of 1:700 is stabilized, implement a dual-provider model assigning an additional behavioral healthcare provider as an embedded asset to Brigade Combat Teams (BCTs). This can occur: (1) prior to deployment through a request for forces, or (2) by re-assigning a combat stress control provider to directly support a given BCT. The dual provider model will better support highly dispersed Soldiers and does not necessarily require additional resources.

4. Appoint a senior Behavioral Health consultant and a senior BH NCO to USFOR-A in order to provide strategic coverage of joint behavioral healthcare in the ATO.

1.8 Key CONUS Recommendations

1. Develop and validate resilience training for at-risk groups. MHATs identify at-risk groups during deployments. Evidence-based research must be conducted to ensure that validated resilience and intervention programs are implemented. Specific training that needs to be developed includes:

    a. Resilience training for personnel serving in detainee operation positions.
    b. Resilience training for multiple deployers and their families.
    c. Resilience training in the use of social media (e.g., social networking, email etiquette).

2. Assign a Behavioral Health Advocate within each Battalion. This recommendation is based on a program established by (b)(2) in 2007-2008. A behavioral health advocate is a Soldier, preferably an NCO, who has received added training in basic behavioral health, coping and life skills, and referral processes. The behavioral health advocate would be an additional duty assignment similar to the Equal Opportunity representative within each Battalion. Behavioral health advocates can be a force multiplier because they are embedded in the unit, know the leaders and Soldiers, and can serve as a conduit to behavioral health resources for Soldiers within the unit. Warrior Resilience Training developed by MEDCOM is an example of training that could be used for this purpose.

3. Add a block of instruction on basic behavioral health to the Combat Lifesaver training course.

4. Consider establishing a permanent organic behavioral health role within National Guard BCTs. Presently, NG BCTs do not have organic behavioral health. A small behavioral health staff would be a force multiplier in that they could aid NG BCT Soldiers throughout their mobilization, activation, demobilization, and return to home state support.