Mental Health Advisory Team (MHAT) VI
Operation Iraqi Freedom 07-09

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and

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The results and opinions presented in this report are those of the Mental Health Advisory Team VI 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 VI team would like to acknowledge the active involvement and in-theater support provided by the MNC-I Surgeon, the Deputy Surgeon and the theater Mental Health Consultant. It was through their initiative and effort that the current report was able to examine a large sample of Soldiers from Support and Sustainment units.

1. EXECUTIVE SUMMARY

1.1 Introduction

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

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

In the period of December 2008 through March 2009, OIF Soldiers at the operational level completed an anonymous survey. In total, 1,260 surveys were collected from Maneuver Unit platoons, and 1,182 were collected from Support and Sustainment platoons. In addition, 159 anonymous surveys were collected from behavioral health personnel. From 24 FEB to 26 MAR, the MHAT VI team (a) processed and analyzed survey data, (b) examined secondary data sources, and (c) conducted focus group interviews with Soldiers and behavioral health personnel. The MHAT VI team report and recommendations are based on these data sources.

MHAT VI 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 BCTs (Maneuver Unit sample), and a sample of platoons from Support and Sustainment units (Support and Sustainment sample).
3. Trends where examined across the six years of MHATs.

1.2 Central Findings

1.2.1 *Outcomes: Behavioral Health, Relationships and Career*

1. Mental health problems (acute stress, depression and anxiety) in maneuver units are 11.9% and significantly lower than every year except 2004. Support and sustainment rates are similar at 12.3%.

2. Divorce or separation intent in maneuver units is 16.5% and steadily increasing across MHATs. Support and sustainment rate is similar at 17.2%.

3. Intent to definitely stay in the Army is 9.8% in maneuver units and steadily increasing across MHATs. Support and sustainment rate is similar at 9.7%.

1.2.2 *Risk Factors*

1. Combat exposure rates are significantly lower than every year except 2004. Support and sustainment units report significantly lower combat exposure than maneuver units.

2. Dwell-time (length of time between deployments) is significantly related to mental health problems and intent to leave the military (Maneuver Unit) and morale (Support and

Sustainment). Soldiers with short dwell-time report high mental health problems, high intent to leave the military and low morale. A near return to garrison rates of mental health problems occurs around 24 months with full return around 30 to 36 months of dwell-time.

3. Soldiers on their second or third/fourth deployment report lower morale and more mental health problems. The multiple deployment effect for mental health problems is particularly strong in Support and Sustainment units. Number of deployments was unrelated to suicide ideation.

1.2.3 *Soldier Resiliency Factors*

1. Maneuver unit platoons differ in resiliency. In some platoons, Soldiers with high levels of combat have low acute stress. Positive officer leadership is the key factor (among several tested) providing resiliency from high combat.

2. In maneuver units, barriers related to seeking behavioral health care are significantly higher than every year except 2003. This is almost certainly due to the MHAT VI sampling design that surveyed a high percent of non-FOB Soldiers. Barriers to care in support and sustainment units are low.

3. In maneuver units, stigma about receiving mental health care has increased relative to MHAT V, but is comparable to other years. Stigma is significantly lower in support and sustainment units.

4. The adequacy of several types of mental health (suicide, deployment stress) have significant increased relative to 2007.

5. Marital satisfaction has significantly declined over the six years of the MHATs. The decline is more extreme for E1-E4 Soldiers than for NCOs. Marital satisfaction was un-related to multiple deployments or dwell-time.

1.3 Summary of Behavioral Health Personnel Findings

1. Behavioral Health personnel in MHAT VI are reporting significantly less burnout and job impairment than in 2007.

2. Behavioral Health personnel report significant increases in the clarity of standards of care relative to 2007.

3. Behavioral Health personnel report conducting significantly less one-on-one counseling with service members at their worksites than in 2007.

1.4 Summary of Suicide Assessment

Since the beginning of OIF, there have been 162 confirmed suicides in the Iraqi Theater of Operations (ITO) of which 132 have been Army. Multi-National Forces-Iraq (MNF-I) is tracking 34 theater suicides for 2008; 26 Army, 6 Marines, and 2 Coalition fatalities, producing an annualized rate in theater of 21.5 per 100,000 US Service Members. This rate is not statistically different from 2007; however, it is the first time since 2004 that the rate is not higher than the

previous year suggesting stabilization. Within the MNF-I and MNC-I, it is clear that leaders at every level are engaged in a robust suicide education and prevention program. The release, distribution, and the implementation in 2008 of the MNC-I Suicide Prevention Action Plan (SPAP) was a significant effort to track and prevent suicides.

1.5 Key Recommendations

1.5.1 *Implement a Dual Provider Model within BCTs*

There are challenges in providing behavioral health care coverage to highly dispersed forces. The high barriers associated with seeking behavioral health care reported in maneuver units suggest a need to re-design how mental health assets are allocated. The goal of the Dual Provider Model is to assign two behavioral health providers per BCT. The current design with one provider per BCT is not adequate to meet the demands of highly dispersed forces in situations where travel is unpredictable and units are spread out over large geographic areas. Importantly, the details of this recommendation do NOT require additional resources; rather, the details revolve around the re-allocation of existing resources.

1.5.2 *Create an NCO 68X30 position in Brigade Behavioral Health Section*

A Staff Sergeant would bring a high-level MOS skill-set and allow for greater flexibility in mission planning and execution. BCT Behavioral Health Officers have well-established professional training, but typically have little operational experience. Therefore, a Staff Sergeant 68X organic to the unit would provide valuable expertise and result in a relationship with the behavioral health officer analogous to the relationship shared between the Platoon Sergeant and the Platoon Leader in maneuver units. The addition of an NCO 68X30 position would further create a behavioral health team of one officer and two enlisted that was consistent with the 2 JAN 08 AMEDD Modularity Initiative (AMI) for CSC detachment reconfiguration.

1.5.3 *Explore Ways to Provide Maneuver Unit Soldiers Greater Opportunities to Discretely Seek Care.*

High barriers to care and high stigma may reflect the fact that it is difficult for Soldiers at remote outposts to discretely seek behavioral health care. Therefore, we recommend that theater consider ways to help maneuver-unit Soldiers discretely seek care. For instance, changes to the reset policy may help Soldiers discretely seek care.

1.5.4 *Develop, Revise, Evaluate, and Integrate Resiliency and Life-Skills Training*

Focus on resiliency training in order to increase Soldiers' skills in meeting the psychological demands of combat. Resiliency training such as the Army's Battlemind Resiliency Training system offers a promising way to help build resiliency in Soldiers. The efficacy of Battlemind Training has been demonstrated in several studies and several efforts are underway to develop and test additional resilience training as part of the integrated system. In addition to Battlemind, MNC-I implemented the *Warrior Resiliency and Thriving Training* program in theater, and the Army is developing a Comprehensive Soldier Fitness program. Efforts need to continue to (a) base the training on empirical findings such as those reported in the MHAT VI report, (b) conduct scientifically sound evaluations of training efficacy, and (c) integrate training into a comprehensive resiliency training program.

1.5.5 *Continue to Emphasize Junior Officers' Roles in Creating Resilient Units through Leadership Training.*

Junior-level leadership continues to be identified as a key factor contributing to Soldier well-being and resilience. Continue to emphasize programs such as (1) Battlemind for Junior Officers and (2) Battlemind for Mid-Grade Officers and integrate them into appropriate courses such as Basic Officer Leadership Course (BOLC); Captain's Career Course (CCC) and Intermediate-Level Education (ILE). Identify other settings to emphasize training for both officers and NCOs.

1.5.6 *Continue Suicide Prevention Review Board (SPRB) process*

The SPRB process executed by MNC-I provided a way to monitor, modify and disperse suicide prevention programs throughout the ITO. We recommend this process be continued.

1.5.7 *Continue Platoon-Based Sampling in Future MHATs.*

The results related to barriers to care from MHAT VI demonstrated the importance of executing a random sampling plan. In MHAT VI, a cluster-based sample of random selected platoons was shown to be a feasible sampling strategy. Future MHATs should maintain this sampling strategy. Future MHATs should also ensure that the core element of the sampling strategy targets Soldiers in maneuver units. Regularly targeting this clearly defined population across deployments will provide a powerful way to detect trends and changes without raising concerns that observed differences are caused by demographic differences in the sampled populations.