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

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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 abou (b)(2) 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 the (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.

2. BACKGROUND

2.1 Mission and Background

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

The sixth Mental Health Advisory Team (MHAT 6) deployed to Afghanistan in support of Operation Enduring Freedom (OEF) in May and June of 2009. This report presents MHAT 6 OEF findings from anonymous surveys, focus groups, and interviews with Service Members in maneuver, support and sustainment, and behavioral health units. The MHAT 6 OEF team members were assigned to US Forces Afghanistan (USFOR-A) and worked directly under the supervision and control of (b)(2) Medical Command.

2.2 Sampling Strategy

As noted above, MHAT recommendations are based upon multiple sources of information (survey data, records, and focus groups and behavioral health care provider interviews). Much of the report, however, centers on data from anonymous surveys. In MHAT 6, two separate samples of Service Member survey data were collected. The first was a cluster sample of pre-selected platoons from maneuver battalions of BCTs (maneuver unit sample). The second was a cluster sample of pre-selected operational support and sustainment units (support and sustainment sample). In both samples, platoons were randomly pre-selected, and surveys were requested from Service Members within these units.

As part of an effort to continually improve the MHAT process, researchers at the Walter Reed Army Institute of Research (WRAIR) worked with sampling statisticians at the Defense Manpower Database Center (DMDC) during 2008 to refine the previous sampling methodology used in earlier MHATs. The goal of these meetings was to identify a sampling plan that could be implemented in theater.

2.2.1 *Maneuver Unit Sample*

The maneuver unit sample was collected by randomly selecting three platoons from three randomly selected line Companies from every maneuver battalion in theater. The random selection of platoons was conducted by the MHAT team based on specific information about deployed units with the consultation of Army G3 (Operations) planners.

There are a number of advantages to using cluster sampling of platoons within maneuver battalions. First, Soldiers in these units are war-fighters engaged in direct combat-related tasks. In practice, platoons vary in the level of combat they experience, but at a conceptual level all platoons in maneuver units can be considered interchangeable; therefore, a random selection of platoons is a convenient way to generate a proportional random sample of war-fighters.

A second advantage to sampling platoons in maneuver battalions is that these units are a core component of nearly every deployed force. In contrast, the configuration of support and sustainment sample forces is more variable. For instance, early in a deployment, forces may require a heavy transportation component, but this capability may be filled by contract personnel as the theater matures. Focusing on platoons in maneuver battalions provides a stable group from which future MHATs can make comparisons across deployments.

A third advantage to cluster sampling platoons is that the sampling plan can be easily implemented in an operational environment. In the case of MHAT 6 OEF, a fragmentary order (FRAGO) identified the units, and organic medical personnel in the brigade who conducted the surveying. In contrast, developing and executing a stratified random sample of individuals would be prohibitively difficult and has historically produced low response rates (personal communication, DMDC).

A fourth advantage is that sampling platoons in maneuver battalions provides a relatively close link to previous MHAT data. Previous MHATs directed units to provide 250 surveys from select BCTs of which no more than 50 could be from support units. The data, therefore, are heavily weighted by the war-fighter population. The link to previous MHATs is not perfect and leads to some issues on how to interpret MHAT 6 relative to other years; nonetheless, the focus on BCTs across MHATs provides a reasonable basis for comparison.

A final advantage with the use of cluster sampling is that it provides some degree of anonymity to Soldiers. As we note below, the anonymity is less than that offered in previous MHATs; however, it is substantially higher than a random sampling approach that identifies specific Soldiers based on individual demographic characteristics.

Despite these advantages, there are also limitations with this approach. First, the population of maneuver unit Service Members represents less than half the deployed population (see McGrath, 2007). Therefore, a maneuver unit sample must not be considered as representative of the entire deployed force in the ATO. Second, by using a cluster sample of platoons, little data is collected from officers, senior NCOs or females. Third, because the sampling provides detailed information about platoon membership, we had to be careful to avoid potentially incriminating items. Specifically, to address concerns raised by DMDC and human use review boards, specific items related to drug use, alcohol use and potential war crime violations were omitted for MHAT 6.

The bottom line is that choosing a sampling strategy required trade-offs. Scientifically, however, it was necessary to ensure that the sample was randomly selected, and we concluded that randomly selecting platoons from maneuver units was the most feasible sampling strategy.

2.2.2 *Support and Sustainment Sample*

For the first time, MHAT 6 (OIF and OEF) employed cluster sampling of support and sustainment platoons in addition to the cluster sampling of maneuver platoons. Support and sustainment platoons were selected from the Brigade Support Battalion (BSB) and Brigade Special Troops Battalion (BSTB) in the BCTs. Specifically, each BCT provided 10 support and sustainment platoons. The support and sustainment sample was also comprised of platoons from other brigade-sized elements in the ATO. Specifically, platoons were sampled from a Maneuver Enhancement Brigade (MEB), an Expeditionary Sustainment Command (ESC), a Combat Aviation Brigade (CAB), a Sustainment Brigade, and the (b)(2) (b)(2).

This support and sustainment sample represents the most comprehensive assessment of non-maneuver unit elements conducted by an MHAT. It also maintains a random cluster design where units were randomly specified beforehand. Strictly speaking, the support and sustainment sample is not a truly representative sample of all support and sustainment assets in theater because some smaller assets were not sampled and we cannot ensure the proportions

of sampled elements in the MHAT 6 OEF sample mirror those in the broader population. Additionally, support and sustainment platoons vary greatly in their functional mission at the platoon level in contrast to maneuver platoons. This reality also makes it difficult to ensure true representativeness using cluster sampling. Nonetheless, the sample provides broad coverage of the support and sustainment population. Furthermore, analytically the issue of representativeness is a concern primarily for point estimates (e.g., statements such as 15% of the population reports some issue). Analyses involving relationships among variables (e.g., multiple deployers report significantly more psychological problems) are largely unaffected (Faraway, 2006). Many of the results in the report involve predictive relationships of this latter nature.

2.2.3 *Comparisons to Other MHATs*

As noted, the maneuver unit sample was developed with the intent that it would allow direct comparisons to previous MHATs; nonetheless, it is important to stress that the sampling design is an abrupt change from previous years. One likely consequence of the change is that the sample may reflect a much higher percent of "hard-to-reach" Service Members. Previous MHATs may have oversampled Service Members within Forward Operating Bases (FOBs) simply because these Service Members were conveniently located with the individual administering the survey. In contrast, the random identification of platoons required those administering the survey to sample the pre-specified platoon even if the platoon was not located on a FOB. We comment more on the sampling effects in Section 3.4 after discussing demographic characteristics of the samples.

2.3 Changes Across Time: OEF 2005, 2007, and 2009

To examine changes across MHATs, we rely on statistical models that include time as a predictor. In the models, time is modeled as a categorical variable using the 2009 MHAT 6 OEF maneuver unit sample as the referent. This provides a way to contrast the MHAT 6 values with previous OEF MHATs in 2005 and 2007.

Graphs included in this report present sample-adjusted values based on male respondents and adjusted for demographic sample differences in rank and months deployed. Specifically, the sample-adjusted values represent (1) male, (2) junior enlisted Soldiers deployed for (3) six months or longer. NCOs are used as the referent when examining multiple deployment effects. In a few cases, we report raw values (e.g., concussion and medication usage, respectively). Note that because sample-adjusted values are based on data combined across all OEF MHATs, the values listed in this report for the past OEF MHATs may not necessarily coincide with the values provided for MHAT OEF 2005 and 2007. Values are adjusted based on the attributes of the combined MHAT 2005, 2007, and 2009 sample, so adding to the total sample produces slight changes in the sample-adjusted values.

2.4 Differences in Maneuver and Support and Sustainment OEF 2009

In addition to across-year changes, maneuver and support and sustainment samples are also compared for OEF 2009. Raw values are presented for these two samples. Tests of significance looking at differences between the samples were computed based on demographic adjustments. Therefore, when a significant difference is noted, it is based on the adjusted values while the raw values are presented. Sample-adjusted values are based on male, junior enlisted respondents who have been deployed for six months or longer.

When comparing maneuver and support and sustainment samples, it is important to note that the raw values listed for the maneuver unit sample for OEF 2009 and the maneuver unit sample from the 2009 change across time is similar but not necessarily the same. This is because 2009 values looking at changes across time were based on the sample adjustments noted previously for the 2005, 2007, and 2009 datasets, while raw values are reported for the 2009 maneuver sample in comparison to the support and sustainment sample.

2.5 Analytical Strategy and Verification of Results

Adjusted values or means were estimated from either a logistic regression model or a linear regression model. All analyses were run in the statistical language R (R Core Development Team, 2009), and replicated by a second member of the research team using the Statistical Package for the Social Sciences program (SPSS).

2.6 Focus Groups

The MHAT 6 OEF team conducted 18 focus groups with a total of 86 Soldiers (46 junior enlisted and 40 NCOs) from both maneuver and support and sustainment units at (b)(2) (b)(2) Themes from the focus groups are summarized in Section 7 and highlights are integrated in the relevant sections of the Soldier and Behavioral Healthcare Provider survey data results.

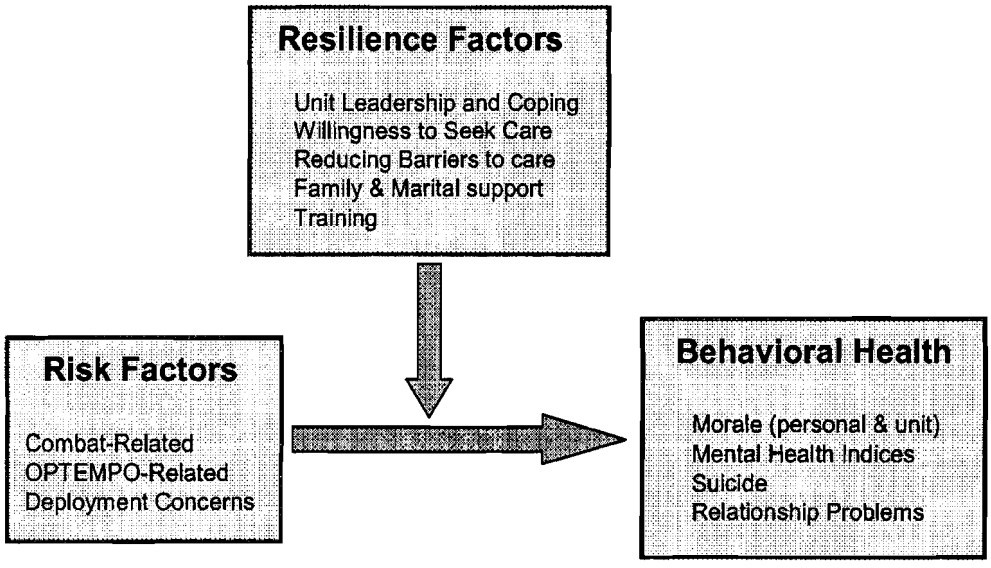
3. OVERVIEW OF SERVICE MEMBER WELL-BEING

The MHAT 6 OEF survey contains the core survey measures used in all previous MHATs. MHAT surveys are adapted from the Land Combat Study conducted at the WRAIR (Hoge, Castro, Messer et al., 2004; Hoge, Terhakopoian, Castro et al., 2007; Riviere, 2008).

3.1 Service Member Combat & Well-Being Model

The MHAT 6 OEF survey covers: (1) Risk Factors, such as combat experiences; (2) Resilience Factors, such as willingness to seek care; and (3) Behavioral Health Status Indices (Figure 1).

Figure 1. Service Member Combat & Well-Being Model (Adapted from Bliese & Castro, 2003).



3.1.1 *Behavioral Health Outcomes*

One of the strengths of the MHAT process is the use of a standard set of behavioral health status indicators. These include:

1. Individual and Unit Morale
2. Acute Stress (PTSD), Depression and Anxiety
3. Suicidal Ideation

This report provides comparisons to previous MHAT samples and examines changes across the three years for which data are available (2005, 2007, and 2009). The report also provides rates of these variables for the current two MHAT 6 OEF samples (maneuver unit and support and sustainment unit).

3.1.2 *Risk Factors*

In the conceptual model, behavioral health rates are driven by risk factors. In this report, risk factors are broken down into three major classes. The first class of factors is composed of

combat-related events. Research has consistently demonstrated that high levels of combat experiences (e.g., being attacked or ambushed, clearing homes and buildings, etc.) are associated with higher levels of psychological problems, such as acute stress (Dohrenwend, et al., 2006). The second class of factors is OPTEMPO-related experiences such as deployment length and multiple deployments. The third category is comprised of deployment concerns related to living conditions, work concerns and family concerns.

With respect to OPTEMPO-related experiences, previous MHAT reports have detailed the effects of OPTEMPO factors, such as deployment length and multiple deployments. These two factors are also examined in MHAT 6 OEF.

3.1.3 *Resilience Factors*

Based on the framework of the conceptual model in Figure 1, behavioral health and performance can be improved either by: (a) reducing or eliminating factors that put Service Members at risk; or (b) strengthening protective factors, so Service Members are better able to cope when exposed to factors that place them at risk.

In a combat environment, many risk factors are unavoidable (e.g., exposure to potentially traumatic combat events) or are the direct product of National Military Strategy decisions (e.g., the size of the military requires deploying Service Members multiple times). For these reasons, many behavioral health interventions focus on developing and enhancing programs designed to help Soldiers cope with known risk factors, in an attempt to improve Service Member resilience. The current MHAT report examines:

1. Stigma and willingness to seek care
2. Perceived barriers to care
3. Perceived adequacy of behavioral health training

MHAT 6 OEF also contains a section examining individual coping behaviors and common activities Soldiers engage in during their off-time while deployed. These items were included in an attempt to identify behaviors that may be useful in developing resilience programs and strategies for Service Members.

3.2 MHAT 6 OEF Service Member Sample and Methods

Units represented in the MHAT 6 OEF assessment are listed in Table 1. These units had Service Members complete the MHAT 6 OEF survey. In addition, selected units also provided Soldiers for focus group interviews.

Table 1. Maneuver and Support and Sustainment Units in the MHAT 6 OEF Sample.

(b)(2)

3.3 Maneuver Unit and Support and Sustainment Sample Demographics

Table 2 provides details on selected demographic variables for the maneuver and support and sustainment samples compared to the MHAT 5 sample. The maneuver unit sample for MHAT 6 OEF differed from the MHAT 5 OEF maneuver sample in terms of: (a) having a lower percentage of multiple-deployed Service Members; and (b) being in theater less time. The samples did not differ in terms of age, rank distribution, or marital status.

Compared to the MHAT 6 OEF maneuver unit sample, the MHAT 6 OEF support and sustainment sample differed in terms of: (a) age (greater percentage of Service Members under 30); (b) marital status (higher percentage of married Service Members); (c) rank (higher percentage of officers, but lower percentage of NCOs); and time in theater (these Service Members reported having been in theater longer). The support/sustainment sample also contained females (16%), whereas the maneuver unit sample had no females.

Table 2: Demographic Comparison MHAT 6 OEF (Maneuver & Sustainment and Support) to MHAT 5 OEF.

	MHAT 5 OEF Total Sample (n=610)		MHAT 6 OEF (Maneuver, n=638)		MHAT 6 OEF (Support/Sustainment, n=722)	
Demographic Variable	n	Percent	n	Percent	n	Percent
Gender						
Male	528	86.6%	---	---	601	83.2%
Female	80	13.1%	---	---	117	16.2%
Unknown	2	0.3%	---	---	4	0.6%
Age						
18-24	268	43.9%	404	63.3%	521	72.2%
25-29	150	24.6%	156	24.5%	151	20.9%
30-39	144	23.6%	63	9.9%	48	6.6%
40+	46	7.5%	12	1.9%	0	0.0%
Unknown	2	0.3%	3	0.5%	2	0.3%
Rank						
E1-E4	275	45.1%	430	67.4%	347	61.3%
NCO	295	48.4%	181	28.4%	156	31.2%
Officer / WO	38	6.2%	21	3.3%	22	6.1%
Unknown	2	0.3%	6	0.9%	1	0.4%
Component						
Active	437	71.6%	633	99.1%	680	94.2%
Reserve	165	27.0%	1	0.2%	36	5.0%
Unknown/Other	8	1.3%	4	0.7%	6	0.8%
Marital Status						
Married	331	54.3%	297	46.6%	397	55.0%
Not Married	272	44.6%	317	49.7%	305	42.2%
Unknown/Other	7	1.1%	24	3.8%	20	2.8%
Deployment History						
First Time	---	---	371	58.2%	387	53.6%
Second Time	---	---	153	24.0%	164	22.7%
Third or More	---	---	50	7.8%	85	11.8%
Unknown	---	---	64	10.0%	86	11.9%
Time in Theater						
6 Months or Less	42	6.9%	341	53.4%	343	47.5%
6 to 12 Months	540	88.2%	158	24.8%	196	27.1%
Unknown	30	4.9%	139	21.8%	183	25.3%

3.4 Cluster Sample Effects

Table 2 identifies differences between the MHAT 5 OEF and MHAT 6 OEF samples with respect to multiple deployment status and time in theater. The length of time spent outside of the units' main Forward Operating Base (FOB) also differed. In the MHAT 5 sample, 24.7% reported living more than 28 days per month outside of the FOB, whereas 31.5% of the MHAT 6 sample reported living outside the FOB that long. By comparison, only 3.9% of the MHAT 6 OEF support and sustainment sample reported living in an outpost more than 28 days per month. This finding is likely due the new sampling strategy for MHAT 6 which pre-selected platoons regardless of their location.

4. BEHAVIORAL HEALTH INDICES

Behavioral health indices provide an overview of the well-being of the deployed force. This section reviews a variety of measures and compares them to previous OEF MHAT data. The standard graph used in this section provides:

1. Across-year adjusted comparisons that represent sample-adjusted maneuver unit values for each of the three OEF MHATs. Values are adjusted for gender, rank and time in theater, and describe male E1-E4 Service Members in theater for 6 or more months. The sample-adjusted value for MHAT 6 OEF is based on the maneuver unit sample. Values that significantly differ from MHAT 6 OEF are underlined.

2. Raw 2009 values for both the (a) maneuver unit sample and the (b) support and sustainment sample. An underlined value for the support and sustainment sample indicates the value is significantly different from the maneuver unit value after controlling for gender, rank, and months deployed.

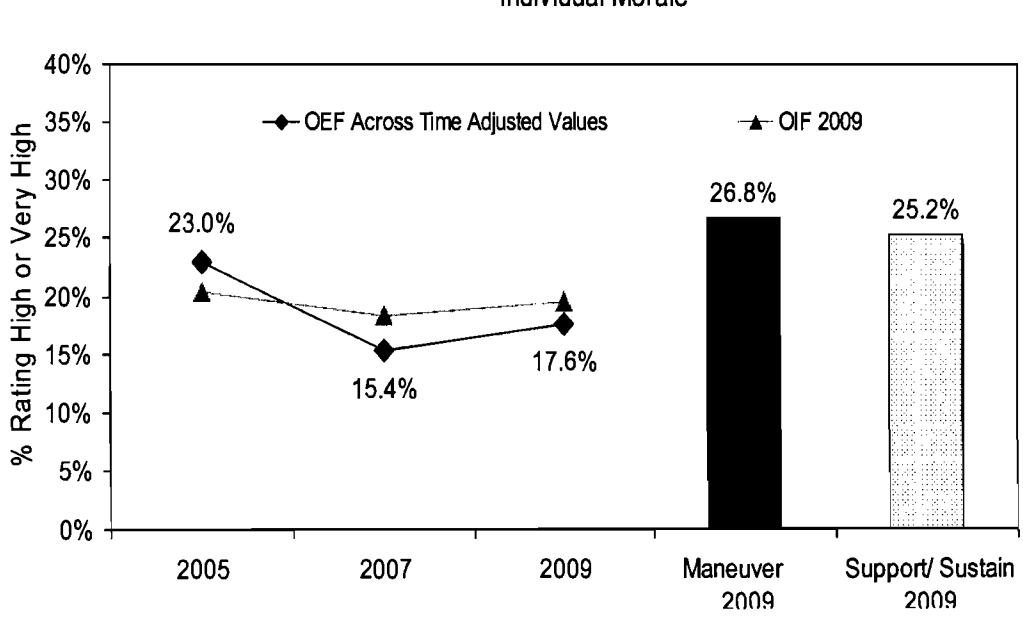
3. In some cases, OIF 2009 values are provided as a reference line for the OEF across year adjusted comparisons. The line is indicated by a gray line with triangle (▲).

4.1 Morale

4.1.1 *Individual Morale*

Figure 2 provides the values for Service Members who reported having high or very high individual morale across the three OEF MHATs. The across-year 2009 value of 17.6% is not significantly different than the value of 15.4% in 2007 or the value of 23.0% in 2005. The 2009 values for the maneuver and support and sustainment units are also included in Figure 2. There are no significant differences between these two samples. It is important to note that the raw value reported for the maneuver unit in the graph below is higher than the 2009 adjusted value. This is because the raw value includes NCOs and officers over the course of the deployment window. NCOs and Officers historically report better morale and psychological health than the junior-enlisted.

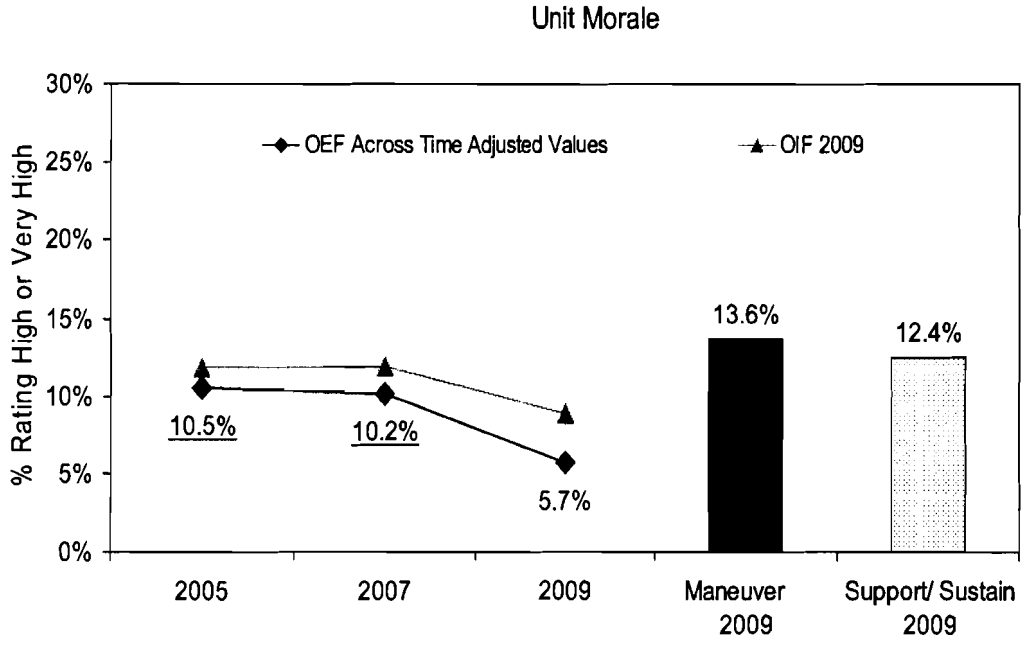
Figure 2: Adjusted Values for Individual Morale Across MHAT OEF Years and Raw Values for 2009 (Maneuver and Support and Sustainment)



4.1.2 *Unit Morale*

The percent of Service Members who rated unit morale high or very high is presented in Figure 3. Compared to previous years, unit morale in 2009 has decreased significantly. The across-year values for 2009 are significantly lower than values in 2005 and 2007. As with individual moral, unit morale for the support and sustainment sample did not differ significantly in 2009 from the maneuver unit sample.

Figure 3: Adjusted Values for Unit Morale Across MHAT OEF Years and Raw Values for 2009 (Maneuver and Support and Sustainment)



In focus groups, Soldiers discussed how morale was mostly influenced by factors that directly affected them both as an individual and as a unit such as leadership and personal time off. An NCO 11 months into his 3rd deployment working support missions (b)(2) (b)(2) emphasized the importance of time off saying, "Morale out here is moderate to high because we have some down time and soldiers have personal times to themselves."

4.2 Behavioral Health: Acute Stress, Depression and Anxiety

Service Members' ratings of depression, generalized anxiety and acute stress (i.e., Post-Traumatic Stress) were assessed using standardized, validated scales (Bliese, et al., 2008; Spitzer, Kroenke, & Williams, 1999; Weathers, Litz, Herman, Huska, & Keane, 1993). Details on scoring specific scales are available in previous MHAT reports.

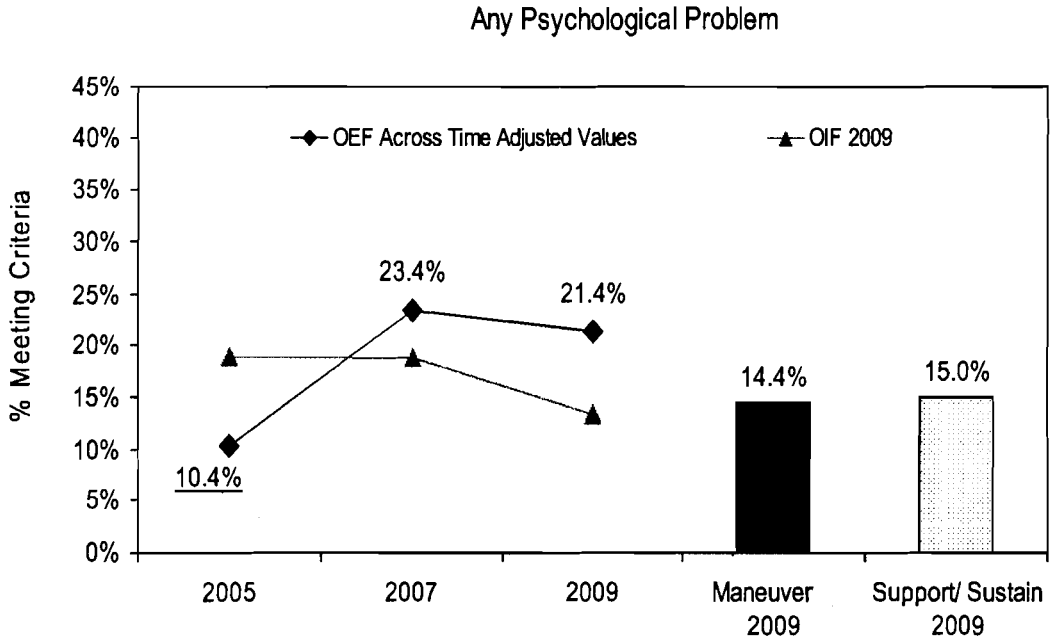
4.2.1 *Behavioral Health: Any Psychological Problem*

The combined rating of any psychological problem (acute stress, depression or anxiety) is presented in Figure 4. The percent of Service Members reporting psychological problems in 2009 (21.4%) is similar to 2007 (23.4%) but significantly higher than in 2005 (10.4%). The

across-year values for OIF are plotted on the graph in gray and indicate a downward trend toward lower rates than those currently seen in OEF.

The 2009 raw value for support and sustainment units was not significantly different than the raw value for the maneuver unit sample.

Figure 4: Adjusted Values for any Psychological Problem Across MHAT OEF Years and Raw Values for 2009 (Maneuver and Support and Sustainment)



4.2.2 *Acute Stress, Depression and Anxiety*

The specific values for acute stress, depression and anxiety are provided in Table 3. The across-year adjusted values for acute stress trended upward. The 2009 rates are significantly higher than in 2005 (7.1% versus 17.9%) but not significantly higher than in 2007 (17.5%). The 2009 value for anxiety did not differ significantly from 2005 or 2007. Rates for depression were significantly lower than in 2007 (14.4% versus 6.7%) but did not differ from 2005 (6.4%). The 2009 raw values for the support and sustainment and maneuver units did not differ significantly for acute stress, depression or anxiety.

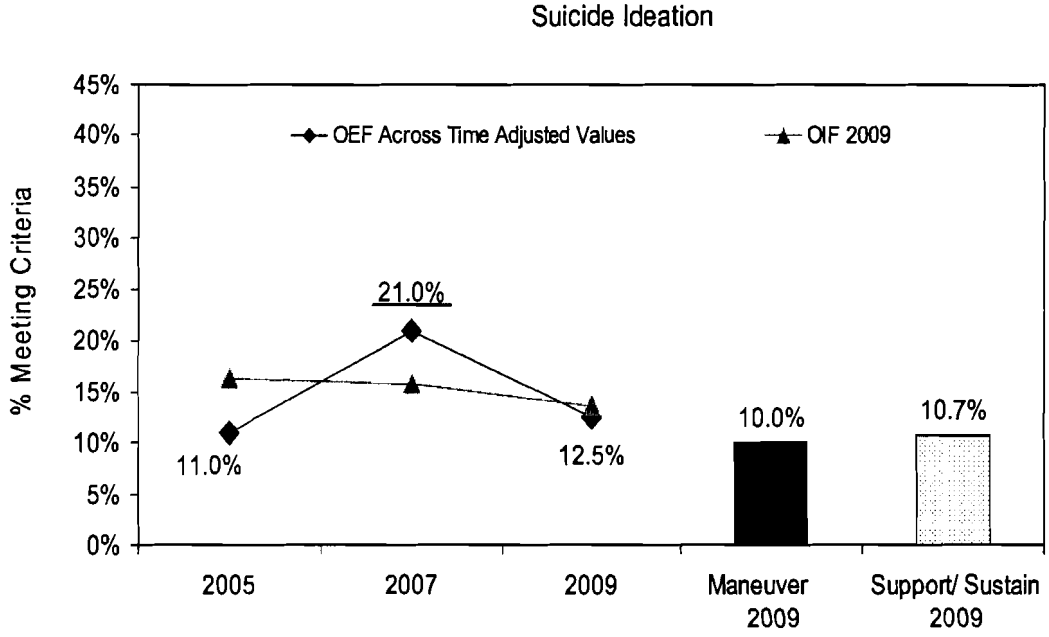
Table 3. Adjusted Values Across MHAT OEF Years and Raw Values for 2009 (Maneuver and Support and Sustainment).

	Across MHAT OEFs			OEF 2009 Maneuver and Support/Sustain	
Mental Health Indicator	2005	2007	2009	Maneuver	Support/ Sustain
Acute Stress	7.1%	17.5%	17.9%	11.9%	13.4%
Depression	6.4%	14.4%	6.7%	4.8%	4.8%
Anxiety	6.3%	12.3%	6.6%	4.1%	4.8%
Any Mental Heatlh Problem	10.4%	23.4%	21.4%	14.4%	15.0%

4.3 Suicide Ideation

Suicide ideation can also be examined using a single depression item on the MHAT 6 OEF survey. This item (item 9 of the PHQ-D) asks Service Members if they have been bothered by thoughts that they would be better off dead or of hurting themselves in some way over the last four weeks. Any response other than "Not at all" is considered a positive response. The 2005 adjusted value was not significantly different from 2009. However, the 2007 value was significantly higher than 2009. The 2009 raw values for the maneuver and support and sustainment units were not significantly different (Figure 5).

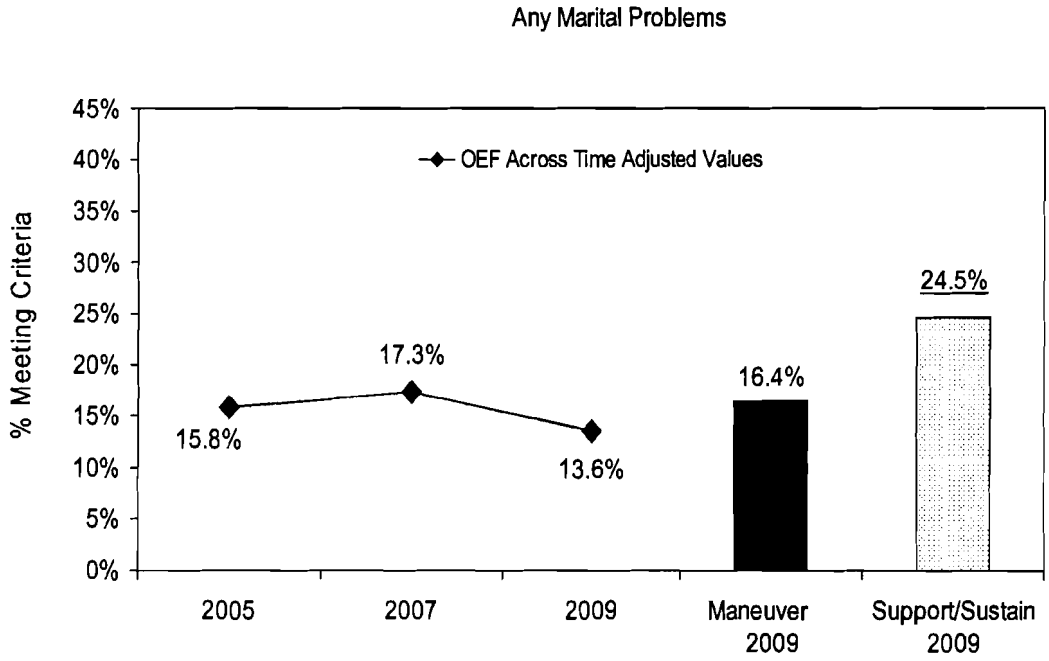
Figure 5: Adjusted Values for Suicide Ideation Across MHAT OEF Years and Raw Values for 2009 (Maneuver and Support and Sustainment)



4.4 Marital Problems

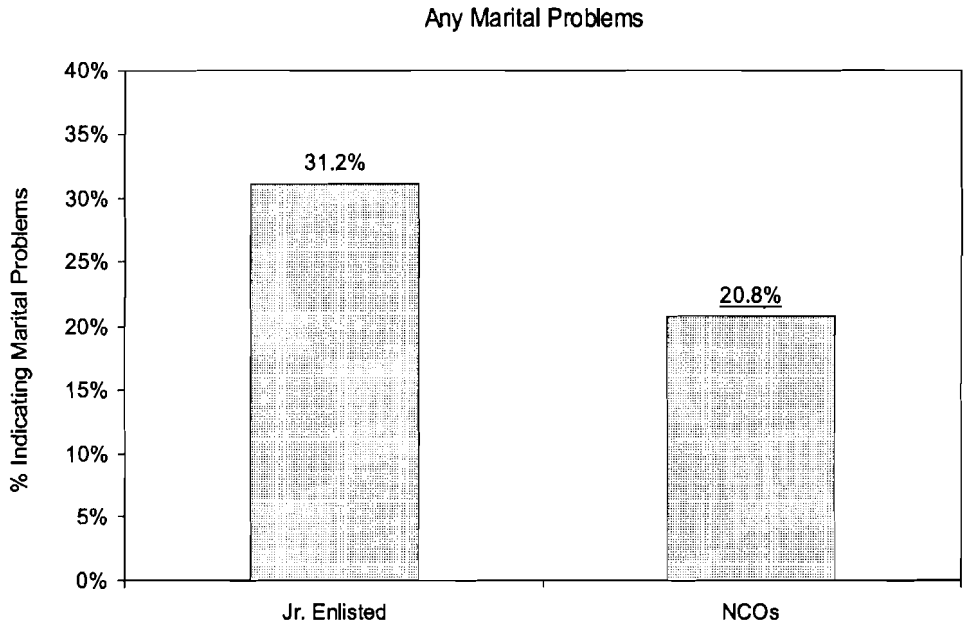
Service Members who indicated that they intend to divorce or that infidelity has been a problem in their marriage were classified as having a marital problem. Across-year values for 'marital problem' are not significantly different. However, the 2009 adjusted values for the maneuver and support and sustainment units are significantly different. A larger percentage of support and sustainment Service Members (24.5%) reported marital problems compared with 16.4% of the maneuver Service Members (Figure 6a).

Figure 6a: Adjusted Values for Any Marital Problems Across MHAT OEF Years and Raw Values for 2009 (Maneuver and Support and Sustainment)



The relationship between rank and marital problems was evaluated using a combined maneuver and support and sustainment sample controlling for gender and time in theater.On this measure, junior enlisted Service Members had significantly higher rates of marital problems than NCOs (see Figure 6b). Due to the small number of Officers in the MHAT 6 OEF sample, we were unable to report a rate for marital problems among Officers.

Figure 6b: Adjusted Values for Any Marital Problems comparing NCOs and Junior Enlisted Service Members in 2009 Sample (combined Maneuver and Support and Sustainment)



In focus groups, many Soldiers discussed troubled relationships. For instance, an NCO with a support and sustainment unit commented that, "I think it (mental health) has to do with things happening at home: people breaking up, tragedies...this could break apart a Soldier, they don't have control." Another Soldier referred to a story about a fellow Soldier, "half way through the deployment he found out she was cheating and taking his money. It was quite troublesome for him." Taking perspective a senior NCO with multiple tours commented that, "you've got to have a Plan B if things don't work out. You've got to move on. It helps you out."

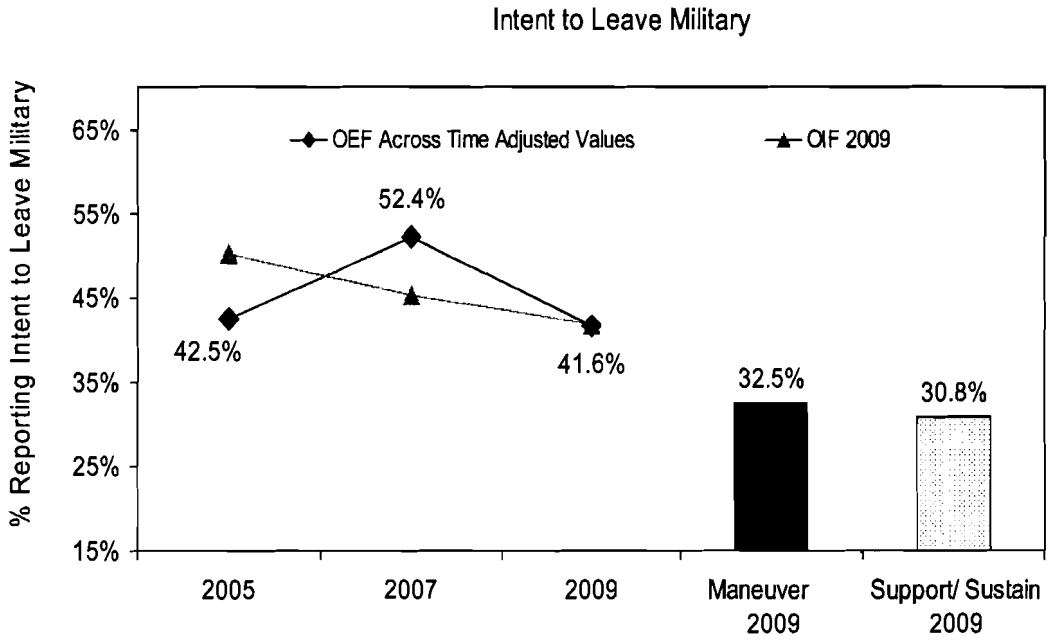
4.5 Concussion (mTBI)

In both MHAT 5 and MHAT 6, Service Members responded to a series of questions about possible concussive events during their deployment. The sample-adjusted percent of OEF 2009 maneuver unit Service Members who reported an injury event with loss of consciousness was 3.0%, significantly lower than the sample-adjusted value of 9.7% for OEF 2007. Of those who reported a concussion with loss of consciousness in OEF 2009, 41.2% reported seeking medical care, which is similar to the 45.8% from OEF 2007.

4.6 Career Intentions

The MHAT 6 OEF survey includes items about Service Members' intent to leave the military upon completion of their current obligation. The 2005 and 2007 across-year adjusted OEF values did not differ from the 2009 sample. Similarly, the 2009 raw maneuver and support and sustainment samples were not significantly different.

Figure 7: Adjusted Values for Intent to Leave the Military Across MHAT OEF Years and Raw Values for 2009 (Maneuver and Support and Sustainment)



5. SERVICE MEMBER RISK FACTORS

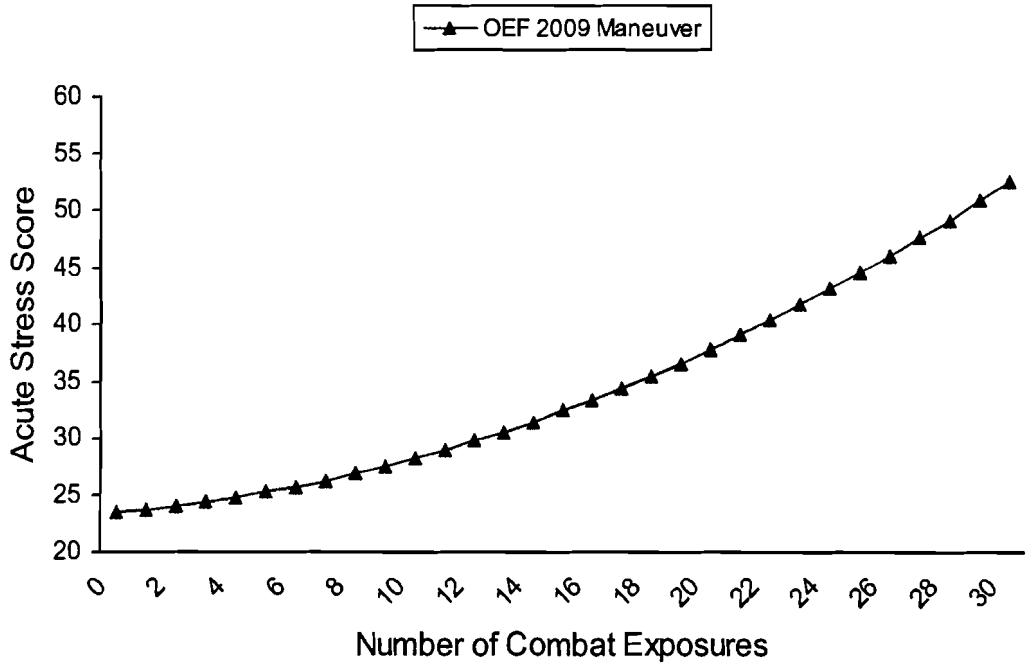
As noted in the conceptual model, it is convenient to classify service member risk factors into three broad categories: combat-related risk factors, OPTEMPO-related risk factors, and deployment concerns. Changes in behavioral health indices should presumably be associated with changes in these three categories of risk factors.

5.1 Combat Experiences

As reported in Section 4.2.2, reports of acute stress increased significantly in the maneuver unit sample relative to 2005. Exposure to potentially traumatic experiences is one of the principal risk factors for behavioral health problems in combat settings (Fontana & Rosenheck, 1998); therefore, based on the findings from Section 4.2.2, we expect to see significant increases in combat-related risk factors relative to data from 2005.

Thirty combat experience items have been consistently assessed since MHAT 2 in 2004. The experiences routinely assessed include items such as "Knowing someone seriously injured or killed", "Being wounded/injured" and "IED/booby trap exploded near you". A combat experience score (ranging from 0 to 30) was created by summing the number of reported experiences. Figure 8 shows the relationship between the combat experiences score and acute stress scores for maneuver units in Afghanistan in 2009. Combat experiences have both a linear and curvilinear relationship with acute stress such that increases in combat experiences are associated with increases in acute stress scores.

Figure 8: The relationship between combat exposure and acute stress



5.1.1 *Combat Experiences*

Figure 9 provides a comparison of the mean number of combat experiences from 2005 to 2009. The mean combat exposure score reported in MHAT 6 OEF (14.3) is significantly higher than in 2005 (10.7) but similar to 2007 (13.9). The levels of combat exposure reported by Service Members in support and sustainment units are significantly lower than rates reported by those in maneuver units (10.0 versus 6.2).

Figure 9: *Adjusted Values for Combat Exposure Across MHAT OEF Years and Raw Values for 2009 (Maneuver and Support and Sustainment)*

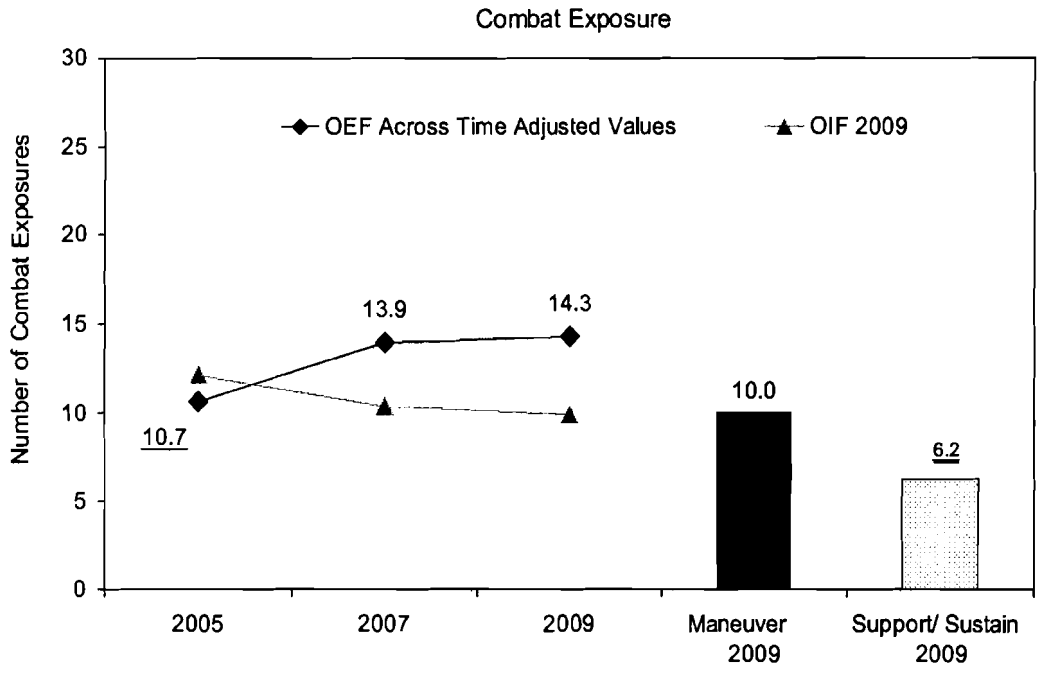


Table 4 provides a list of the 30 combat experiences for maneuver units in 2005, 2007 and 2009. All values are sample-adjusted for male E1-E4s in theater 6 months. With a conventional p-value of .05, the large number of analyses comparing MHAT 6 to MHAT 5 OEF (30 different tests) raises the possibility that one or two significant results would be observed by chance. Therefore, to adjust for the family-wise error rate, Table 4 only lists as significant results p-value equal to or less than .01.

Table 4 shows that, overall, 19 combat experiences increased significantly from 2005 to 2009 and seven combat experiences increased significantly from 2007 to 2009. It is evident that levels of combat in the ATO in 2009 remain high and has increased significantly since 2005.

Table 4. Combat Exposure: Adjusted Percents for Male, E1-E4 Soldiers in Theater 6 Months or Longer.

Combat Experiences (OEF)	Percent		
	2005	2007	2009
During this deployment did you experience being attacked or ambushed	49.9%	74.3%	83.3%
During this deployment did you experience seeing destroyed homes and villages	62.5%	58.2%	65.0%
During this deployment did you experience receiving small arms fire	48.5%	68.6%	74.1%
During this deployment did you experience witnessing an accident which resulted in serious injury or death	41.5%	46.5%	59.6%
During this deployment did you experience witnessing violence within the local population or between ethinic groups	44.9%	48.4%	53.8%
During this deployment did you experience seeing dead or seriously injured Americans	49.1%	63.5%	62.2%
During this deployment did you experience knowing someone seriously injured or killed	70.4%	87.1%	82.9%
During this deployment did you experience participating in demining operations	25.4%	34.6%	41.7%
During this deployment did you experience IED/booby trap exploding near you	37.9%	45.5%	46.1%
During this deployment did you experience working in areas that were mined or had IEDs	73.4%	65.2%	68.9%
During this deployment did you experience having hostile reactions from civilians	49.8%	57.0%	57.8%
During this deployment did you experience disarming civilians	41.8%	37.2%	30.3%
During this deployment did you experience being in threatening situations where you were unable to respond because of rules of engagement	33.1%	48.2%	58.2%
During this deployment did you experience shooting or directing fire at the enemy	36.0%	58.8%	74.8%
During this deployment did you experience calling in fire on the enemy	17.0%	30.6%	44.1%
During this deployment did you experience engaging in hand to hand combat	5.4%	4.6%	5.7%
During this deployment did you experience clearing/searching homes or buildings	49.3%	52.5%	52.5%
During this deployment did you experience clearing/searching caves or bunkers	42.0%	46.1%	52.6%
During this deployment did you experience being wounded/injured	5.8%	24.5%	15.8%
During this deployment did you experience seeing ill/injured women or children who you were unable to help	46.7%	39.1%	39.3%
During this deployment did you experience receiving incoming artillery rocket or mortar fire	75.2%	91.0%	92.9%
During this deployment did you experience being directly responsible for the death of an enemy combatant	12.9%	30.9%	51.6%
During this deployment did you experience having a member of your own unit become a casualty	56.4%	75.0%	77.1%
During this deployment did you experience a close call dud landed near you	19.6%	38.7%	39.2%
During this deployment did you experience a close call equipment shot off your body	3.0%	16.1%	11.5%
During this deployment did you experience a close call was shot or hit but protective gear saved you	2.5%	11.9%	11.0%
During this deployment did you experience having a buddy shot or hit who was near you	8.8%	24.1%	36.4%
During this deployment did you experience informing Unit members/friends of a Service Members death	9.0%	20.8%	8.7%
During this deployment did you experience seeing dead bodies or human remains	52.3%	68.1%	54.6%
During this deployment did you experience handling or uncovering human remains	27.6%	42.5%	26.1%

5.2 OPTEMPO Factors: Deployment Length

Months deployed was identified as a risk factor associated with negative behavioral health outcomes in previous MHATs (see MHAT 4 and MHAT 5). The MHAT 6 OEF sample contained a bimodal distribution for months deployed. Therefore deployment analyses were conducted by dividing the sample into deployment lengths less than 6 months or deployment lengths greater than 6 months.

Figure 10 presents the values for individual morale as a function of deployment length for maneuver and support and sustainment units. Individual morale ratings did not change significantly from the first half of deployment to the second half. This finding was consistent for both maneuver and support and sustainment units. Previous MHATs have reported that morale decreases during deployment, is lowest at the deployment midpoint and then trends upward as redeployment nears. Because of the bi-modal distribution of data in the current sample, month by month analyses could not be conducted.

Figure 10: Deployment Length and Individual Morale in Maneuver and Support and Sustainment Units.

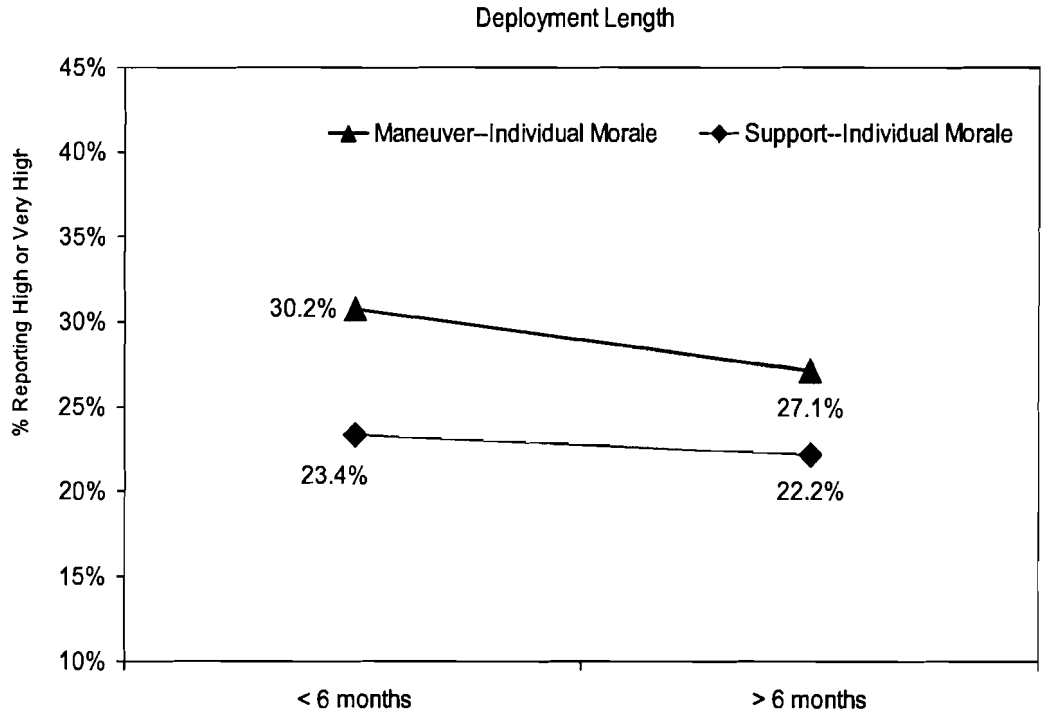
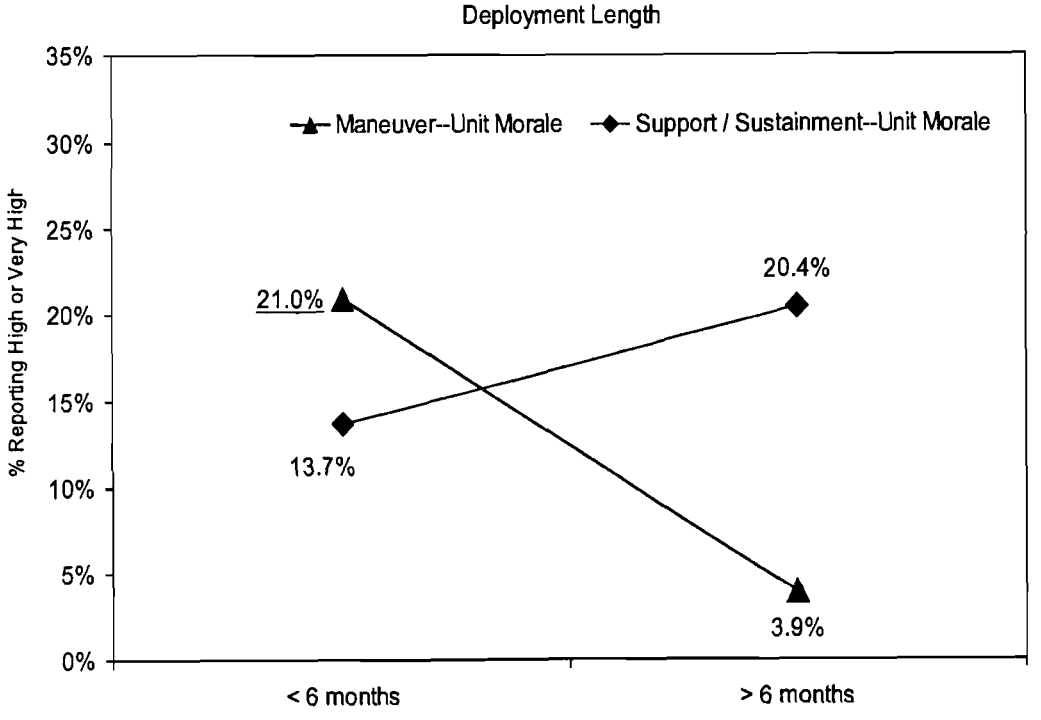


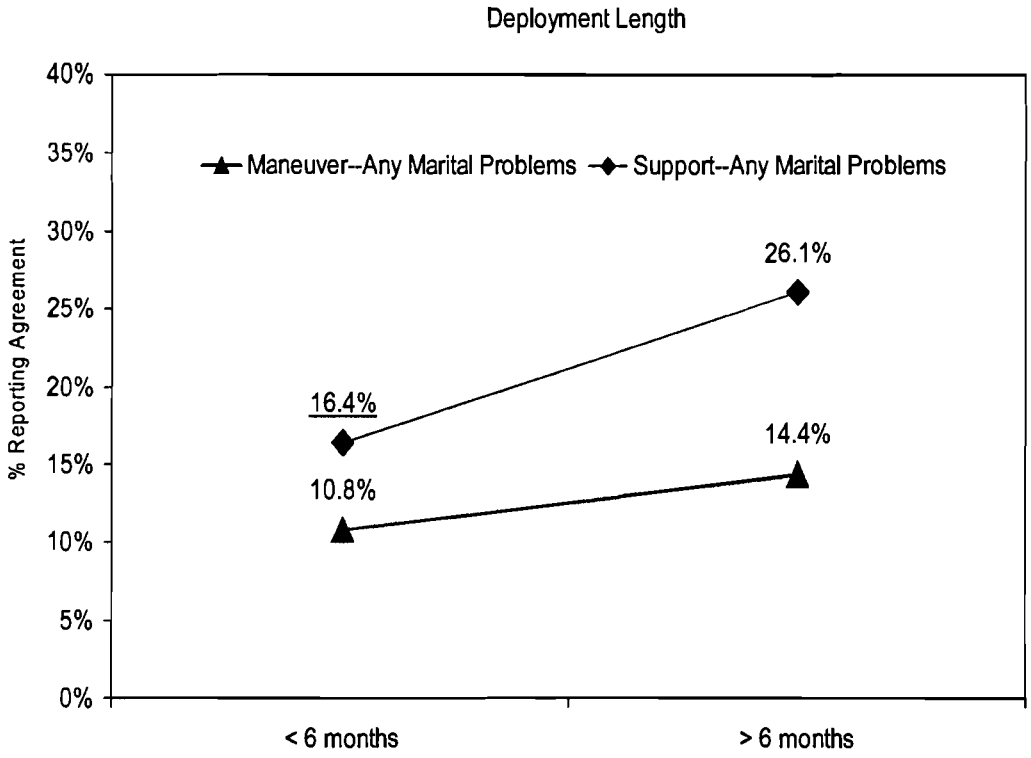
Figure 11 presents changes in unit morale as a function of deployment length. Unit morale in the maneuver sample declined significantly in the last 6 months compared to the first 6 months. In contrast, unit morale in the support and sustainment sample increased in the last 6 months.

Figure 11: Deployment Length and Unit Morale in Maneuver and Support and Sustainment Units.



Reports of marital problems increased significantly during the second half of the deployment for support and sustainment units but not for maneuver units (Figure 12).

Figure 12: Deployment Length and Any Marital Problem by Deployment Length in Maneuver and Support and Sustainment Units.



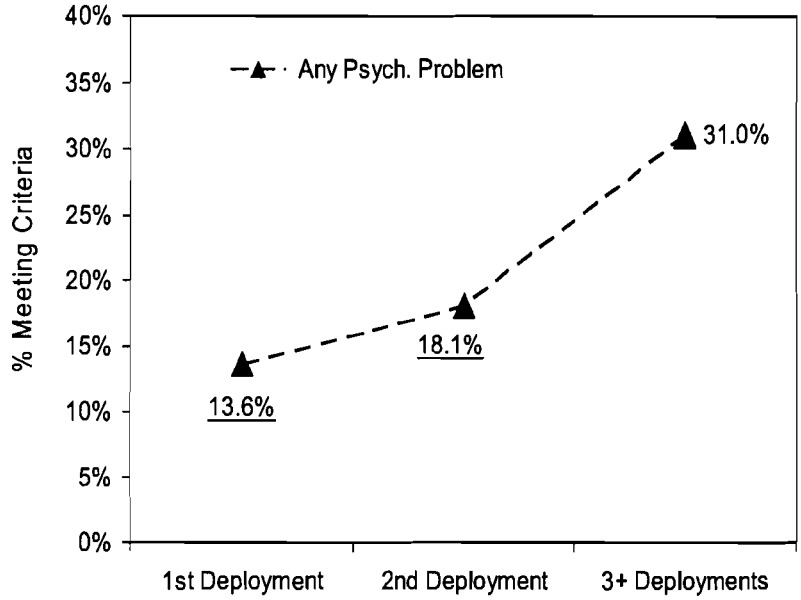
5.3 OPTEMPO Factors: Multiple Deployments

In 2007, the OEF sample examined the effects of multiple deployments on behavioral health by comparing first-time deployers to those who had deployed at least one time before. This year, by combining maneuver and support and sustainment samples, there were enough Service Members on their third or fourth deployment to create three deployment groups: first-time deployers (55.7%), second-time deployers (23.3%), and those with 3 or more deployments (9.9%).

As in previous years, Service Members in the multiple-deployer group are predominately NCOs. Specifically, NCOs constitute 14.1% of the first-time deployer group, 59.0% of those on their second deployment and 69.3% of those and those with 3 or more deployments.

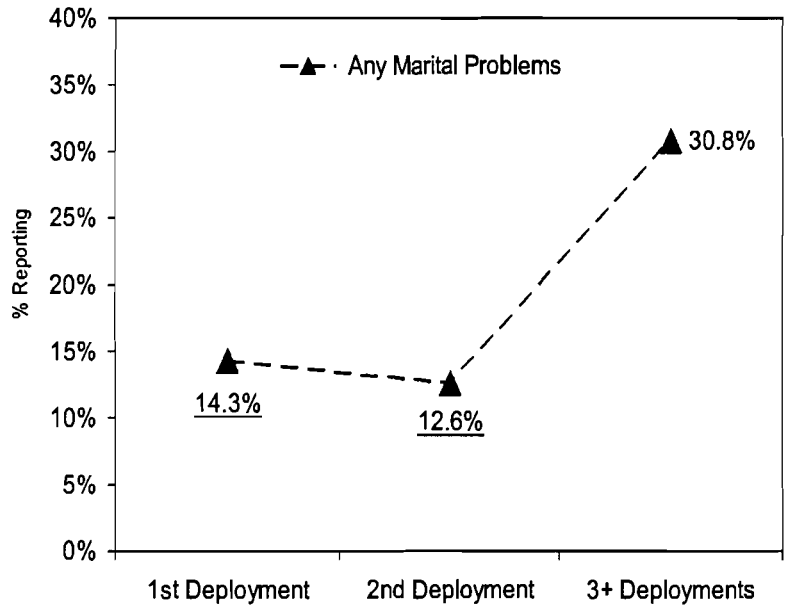
Previous MHATs in Iraq and Afghanistan have identified multiple deployments as a risk factor for psychological problems. Figure 13 shows 2009 OEF sample-adjusted rates for male, NCOs in theater 6 months or longer. These data indicate a clear multiple deployment effect on rates of behavioral health. Three-plus times deployers are significantly more likely to meet the criteria for a psychological problem (31%) than are first (13.6%) or second time (18.1%) deployers.

Figure 13: Multiple Deployments and Any Psychological Problem



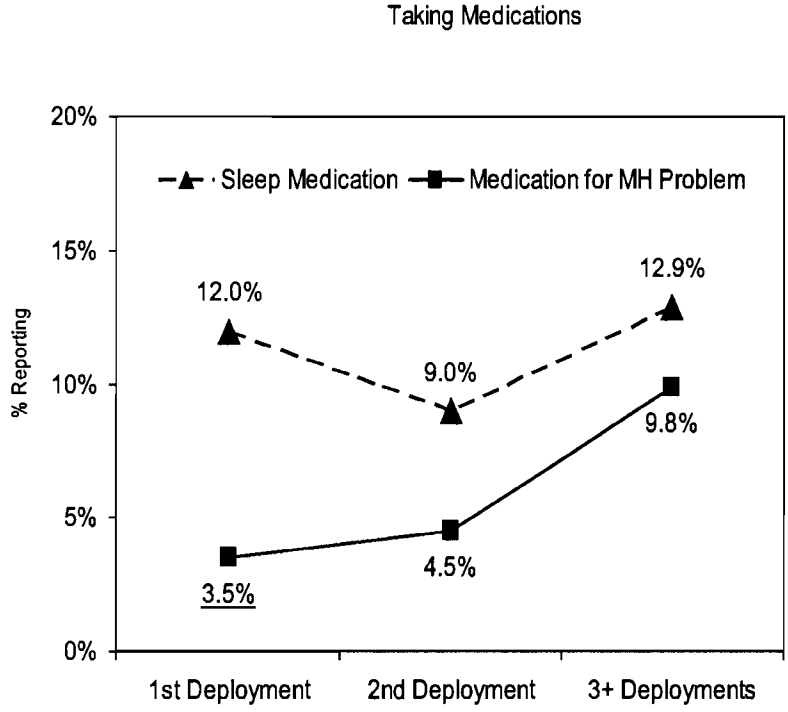
Similarly, Figure 14 presents rates for marital problems as a function of deployment length. Rates for three-plus time deployers are significantly higher (30.8%) than those for first time (14.3%) or second-time deployers (12.6%).

Figure 14: Multiple Deployments and Any Marital Problem



The MHAT 6 OEF survey collected information about the use of sleep or combat stress medications on behavioral health. Overall, 2.9% of maneuver unit Soldiers reported using medications for a mental health problem and 9.2% reported using sleep medications. For Support units, 6.4% reported using mental health medications and 13.5% reported using sleep medications. The reported rates for using sleep medications did not change significantly among first, second or third-time deployers. However, reported usage rates for other behavioral health medications increased significantly by the third deployment (Figure 15).

Figure 15 Multiple Deployments and Medication Use



The negative effects of multiple deployments were discussed in the majority of focus groups. One maneuver unit Soldier summed it up by saying, "multiple long-term deployments--it is hard on everyone. It is starting to wear on people."

5.4 Deployment Concerns

While combat experiences are intense events that put service members at risk, other less dramatic, but more chronic concerns can impact behavioral health. The MHAT 6 OEF survey asked service members to rate how much trouble or concern they have about a series of eleven non-combat related issues including family, job and personal time. These items and the rates for each are presented in Table 5 below. In general, rates for most of the items have been constant across years and did not change significantly. Interestingly, there was a significant drop this year for the long deployment length item. This may reflect the fact that the 2007 sample was collected mainly from units that were on 15 month deployments compared to the current 12 month deployment length. Reported rates for difficulties communicating back home

are also down compared to 2007. Increased communication capabilities via personal computers and cell phones may be influencing these rates.

Table 5. Adjusted Percentages Across Years and Raw Percentages for 2009 Maneuver and Support and Sustainment Units.

Deployment Concerns	Across Years (Maneuver) 2005	2007	2009	2009 Maneuver	Support
Being separated by family	43.5%	33.8%	37.4%	29.1%	29.8%
Illness or problems back home	26.5%	18.3%	17.2%	12.9%	18.0%
Boring or repetitive work	42.0%	43.8%	39.1%	29.8%	33.2%
Difficulties communicating back home	17.3%	30.1%	18.9%	18.3%	14.5%
Uncertain redeployment date	35.0%	40.1%	40.8%	22.9%	24.8%
Lack of privacy or personal space	39.1%	40.8%	41.3%	30.3%	35.1%
Lack of time off for personal time	38.2%	45.5%	39.8%	32.5%	38.4%
Not having the right equipment or parts	22.1%	31.8%	34.5%	25.5%	26.7%
Not getting enough sleep	23.4%	35.9%	33.2%	24.9%	29.1%
Continuous operations	27.8%	39.1%	32.1%	24.7%	28.0%
Long deployment length	56.7%	67.0%	32.5%	22.2%	29.3%

Forward Operating Bases (FOBs) had varying levels of infrastructure and amenities depending on their size and location, how long it has been in operation, and the missions of the Soldiers it supports. However, as one Infantry Soldier commented, "we are Infantry, so we are used to living in the suck."

6. SERVICE MEMBER RESILIENCE FACTORS

Resilience factors are the third broad category of factors in the conceptual model of Service Member well-being (see Section 3.1). The concept of psychological resilience can be defined as the ability to maintain psychological health (or even to experience psychological growth) when faced with challenges. As illustrated in this section, resilience is affected, both positively and negatively, by multiple factors to include unit climate, individual coping behaviors, the willingness and ability to seek care, marital support, and perceptions of behavioral health training designed to help Service Members.

6.1 Unit Climate

Unit factors such as leadership, cohesion, and readiness also play a role in either exacerbating or attenuating the link between deployment stressors and behavioral health outcomes (e.g., Bliese & Castro, 2003; Bliese, 2006). Because unit climate variables tend to be highly and positively related (i.e., leadership ratings and readiness ratings), one approach is to create a single index measure that accounts for different aspects of unit climate and simply classifies it as positive or negative (see James and James, 1989).

This approach to assessing unit climate was first used in MHAT 5 OIF (2007). We use the same constructs and scoring algorithm for the current report. The unit climate index combines cohesion, unit efficacy, and NCO and Officer leadership ratings. A mean score of above 3 is considered indicative of a positive climate whereas a score of below 3 is considered as indicative of a negative climate.

Significantly more Service Members rated their unit climate as positive this year (2009, 72.3%) compared to 2005, (62.1%). Looking within the 2009 OEF sample, 76.9% of maneuver units deployed longer than 6 months rated their unit climate as positive compared to 70.3% in support and sustainment units. This difference is statistically significant.

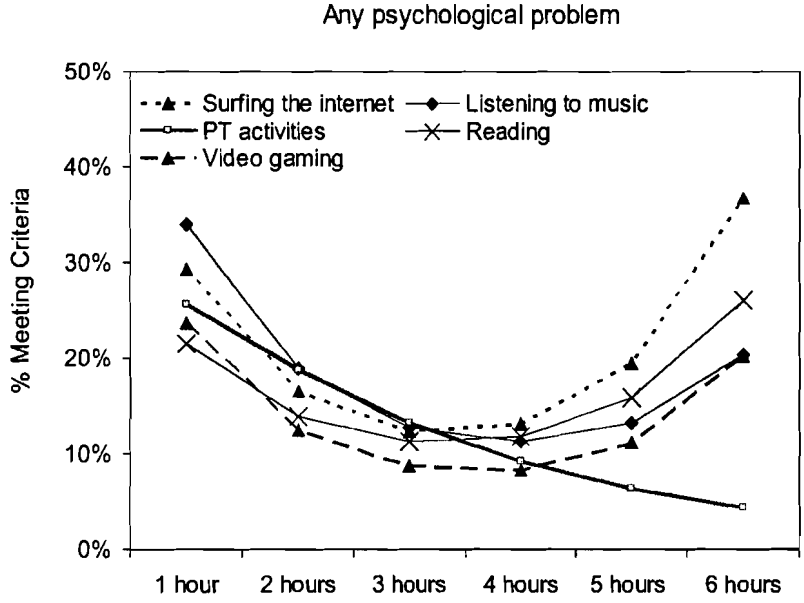
Focus group comments from Service Members further illustrate how important unit climate variables such as leadership and cohesion to building resilience within a deployed unit. When Soldiers were asked about leadership, communication was a common concern. For example, an NCO noted that "a lot of issues has to do with, a lot of us are detached from our command. We hear other Soldiers getting information. We haven't got too much information about when we are going home." Unit and team cohesion was also often mentioned in focus groups as a benefit to maintaining morale, health, and mission accomplishment. One NCO commented that, "all the camaraderie was built (within the team) and then you get with some schmo who (you) don't know who is going to last. Echoing the importance of team cohesion, another NCO noted that, "you know what one guy is capable of doing (when you train with them).

6.2 Individual Coping Behaviors

For the first time, the MHAT 6 surveys asked Service Members about activities they engaged in during off-duty hours such as surfing the internet, video gaming, doing physical training (PT). Potentially, these behaviors can be viewed as strategies used to cope with the effects of combat deployments and to maintain resilience. Service Members were asked to identify how many hours per day they spent engaging in a series of non-work related activities. For several of these activities, a "U" shaped relationship was identified between hours spent engaging in the

activity and meeting the criteria for a psychological problem (Figure 16). Using email or the internet, listening to music, and playing video games were associated with lower psychological problems when done in moderation but negatively associated when engaged in for longer durations. Interestingly, PT seemed to be associated with lower scores in a linear fashion such that rates continued to drop as time spent engaging in the activity increased. The effects seen below in Figure 16 still held true even after controlling for self-reported hours of sleep per night.

Figure 16: Time Spent Daily Engaged in Coping Activities and Any Psychological Problem



6.3 Stigma

At an organizational level, one way to enhance resilience would be to encourage Service Members to seek care before problems escalate. From this perspective, low levels of stigma could be considered a resilience factor. A key factor for seeking care is overcoming the stigma associated with it. One of the challenges is that stigma is strongest among individuals who screen positive for psychological problems (Hoge, et al., 2004). Therefore, when looking at changes in rates of perceived stigma, it is informative to examine those who screen positive for psychological problems. Table 6 provides the across-year adjusted rates for maneuver units and the 2009 adjusted maneuver and support and sustainment rates for the six stigma related questions included in the survey. Rates did not differ significantly across the three years on any of the questions accept 'my unit would treat me differently'. For this item, stigma rates decreased significantly compared to 2005. There were no differences between the 2009 raw values for maneuver and support and sustainment unit samples. In general, response rates to these questions have remained stable across years.

Stigma concerns were often raised by Soldiers in focus groups. One of the key concerns was the lack of familiarity of behavioral healthcare providers. For instance, one senior NCO commented that "Soldiers would not 'let their hair down' with someone they do not know'". Thus, having behavioral health embedded with the units was the consensus recommendation from the focus groups. Others commented on the negative aspects of seeking care in a line

unit. "To the 11 series (Infantry) seeking mental health is seen as breaking. If you go to the Shrink you are trying to get out of the Army (NCO)." Similarly, another NCO explained, "to many going to mental health is a sign of weakness or a sign you don't want to deploy again(NCO)" Many felt that behavioral healthcare should come to them instead of them seeking it out, "you need to get them out of their offices (NCO)." This would help overcome stigma concerns and barriers to receiving care.

Table 6. Adjusted Percents Across Years and Raw Percents for 2009 Maneuver and Support and Sustainment Units for Stigma among those meeting criteria for a psychological problem

Table 6 Adjusted Percents for Male, E1-E4 in Theater 6 Months or Longer who Screen Positive for a Mental Health Problem.

	Across Years (Maneuver)			2009	
Factors that affect your decision to receive mental health services	2005	2007	2009	Maneuver	Support
It would be too embarrassing.	33.5%	36.8%	26.7%	32.5%	26.3%
It would harm my career.	42.2%	34.1%	33.6%	34.1%	26.2%
Members of my unit might have less confidence in me.	50.5%	52.0%	42.8%	48.8%	37.0%
My unit leadership might treat me differently.	62.0%	60.4%	49.9%	44.6%	45.0%
My leaders would blame me for the problem.	44.4%	42.1%	40.1%	28.6%	31.0%
I would be seen as weak.	51.1%	57.4%	52.9%	43.9%	43.0%

6.4 Barriers to Care

Barriers to care in the across-year maneuver sample showed an increase relative to 2005. Sample-adjusted rates for Soldiers meeting the criteria for a psychological problem are presented in Table 7. The across-year adjusted rates for four of the six survey items increased significantly from 2005 to 2009. In contrast, the support and sustainment sample reports lower barriers to care on four of the items relative the maneuver units.

It should be noted that increases in the across-year comparisons of barriers to care may reflect differences in the sampled populations (see Section 2.2). At the same time, however, the results do make clear the challenges associated with providing care to maneuver units under conditions of high troop dispersion, increased kinetics, challenging terrain and adverse winter weather. This challenge is clearly highlighted by examining maneuver unit responses to the item "It's too difficult to get to the location where the mental health specialist is." Notice the dramatic increase in the maneuver unit sample (36.1%) compared to the low rates in the support and sustainment sample (4.4%) on this question.

Table 7 Adjusted Barriers to Care Rates Across Years and Raw 2009 Rates for Maneuver and Support and Sustainment Units for those screening positive for a psychological problem

	Across Years (Maneuver)			2009	
Factors that affect your decision to receive mental health services	2005	2007	2009	Maneuver	Support
Mental health services aren't available.	18.4%	30.8%	45.6%	23.3%	3.0%
I don't know where to get help.	17.0%	24.0%	17.6%	11.7%	4.4%
It is difficult to get an appointment.	21.3%	38.3%	49.5%	24.6%	7.4%
There would be difficulty getting time off work for treatment.	46.9%	66.6%	62.1%	42.6%	26.5%
It's too difficult to get to the location where the mental health specialist is.	20.9%	44.0%	49.8%	36.1%	4.4%
My leaders discourage the use of mental health services.	17.8%	29.6%	19.4%	9.8%	10.5%

Barriers to care were universally seen as a problem by Soldiers participating in the focus groups. "You have to go to a different FOB, drive or fly...it is better to have someone on the FOB to take care of the problem." "They seem to be waiting for us to come see them, maybe

they should come out and see us (Junior Enlisted)". A unique barrier to care was not knowing that behavioral healthcare existed. This was the case in a few focus groups. "I never even heard of it (Behavioral Health specialty) until you said that (NCO from National Guard)." This qualitative comment further underscores the need for National Guard units to have their own organic behavioral health. Most Soldiers referred to the unit Chaplain as their behavioral healthcare asset but not all were comfortable approaching a problem from a spiritual perspective.

6.5 Marital Satisfaction

Social support from spouses and family members has been identified as a protective factor in helping individuals cope with stress (Cohen & Wills, 1985). No decline in marital satisfaction was detected across years for the maneuver units (Table 8). In general, over 70% consistently report that they have a good marriage. Similarly, rates for marital satisfaction did not differ between the 2009 maneuver and the support and sustainment unit samples.

Table 8 Adjusted Percents for Reporting a Good Marriage Across Years and 2009 Raw Percents for Maneuver and Support and Sustainment Units.

	Across Years (Maneuver)			2009	
Please rate how much you agree with the following:	2005	2007	2009	Maneuver	Support
I have a good marriage	78.7%	81.6%	74.0%	76.0%	68.2%

6.6 Training

The final section on protective factors focuses on Service Members' reports of whether or not they have received training and whether this training is perceived to have been effective.

6.6.1 *Training Adequacy for Deployment Stress and Suicide*

Table 9 compares Service Members' responses across years to whether or not they agreed that they had received adequate training for deployment stressors and suicide and whether they felt confident in their ability to identify and help others in need of behavioral health care. The majority of respondents in 2009 agreed or strongly agreed that training was adequate and felt confident in their abilities to assist others in need of care. Rates for three of the items were significantly higher than in 2007. No significant differences were noted in the 2009 maneuver unit or support and sustainment unit samples with the exception of one item.

Table 9: Adjusted Percents for Behavioral Health Training Across Years and Raw Percents for Maneuver and Support and Sustainment Units

	Across Years (Maneuver)			2009	
Adequacy of Suicide and Stress Training	2005	2007	2009	Maneuver	Support
I have received suicide prevention training in the last year	85.9%	80.4%	94.8%	90.1%	94.4%
I have assisted one or more Service Members with a mental health problem in the past year	30.6%	30.0%	42.3%	39.6%	42.6%
I helped a Service Member with a mental health problem get professional help	16.0%	19.1%	25.8%	33.5%	38.4%
I am confident in my ability to identify Service Members at risk for suicide	53.5%	55.8%	54.0%	60.7%	59.7%
I am confident in my ability to help Service Members get mental health assistance	69.2%	59.6%	56.0%	66.1%	69.8%
The training for identifying Service Members at risk for suicide was sufficient	55.1%	48.2%	57.4%	57.2%	60.2%
The training in managing the stress of deployment and/or combat was adequate	45.2%	36.0%	44.2%	51.6%	51.3%
I attended Pre-Deployment Battlemind Training	NA	63.8%	76.6%	74.9%	72.9%

6.7 Additional Focus Group Findings: Resilience

In focus groups, Soldiers discussed some of the challenges they faced during deployment and how they grew from their experiences. One senior NCO described his experiences by stating "I didn't know I had these breaking points until I got here." He continued that, in his mind, he hid certain things that he saw and that these things "eat on you after a while". He recognized that "everyone processes things differently" but for him he learned to cope by reading the bible, singing, going to the gym and talking with peers each day. Others indicated that their experiences had taught them to be more tolerant, adaptable and patient. As one Infantry Soldier put it "I mellowed my command style a lot" and another stated "hurry up and wait is easier to deal with". Soldiers reported that they relied on a strong sense of spirituality, humor and healthy family relationships to grow through challenges.

7. FOCUS GROUP SUMMARY

7.1 Methods

The MHAT 6 OEF team conducted 18 focus groups with a total of 86 Soldiers [46 junior enlisted (E1 to E4) and 40 NCOs (E5 to E9)], from both maneuver and support and sustainment units (b)(2) (b)(2) within the ATO. Three teams of two staff members each, one mid-grade Officer and one Senior NCO, traveled by air to meet with Soldiers at the following FOBs: (b)(2) The Behavioral Health provider or technician at each location met the team and made arrangements for the focus groups.

The team developed an outline based on four topics for discussion: quality of life, mission, morale and coping, behavioral health support and training. Each topic began with an open-ended question, followed by specific inquiries into targeted areas of interest. The quality of life section asked about living quarters, food, and Morale, Welfare, and Recreation (MWR) services. The Soldiers were asked about their mission, expectations for the deployment and perceptions of the mission's importance. The morale and coping questions asked about both individual and perceived unit morale, strategies for maintaining a positive outlook and developing strengths through the deployment. Soldiers were also asked to comment on their family's level of morale and coping methods, specifically the utility of the unit's Family Readiness Group (FRG). The last set of questions related to their awareness of and access to behavioral health services, pre-deployment or in-theater training on peer support and suicide prevention, and experiences with traumatic event debriefings. The focus groups concluded by discussing potential issues related to the recent increase in suicides among Army Soldiers both in-theater and upon redeployment. Each focus group lasted approximately one hour in length.

Focus group participants were self selected or Command requested to attend the session. Participation was anonymous. Each Soldier was assigned a sequence number 1 through 7 that corresponded to their self-reported demographic information of: rank, gender, years in military, time on current deployment, number of times deployed, marital status and number of children.

One staff member facilitated the group discussion using the outline. The second staff member hand wrote each individual's comments coded by sequence number. Voice recording was not used in order to reduce the perception that an individual's identity would be compromised.

7.2 Results and Discussion

Table 10 contains the demographic characteristics of the focus groups. Eleven focus groups included Soldiers from support and sustainment units with missions such as: route clearance, vehicle maintenance, transportation, logistical and medical support. Seven focus groups included Soldiers from maneuver units with missions of force protection and Police Mentor Teams (PMT). Four of the focus groups, 2 support and sustainment, and 2 maneuver, included both junior enlisted and NCO Soldiers. Even though there were more focus groups with support and sustainment units, only nine of the Soldiers were female, 7 junior enlisted and 2 NCOs.

Table 10: Demographic Characteristics of Focus Groups

	Maneuver (n=40)			*Support and Sustainment (n=46)*		
Rank	*Jr. Enlisted*	*NCO*	*Mixed*	*Jr Enlisted*	*NCO*	*Mixed*
Groups	*3*	*4*	*1*	*6*	*2*	*2*
Partcipants	*14*	*21*	*5*	*26 *(7)*	*10*(2)*	*10*

*Note: * ( ) Number of Female Focus Group Participants*

7.2.1 *Quality of Life*

Overall, Soldiers described the living conditions on the various FOBs as "good." Each FOB is at a different stage of development with varying levels of infrastructure and amenities given its location, how long it has been in operation, and the missions of the Soldiers it supports. A junior enlisted Soldier a few months into his first deployment expected more development (b)(2) (b)(2) as he said, "It could be better - we have been here for 9 years." An NCO from a support unit explained that during this deployment conditions were now "110 percent better than before, but after eight years we shouldn't have guys crammed into a small room." Short-term progress was evident to a junior enlisted maneuver Soldier who, at 11 months into his first deployment, observed, "It could be a lot worse, they have improved since I got here." Long-term progress was noted by an NCO finishing his 3rd deployment, "The quality of life here is good compared to last deployment." Another NCO reflected, "From my first deployment, we were in tents last time. We live decent now."

The living quarters progress from tents and B-huts to containerized housing units (CHU) and fixed facilities with hot and cold running water. Personal space is valued, and the Soldiers anticipate that the surge of forces will further limit any privacy. The second priority was to have a sufficient number of separate showers for both male and female service members and third country national workers due to cultural differences in hygiene practices. Soldiers stationed at smaller FOBs that are experiencing an influx of personnel also prioritized having sufficient laundry facilities with faster turn-around or self-service capability. Soldiers stated that the dining facility food quality was good, but the menus were repetitive and boring. Junior enlisted Soldiers with maneuver units highlighted the importance of an adequate supply of MREs and first strike rations to take on missions.

Across the focus groups Soldiers requested expanded MWR facilities to include: more new computers, faster internet access, more DSN telephone and SPAWAR capabilities, and more options for recreational activities. An NCO with a maneuver unit 5 months into his first deployment commented, "Cell phones are well and good but up front there is no signal." By "up front" he was referring to the combat outposts (COP) and joint security stations (JSS) which are smaller and more austere than FOBs. There is limited access to televisions to watch sports and movies or play Xbox. Several Soldiers suggested that the televisions in the DFAC be available for groups to use between meal times. Others wanted more indoor games like pool and ping-pong, and outdoor recreational sports areas for basketball.

At several locations, access to the PX was limited because only one NCO managed the store and that individual had to travel to (b)(2) to re-supply the inventory. An NCO at the end of his

second deployment stated, "Some guys can't even get the bare essentials. Let me go to the post office and have it forwarded to the FOB so they can have the items." Soldiers commonly requested that family mail personal care items. For another NCO, "The only complaint I have is the mail system." Some packages take a few days to months to arrive. Some people have packages that are floating from FOB to FOB and the mail lags behind. Despite the challenges, a senior NCO acknowledged, things are "Getting better as we go."

Soldiers with multiple deployment histories discussed the importance of personal time to refit: rest, eat, work-out, and communicate with family and friends. An NCO with a maneuver unit compared deployments stating, "Last deployment we would rotate platoons out monthly, we could be more free then - even when we get back here we cannot refit." An NCO with 12 years of service and 5 months into his 3rd deployment commented, "The OPTEMPO is bam to bam to bam. [ibid] The guys have no time. They need to refit the Soldiers back (to a FOB)." A junior enlisted infantry Soldier finishing his first deployment said, "Our off time is our off time – freedom – someone isn't breathing down my neck." An NCO with 16 years of service and multiple deployments acknowledged, "Soldiers focus on having a day off. If it helps them I know it makes a difference even though I have to bear it. It is a huge deal, it means a lot to them."

7.2.2 *Mission*

Junior Enlisted Support and Sustainment

In general, junior enlisted Soldiers on their first deployment expected to work their MOS, but discovered they needed to learn many other skills such as setting up observation points, staffing the Quick Reaction Force (QRF) and Entry Control Point (ECP). One Soldier stationed at a small FOB commented, "You will find that a lot of Soldiers are pulling 11B [infantry] work no matter their MOS."

A group of junior enlisted Soldiers with a maintenance unit found that during pre-deployment, despite their specialty MOS, they worked on basic infantry skills. One Soldier voiced frustration with pre-deployment training saying, "They prepare you for convoy after convoy, we are mechanics and have been preparing to do that, so why can't we just do our job?" When asked whether or not this deployment was what he expected, another Soldier replied, "As a mechanic, yes, but as a Soldier no. When we came over here I thought we would be doing convoys because of hearing stories from other people." Now, half-way through their first deployment one of the Soldiers felt that the mission was successful because, "vehicles are getting their maintenance done, so other Soldiers can get their mission done, which in turn helps the Afghan people." Another added, "If it wasn't for the mechanics and welders, trucks would not roll."

A medic on his 2nd deployment said, "Coming out here we didn't know what our mission was going to be. Only 2 or 3 people had been in a support battalion." He added it was, "Hard to know what to expect." For a few medics stationed at one FOB they expected to work more traumas with the Field Surgical Team (FST) instead of sick call. A female medic at the end of her 1st deployment expressed that she would have liked to have had the opportunity to do more. She expected to have more responsibility, like the medics of the FST. Another medic who moved forward with the maneuver units said, "I never expected that I would be bam, pushed out, rucking in mountains with guys."

At one FOB (b)(2) a few infantry Soldiers were working with engineers. One infantry Soldier said, "I didn't know what engineers did, I figured it was mine sweeping, pretty much driving on a route before someone else. I wasn't trained to do route clearance." This was a change of mission for him. The Soldier explained that earlier, "I was stuck in another FOB doing MP stuff, what I expected."

At a different FOB a group of junior enlisted Soldiers said that they expected to work the route clearance mission during their first deployment, but they voiced frustration because they did not see progress. One Soldier stated, "Once we clear the route it gets another IED because the villagers are putting it there."

Junior Enlisted Maneuver

For a group of junior enlisted infantry Soldiers approaching the end of their first deployment, this experience was not what they expected. They described short-notice for missions and movement with limited planning and coordination. One Soldier recounted a night patrol when he was told, "Get your men together and get out there." He then said, "We go out there we think we're all going to die." Another explained, "We will do any mission as long as there is a plan and assets."

A different group of infantry Soldiers half-way into their first deployment at another FOB voiced frustration with the operational tempo. One Soldier reported that he was on 3 missions a day with one to two hours in between. Another said, "I started out loving my mission, but over the last 6 weeks it has changed and the focus is completely gone. I do dismounted patrols around the FOB. Now we are stretched so thin...every week it is a new group of people going out." This constant rotation of personnel disrupts the unit cohesion for patrols.

For a group of E4 and E5 Soldiers at the end of their deployment on a PMT, the mission was not what they expected and did not end the way they had hoped. The most junior Soldier in the group said, "I really didn't know what to expect with the first deployment, it wasn't that much security, more helping train Afghan police." Another NCO explained that none of them are doing their trained MOS, but instead they train the Afghan National Police (ANP). He said, "We train them, but as soon as we're gone, they do their own thing." The most senior and experienced NCO in the group commented, "They tell us that we're in the business of building relationships."

In summary, for the junior enlisted Soldiers, the theme regarding the mission was expectation management. The primary focus for junior Soldiers was to work their trained MOS. However, for some of the Soldiers that did work their MOS, they did not feel challenged. For others, their missions sometimes required them to develop skills in other duties and tasks.

In contrast, the NCOs as a whole, from both maneuver and support and sustainment units, framed their comments about the mission from a broader perspective.

NCO Maneuver

Regarding the missions, the NCOs in maneuver units based their comments from experiences to include previous deployments to both Afghanistan and Iraq. For example, Soldiers who had served in OIF stated that the Rules of Engagement (ROE) and the criteria for escalation of force were notably different than during previous deployments. Two NCOs, each with 12 years of service and several months into his 3rd deployment, discussed how the current ROEs have influenced daily missions. One explained that the ROE have, "limited what the Soldiers can and

cannot do outside the wire." He added, "I have no time to react – it has everyone on edge." A more junior NCO on his second deployment elaborated, "Soldiers do not understand when they could shoot due to the ROE." The other more senior NCO commented, "I had more freedom to engage [the enemy] in Iraq than here." As a result, the Soldiers feel that they are not being effective in their mission.

A focus group with mid-level National Guard NCOs at the end of their nine month deployment also voiced frustration with their PMT mission. They agreed that the mission was not what they expected based on their training. For some the mission was to mentor the ANP and Afghan National Army (ANA), but feel that they are, "constantly holding their hands." As his first deployment, one Soldier described his mission as a "taxi service" to and from the airport, or be on "tower watch" or "force protection."

For a group on NCOs half-way through their first deployment with a force protection mission, the majority felt prepared, well trained, and appreciative that, "they are providing better equipment." One expected, "more convoys and dismounted operations" but overall felt good about the mission.

NCO support and sustainment

A focus group with E5s, all at the end of their 2nd deployment with a Route Clearance Platoon (RCP)(b)(2) felt that their missions were not well coordinated. One Solder explained, "Some missions we do are justified getting infantry guys where they need to be," but felt that other missions were "just to give them something to do." For another group of experienced NCOs with an RCP(b)(2) the mission was "good because of the equipment," especially the mine-resistant armored personnel carrier (MRAP). From the maintenance perspective, a focus group with mid-level NCOs with multiple deployment experiences felt that the mission was going well. "Parts access can be a problem at times," but had, "already doubled what the last unit had done." As one Soldier commented, "Without vehicles nothing would happen in this country."

7.2.3 *Morale and Coping*

A Soldier's level of morale was mostly influenced by factors that directly affected them both as an individual and as a unit. Morale was most often described relative to how well leadership managed Soldiers' time and how well leadership communicated to keep Soldiers informed about daily missions and timetables for redeployment.

Junior enlisted Soldiers voiced frustration that leadership limits their free time with mandatory physical training (PT) and warrior skills training. NCOs from support and sustainment units discussed the limited value of training between missions. Two NCOs who are 3 months into their 2nd deployment with support units stated that spending time on warrior training instead of time off is bringing them down. One added, "On mission it is ok, but when we come off, bull crap happens." Across support and sustainment units, both junior enlisted and NCO groups mentioned that some FOBs have a "garrison environment" and Soldiers are tasked with room and weapons inspections. An NCO at the start of his 4th deployment said, "A lot of the stuff could be cut out. Even out here we need time off. We could use a little downtime." Another NCO at the end of his 3rd deployment working support missions at a FOB (b)(2) (b)(2) confirmed the importance of time-off saying, "Morale out here is moderate to high because we have some down time and Soldiers have personal time to themselves."

Morale was also influenced by how well the leadership informed the Soldiers about daily missions and redeployment timeline. A junior enlisted Soldier with a maneuver unit said, "In some respects it is low and some respect it is high. With the Joes it is high as it has ever been. I had a guy get killed in October, there was a firm resolution that it will never happen again. I would say in that respect camaraderie is high, holding our leadership accountable is low."

Soldiers want to know what to expect when going on mission. An NCO at the end of his first deployment with a PMT said, "It affects my morale not being with the people I trained with." He explained that the mission is a lot easier if you're working with people you train with - because "this is not a training environment." Soldiers build a level of trust and rapport with one another.

At the beginning on his 4th deployment, an NCO in a support role stated that, "Morale was high when we first got here," but now the Soldiers are dispersed. "We went from 90 in our platoon to an average size platoon because people keep taking from us," yet the mission remains. "We have a lot of stuff to do and not enough to do it."

A senior NCO with a maintenance unit, half-way through his 4th deployment commented on morale saying, "I would go with moderate - groundhog day, same thing over and over." He added that the "guys try to get out on missions and stuff," but there is only so much room in the vehicles. He concluded that going out on missions, "pumps up morale."

An NCO explained that at the end of their tour his Soldiers' morale was low because they were detached from the command and received limited communication. "We hear other Soldiers getting information. We haven't got too much information about when we're going home. It is a morale booster knowing when you are going home." A junior enlisted Soldier working toward the end of his deployment of route clearance missions simply stated, "Lack of communication bothers me." His buddy added, "then we have to ask and ask, then next day some other news." Being aware of a planned timeline for redeployment was a significant morale booster for a junior enlisted Soldier half-way through his first deployment with a maintenance unit, "Now that we're on the downhill slide – when you find out you're going home, your morale goes up!"

7.2.4 *Family and Communication*

Soldiers of all ranks shared that communicating with their family members was often stressful. The most common issue was that Soldiers could not give any details of their situation due to Operational Security (OPSEC). A junior enlisted Soldier with a support mission said, "I cannot tell my wife the truth because of OPSEC. It is better if they do not know." Another junior enlisted Soldier said, "Families think we are building stuff. It is different than Iraq; we are just out there to be blown up." One Soldier shared that his family is very concerned, "I don't tell them everything, but I've told them a couple things."

Other Soldiers said that media coverage increased the level of concern of their families due to the emphasis on events that led to the injury or death of U.S. Service Members. A junior enlisted Soldier 6 months into his first deployment with a support unit shared, "My fiancé is sweating bullets; she has been watching the news." An NCO with 11 months into his 3rd deployment said, "I tell my family to not look at the news. Everything you see on TV that is not what is happening. Where I'm at everything is okay. I tell my family that if you don't hear from me for a couple days when I'm on a mission to not worry."

A junior medic who was in a roll-over accident explained that there was no time to tell them everything. "I've told them a lot about my physical condition; since I rolled over...basically they think I'm fine." An NCO at the end of his first deployment with a PMT said, "Your family can tell if something is wrong with you. Don't tell them expect this or expect that." Another NCO added, "No matter what you're going through don't let it show."

Soldiers expressed a wide range of opinions regarding the utility and effectiveness of the unit's Family Readiness Group (FRG). While some Soldiers stated that their family members had little to no exposure with the support group, other Soldiers reported that their spouse was part of the FRG leadership. Several Soldiers expressed concern regarding the accuracy of the information provided by the FRG. For example, rumors regarding the unit's redeployment date were a source of confusion for both the Soldier and family members. A senior NCO reported that an "FRG leader had to be fired because they posted videos online of a firefight." Other Soldiers felt that their FRGs had strong leadership and provided a good support network for their families. An NCO with 7 years of service and a few months into his first deployment in a maneuver unit with a force protection mission commented, "Ours is pretty good. My wife knows more about the military now, I talk to her, and I'm like how did you know that?"

7.2.5 *Deployment Length*

Soldiers in both maneuver units and support and sustainment units reported utilizing the same strategies to maintain their individual morale. The most common response was to keep in communication with family and friends via internet and phone as much as possible. Additionally, Soldiers sought distractions through surfing the internet, video gaming, music, reading, watching TV and movies, playing card games or working out at the gym; peer support through group sports like basketball or grappling, lifting weights and talking with Battle Buddies; individual spiritual growth through prayer and scripture reading. A few focused on saving money. A junior Soldier, 6 months into his first deployment with a maneuver unit said, "To be honest with you, how much dough I'm going to have when I get home brings my spirits up."

Others highlighted a positive outlook about the time spent in theater. A junior enlisted Soldier with working a support and sustainment mission shared, "I tell myself I made it 6 months; I can do it another 6." Several Soldiers scheduled their R&R (rest and rehabilitation leave) later into the deployment so that, "when we come back, we are packing up." An NCO at the end of his 2nd deployment with a PMT summarized his perspective by saying, "It only lasts for a season."

Potential detriments to individual morale were also similar across the focus groups. Soldiers were focused on information about deployment timelines and unnecessary overutilization of an individual's time. An NCO with a route clearance team explained that when Soldiers are detached from their Command, information does not get passed down correctly or in a timely manner saying, "We haven't got too much information about when we're going home," then added, "It is a morale booster knowing when you are going home." A few Soldiers expressed frustration with the uncertainty of when they were redeploying. Not knowing an exact date had a negative effect on their morale. One Soldier 11 months into his first deployment voiced his frustration, "We are pretty much at the end but dates keep changing. I can't make plans." Conversely, another junior enlisted Soldier said, "The other day we were told when we were going home so it kind of boosted the morale and people were happy about it." Soldiers mentioned the cost of the previous 15 month deployment policy. A junior female Soldier summed it, "I don't think the 15 month will happen again. The emotional toll it took on people—

people totally crumpled." A junior Soldier, 6 months into his first deployment with a maneuver unit said, "Throw me incentives, only thing that makes me get up is that I'm gone in 80 days."

Both NCOs and junior enlisted Soldiers complained about the garrison environment and time spent on tasks that are unnecessary in theater. Two NCOs in their 2nd deployment protested that time spent on, "AWT (army warrior training) instead of time off is bringing us down." Junior Soldiers objected to physical training between missions, conducting Army Physical Fitness Tests on rocky roads and room inspections for some but not all. An NCO in this 4th deployment concurred, "A lot of the stuff could be cut out. Even out here we need time off, we could use a little downtime."

A significant decrease in morale over time among Soldiers in maneuver units may be the result of several contributing factors, such as decreased level of mission support, diminishing unit cohesion and distracted leadership as described during focus groups. A senior NCO, 6 months into his 7th deployment explained that the Soldiers who have been to Iraq and now serve in Afghanistan are struggling to adapt to the limitations of this theater's Rules of Engagement (ROE) and the subsequent frustration with their perceived limited success of missions from the far forward COPs and JSSs. An NCO 5 months into his 2nd deployment within 5 years said that the current mission focus is on the build-up (b)(2) and "the Soldiers feel that they are not being taken care of." The NCOs agreed that morale should be a top priority and can be addressed through monthly platoon rotations back to a FOB for time to refit and recover. At the end of a 9 month deployment, a group of National Guard NCOs that arrived in theater together said, "It helps that we know each other." NCOs at the end of their deployment with a PMT stressed to, "Keep the groups together," because, "all the camaraderie was built and now you get with some schmo who you don't know who is going to last." "It affects my morale not being with the people I trained with." The majority of Soldiers agreed that unit morale was directly linked to the leadership provided by their command. A junior Soldier approaching the end of his deployment remarked, "Everyone is trying to look good for the higher up person, not worrying about what is happening outside the wire." Another Soldier said, "I think if our command was good we would be tight."

Conversely, Soldiers 6-11 months into their deployment with support and sustainment units generally agreed that their unit morale was medium to high, as one Soldier said, "Medium because everyone is pretty much tired; high because we're about to go home." A group of NCOs 6 months into their deployment with a maintenance unit agreed on "moderate." One described, "groundhog day, same thing over and over." The caveat is that the Soldiers try to get out on missions which "pumps up morale," and "breaks the monotony." Soldiers in focus groups recognized that unit morale was cyclical, and especially low in response to a casualty or difficulty making mission with limited resources. This reinforced the importance of time to refit.

7.2.6 *Behavioral Healthcare Support and Training*

Three barriers to behavioral healthcare (BH) were identified during the focus group discussions: 1) limited awareness of BH, 2) difficulty accessing BH while maintaining confidentiality, and 3) hesitation to establish trust and rapport with someone outside of the unit.

First, Soldiers typically did not know their BH provider. They identified the Chaplain as their BH asset. When asked to identify their BH provider a SGT at the end of his deployment with a PMT responded, "I never even heard of behavioral health until you said that." In another focus group an NCO at the end of his 5th deployment with a sustainment unit reported that, "The Chaplain is always around, if there is a problem he is there." A junior enlisted Soldier working a support

mission at a small FOB said, "I do not know of behavioral health but we have a chaplain." At other FOBs a few Soldiers were familiar with who to contact for behavioral health services. An E-4 with a support unit said, "Yes, that SGT over there. A mental health person is always around there. Someone is available." A maneuver unit NCO from a different location said he had "no idea," when asked about BH assets while another NCO in the same focus group identified the BH provider as, "The CPT stress management guy." An NCO finishing his 2nd deployment in 4 years remembered that Combat Stress Control came to their location when several Soldiers were killed in action. A few Soldiers, especially those on smaller FOBs, were familiar with the BSO or behavioral health technician who was stationed there.

Second, in order to meet with either the unit Chaplain or the nearest BH provider, Soldiers often had to coordinate transportation which in turn revealed the purpose of their travel. As one Soldier explained, "There is no chaplain on the FOB. You have to set up a convoy or flight just to see the Chaplain. And if you do that, everyone knows that something is wrong."

The focus groups verified that a negative stigma was still associated with seeking BH care. An infantry NCO a few months into his 2nd deployment said, "To the 11 series seeking mental health is seen as breaking. If you go the shrink you are trying to get out of the Army." Another NCO with 8 years of service commented, "You don't want everyone to know because you may be labeled a crazy guy." In the same group, an NCO with 10 years of service explained that, "Guys are not sure that their personal business will remain confidential." A senior NCO with 20 years of service said, "They know where the Soldier is going if they have to seek it out."

A PFC with 11 months into his 1st deployment with a maneuver unit commented, "The only thing that I was thinking, if you think you have a problem sometimes you don't know if you have a problem. I don't think they've reached out to those who need it. I think they could do a better job if they went out to the COPs. Someone has to die or be suicidal. They should just come out there." Similarly, a junior enlisted Soldier from a maintenance company said, "They are waiting for you to come see them, maybe they should come out and see the people."

Third, Soldiers expressed hesitation to share personal information with someone they do not know. NCOs from a maneuver unit explained that Soldiers would "not let their hair down with someone they do not know." Soldiers do not feel that non-organic behavioral health assets "have stepped in their shoes." It takes time to establish trust and rapport, as an NCO said, "It would take a good two months before we could talk to the docs." Therefore the Soldiers prefer the buddy system. "I can go to a person I know, I can talk to an 11 series," said an infantry NCO. He added, "We need to have the Behavioral Health in the organization, we will not talk to the new ones."

A senior NCO with 18 years of service and multiple deployments explained that NCOs are the behavioral health counselors for other Soldiers. "I am clueless on how to do this." He described, "Lots of times our counseling is right off the hip." He added, "We get our counseling training from experience." He suggested that the training on how to counsel Soldiers be updated. He also felt that Soldiers should be trained at the troop level in order to be most effective.

Interestingly, the majority of Soldiers in the focus groups were very receptive to the idea of behavioral health training. On his 3rd deployment, an NCO in a maneuver unit identified the need for a behavioral health asset as an additional duty appointment, like the unit's EO representative. He felt that this would give Command an additional behavioral health asset and

provide the battalion Behavioral Science Officer (BSO) with an assistant to augment training at the troop level. A focus group with NCOs who work route clearance missions agreed that leadership needed more training, "Teach us how to recognize when a Soldier is in trouble." A junior medic recalled when a Soldier had an issue, "We sat for 20 hours to talk about it. We both knew that physical actions and getting angry was not the way to handle it. We're there for each other."

8. (b)(2)

(b)(2)

The MHAT 6 OEF surveyed 63 military (Army and Navy) personnel working (b)(2) in detainee operations. The primary job (b)(2) is to guard the detainees currently being held at (b)(2) This is the first time that an MHAT has surveyed personnel who conduct detainee operations in Afghanistan. This section of the report presents data from the (b)(2) survey sample which is a small subset of the MHAT 6 OEF support and sustainment sample with a unique mission (detainee operations). Statistical comparisons between the (b)(2) and larger support and sustainment sample were not made for three reasons: (1) the (b)(2) mission and population are different than units from the larger support and sustainment sample, (2) a convenience sample was employed instead of cluster sampling because of the operations tempo and security concerns at (b)(2) and (3) small (b)(2 sample size (n=63) precludes tests for statistically significant differences. Therefore, descriptive statistics are reported for the (b)(2) and the larger MHAT 6 support and sustainment sample. Support and sustainment values are provided for a reference point only.

8.1 Demographics

The majority of (b)(2 sample respondents were between 18 and 24 yrs of age (54.8%), primarily Army (67.7%), Reserve or National Guard (92.1%), and NCOs (59.7%). A larger majority of support and sustainment sample respondents were between 18 and 24 yrs of age (72.2%), almost all were Army (99.6%), active duty (94.2%), and the majority were junior enlisted (62.3%). Seventy five percent (75%) of the respondents who identified their Military Operational Specialty (MOS) on the survey were Army military police (31B) or Navy Master-at-Arms (MA) while 25% did not have an MP MOS. Selected demographic variables for (b)(2) and support and sustainment sample are presented in the table below. (Table 11).

Table 11: Demographics for MHAT 6 OEF: (b)(2) and Support & Sustainment Units

Demographic Variable		(b)(2) n	(b)(2) Percent	Support & Sustainment n	Support & Sustainment Percent
Age					
	18-24	34	54.8%	521	72.2%
	25-29	21	33.9%	151	20.9%
	30-39	7	11.3%	48	6.6%
	Unknown	1	1.6%	2	0.3%
Branch					
	Army	42	66.7%	720	99.6%
	Other Service	20	31.7%	2	0.3%
	Unknown	1	1.6%	1	0.1%
Component					
	Active	4	6.3%	680	94.2%
	Reserve	42	66.7%	36	5.0%
	National Guard	16	25.4%	0	0.0%
	Unknown	1	1.6%	6	0.8%
Rank					
	E1-E4	25	39.7%	450	62.3%
	E5-E9	37	58.7%	225	31.2%
	Officer/Warrant	0	0.0%	44	6.1%
	Unknown	1	1.6%	3	0.4%
Marital Status					
	Not Married	35	55.6%	306	42.4%
	Married	26	41.3%	397	55.0%
	Unknown	2	3.2%	19	2.6%

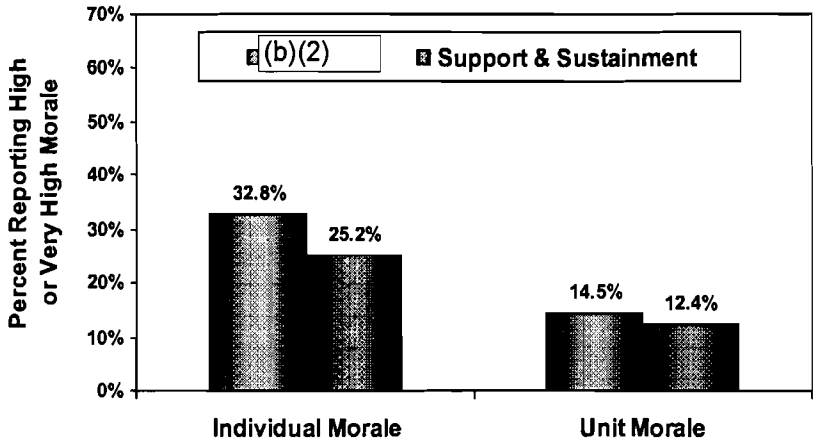
8.2 Behavioral Health Indices

As outlined in the main section of the report, behavioral health indices provide an overview of the well-being of the deployed force. This section of the report presents descriptive data only from the (b)(2) sample (n=63) and the larger, support and sustainment sample (n=722) as a reference for comparison.

8.2.1 *Morale: Individual and Unit*

The percentage of (b)(2) service members who rated their individual morale as 'high or very high' was 32.8%. This was higher than the support and sustainment rate of 25.2%. Unit morale for both groups was similar. Figure 17 presents the individual and unit morale rates for both groups.

Figure 17: Raw Percents of Individual and Unit Morale in (b)(2) and Support and Sustainment



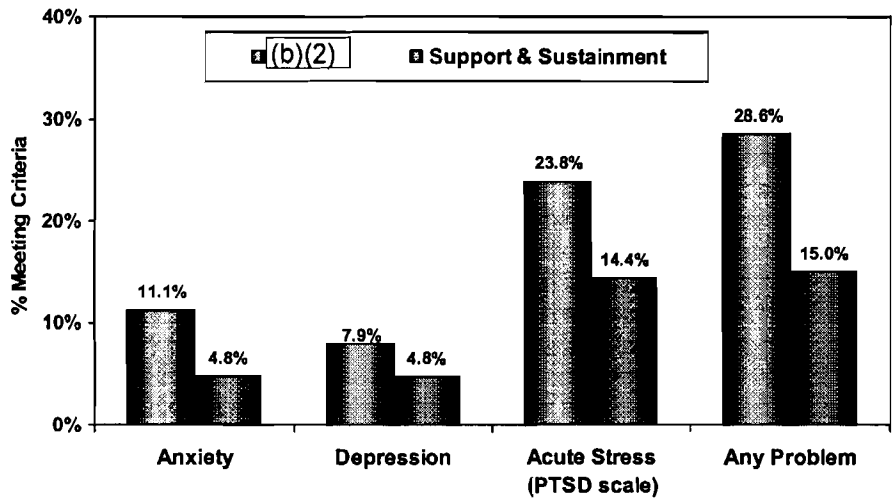
8.2.2 *Behavioral Health: Anxiety, Depression and Acute Stress*

Service members' ratings of depression, generalized anxiety and acute stress (i.e., Post-Traumatic Stress) were assessed using standardized, validated scales noted above. Details on scoring specific scales are available in previous MHAT reports.

Figure 18 below presents the percent of (b)(2) and support and sustainment service members who met the criteria for anxiety, depression, acute stress, or any of these three (any problem). On all measures, rates for the (b)(2) sample are higher than for the general support and sustainment sample. In particular, rates on three of the four measures are almost double the values for the support and sustainment group.

Service members that did not hold an MP- related MOS (Army 31B or Navy Master-at-Arms) were more likely to screen positive for a psychological problem than those respondents who indicated that they were MPs. Specifically, 35.7% of those who reported that they were not MPs met the screening criteria for a psychological problem compared to 23.1% of the MPs. Further, the key indicator driving the difference between groups was acute stress. Non-MPs met the criteria for acute stress at over 2 times the rate of MPs (35.7% vs. 15.4%)

Figure 18: Raw Values of Behavioral Health Problems in (b)(2) and Support and Sustainment



8.2.3 *Suicide Ideation*

One item included in the MHAT 6 survey can be used as an indicator of suicidal ideation. This item, included in the depression scale (on the PHQ-D), asks Soldiers if they have been bothered by thoughts that they would be better off dead or of hurting themselves in some way over the last four weeks. Any response other than "Not at all" is considered a positive response. Both samples had similar response rates to this item with 11.1% of (b)(2) respondents endorsing this item compared with 10.8% support and sustainment respondents.

8.3 Combat Experiences

The MHAT 6 OEF survey includes a list of 30 combat experience items. Respondents were asked to indicate the number of times they experienced each of the items on the scale at least once. Twenty two of the thirty individual items on the combat exposure scale were lower for the (b)(2) sample than the support and sustainment sample. The 22 items that were lower primarily addressed experiences that would occur outside of the FOB and therefore the low endorsement rate of these items by (b)(2) respondents is not unexpected. (b)(2) respondents reported spending, on average, less than 2 hours per week outside of the wire while support and sustainment respondents reported spending on average 21 hours per week outside the wire. The top and bottom five most frequently endorsed items by (b)(2) service members are presented in Table 12 below.

Table 12: Raw Percents for (b)(2) and Support & Sustainment Units

Combat Experiences	Percent (b)(2)	Percent Support
Top Five		
Receiving incoming artillery, rocket or mortar fire.*	76.2%	69.4%
Engaging in hand to hand combat.	49.2%	2.5%
Being in a threatening situation where you were unable to respond because of rules of engagement.	47.5%	26.1%
Being attacked or ambushed.	43.3%	45.1%
Witnessing violence within the local population or between ethnic groups.	37.7%	25.7%
* Note: The (b)(2) facility had a mortar land on its roof a few months prior to this		
Bottom Five		
Clearing/searching caves or bunkers.	1.6%	9.8%
Handling or uncovering human remains.	1.6%	16.5%
Being directly responsible for the death of an enemy combatant.	0.0%	9.3%
Had a close call, was shot or hit but protective gear saved you.	0.0%	5.0%
Had a buddy shot or hit who was near you	0.0%	3.4%

The (b)(2) service members work in a fixed facility and, as noted above, rarely leave the FOB. Therefore, the particularly high response rates to several combat experience items may reflect the unique nature of their assignment. They interact on a daily basis with detainees whose conduct toward the staff is reportedly hostile at times. This may have contributed to the higher percentage of respondents who endorsed the items "being in a threatening situation where you

were unable to respond because of rules of engagement" and "engaging in hand to hand combat."

8.4 Deployment Concerns

Concerns associated with being deployed also contribute to an individual's overall behavioral health. The survey includes a list of eleven deployment concern items and asks respondents to rate these on a scale of 1 (very low trouble or concern) to 5 (very high trouble or concern). The top 5 rated deployment concerns for (b)(2) respondents are listed below in Table 13

Table 13: Raw Percents of Deployment Concerns in (b)(2)

Top 5 Deployment Concerns	Percent Rating High or Very High	Support
Not getting enough sleep	43.3%	26.9%
Boring repetitive work	42.9%	32.2%
Lack of time off for personal time	39.3%	33.8%
Continuous operations	32.8%	23.9%
Lack of privacy/personal space	27.9%	30.1%

8.5 Perceptions of Leadership

Several items addressed service members' perceptions of NCO and Officer leadership. In general, (b)(2) service members rate NCOs higher on these leadership items than officers. This rating trend is consistent with findings from previous MHATs. However, it should also be noted that the majority of (b)(2) sample respondents were NCOs (58.7%) which may have introduced some response bias for these particular items. The individual items and responses are presented in Table 14 below.

Table 14: Raw Percents for Perceptions of NCO and Officer Leadership in (b)(2)

Rate how often NCOs/Officers:	Percent Responding 'Often/Always' NCOs	Officers
Exhibit clear thinking and reasonable action under stress	47.5%	28.8%
Tell Service Members they have done a good job	41.0%	23.3%
Ensure Service Members do not assume unnecessary risk when conducting missions	55.9%	41.7%

8.6 Utilization, Stigma and Barriers to Care

The MHAT 6 OEF survey has a series of questions that address service members' willingness to seek behavioral health care. From an organizational perspective, one way to enhance an individual's well-being and resilience is to encourage care before problems escalate. For some, stigma is often a key obstacle to seeking care.

In terms of utilizing care, 29% of (b)(2 respondents indicated that they received behavioral health counseling or services from a medical professional, behavioral health professional or Chaplain. However, when asked about factors that affect their decision to receive behavioral health services, over 25% indicated that they had concerns about seeking care (Table 15).

Access to care is another factor that influences whether or not an individual receives behavioral health care. Less than 10% of the (b)(2) respondents endorsed a lack of availability, difficulty getting appointments, difficulty getting to a MH location or leaders discourage use of services However, 26.2% of (b)(2) respondents endorsed having difficulty getting time off from work for treatment (Table15).

Table 15: Stigma and Barriers to Care in (b)(2)

Factors that affect your decision to receive mental health care services	Percent Agree
Members of my unit might have less confidence in me	29.5%
My unit leadership might treat me differently	29.0%
I would be seen as weak	29.0%
It would be difficult getting time off work for an appointment	26.2%
It would be too embarrasing	25.8%
It would harm my career	24.2%
My leaders would blame me for the problem	17.7%
My leaders discourage the use of MH services	9.8%
Mental health services are not available	6.5%
It is difficult to get appointment	6.5%
It is too difficult to get to the location where the MH specialist is	6.5%
I don't know where to get help	4.9%

8.7 Interviews with Staff

Interviews with the staff provided additional insight into the well-being of (b)(2 personnel. Of note, the staff commented that the (b)(2 Command is very concerned about the behavioral health of their personnel and support them accessing behavioral healthcare.

It was also pointed out that a fair number of service members currently assigned had volunteered for convoy operations, but were diverted to the (b)(2) instead. The majority of (b)(2) service members were trained as military police, however for some, transitioning to detainee operations has been a stressful experience. Some suggested that these units would benefit significantly from having an organic senior NCO (68X, MH Technician) dedicated to them. Another observation was that for those who have been deployed multiple times, rules of engagement in this position are different than for previous assignments.

Another perceived source of stress was due to increased crowding in living quarters. As one staff member described, before the troop surge, detainee personnel could go to their private sleeping place and "pull the sheets over their head" to get away. Now, however with increased force strength, their personal space is being limited.

Staff observed that there seemed to be an increase in stress reactions as service members got close to redeployment. This particular staff member speculated that because this population is mostly Reserve and National Guard, not all of them will return to secured jobs.

8.8 Summary of Findings

As noted in the introduction, the sample size and demographic differences between the (b)(2) and support and sustainment data sets only permit descriptive comparisons of the two populations. Therefore no statistical assessments were made.

Service members working at the (b)(2) had higher ratings of individual morale than Support and Sustainment. Ratings for unit morale were similar for both groups. On measures of anxiety, depression, acute stress or any of these three, ratings for the (b)(2) sample are higher than for the support and sustainment sample. In particular, ratings on three of the four measures are almost double the values for the support and sustainment group. Additionally, these rates were higher for staff members that were not trained as MPs. Endorsement of the suicidal ideation measure (~10%) was similar for both groups.

(b)(2) service members had particularly high response rates to several combat experience items even though they spend, on average, less than 2 hours per week 'outside the wire'. This finding may characterize the nature of their assignment. The most highly rated deployment concerns for (b)(2) respondents were 1) not getting enough sleep, 2) boring or repetitive work, 3) lack of time off, 4) continuous operations and 5) lack of privacy. Perceptions of leadership were higher for NCOs than Officers. This is a trend that has historically been reported in previous MHATS but may also be influenced by sample response bias (see section above).

Almost one third of (b)(2) respondents indicated that they accessed behavioral health counseling or services. However, when asked about factors that affect their decision to receive behavioral health services, over 25% indicated that they had concerns about seeking care. Survey results from the (b)(2) suggest that these types of units are a particularly at risk group for behavioral health problems based on its very high stress mission. These data suggest that maintaining appropriate behavioral health staffing levels in these units should be a high priority.

9. TASK FORCE (b)(2)

MHAT 6 OEF surveyed 126 Soldiers from Task Force (TF) (b)(2) using a convenience sample. (b)(2) (b)(2) TF (b)(2) fields military transition teams to train, mentor, assist, and advise Afghan National Security Forces "in order to develop a stable Afghanistan, strengthen the rule of law, and deter and defeat terrorism within its borders." (Combined Security Transition Command-Afghanistan website: http://www.cstc-a.com/mission/CSTC-AFactSheet.html)

9.1 Demographics

The majority of the TF (b)(2) sample was over 25 years of age (63%), NCOs (49.2%), and from the National Guard (98.4%). Maneuver unit Soldiers were primarily between 18 and 24 yrs of age (63.3%), and junior enlisted (67.4%) from the Active Component (99.4%).

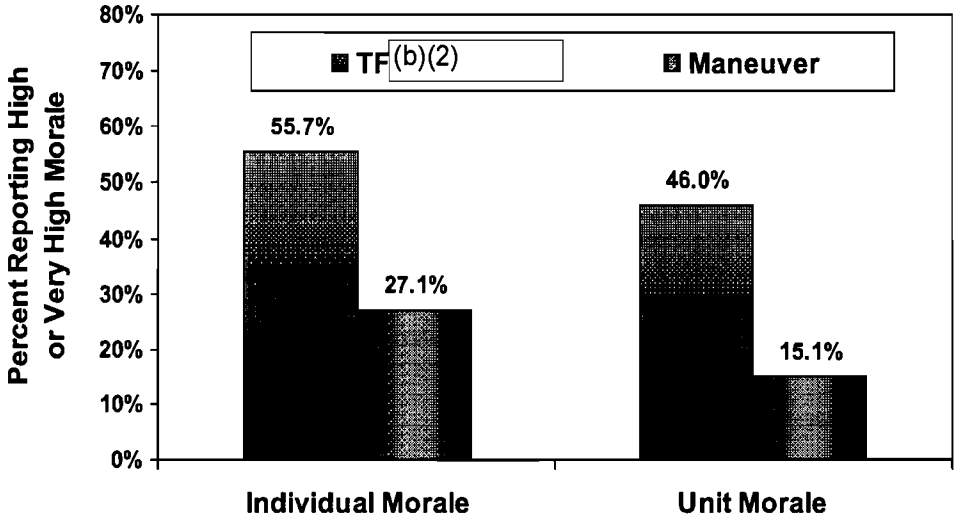
9.2 Behavioral Health Indices

As outlined in the main section of the report, behavioral health indices provide an overview of the well-being of the deployed force. Due to sample constraints, this section of the report presents raw descriptive data only from the TF (b)(2) sample (n=126) and the larger, maneuver sample (n=638) as a reference for comparison only.

9.2.1 *Morale: Individual and Unit*

TF (b)(2) Soldiers reported fewer behavioral health problems when compared to maneuver Soldiers. TF (b)(2) Soldiers rated their morale and their unit's morale much higher than Soldiers in maneuver units (see Figure 19). Fifty-six percent (56%) of TF (b)(2) Soldiers rated their morale as high or very high and 46% rated their unit's morale as high or very high compared to Soldiers in maneuver units who rated their morale at 27% and their unit's morale as 14%. Examining specific clinical behavioral health indices, 10% screened positive for acute stress (12% in maneuver sample), 2% for depression (5% in maneuver sample), 3% for anxiety (4% in maneuver sample), and 12% screening positive for any combination of acute stress, depression, or anxiety (14% in the maneuver sample). This finding is consistent with past data collected with security transition teams in OIF (b)(2) and OEF (b)(2) [see MHATs IV and V] where security transition team members reported fewer behavioral health problems than maneuver Soldiers.

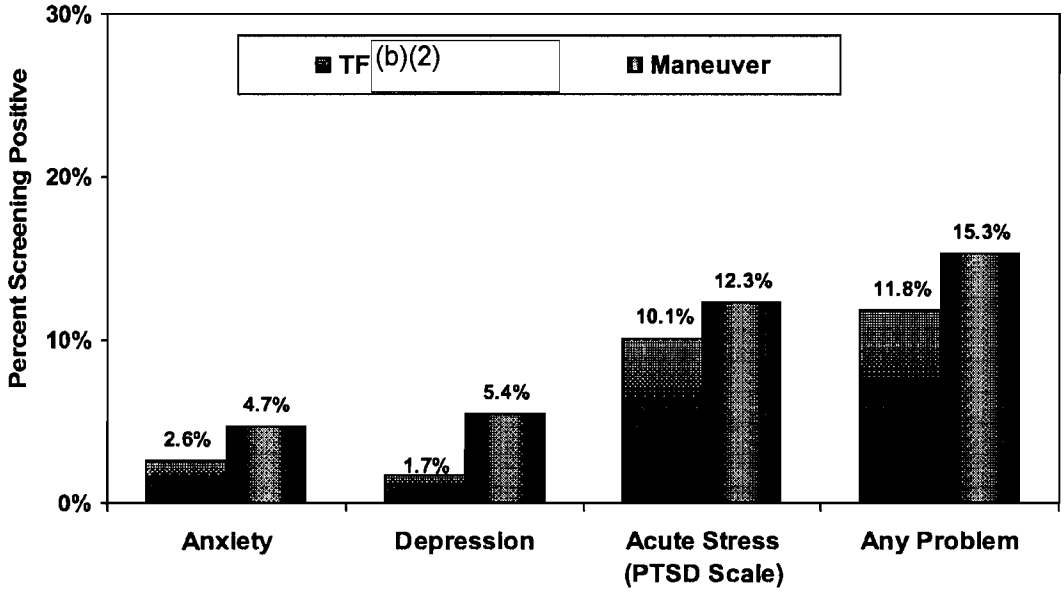
Figure 19: Raw Scores for Individual and Unit Morale in TF (b)(2) and Maneuver Units



9.2.2 *Behavioral Health: Anxiety, Depression and Acute Stress*

Figure 20 below presents TF (b)(2) and maneuver service members' ratings of anxiety, depression, acute stress or any of these three (any problem). On all measures, ratings for the TF (b)(2) sample are lower than for the maneuver sample, consistent with past MHATs.

Figure 20: Raw Scores for Behavioral Health Problems in TF (b)(2) and Maneuver Units



9.3 Combat Experiences

The MHAT 6 OEF survey includes a list of 30 combat experience items. Respondents were asked to indicate the number of times they experienced each of the items on the scale. In general, TF (b)(2) Soldiers reported comparable or slightly higher levels of combat exposure compared to maneuver units. The top and bottom five most frequently endorsed items are presented in Table 16.

Table 16: Raw Percents for Combat Exposures in TF (b)(2) Top and Bottom Five

Combat Experiences	Percent
Top Five	
Knowing someone seriously injured or killed	93.4%
Working in areas that were mined or had IEDs	82.2%
Seeing destroyed homes or villages	77.7%
Having a member of your own unit become a casualty	75.6%
Having hostile reactions from civilians	74.6%
Bottom Five	
Had a close call, equipment shot off your body	8.3%
Engaging in hand to hand combat	9.2%
Had a close call, was shot or hit but protective gear saved you	11.7%
Being wounded or injured	18.8%
Had a buddy shot or hit who was near you	19.3%

9.4 Deployment Concerns

Chronic concerns while deployed also contribute to an individual's overall behavioral health. The survey includes a list of eleven deployment concern items asking respondents to rate these on a scale of 1 (very low trouble or concern) to 5 (very high trouble or concern). The top 5 deployment concerns for the TF (b)(2) group are listed in Table 17 below.

Table 17: Raw Percents for Deployment Concerns in TF (b)(2)

	% Rating High or Very High
Top 5 Deployment Concerns	
Not having right equipment/repair parts	34.0%
Separated from family	26.2%
Continuous operations	23.8%
Not getting enough sleep	23.4%
Lack of privacy/personal space	20.0%

9.5 Utilization of Behavioral Healthcare, Stigma and Barriers to Care

An important issue across the ATO is behavioral health access. Eighteen percent of TF (b)(2) Soldiers reported that they had visited behavioral health at least one time during the deployment

TF (b)(2) Soldiers were asked about barriers to seeking behavioral health care, and in general, reported fewer barriers than maneuver Soldiers. Overall, 19% endorsed that it was difficult to get to a location where a behavioral health was located. Sixteen percent felt that behavioral health personnel did not come to their location often enough. Eighteen percent felt it was hard to get time off. And 10% agreed that it was difficult to get an appointment.

Perceptions of stigma tended to be lower than in maneuver Soldiers (Table 18). However, TF (b)(2) Soldiers felt the military could do a better job supporting Soldiers with psychological problems; only 20% agreed that the military is supportive of service members with problems.

Table 18: Raw Percents for Stigma Concerns in TF (b)(2)

Factors that affect your decision to receive mental health care services	Percent Agree TF (b)(2)
It would be too embarrasing	10.7%
It would harm my career	10.8%
Members of my unit might have less confidence in me	14.7%
My unit leadership might treat me differently	13.5%
My leaders would blame me for the problem	13.3%
I would be seen as weak	12.2%

Finally, TF (b)(2) does not have a BH provider assigned to the unit. The only asset they have is a BH NCO who is expected to be supported by a specialist, not an additional provider. They have been without a provider since June 2008 (11 months at time of writing) and no replacement is planned for the current unit or the unit replacing TF (b)(2)

9.6 Interviews with Soldiers

During focus groups with TF (b)(2) Soldiers and the interview with the behavioral health technician, several themes emerged including mission concerns, status of morale, and behavioral health care.

When TF (b)(2) Soldiers were asked about their mission, a common concern was that what they were doing—teaching, training—would be lost after they left. Moreover, a common concern related to mission was having the right equipment. As noted above, this was also expressed as one of the most endorsed concerns of the survey. Many of the Soldiers in the focus groups mentioned that there was value in keeping groups together because you train with and know what to expect from team members and this will aid the mission. A concern was that by having groups assigned to different units after training, they don't know capabilities and weaknesses of new team members.

When asked about what they do to maintain their morale and cope with their deployment, Most Soldiers mentioned the benefit of being together as a group since their training. Many others noted that to maintain their morale and cope, communication was very helpful via email and phones with family and friends. TF (b)(2) Soldiers were also asked how they had grown during their deployment. Many expressed that they had more appreciation for life, confidence in their training, patience, and had learned to take a positive out of negative situations.

As noted above, TF (b)(2) Soldiers were comprised of National Guard Soldiers. The National Guard has no organic behavioral health personnel that deploy with the unit. This was very evident in responses to questions asked about behavioral health access and training. Nearly all reported that behavioral health was not available. One Soldier commented that they had never even heard of behavioral health until MHAT personnel mentioned it in focus group questions. This is not surprising considering that the only BH asset they have is a BH NCO and no provider replacement is planned. They were however aware of the Chaplain as a resource. Most discussed the buddy system as the most frequent way in which they get support for problems.

9.7 Summary of Findings

MHAT 6 OEF found that in general TF (b)(2) Soldiers were older and more experienced, reported fewer behavioral health problems and had fewer problems with access and barriers to behavioral health care than maneuver Soldiers. Although TF (b)(2) Soldiers reported fewer concerns with access to care and barriers to care, only one behavioral health technician (NCO) was working in TF (b)(2) providing behavioral health support.

As is the case throughout the ATO, TF (b)(2) is expected to surge in forces. Senior Army leadership was aware of the shortage and was actively seeking to provide further support in TF (b)(2) Behavioral health support must be carefully considered throughout surge operations in order to have the required behavioral health staff relative to TF (b)(2) troop strength.

10. BEHAVIORAL HEALTH CARE SYSTEM ASSESSMENT

10.1 Behavioral Health Staffing and Distribution

Within the Afghanistan Theater of Operations (ATO), personnel numbers for both behavioral health staff and overall military personnel are constantly changing as a function of deployment rotations, operational requirements, and Soldier needs. For these reasons, it is important to recognize that the data presented below represent a snapshot of staffing and distribution as of May 2009.

Table 19 provides a breakdown of the behavioral health (BH) personnel by occupational specialty and branch of service for OEF 2005, OEF 2007, OEF 2009 and OIF 2009. Since 2005, there has been an increase in the number of Navy and Air Force BH personnel supporting the OEF and OIF theaters. In 2005 the Navy and Air Force had no BH assets in OEF. However, in 2009 the Air Force serves as the lead BH provider (58%) in Afghanistan and has added significant in-theater staffing resources. The Army provides 37% of the in-theater BH assets and the Navy provides 5%. In Iraq (2009), the Army is the lead BH provider (74%) followed by the Air Force (14%) and Navy (12%).

Table 19. Distribution and Ratio of Behavioral Health Specialties by Service

SPECIALTY	MHAT OEF 2005	MHAT OEF 2007	MHAT OEF 2009	MHAT OIF 2009
ARMY				
Psychiatrist	2	0	1	14
Psychologist	1	1	2	16
Soc Worker	1	2	4	24
Psych Nurse Practitioner	0	0	0	7
Psych Nurse*	0	0	0	7
MH Specialist	5	7	7	83
Occ. Therapist	0	0	1	7
OT Tech	0	0	1	10
TOTAL	9	10	16	168
NAVY				
Psychiatrist	0	0	2	4
Psychologist	0	0	0	8
Soc Worker	0	0	0	2
Psych Nurse Practitioner	0	0	0	2
Psych Nurse*	0	1	0	0
MH Specialist	0	0	0	11
Occ. Therapist	0	0	0	0
OT Tech	0	0	0	0
TOTAL	0	1	2	27
AIR FORCE				
Psychiatrist	0	3	3	4
Psychologist	0	4	4	6
Soc Worker	0	3	3	5
Psych Nurse Practitioner	0	0	2	1
Psych Nurse*	0	1	0	1
MH Specialist	0	7	13	15
Occ. Therapist	0	0	0	0
OT Tech	0	0	0	0
TOTAL	0	18	25	32
JOINT SERVICE THEATER FORCES STAFFING RATIO				
Total	9	29	43	227
Overall Staffing Ratio	1756	651	1123	627
Independent Practitioner + Ratio	3951	1452	2194	1424

*Psychiatric Nurse Practitioners and Psychiatric Nurses were not differentiated in previous MHATs
+ Independent Practitioners include Psychiatrists, Psychologists, Psychiatric Nurse Practitioners, Social Workers and occupational Therapists
Note: Rates do not include OSCAR or Coalition personnel

In 2007, the (b)(2) Command Surgeon and the Combat Stress Control (CSC) Commander redistributed BH personnel throughout the Afghanistan Theater in order to provide improved BH support to smaller FOBs and outposts (see MHAT V OEF report). This redistribution of assets to outlying, forward deployed locations has been maintained within the ATO. Additionally, a restoration center has been opened at the (b)(2) to provide in-theater treatment for Soldiers experiencing combat operational stress reactions.

The bottom of Table 19 provides the ratio of behavioral health personnel to military personnel (overall staffing ratio). The ratio for MHAT 6 OEF is estimated to be 1:1123 which is higher (meaning that fewer providers are available per Soldier) than the ratio observed in MHAT 5 OEF (1:651) and MHAT 6 OIF (1:627). This ratio is also above the recommended staffing level (1:700) recommended by combat and operational stress control doctrine. The bottom of the table also provides an estimate of the ratio of independent practitioners to the total population in theater (1:2194 for OEF 2009). Independent practitioners are defined as psychiatrists, psychologists, psychiatric nurse practitioners, social workers and occupational therapists. These OEF ratios indicate that there is approximately one behavioral health asset for every two battalion-sized units in theater, and one independent practitioner for roughly every four battalion-sized units. This is almost half the provider-to-battalion ratio found in OIF (1:1424). These values indicate a shortage of providers in the current ATO relative to OIF and current staffing level doctrine. Predicted increases in OEF troop strength over the next year will push these ratios even higher unless additional assets are assigned to the ATO.

10.2 Behavioral Health Survey and Interviews

A census sample of theater BH personnel was conducted in April and May of 2009 and 31 BH surveys were returned. The 2009 BH survey was identical to the previous MHAT 2007 survey. The survey assessed:

1. Behavioral health personnel well-being
2. Combat and Operational Stress Control (COSC) training
3. Standards of practice
4. Resources from command
5. COSC consulting
6. Coordination
7. Stigma and barriers to care
8. Procedures and availability of medication

Survey results were augmented with interviews. In total, 18 interviews were conducted with behavioral health personnel. It should be noted that the small number of BH survey responses in OEF 5 and OEF 6 did not permit valid statistical comparisons between the two samples. Therefore reported differences between the two samples are descriptive only.

10.2.1 *Behavioral Health Survey Demographics*

Demographics for BH personnel responding to the survey are presented in Table 20. In general, the MHAT 6 OEF sample had more active duty personnel, fewer officers and reported fewer months deployed since 9/11 than the OEF 5 sample. They also reported that they spent more hours per week outside the FOB, but supported a fewer number of locations.

Table 20. Demographics of Surveyed BH Personnel

	MHAT 5 OEF	MHAT 6 OEF
Sample Size	n = 23	n = 31
Age Range (Mode)	30-39 y.o.	30-39 y.o.
Gender	55% Male	52% Female
Rank		
Jr. Enlisted (E1-E4)	22%	23%
NCO (E5-E9)	17%	27%
Officers / Warrant Officers	61%	50%
Branch of Service	61% AF	70% AF
Component (Mode)	87% Active	97% Active
Average Months Deployed since 9/11	8.17	4.43
Average Number of Service Members supported by your team	5,597	5,123
Average Hours spent per Week Outside FOB*	2.91	21.13
Average Days per Month Living Outside FOB*	4.91	3.96
Average Number of Locations your BH/COSC Team Supports*	30.17	8.08

* Restoration center staff were excluded from these OEF 6 demographics because their mission does not include travel outside of the FOB

10.2.2 *Behavioral Health Survey Results*

MHAT 5 OEF and MHAT 6 OEF response percentages to all survey questions are included in Appendix B. Below, we comment on these findings and integrate both survey results and interview notes.

10.2.3 *Standards of Clinical Care*

In general, BH personnel report that the standards of care for clinical documentation, records management and transfer of clinical behavioral health information are clearer than in 2005. Use of COSC-WARS has risen considerably from 13% in 2007 to 67% in 2009. However, the use of psychological debriefings and unit needs assessments has decreased. The MHAT 6 OIF report details a similar decline in the use of these resources. Personnel also report using fewer testing surveys or instruments. During interviews, providers stated that it is difficult to get replacement testing materials in theater.

More personnel received pre-deployment COSC training than in 2005 (56% vs. 83%), but only 50% reported that the training adequately prepared them for deployment. Several personnel commented that the COSC training was too basic for an audience already trained in behavioral health and did not address skills specific to the combat environment.

While 87% of personnel reported that they frequently talked with unit Commanders, only half (53%) agreed that Commanders respected patient confidentiality on behavioral health issues and only 50% agreed that Commanders supported BH provider recommendations for medical evacuation out of the AO. Providers commented that in some instances service members were sent to the clinic under Command direction with limited or no patient history which in turn lengthened the triage process. In some cases, the service member was also unaware of why they were being referred.

The majority of BH providers with prescriptive privileges (73%) reported that psychiatric medications were not adequately available at level 1 or 2 medical care facilities and 90% reported that the procedures for ordering and replenishing medications were not clear. The most frequently prescribed medication was for sleep problems.

During interviews, BH personnel indicated a need to provide additional behavioral health training to non-behavioral health care givers as a force multiplier. The AMEDD Center and School offers a training course (Battlemind Warrior Resiliency) that is designed for this purpose. This course was recently offered in the ATO and additional in-theater course offerings should be considered.

10.2.4 *Personnel Resources and Travel*

Survey responses indicated that only 17% of BH personnel felt that there were sufficient BH assets in theater to cover the mission across the ATO. This was notably lower than the 2005 survey response of 30%. Although responses to this item were low in 2005, the continued drop may be due to recent increases in force strength that have not included equally proportional increases in BH assets.

Since 2007, behavioral health personnel have been decentralized to provide care at far forward operating bases and combat outposts. In 2009 BH staff reported spending, on average, 21 hours per week outside the FOB compared with 3 hours per week in 2007. This difference may reflect the fact that in 2009 BH personnel are closer to outlying posts and can provide outreach services to more units. Nonetheless, BH personnel report that because of staffing shortages they are unable to adequately cover both routine support and critical event generated debriefings at all of their designated locations.

The chaplains serve as a BH force multiplier in theater. Often times when Soldiers were asked to identify their BH provider, a common response was 'the chaplain'. The majority of BH personnel (87%) reported that they frequently spoke with chaplains to coordinate referrals and manage individual cases. At locations where there is only a technician, chaplains serve as the primary source for BH counseling. In cases where providers are not part of a unit, Soldiers report that they are more comfortable talking to the Chaplain because he/she has been organic to the unit since pre-deployment. Behavioral health personnel have consistently recommended that both a behavioral health technician and behavioral science officer be organic to the unit versus a PROFIS assignment.

While the Chaplain plays an important role in theater BH care, several Soldiers expressed hesitation when asked about the ability of the Chaplain to work with patients in need of serious attention. One Soldier stated, "I'm a religious person, ask anybody. The Chaplain leans more toward the religious side where a mental health person leans toward the scientific side. Science takes the cake when it comes to helping someone. Religion can't do everything." As one provider put it, "the Chaplain approaches the Soldier spiritually while the BH provider approaches the Soldier clinically."

Personnel also report that ground transportation is difficult due to kinetics and terrain. Over a third (40%) indicated that missions have been cancelled because convoys could not be arranged. Terrain in the AOR dictates that air is the primary mode of transportation. However, air assets require advance coordination, are difficult to arrange on short notice and may incur additional travel delays.

10.2.5 *COSC and Counseling*

In OEF 2009, behavioral health personnel reported doubling weekly COSC outreach services (63% vs. 30%) to include an increase in weekly educational classes (33% vs. 17%) compared with OEF 2007. Additionally, they report providing more one-to-one COSC services at the BH clinic (83% vs. 65%) than in 2007. In comparison, reported rates for worksite counseling and COSC services are down compared to 2007. In interviews, providers stated that Soldiers are more willing to talk to them if they actively interfaced with them outside of the clinic.

In both 2007 and 2009, over 90% of BH personnel reported that they were confident in their ability to 1) evaluate and manage service members with suicidal thoughts or behaviors, 2) help service members adapt to the stressors of combat or deployment, 3) evaluate and treat combat and operational stress reaction and 4) evaluate and treat acute stress disorder or PTSD. In terms of evaluating or managing service members with substance abuse or dependence, personnel were less confident (61% in 2007 and 63% in 2009). In garrison these issues would primarily be referred to the Army Substance Abuse Program (ASAP), which is not available in theater. Therefore, pre-deployment substance abuse training for BH personnel should be considered. Compared to 2007, fewer providers in 2009 reported confidence in their skills to evaluate and treat victims of sexual assault. This may also be a topic for inclusion in pre-deployment training.

The vast majority of respondents indicated that both medical and unit leadership support behavioral health and COSC outreach services. Through interviews, behavioral health providers stated that conducting outreach services was a good role for the technicians. This in turn allows credentialed providers more clinic time for direct patient care. The degree to which BH personnel coordinate with unit ministry teams (67%) and primary care providers (87%) on counseling or COSC activities has remained relatively consistent between 2007 and 2009.

Several providers mentioned that they spend a disproportionate amount of time with service members who, due to pre-existing psychological problems, should not have qualified for military service. One provider estimated that he spends 25% of his time on "really sick people who never should have been let in to begin with."

10.2.6 *Well Being and Safety*

Behavioral health personnel report a relatively high level of overall well-being. Over 90% agree that their ability to perform their job and maintain their spiritual and mental well-being has not been affected by their deployment. Approximately two thirds of the surveyed personnel rated their morale, energy level and motivation as high or very high in 2009. Overall, these rates were similar to those reported in 2007. Reported rates of burnout increased slightly between 2007 (17%) and 2009 (23%). One provider holding a particularly high stress assignment commented that "normal is abnormal here continually" and that "no amount of training prepares you for this job." Another noted, "We are on call 24 hours a day. Our day does not end at 5:00 pm." In light of the recent homicides at the (b)(2) Restoration facility in Iraq, questions have been raised about safety and security at BH clinics in theater. The physical environment in theater restricts the implementation of many standard operating procedures found in CONUS clinics such as surveillance cameras, controlled entry and "duress" alarm systems. Additional limitations at many of the outlying FOBs include a lack of basic communication systems within their clinic including DSN phone lines or internet/email connections. Providers at some locations purchase and finance their own internet and cell phone services because they lack this necessary logistical support. A safety procedure that is routinely implemented in theater

requires service members to remove their weapons when in the BH clinic. However, in many locations, weapons racks are not lockable or even available.

Several providers mentioned that there is a stigma attached to removing your weapon in the BH clinic and suggested that this procedure be expanded to include all medical facilities. This would reduce spotlighting those service members accessing BH services at a medical facility, but may pose additional logistical requirements to accommodate the storage of more weapons. BH personnel were asked to comment about perceptions of their own safety and security in theater. In general, most personnel felt that the recent event in Iraq was an anomaly that was almost unavoidable in an environment where immediate access to weapons is the norm. As they pointed out, the existing clinic safety procedures would not have prevented it. As one provider stated, "it was more of a fluke or random event".

Providers were specifically asked about how the incident affected their work. Many commented that they are more vigilant about monitoring verbal and physical signs of emotional escalation. Some said it increased their dialogue with colleagues about these types of issues. Other responses included, "it scared the hell out of me" and "it blew my mind that you could come to work to help people and get shot". Another provider stated that their work was not impacted, but the incident "brought into perspective what we do here".

When asked about whether or not they have changed the way they view safety or feel safe in the workplace, one provider stated "I work, live, shower with these guys at the [location removed], a lot of people are watching their back when they go home". Another provider pointed out that they are in a vulnerable environment and would like to see more stateside type security measures put in place. Yet another commented that "the thing with this job is you don't know what is going on with them [the client] until you see them". They felt the service member's weapon needs to be secured *before* coming to the clinic. They concluded "other than that, we are doing all we can do."

BH personnel were also asked how they handle difficult to treat or hard to handle service members. In general, most providers indicated that these types of cases were much more an exception than a rule. Providers commonly responded that they handle these cases by empathizing, speaking in a calm but firm voice and letting the service member vent. Then they move the conversation off of an emotional tangent and refocus on more "intellectual/cognitive" issues.

Providers were asked to comment about existing policies and SOPs for service members presenting with suicidal/homicidal ideations or behaviors. The general consensus by providers was that overarching SOPs were not 'value added' because they do not provide specific instructions that characterize the individuality of the situation. As one provider put it, "you can SOP yourself until you are blue in the face." Another provider commented that SOPs for medical treatment facilities may be adequate, but they do not fit the physical and environmental realities of a deployed environment. Rather than SOPs, providers felt that the most effective approach in these situations was to draw on training and experience.

BH personnel working at larger FOBs (with more than one provider) stated that they consult about cases on a routine basis. They indicated that this was common practice for case management. This was much more challenging for sole providers at other locations. In these instances, distance, communication and transportation challenges significantly limited their ability to consult with colleagues.

Providers were also asked about service members seeking second opinions. They stated that second opinions were rarely requested by service members or other providers. Rather, they were more commonly requested by Commanders and were often driven by the intent to administratively remove a Soldier from their unit.

10.3 (b)(2) Restoration Center

The first behavioral health Restoration Center in Afghanistan was opened on 1 February 2009 (b)(2) The program is a structured three to five day curriculum for service members with Combat Operational Stress Reaction (COSR). The goal of the program is to maximize the return-to-duty (RTD) rate of service members who are temporarily impaired or incapacitated by stress related conditions. Service members who participate in the program must be referred by a Combat Stress Control (CSC) or behavioral health provider. Commanders or individual Service members can request entry into the program but there has to be a screening through CSC or behavioral health before a final recommendation is made. The program promotes service member and unit readiness by enhancing adaptive, rather than maladaptive, stress reactions. The program of instruction teaches basic coping skills and focuses on secondary gains such as proper nutrition, sleep habits and hygiene. There are three major program components:

1. Regular sleep hours (8 hrs a day) are set with lights out at 2200 every day.
2. Service members must go to DFAC three times a day. They are not required to eat but they must go to the facility.
3. Service members must attend structured classes taught in a group setting by the restoration center staff.

The restoration center staff describes the program as structured, but adaptive. As one provider stated, "structure helps ease the mind". They use the term 'service member' rather than client or patient to reduce stigma. In order to prevent service members from adopting the role of a patient, the staff maintains a highly structured military environment where service members are required to wear their uniforms and maintain appropriate military standards and bearing. Service members carry their weapons, however, the bolt is removed and their ammunition is secured in the office. Some command elements do secure the service member's weapon prior to sending the service member to the program, if safety is a concern. The staff emphasize that the program is not R&R (Rest and Relaxation), not an inpatient psychiatric ward, and not a holding facility or an aero-medical evacuation stopping point. Thirty days after a service member returns to their unit, the Restoration Center staff follows up with the individual's Command to see how they are doing.

The facility is housed in four 'B-Huts' (semi-permanent plywood structures, used as replacements for tents) and can accommodate up to 12 service members at a time (6 males and 6 females). Service members utilizing the facility have primarily been Army Soldiers, but Air Force and Navy personnel have also participated. The 'average' service member is a male E3/E4 in their early 20s, but ranks as high as E8 have participated. The staff report that they have received very positive feedback from program participants. They report that the most frequent comment made is that the program should be longer. They also report that, from their perspective, one of the biggest issues is "getting the leadership to 'get' the concepts taught in the program". Between February 1, 2009 (the date the center opened) and 31 May 2009, 46

service members utilized the facility. Only one of these participants was evacuated to higher echelon care resulting in a 99% return to duty (RTD) rate for participants.

In terms of outreach, the staff actively promotes the program by advertising in the Stars and Stripes newspaper, presenting at new Soldier orientation classes and providing 'stress tips of the week' on the (b)(2) Radio Channel. Plans are currently underway to expand to a new, larger facility that will be able to accommodate up to 20 service members.

An issue that was raised by the Restoration staff was the lack of an intermediate reconditioning facility for those service members who may need additional help (as recommended in FM 4-02-51, "Combat and Operational Stress Control – July, 2006). Currently, there are two Combat Stress Control rehabilitative courses of action in the ATO: (1) utilizing the Restoration facility or, (2) evacuation to Landstuhl. An intermediate reconditioning facility is needed for service members who may require additional therapy beyond the 3-5 day restoration center program but do not necessarily need to be evacuated to Landstuhl. This would increase the return to duty (RTD) rate in the ATO.

11. Theater Suicide Review

11.1 Demographics

Since the beginning operations in the Afghanistan Theater of Operations (ATO) in 2001, there have been an increasing number of U.S. Army suicides annually; with 26 suicides as of 1 June 2009. Per the Army G-1 Suicide Prevention Program Manager, suicide population rates per 100,000 are not calculated for OEF due to the low number of cases. Although the number of suicides in Afghanistan is small, the annual counts are increasing. Table 21 presents annual suicide counts for OEF, and as a reference, OIF. In 2008, the OEF suicide count more than doubled compared to any previous calendar year. Less than half-way through 2009, the suicide count is higher than each previous year. Suicide continues to be an important issue of concern.

Table 21. Suicides in Afghanistan & Iraq Theater of Operations, CY 2001 - 1 June 2009

	Year								
	2001	2002	2003	2004	2005	2006	2007	2008	2009
US Army OEF	1	2	1	1	3	3	3	7	5*
US Army OIF	n/a	n/a	22	11	20	22	31	26	

*as of 1 June 2009

Firearms are the most lethal method of suicide (Shenassa, Catlin, Buka, 2003). Firearms and ammunition are part of the uniform in the theater of operations, thus Soldiers have easy access to a lethal means (Nock, et al). During both 2007 and 2008 in OEF, each of the suicides were committed by a deliberate gun-shot-wound (GSW) versus other less imminent lethal methods which may result in an incomplete attempt at suicide. By far, firearms were also the most common method of suicide in Iraq in 2008. (Table 22) Of note, the 5 suicides to date in OEF were also by self-inflicted GSW.

Table 22. Demographic Characteristics of Confirmed Soldier Suicides

	Year and Theater		
	OEF 2007	OEF 2008	OIF 2008
Firearm	100%	100%	94%
Male	66%	86%	91%
Age < 30 yrs	100%	71%	84%
E1 - E4	100%	57%	75%
Married	0%	43%	41%
Non-white	0%	29%	28%

In the U.S. Army, the high risk population is generally considered to be a young, single, white male, less than 30 years of age and junior enlisted ranks between E1 - E4. This is a trend that held in Afghanistan in 2007 and 2008.

11.2 Survey and Focus Group Findings

In the Behavioral Health / Combat and Operational Stress Control Personnel Survey, 96% of behavioral health staff in theater reported confidence in their ability to evaluate and manage Service Members with suicidal thoughts or behaviors. This is consistent with the responses from OEF 5 in 2007 (92%) and responses from OIF 6 in 2009 (95%).

The survey also asked BH personnel "How often do you conduct Suicide Prevention Training" for which 25% of respondents reported once a month or more; this is an increase from 13% in 2007. A Combat Stress Control staff member said that they were detailed to teach ACE, and that it was effective if the training was enforced by leadership. During interviews, most BH personnel reported that the Suicide Prevention Program were conducted by the Chaplain. A senior Chaplain stated that the pre-deployment suicide prevention trainings to include ACE, "were pushed back to Chaplains" from unit leaders. During focus groups, the majority of Soldiers said that a Chaplain provided their suicide prevention training. Soldiers provided mixed reviews about suicide prevention training. For example, one Soldier thought the ACE card was useful when used in conjunction with consistent training, instead of classes "all at once." Another Soldier, who saw a "good video" on suicide prevention, said "now can look at my ACE card."

The across-year adjusted values for maneuver units indicated that the percentage of service members that received suicide prevention training is higher than in previous years. Although 95% of OEF 2009 service members reported receiving this training, only 58% reported the training to be sufficient. During focus groups, few referred to the training by name, but most were familiar with and had an ACE card. Only 54% of maneuver unit service members were confident that they could identify a service member at risk for suicide. During focus groups, most service members expressed confidence in their ability to identify other Soldiers at risk for suicide. Most Soldiers described that they looked for "a change." A junior enlisted Soldier

commented, "It is hard to explain, you must know the Soldier and what is going on." An NCO with a PMT said, "Being around you can tell if something is wrong."

When asked how they would intervene, the majority of focus groups said they would take someone to the Chaplain. An Air Force BH provider observed, "If they need help they go to the Chaplain," and when the Soldiers need care beyond their expertise, the Chaplains will walk them down to the BH office. The provider noted that the Air Force does not have Chaplains organic to their unit, as does the Army. On the survey, 87% of BH personnel reported routine discussions with a chaplain.

During focus groups, Soldiers were asked, "What do you think is causing the increase in suicides down range and back home?" Five key themes emerged: Relationships, Change, Operational Tempo, Behavioral Healthcare and Resilience.

Suicide Awareness Training

The majority of Soldiers acknowledged that they received some kind of suicide awareness or prevention training which they described as videos, PowerPoint® presentations, and the ACE card. The trainers included the Company Commander, BH care provider, Chaplain, NCOs, and Platoon Sergeant. The Soldiers reported that that the effectiveness of the training depended on the presenter's experience and knowledge of the content. Comments ranged from just another check the block requirement, "This has to be done, read it to everyone, then sign this..." to more positive responses such as "Makes you think, notice it better after we got one of those."

12. DISCUSSION AND RECOMMENDATIONS

The mission of MHAT is to assess Soldier behavioral health, examine the delivery of behavioral health care, and provide recommendations for sustainment and improvement. One of the key strengths of the MHAT teams has been the ability to analyze data and write the report in the ATO, resulting in real-time feedback. In-theater medical assets at the Combined Joint Task Force as well as the Medical Task Force have provided excellent support with survey distribution and collection. This active involvement by in-theater medical assets has generated large samples, and has allowed MHAT personnel to focus on data processing, data analyses and the collection of focus group information. One by-product of this arrangement is that MHAT teams have tended to staff these missions with personnel specialized in data analysis.

While empirical data from surveys and qualitative data from focus groups provide a solid basis for making recommendations, these data have limitations. The main limitation is that many of the issues that arise are complex and MHAT team members may not have complete access to all relevant information (particularly because a goal is to quickly conduct analyses and report findings). Therefore, in the following sections we discuss the nature of MHAT recommendations and how these recommendations are generated.

12.1 Nature of Recommendations

12.1.1 *Army-Wide Recommendations*

While MHAT data are quite comprehensive, Army-wide or DoD-level recommendations are rare. This is primarily because results by themselves are generally not compelling enough to support recommendations at this level. When Army-wide recommendations are made, it is usually because other information also supports the recommendation. For instance, MHAT 4 recommended the Army adopt Battlemind training; however, the authors knew that Battlemind

had been subjected to a group-randomized trial that had demonstrated the efficacy of this training (Adler et al, in press). With evidence from the MHAT showing a need for behavioral health training, and evidence of a validated training program, the recommendation was logical and was subsequently adopted.

Even though MHAT results, by themselves, may rarely warrant Army-wide recommendations, the results can inform policy decisions. For instance, MHAT 5 provided detailed analyses of the effects of OPTEMPO-related stressors, such as months deployed and multiple deployments, findings replicated in the current report. These findings were briefed to senior Army and DoD leadership (b)(2) and provided information that may have influenced the decision to return to 12-month deployments. In this way, the results likely played a role in Army-level policy. (For a discussion of the role of the MHAT 5 report see, "Army Is Worried by Rising Stress of Return Tours to Iraq", *New York Times*, April 6, 2008).

12.1.2 *Behavioral Health Care and Product Development*

Most MHAT recommendations focus on behavioral health care delivery and product development. Product development recommendations emerge because MHAT missions have been typically staffed with researchers from laboratories within the US Army Medical Research and Material Command (USAMRMC); these researchers rely on MHAT results to help inform product development. Historically, MHAT personnel have had considerably less expertise in the area of theater-based behavioral health care delivery.

Previous MHATs have made important recommendations, even without team members who have been direct providers in Iraq or Afghanistan. Nonetheless, the nature of team composition speaks to the process by which recommendations are generated. Specifically, MHAT teams rely on input from providers in theater to generate recommendations. The MHAT team is ultimately responsible for deciding which recommendations to emphasize, but wish to acknowledge the source of the ideas.

12.2 In-Theater Recommendations versus CONUS Recommendations

Recommendations are divided into two types: (1) those recommendations targeted for implementation in the ATO, and (2) those recommendations targeted for implementation in CONUS. The first set of recommendations is geared to meet immediate or intermediate-term needs in the ATO. The second set of recommendations is geared for the long-term, to lay the groundwork for the augmentation of training, skills, and capabilities of personnel or units not yet deployed.

12.3 MHAT 6 OEF Recommendations

In MHAT 6 OEF, one of the largest issues was the perceptions of barriers to care reported by Soldiers in Maneuver units. Although the increase in barriers relative to 2007 could have been driven by sampling strategy differences, there are nonetheless difficulties associated with providing care to highly dispersed Soldiers in a theater of operations where behavioral health care personnel shortages and transportation are critical challenges, as is the case in Afghanistan.

12.3.1 *Recommendation #1 (In-Theater): Increase Current Behavioral Health Staff*

The first recommendation is to increase the number of behavioral health personnel staffing in accordance with established combat and operational stress control (COSC) doctrine: one behavioral health asset for every 700Soldiers. MHAT 6 OEF recommends the 1:700 ratio be targeted in order to better support the current force, as well as to address troop dispersion in the ATO.

12.3.2 *Recommendation #2 (In-Theater): Maintain 1:700 Ratio through the Expected Force Surge* (b)(2),(b)(5)

The surge of forces through 2009 could, once again, create personnel shortages, such that the ratio of behavioral health personnel to warfighters could "slip" below that recommended under COSC doctrine. It is thus critical that the 1:700 ratio be maintained as the build-up of forces continues, to ensure that the end-state ratio supports the final end-state force strength. Directly related to this, MHAT OEF 6 recommends:

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

12.3.3 *Recommendation #3 (In-Theater): Implement Dual Provider BCT Model after Staffing Ratio Stabilization.*

Once the staffing ratio of 1:700 is stabilized, implement a dual-provider model assigning an additional behavioral healthcare provider as an organic 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 in direct support of a given BCT. The dual provider model will better support highly dispersed Soldiers and does not necessarily require additional resources.

12.3.4 *Recommendation #4 (In-Theater): Appoint Theater-Level Behavioral Health Consultants*

Appoint a senior Behavioral Health Consultant and a senior Behavioral Health NCO to USFOR-A. The focus of this team would be to provide theater-level, strategic coverage and oversight of joint behavioral health care in the ATO.

12.3.5 *Recommendation #5 (CONUS): Develop, Validate, and Deploy Resilience Training for At-Risk Groups*

Develop and validate resilience training for at-risk groups. MHATs have identified groups at higher risk for psychological problems, such as those who have deployed multiple times. Evidence-based research must be conducted to ensure that validated resilience and intervention programs are implemented, to augment Soldiers' skills in meeting the psychological demands of combat deployment. 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).

12.3.6 *Recommendation #6 (CONUS): Allocation of Battalion-Level Behavioral Health Advocates*

Assign a Behavioral Health Advocate to each Battalion. This recommendation is based on a program established by the (b)(2) in 2007-2008. A behavioral health advocate is a Soldier, preferably an NCO, who has received additional training in basic behavioral health, coping and life skills, and behavioral health referral procedures. The behavioral health advocate would be an additional duty, analogous to the assignment of a Battalion-level Equal Opportunity representative. Behavioral health advocates can be a force multiplier: (1) they are organic to the unit, a "known factor" to leaders and Soldiers; and (2) they can serve as a first-line resource for Soldiers within the Battalion. Warrior Resilience Training developed by MEDCOM is an example of the training that could be used for this purpose.

12.3.7 *Recommendation #7 (CONUS): Augment Combat Lifesaver Training*

Recommend changes to the current Combat Lifesaver training course by the addition of a block of instruction on basic behavioral health.

12.3.8 *Recommendation #8 (CONUS): Assign Permanent Behavioral Health Personnel to National Guard Units.*

Establish a permanent, organic behavioral health asset within National Guard BCTs. Presently, NG BCTs do not have organic behavioral health care providers/specialists. A small behavioral health staff within NG BCTs would be a force multiplier in at least two ways. First, they would aid NG BCT Soldiers throughout the entire deployment cycle of that unit. Second, organic assets within NG BCTs would be "value added" at the time of deployment, since that unit would not rely as heavily on in-theater, active-duty behavioral health care resources to meet their needs.

12.4 Status of MHAT 5 OEF Recommendations

The status of MHAT 5 recommendations are assessed below. GREEN indicates that the recommendation has been acted upon. AMBER indicates that the recommendation is currently being implemented but is not complete. RED indicates that the recommendation has not been acted upon as of the writing of this report.

Recommendation 1: Every 3 months and/or following significant events, rotate remote units back to more established FOBs for a minimum of 7 days (+ travel time) in order to allow them to re-set.

AMBER: Based on anecdotal data, this seems to be occurring more so at the smaller FOBs that are more austere and dangerous. But it depends on the kinetics, troop strength, and mission in each unit. There did not appear to be any systematic policy.

Recommendation 2: Re-structure R&R program to give priority to Soldiers working outside the base camp.

RED: MHAT 6 was unable to find reference to any policy focusing on smaller base camps for R&R.

Recommendation 3: Develop and monitor work cycles using Combined Arms Doctrine Directorate (CADD) Sleep Management Guidance and encourage treatment seeking for sleep problems. The (CADD) is available through the (b)(2) Command Surgeon.

AMBER: This is a Commander's program so its use is dependent on a Commander's guidance. However, CSC/BH advocates for good sleep hygiene in outreach and consultation. Approximately 1/3 of MHAT 6 OEF survey respondents indicated that they felt they did not get enough sleep. This has not changed significantly across 2005, 2007, and 2009. Roughly 11% of MHAT 6 OEF survey respondents indicated that they used sleep medications during their deployment. It is unclear the extent to which leaders are making use of the CADD Sleep Management Guidance that was attached to the MHAT 5 OEF and OIF reports.

Recommendation 4: Follow MEDCOM policy on in-theater Battlemind Psychological Debriefings after deaths, serious injuries and other significant events.

GREEN: From the MHAT 6 OEF Behavioral Health surveys and Provider interviews, psychological debriefings are being conducted although with less frequency than in 2007. Providers noted that they were much more likely to use event-driven Battlemind Psychological Debriefing rather than time-driven. Behavioral health providers further noted that they did not have the time to conduct the time-driven version of Battlemind Psychological Debriefing due to staffing shortages and operational demands.

Recommendation 5: Focus BH outreach on platoons with the highest levels of combat and conduct outreach using the Proximity, Immediacy, Expectancy and Simplicity (PIES) model.

AMBER: From discussion with the Combat Stress Control Commander, it depended on the number of FOBs that were supported in the CSC area and how many personnel are available to cover. CSC has their personnel make initial contact with leaders and unit in order to prioritize their outreach and consultation. At smaller FOBs or a smaller CSC areas of responsibility, outreach and consultation was easier to execute. Transportation difficulties greatly affected outreach and consultation.

Recommendation 6: Require BH providers from all services be qualified to travel throughout the theater in order to conduct outreach.

GREEN: All Providers are now qualified to travel within the ATO.

Recommendation 7: Mandate all combat medics and Chaplains receive Battlemind Warrior Resiliency Training (formerly Battlemind First Aid Training) before deploying to OEF or OIF.

GREEN: Walter Reed Army Institute of Research and the Army Medical Department Center and School developed Battlemind Warrior Resiliency (BWR) Training. This training is specifically targeted for Medics and provides them with basic behavioral health and training skills. During February and March of 2009, the Army Medical Department Center and School sent personnel to the ATO to train Battlemind Warrior Resiliency in-theater. Pre-

deployment training has been provided to deploying units when requested. BWR Training was also presented by the (b)(2) Psychiatrist at the Surgeon's conference.

Recommendation 8: Appoint a behavioral health consultant to the Command Surgeon who has the knowledge of the theater and the authority to assign BH personnel.

AMBER: The previous (b)(2) Psychiatrist fulfilled this role informally in but we are not aware that there was formal designation or duty title. With the creation of the USFOR-A in 2008, the need for a strategic BH asset (Officer and NCO) was recommended this year at USFOR-A to oversee both embedded BH and CSC assets in the ATO.

Recommendation 9: Tailor interventions to units based on their level of combat experiences.

GREEN: Walter Reed Army Institute of Research is currently developing a research protocol designed to augment basic Battlemind training for Soldiers and units exposed to high levels of combat and trauma. The research protocol is pending execution.

Recommendation 10: To facilitate Soldiers reintegrating with their families and transitioning home, ensure Soldiers receive mandated Post-Deployment Battlemind Training.

GREEN: Based on the 2007 mandate to conduct post-deployment Battlemind training, behavioral health assets organic to the redeploying unit as well as from fixed facilities have been conducting this training at the Post-Deployment Health Assessment (PDHA) and Post-Deployment Health Re-Assessment (PDHRA) timeframe. However, although this training is mandated, the implementation of the training varies significantly depending on the unit.

Recommendation 11: Provide Spouse/Couples Battlemind Training to improve relationships and facilitate transitioning home.

AMBER: Spouses/Couples Battlemind Training at pre-deployment is being given by Walter Reed Army Institute of Research and the Army Medical Department Center and School. Post-deployment training has not been systematically implemented across the Army. Training material is being updated and refined for the post-deployment cycle.

Recommendation 12: Require NCO and Junior Officers receive Battlemind for Junior Leaders Training.

GREEN: See status of recommendation 13 below.

Recommendation 13: Educate and train NCOs and Officers about the important role they play in maintaining Soldier behavioral health and well-being and reducing stigma/barriers by including behavioral health awareness training in ALL leader development.

GREEN: The Walter Reed Army Institute of Research and the Army Medical Department Center and School have partnered to develop and field Battlemind training for junior and mid-level leaders. The Training and Doctrine Command (TRADOC) is the proponent and has been incorporating Battlemind training into programs of instruction. The Army G3/5/7 Comprehensive Soldier Fitness Program is in the initial stages of developing resilience training programs for mid-grade NCOs. This train-the-trainer program is designed to teach

military-centric resilience-building skills to NCOs who will then teach these skills to junior-enlisted Soldiers.

Recommendation 14: Hold leaders accountable for directly or indirectly demeaning Soldiers that seek behavioral health resources.

AMBER: Stigma rates have not decreased significantly in OEF 2009 relative to OEF 2005 and 2007. Continue to emphasize the role that leaders play at all levels in establishing a climate where Soldiers feel they can seek out behavioral healthcare without reprisal.

Recommendation 15: Tailor suicide prevention training packages focused on the phase of deployment and aimed at building psychological resilience. Ensure that the training is scenario-based and includes buddy-aid and leader actions.

AMBER: Beginning in the winter of 2009, the Army Chief of Staff mandated a Suicide Safety Stand Down involving multiphase and multimedia suicide awareness and prevention training. The training was created in order to bring awareness of suicidal symptoms and provide skills to Soldiers in identifying those at risk for suicide. Ninety-five percent of surveyed Soldiers in MHAT 6 OEF reported receiving the training. Thus far, suicides have increased during CY 2009 relative to previous years. The training has been largely well-received by Soldiers but the efficacy of the program is still unknown.

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APPENDIX B: BEHAVIORAL HEALTH SURVEY RESULTS

Appendix A: All Behavioral Health Survey Results

STANDARDS OF CLINICAL CARE (% AGREE)	MHAT 5 OEF	MHAT 6 OEF	MHAT 6 OIF
The standard of BH care in this theater or Area of Operations are clear	60.9%	75.0%	57.7%
The standards of COSC services in this theater or Area of Operations are clear	56.5%	78.6%	53.6%
The standards for clinical documentation in this theater or Area of Operations are clear	30.4%	50.0%	66.6%
The standards for records management in this theater or Area of Operations are clear	26.1%	39.3%	51.1%
The standards for transfer of clinical BH information between levels of care in this theater or Area of Operations are clear	30.4%	75.0%	37.5%
Commanders are satisfied with the amount of information I can provide	60.9%	74.1%	75.4%
I encountered situations involving medical ethics in this AO to which I did not know how to respond	17.4%	14.3%	30.1%
The standards of how much patient information I can share with commanders is clear	73.9%	75.0%	64.0%
RESOURCES FROM COMMAND (% ARGEE)			
My higher headquarters provides us with the resources required to conduct our BH or COSC mission	52.2%	50.0%	50.9%
My higher headquarters encourages us to provide feedback/comments to theater/Area of Operations BH or COSC policies	60.9%	67.9%	52.5%
We coordinate or integrate our BH or COSC activities with the Unit Ministry Teams in our Area of Operations	65.2%	64.3%	53.9%
We coordinate or integrate our BH or COSC activities with primary care medical personnel in the battalion aid stations or medical companies	91.3%	85.7%	82.7%
COMBAT AND OPERATIONAL STRESS CONSULTING (% AGREE)			
During this deployment how frequently did you:			
provide COSC outreach services (weekly)	30.4%	60.7%	49.3%
conduct educational classes (weekly)	17.3%	32.1%	47.1%
consult with unit leaders (weekly)	56.5%	65.4%	79.1%
conduct Battlemind psychological debriefings (monthly)	17.4%	7.1%	19.7%
conduct psychological debriefings (CED/CISD; monthly)	39.1%	14.8%	17.8%
conduct systematic unit needs assessments (every 2-3 months)	34.8%	21.4%	30.6%
conduct Suicide Prevention Training (monthly)	13.0%	25.0%	32.8%
provide one-to-one BH counseling with Service Members at their worksite (weekly)	31.8%	10.7%	18.0%
provide one-to-one COSC services with Service Members at their worksite (weekly)	26.1%	21.4%	30.8%
provide one-to-one BH counseling with Service Members at the BH/COSC unit location (weekly)	91.3%	78.6%	82.0%
provide one-to-one COSC services with Service Members at BH/COSC unit location (weekly)	65.2%	82.1%	77.1%

CONFIDENCE IN SKILLS AND TRAINING (% AGREE)			
I feel confident in my ability to:			
use the COSC Workload and Activity Reporting System (COSC-WARS)	13.0%	67.9%	72.3%
help Service Members adapt to the stressors of combat or deployment	93.1%	92.9%	94.8%
evaluate and manage Service Members with suicidal thoughts or behaviors	92.4%	96.4%	95.4%
evaluate and manage Service Members with substance Abuse or Dependence	60.9%	60.7%	76.1%
evaluate and treat Combat and Operational Stress Reaction	100.0%	92.9%	95.7%
evaluate and treat acute Stress Disorder or PTSD	91.3%	92.9%	87.1%
evaluate and treat victims of sexual assault	82.6%	63.0%	74.0%
perform clinical evaluation and treatment of detainees	26.1%	10.7%	15.8%
COMBAT AND OPERATIONAL STRESS COURSE TRAINING (% AGREE)			
I attended pre-deployment COSC Training Course (e.g. AMEDD)	56.5%	82.1%	77.1%
I received adequate training pre-deployment to prepare me for my COSC duties	45.0%	53.7%	47.9%
STIGMA AND BARRIERS TO CARE (% AGREE)			
The medical leadership does not support BH/COSC outreach	13.0%	0.0%	5.3%
The supported units leadership does not support BH or COSC outreach	8.7%	3.6%	13.7%
There is inadequate transportation to conduct outreach activities	39.1%	25.0%	31.0%
There is inadequate communication between BH or COSC and supported units	17.4%	21.4%	27.3%
Service Members feel uncomfortable talking to BH or COSC personnel about their problems	21.7%	14.3%	32.1%
BH or COSC personnel are unfamiliar with supported unit leadership and Service Members	26.1%	10.7%	9.6%
Traveling to supported units is too dangerous	26.1%	7.1%	7.3%
Arranging convoys to supported units is too difficult	39.1%	28.6%	32.7%
The inability to arrange convoys has led to mission cancellations	52.2%	35.7%	30.9%
BH or COSC personnel do not like to perform outreach services	21.7%	3.6%	8.3%
BH or COSC personnel are not trained to conduct outreach services	30.4%	3.6%	12.9%
BH or COSC personnel are not available due to performing non-BH or COSC missions	17.4%	7.1%	4.8%
BH or COSC personnel do not think preventive outreach activities are effective	21.7%	0.0%	12.2%
Commander's support BH provider recommendations for medevac out of theatre	56.5%	46.4%	55.6%
Commanders respect patient confidentiality when it comes to mental health issues	47.8%	50.0%	46.4%
There are sufficient BH assets in theater to cover the mission across the AO	30.4%	17.9%	29.7%

DOING THEIR JOB (% AGREE)			
How *often* do you:			
talk informally to the Service Members	100.0%	92.9%	98.2%
conduct focus groups with Service Members	47.8%	51.9%	62.7%
talk with the chaplains	95.7%	85.7%	93.1%
talk with the units commander	95.7%	85.7%	96.2%
talk with the units medical personnel	100.0%	85.7%	97.0%
use validated surveys or instruments	69.6%	32.1%	75.1%
use locally developed surveys or instruments	56.5%	32.1%	56.6%
develop a BH or COSC unit prevention and early intervention plan	59.5%	42.9%	69.9%
conduct Command Consultation	60.9%	75.0%	88.7%
WELL-BEING(% AGREE)			
My ability to do my behavioral health job is impaired by the stressors of deployment or combat	4.3%	3.6%	9.2%
My mental well-being has been adversely affected by the events I have witnessed on this deployment	13.0%	7.1%	12.9%
My spiritual well being has been adversely affected by the events I have witnessed on this deployment	4.3%	7.1%	4.0%
Since this deployment, I have become less sensitive to the needs of the Service Members I serve or support	4.3%	7.1%	11.1%
My ability to do my job is impaired by listening to the combat experiences of Service Members I have talked with while performing my BH or COSC mission	4.3%	3.6%	8.1%
Rate your personal morale	65.2%	64.3%	53.2%
Rate your energy level	43.5%	60.7%	37.2%
Rate your level of burnout	17.4%	21.4%	32.5%
Rate your motivation	73.9%	67.9%	45.5%
PSYCH MEDS (% AGREE)			
The procedures for ordering or replenishing psychiatric medications in this theater or Area of Operations are clear	66.7%	11.1%	57.4%
In general, there has been adequate availability of appropriate psychiatric medications in the area of operations	66.7%	16.7%	91.9%
There has been adequate availability of appropriate psychiatric medication at Level I (Battalion Aid Station)	66.7%	16.7%	60.2%
There has been adequate availability of appropriate psychiatric medication at Level II (Forward Support Medical Company)	50.0%	16.7%	82.8%
There has been adequate availability of appropriate psychiatric medication at Level III (Combat Support Hospital)	50.0%	0.0%	98.1%