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

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Office of the Surgeon
Multi-National Corps-Iraq

and

Office of The Surgeon General
United States Army Medical Command

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

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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.

2. BACKGROUND

2.1   Background and Mission

This report presents findings from the sixth Mental Health Advisory Team (MHAT VI). The MHAT deployed to Iraq in support of Operation Iraqi Freedom (OIF) in February and March of 2009. The MHAT VI members were assigned to MNC-I and worked directly under the supervision and control of the Command Surgeon.

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

2.2   Sampling Strategy

MHAT recommendations are based upon multiple sources of information (survey data, records, and focus groups). Much of the report, however, centers on data from anonymous Soldier Well-Being surveys. In MHAT VI, two separate samples of Soldier survey data were collected. The first was a cluster sample of platoons from maneuver Battalions of BCTs (Maneuver Unit sample). The second was a cluster sample of operational Support and Force Sustainment units (Support and Sustainment sample). In both samples, platoons were randomly selected, and surveys were requested from all Soldiers 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 revise the sampling methodology from that used in previous MHATs. The goal of these meetings was to identify a random sampling plan that could be implemented in theater.

2.2.1 Maneuver Unit Sample

The Maneuver Unit sample was collected by randomly selecting two platoons from two randomly selected line Companies from every maneuver Battalion in theater for more than two months. The random selection of platoons was conducted by the MHAT team based on specific information about deployed units.

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 VI, a FRAGO identified the

units, and organic medical personnel in the brigade 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 relative 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. As we note later, the link to previous MHATs is not perfect and leads to some issues on how to interpret MHAT VI 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, in deployments the population of war-fighters represents less than half the deployed population. In a comprehensive analysis of the tooth-to-tail ratio, McGrath (2007) estimated that 40% of the deployed Armed forces in Iraq in 2005 were Combat Arms. Therefore, the maneuver unit sample must NOT be considered representative of the theater.

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.

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*

In MHAT VI, the cluster sample of platoons from maneuver units was augmented with roughly an equally large sample of platoon and platoon-sized units from support and sustainment units. 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 also included non-BCT units. Specifically, platoons were sampled from a Combat Aviation BDE, an Expeditionary Sustainment Command (ESC), an Engineer BDE, and MP BDE, and a Medical BDE.

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 VI sample mirror those in the broader population. That is, if medical assets represented 12% of the population, medical platoons would have to be surveyed in a way that maintained the 12% ratio or (alternatively) sampling weights would have to be used. Surveys were not administered with respect to sample ratios, and for the current

report weights are not used due to the complexity of estimating and applying defensible weights. 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 mental health 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 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" Soldiers. Previous MHATs may have oversampled Soldiers within Forward Operating Bases (FOBs) simply because these Soldiers were conveniently located to 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   Trends Across Time

To examine trends across MHATs, we rely on statistical models that include time as a predictor. In the models, time is modeled two ways: first, as a categorical variable using the 2009 MHAT VI Maneuver Unit sample as the referent; second, as a linear vector. The first categorization provides a way to contrast the MHAT VI values with previous MHATs on a year-by-year basis. The second method determines whether a significant linear trend (increase or decrease) is evident across the six years. The linear trend is included in the graph only if it is significant.

In the graphs, sample-adjusted values are 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 Soldier deployed for (3) nine months. Note that because sample-adjusted values are based on data combined across all MHATs (to include MHAT VI), the values listed in this report may not necessarily coincide with the values provided in previous MHAT reports. Values are adjusted based on the attributes of the entire sample, so adding to the total sample produces slight changes in the sample-adjusted values.

To a certain degree, the analysis of trends should be considered exploratory because of the new sampling strategy implemented in MHAT VI. Nonetheless, we believe it is valuable to examine trends in behavioral health issues over the course of the six MHATs because we may be able to detect small changes over the course of six years that would not be evident in year-by-year comparisons.

Adjusted means were estimated from either a logistic regression model or a linear regression model. Key results were also confirmed using generalized linear mixed effects models (GLMMs) to control for hierarchical nesting of the data. These additional analyses were conducted to ensure that parameter estimates and standard error values were not biased by the nested nature of the data (Bliese & Hanges, 2004; Pinheiro & Bates, 2000).

2.4   Focus Groups

The MHAT VI team used junior enlisted Soldier and NCO focus groups to augment the survey results. Focus groups were conducted across several regions of the Iraqi theater of operations (ITO). In total, 24 junior enlisted Soldiers and 18 NCOs participated in focus group sessions. Themes from the focus groups are integrated into the relevant sections of the Soldier survey data results.

2.5   Verification of Results

In the MHAT VI report, 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).

3. OVERVIEW OF SOLDIER WELL-BEING

The MHAT VI Soldier Well-Being 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   Soldier Combat & Well-Being Model

The MHAT VI 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).
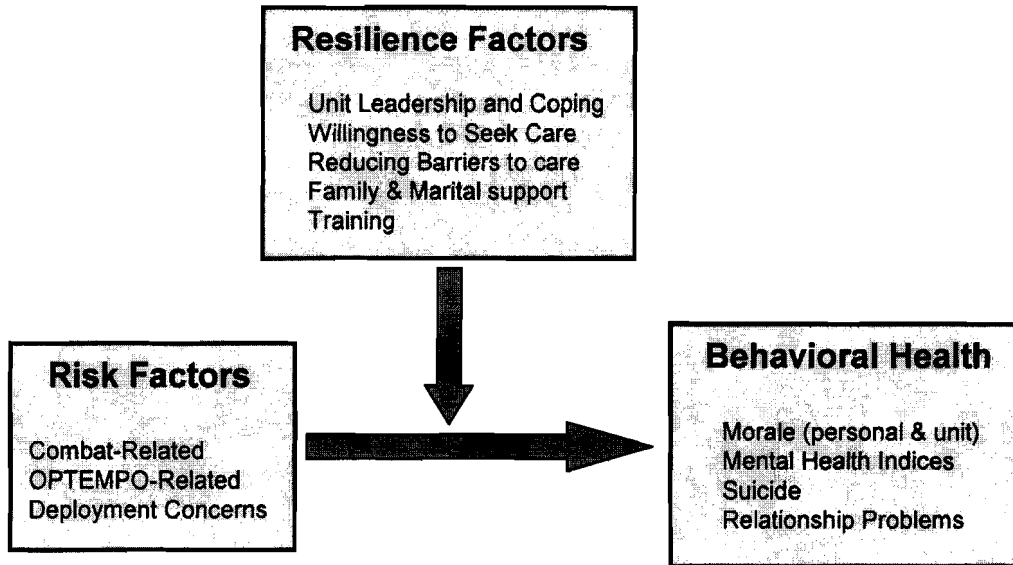
Figure 1. Soldier Combat & Well-Being Model (Adapted from Bliese & Castro, 2003).

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

The report provides rates of these variables for the current two MHAT VI samples (Maneuver Unit and Support/Sustainment). The report also provides comparisons to previous MHAT samples, and examines trend lines across the six years.

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 are 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 mental health symptoms such as acute stress (Dohrenwend, et

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al., 2006). The second class of factors are OPTEMPO-related experiences such as deployment length and multiple deployments.

Deployment concerns related to living conditions, work concerns and family concerns are the third category of stressors. Unfortunately, a survey error directed only those who had taken mid-tour leave to complete the items. As it turned out, a large percent of the sample had taken mid-tour leave (59.8% of the Maneuver Unit sample and 42.4% of the Support and Sustainment sample); nonetheless, this error does seriously limit comparability to previous data. Due to this limitation, we examine trends across the six years to see how MHAT VI fits into broader patterns, but we do not provide tests of statistical significance.

With respect to OPTEMPO-related experiences, previous MHAT reports detailed the effects of factors such as (1) deployment length and (2) multiple deployments. These two factors are re-examined in MHAT VI in part to determine whether the new sampling strategy leads to different findings. A third OPTEMPO-related experience examined in MHAT VI is a detailed analysis of dwell-time between deployments.

3.1.3 *Resiliency 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 Soldiers at risk or (b) by strengthening protective factors so Soldiers are better able to cope when exposed to factors that put them at risk.

In combat environments, many risk factors are either unavoidable (e.g., exposure to potentially traumatic combat events) or they are the direct product of National policy decisions (e.g., the size of the military requires deploying Soldiers 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 enhance the resilience of Soldiers. The current MHAT report examines:

1. Unit Leadership
2. Stigma and willingness to seek care
3. Perceived barriers to care
4. Perceived adequacy of mental health training
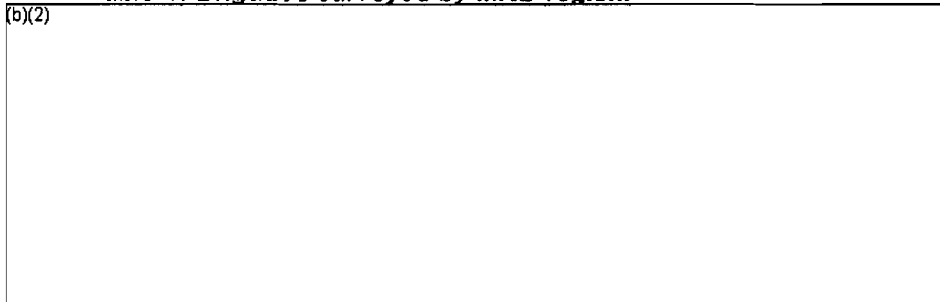
MHAT VI also contains a section examining individual coping strategies. These items were included in an attempt to identify coping strategies that appear to be particularly useful for developing resiliency programs for Soldiers.

3.2   MHAT VI Soldier Sample and Methods

Units represented in the MHAT VI assessment are listed in Table 1. These units had Soldiers complete the Soldier Well-Being survey or the units provided individuals to complete the behavior health (BH) surveys. In addition, selected units also provided Soldiers for focus group interviews.

Table 1. Brigades surveyed by MND region.

(b)(2)

3.3   Maneuver Unit and Support/Sustainment Sample Demographics

Table 2 provides details on selected demographic variables for the Maneuver Unit and Support and Sustainment samples compared to the MHAT V sample. The Maneuver Unit sample differed from the MHAT V sample in 2007 in terms of being (a) significantly younger (more Soldiers younger than 30), (b) containing less officers, (c) having a higher percent of multiple deployed Soldiers and (d) being in theater less time. The sample did not differ in terms of marital status.

The Support and Sustainment sample differed from the Maneuver Unit sample in terms of (a) being older, (b) containing more National Guard and Reserve Soldiers, (c) fewer single, and (d) less time in theater. The Support and Sustainment sample also differed from MHAT V in 2007 in terms of having a higher percentage of females.

Table 2: Demographic Comparison MHAT VI (Maneuver & Sustainment/Support) to MHAT V (2007).

Demographic Variable	MHAT V		MHAT VI (Maneuver)		MHAT VI (Support/Sustainment)	
	n	Percent	n	Percent	n	Percent
Gender						
Male	1983	90.3%	---	---	970	82.1%
Female	206	9.4%	---	---	202	17.1%
Unknown	6	0.3%	---	---	10	0.8%
Age						
18-19	87	4.0%	55	4.4%	27	2.3%
20-24	1102	50.2%	672	53.3%	488	41.3%
25-29	539	24.6%	331	26.3%	313	26.5%
30-39	378	17.2%	182	14.4%	256	21.7%
40+	86	3.9%	14	1.1%	86	7.3%
Unknown	3	0.1%	6	0.5%	12	1.0%
Rank						
E1-E4	1315	59.9%	774	61.4%	696	58.9%
NCO	720	32.8%	441	35.0%	418	35.4%
Officer / WO	150	6.8%	37	2.9%	52	4.4%
Unknown	10	0.5%	8	0.6%	16	1.4%
Component						
Active	2091	95.3%	1241	98.5%	911	77.1%
Reserve	49	2.2%	0	0.0%	111	9.4%
National Guard	44	2.0%	0	0.0%	141	11.9%
Unknown/Other	11	0.5%	19	1.5%	19	1.6%
Marital Status						
Single	924	42.1%	525	41.7%	413	34.9%
Married	1076	49.0%	636	50.5%	622	52.6%
Divorced	132	6.0%	61	4.8%	91	7.7%
Unknown/Widowed	63	2.9%	38	3.0%	56	4.7%
Deployment History						
First Time	1496	68.2%	759	60.2%	736	62.3%
Second Time	538	24.5%	371	29.4%	320	27.1%
Third or More	129	5.9%	117	9.3%	106	9.0%
Unknown	32	1.5%	13	1.0%	20	1.7%
Time in Theater						
6 Months or Less	456	20.8%	442	34.1%	711	60.2%
6 to 12 Months	1318	60.0%	496	38.2%	378	32.0%
Over 12 Months	255	11.6%	269	20.7%	2	0.2%
Unknown	166	7.6%	91	7.0%	91	7.7%

3.4 Cluster Sample Effects

Table 2 identifies some relatively minor differences between the MHAT V and MHAT VI (Maneuver) samples with respect to demographics and time in theater. One of the most dramatic changes between MHAT V and MHAT VI, however, is the number of Soldiers in the Maneuver Unit sample that reported living in an outpost outside of their units main Forward Operation Base (FOB). Figure 2 provides histograms showing differences across years and

across the two MHAT VI samples. In the MHAT V sample, slightly over 10% of the sample (males only) reported living an average of 29 to 31 days per month outside of the FOB. In contrast, in the MHAT VI Maneuver Unit sample, over 30 percent of the sample reported living 29 to 31 days per month outside of their unit's FOB while in the MHAT VI Support and Sustainment sample only about 8% of the sample report living outside the FOB 29 to 31 days per month.

This difference across MHATs for the Maneuver units cannot be explained solely by the troop dispersion associated with the surge, because the MHAT V sample from 2007 was collected during a time when there was a high degree of dispersion (October and November of 2007). The most likely explanation for the difference is the difference in sampling in that hard to reach platoons were more likely to be included in the sample. The increase in the percent of Soldiers living outside of their FOBs has a number of implications for comparisons drawn across years that will be detailed in the report.

Figure 2: Average Days per Month Lived Outside the FOB: (MHAT V versus MHAT VI)

MHAT V (2007)

MHAT VI Maneuver Sample (2009)

MHAT VI Support and Sustainment Sample (2009)
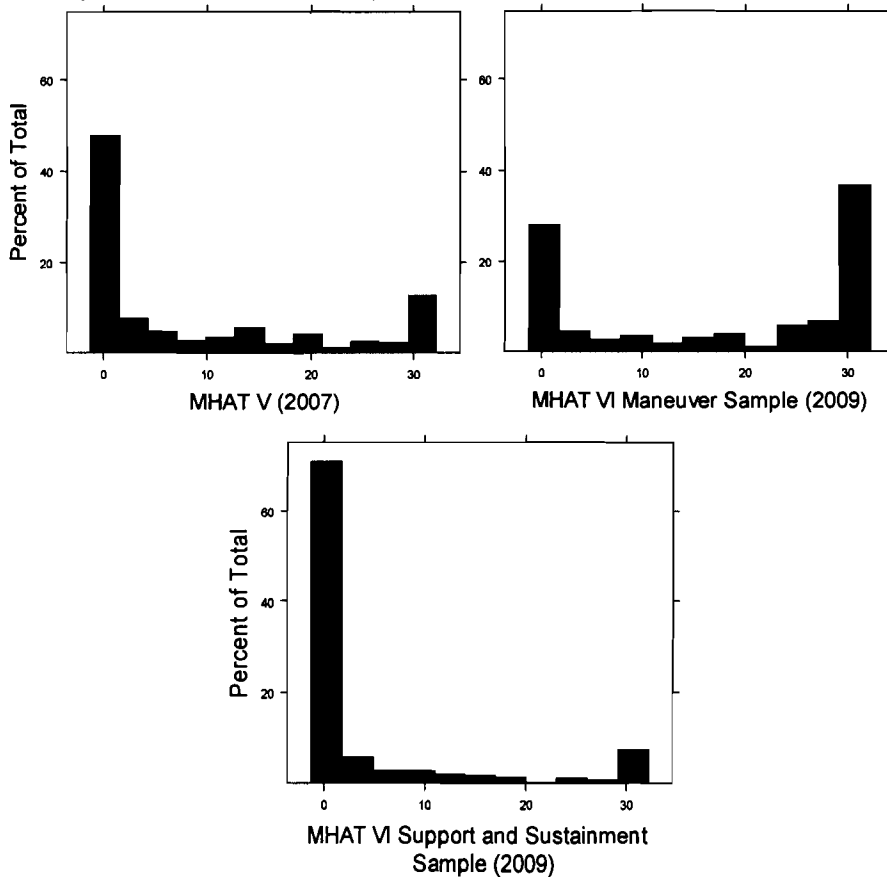
4. SOLDIER BEHAVIORAL HEALTH INDICES

Soldier 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 MHAT data. The standard graph used in this section provides:

1. Sample-adjusted values for each MHAT. Values are adjusted for gender, rank and time in theater, and describe male E1-E4 Soldiers in theater for nine months. The sample-adjusted value for MHAT VI is based on the Maneuver Unit sample. MHAT values that significantly differ from MHAT VI are underlined.

2. Raw 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 adjusting for gender, rank, and months deployed.

3. Trend lines if a significant linear trend is detected.

4.1   Morale

4.1.1 *Individual Morale*

Figure 3 provides the percent of Soldiers who reported having high or very high individual morale across the six MHATs. The sample-adjusted MHAT VI value of 19.6% is significantly higher than the sample-adjusted value of 15.8% in 2006 and the value of 12.2% in 2003. The trend line indicates a small, but significant, increase in individual morale across MHATs.

Figure 3: Individual Morale
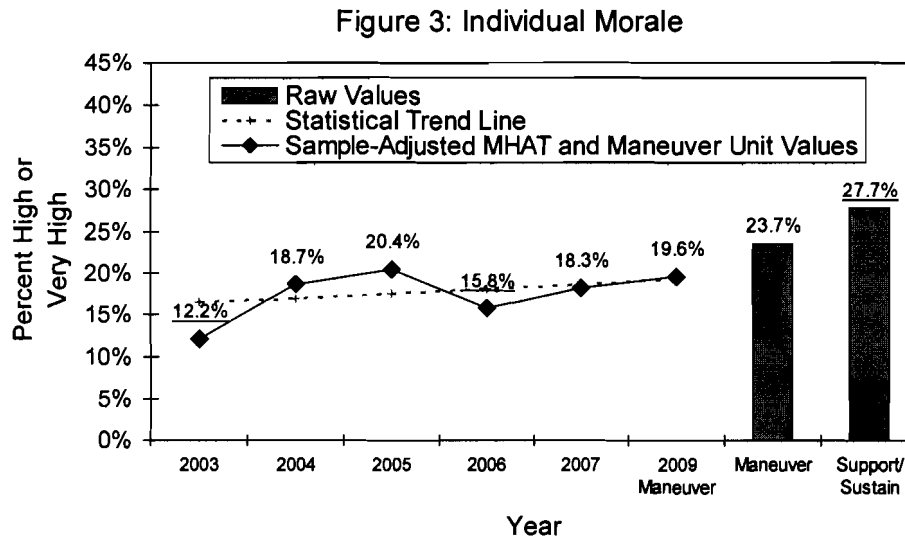
In Figure 3, there is a relative large difference between the raw and sample-adjusted values for the Maneuver Unit sample (23.7% raw versus 19.6% for sample-adjusted). Raw values are higher than adjusted values primarily because the adjusted values are based on E1-E4 Soldiers, and E1-E4 Soldiers typically report lower morale than NCOs and Officers. The inclusion of NCOs and Officers in the raw data raises the value to 23.7%. Finally, notice in

Figure 3, that the value for the Support and Sustainment sample is significantly higher than the value for the Maneuver Unit. This difference remains significant after for controlling for time in theater, rank and gender.

4.1.2 *Unit Morale*

Figure 4 shows the percent of Soldiers who rated unit morale high or very high. The values for MHAT VI Maneuver units are within normal ranges – significantly lower than values in 2005 and 2007, but significantly higher than values from 2003 and 2006. Overall, the trend is for an increase in unit morale across the six MHATs. As with individual moral, the Support and Sustainment sample reported significantly higher levels of unit morale.

Figure 4: Unit Morale
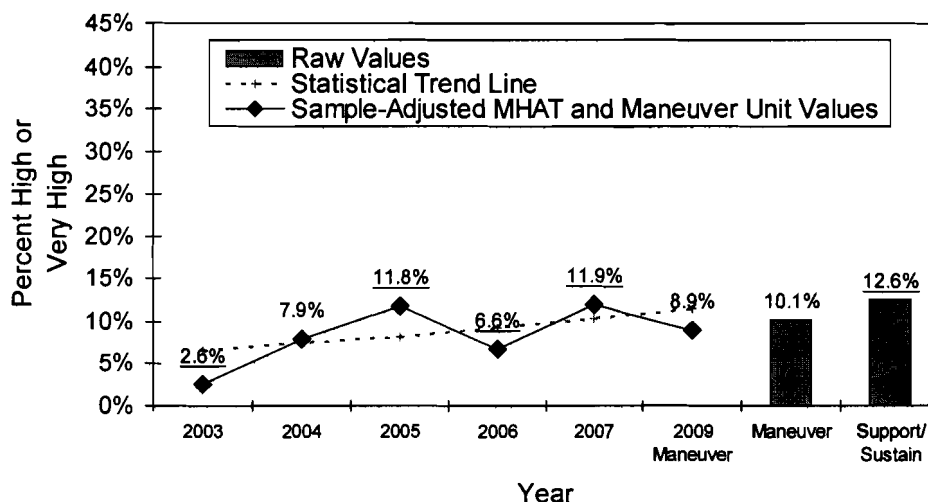
In the focus groups, a number of junior enlisted Soldiers and NCOs perceived an increase in morale compared to prior deployments and frequently attributed this to a higher quality of life. Specifically, focus groups attributed high morale to MWR services, entertainment nights, videos and group sports. Factors most often brought up as lowering morale included a lack of purpose with mission, perceived lower recruitment standards and negative leadership.

4.2   Behavioral Health: Acute Stress, Depression and Anxiety

Soldiers' 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 Problem*

The combined rating of any mental health problem (acute stress, depression or anxiety) is presented in Figure 5. Both the raw and adjusted values for the Maneuver Unit sample show that the percent of Soldiers reporting mental health problems is lower than at any other time during OIF. In terms of statistical significance, MHAT IV (Maneuver) is lower than every year except 2004. There was no evidence of a significant trend line. The Support and Sustainment sample value was not statistically different than that reported by the Maneuver Unit sample.

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Figure 5: Any Psychological Problem (Acute Stress,
Depression, Anxiety)
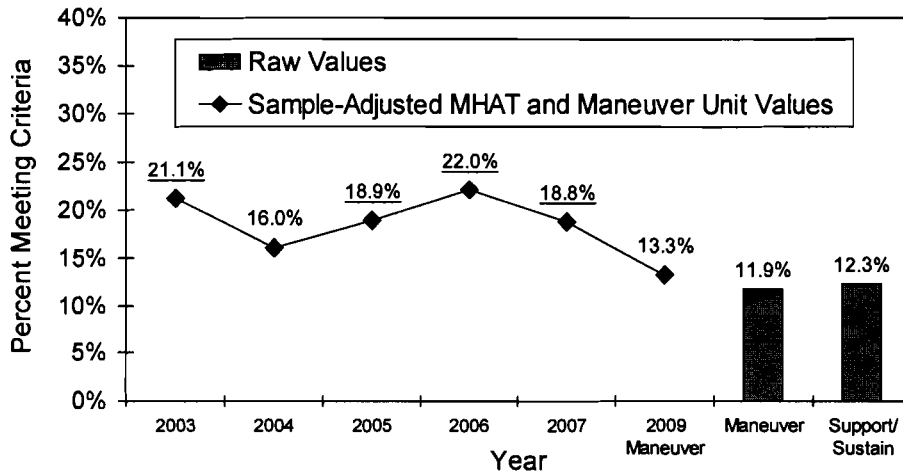
4.2.2 Acute Stress, Depression and Anxiety

The specific values for each of the components in Figure 5 are provided in Table 3. The sample-adjusted Maneuver Unit sample values (labeled "2009 Maneuver") for Acute Stress, are significantly lower than values reported in 2007 (9.9% versus 15.8%).

Raw values from the Support and Sustainment sample are comparable to those from Maneuver units. Acute stress scores are highly correlated with combat exposure (see section 5.1), and the Support and Sustainment sample reports low levels of combat exposure (see section 5.1.1); therefore, it is interesting that rates of acute stress in the Support and Sustainment sample are not lower. The comparability of acute stress scores between the two samples suggests factors other than current combat experiences may be responsible for acute stress scores. One possible explanation may be the strong relationship between multiple deployments and acute stress in the Support and Sustainment sample (see section 5.3.5).

Table 3: Raw Values and Sample-Adjusted Percents for Male, E1-E4 Soldiers in Theater 9 Months.

| Mental Health Indicator | Sample Adjusted MHAT and Maneuver Values | | | | | | 2009 Raw Values | |
	2003	2004	2005	2006	2007	2009	Maneuver	Support/ Sustain
Acute Stress	16.5%	12.3%	15.2%	18.6%	15.8%	9.9%	9.1%	9.7%
Depression	9.9%	7.1%	9.8%	10.6%	7.7%	6.0%	4.9%	4.9%
Anxiety	10.4%	7.2%	8.8%	10.3%	7.7%	6.5%	5.4%	5.2%

4.3   Medications for Sleep and Mental Health Problems

In previous MHATs, Soldiers were asked "Have you taken any medication for a mental health, combat stress, or sleep problem during this deployment?" In MHAT V in 2007, 12.3% of the Soldiers indicated that they had taken medication. In MHAT VI, the original item was divided

into two separate items (1) Have you taken any medication for a sleep problem during this deployment and (2) Have you taken any medication for a mental health or combat stress problem during this deployment.

In all, 8.1% of the Soldiers in the Maneuver Unit sample reported taking medications for sleep problems, and 4.8% reported taking medication for a mental health or combat stress problem (2.5% reported taking medication for both). In the Support and Sustainment sample the corresponding percents were 13.5% and 5.1% (3.2% reported taking medication for both). The difference between 8.1% and 13.5% for sleep medications was statistically significant even after controlling for rank, time in theater and gender differences in the samples.

4.4 Suicide Ideation

The current report contains a detailed section on suicide (see section 8); however, suicide ideation can also be examined using a single depression item on the Soldier Well-Being Survey. This item (item 9 of the PHQ-D -- Spitzer, Kroenke, & Williams, 1999) 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. Figure 6 provides details on responses to this item over the course of the MHAT assessments. Sample-adjusted values for the Maneuver Unit sample in MHAT VI are significantly lower then values reported in 2006 and 2003. Notice, also that the trend line across the six years of the MHAT is a decline in suicide ideation. The value for the Support and Sustainment sample is not significantly different than the Maneuver Unit value.

Figure 6: Suicide Ideation
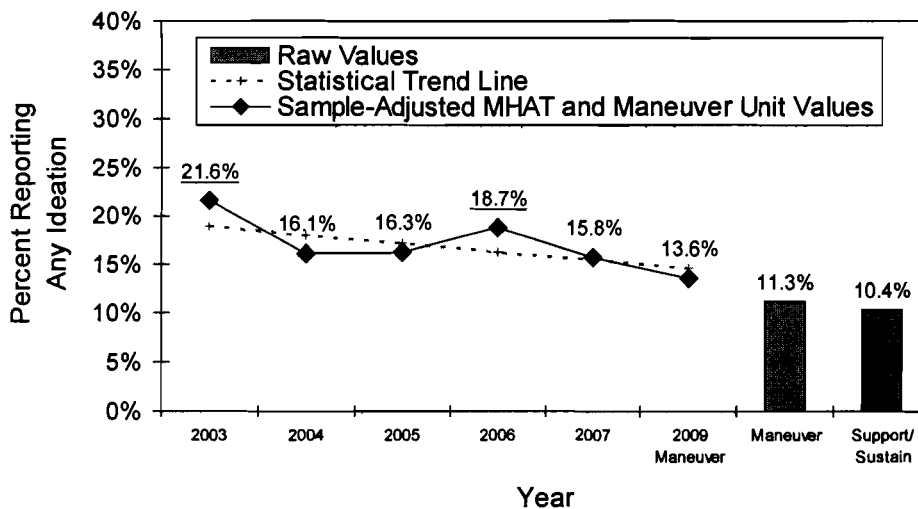
4.5 Trends in Intent to Divorce or Separate

A straight-forward index of relationship problems is the percent of Soldiers who report they are planning to get a divorce or separation. In MHAT VI, there is no evidence of a significant increase in the percent of married Soldiers seeking a divorce or separation relative to MHAT V; however, Figure 7 shows that the six year trend is significant and indicates a small, but steady, increase such that the value in 2009 is significantly different from the value in 2003. A similar trend is evident for an item asking spouses' intent to get a divorce or separation (not shown), and in marital satisfaction (see section 6.7).

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In Figure 7, the large difference between the sample-adjusted values and the raw values for the Maneuver Unit sample occurs because the E1-E4 population (upon which the sample-adjusted values are based) are significantly more likely to endorse the divorce/separation item than are either NCOs or Officers. The raw value contains a large number of NCOs, so the value is low relative to the sample-adjusted value. The value for the Support and Sustainment sample is not significantly different than the value for the Maneuver Unit sample.

Figure 7: Planning Divorce or Separation
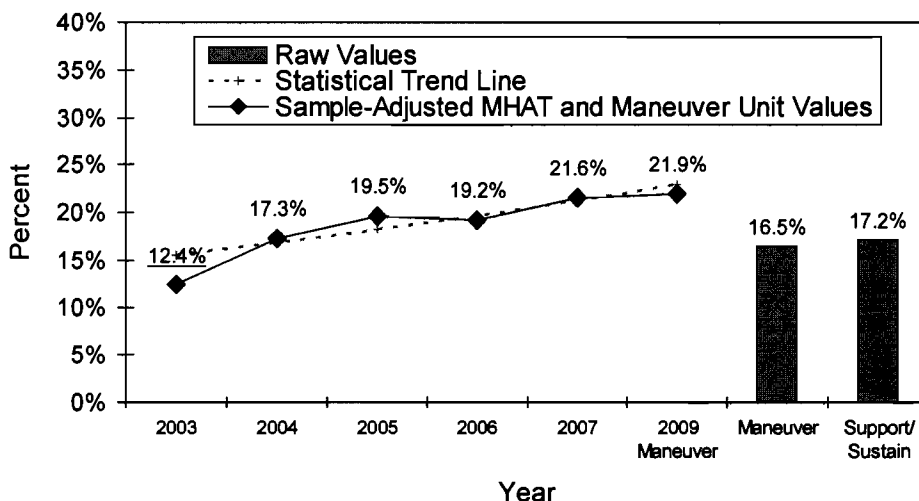
4.6   Concussion (mTBI)

In both MHAT V and MHAT VI, Soldiers responded to a series of questions about possible concussive events during this deployment. The sample-adjusted percent of Maneuver units Soldiers who reported an injury event with loss of consciousness was 3.9%, significantly lower than the sample-adjusted value of 6.1% for MHAT V. Of those who reported a concussion with loss of consciousness, 50.4% reported seeking medical care, which is similar to the 52.1% sample-adjusted value for MHAT V. In the Support and Sustainment sample, 1.3% reported an injury event with loss of consciousness. This value is significantly lower than the value reported by the Maneuver Unit sample.

4.7   Career Intentions

Family concerns and mental health status are significant predictors of career intentions, and the current analyses show divergent trends on these two variables. On the one hand, several of the mental health indices (morale, suicide ideation) show trends indicating improvements over the six MHATs. In contrast, the intent to divorce or separate has increased across MHATs. It is unclear, therefore what would be expected in terms of trends related to career intentions.

Figure 8(a) shows the percent of E1-E4 male Soldiers in theater 9 months who report that they will definitely leave upon completion of their current obligation while Figure 8(b) shows the percent who intend to definitely stay past their current obligation. Both trend lines indicate a greater willingness to stay in the Army over the six years. The sample-adjusted Maneuver Unit values in 2009 are significantly different from all other MHAT years except 2007.

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Soldiers in the Support and Sustainment sample were significantly less likely than those in the Maneuver Unit sample to report that they would definitely leave after their current obligation. This raw difference shown in Figure 8(a) remained highly significant even after adjusting for rank, months in theater and gender. Interestingly, while Support and Sustainment unit Soldiers were less likely to leave, they did not differ in terms of definitely staying past their current obligation [see Figure 8(b)].

It is not clear what factors explain the trends in Figures 8(a) and 8(b). Career decisions may be influenced by numerous factors to include broader economic conditions, changes in educational benefits and bonuses; nonetheless, the trend is positive in terms of retention intent.

Figure 8 (a): Definitely Leave After Current Obligation

Figure 8(b): Definitely Stay Past Current Obligation

Year
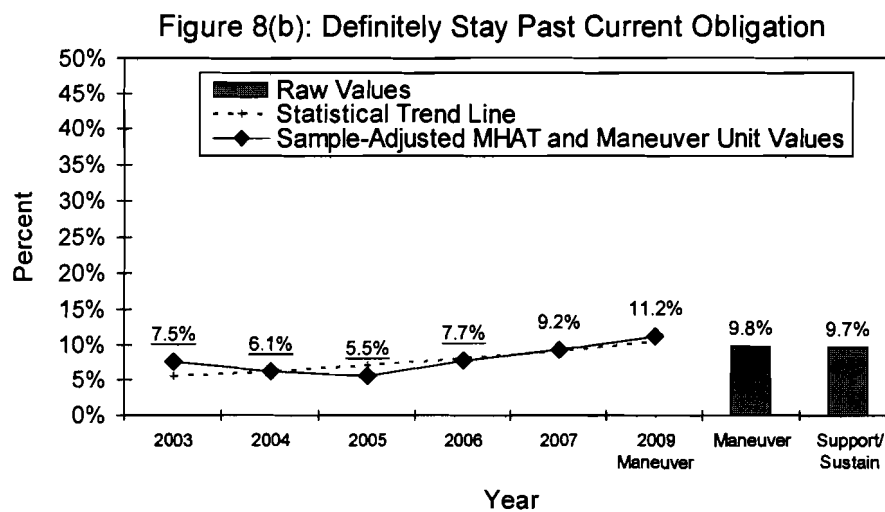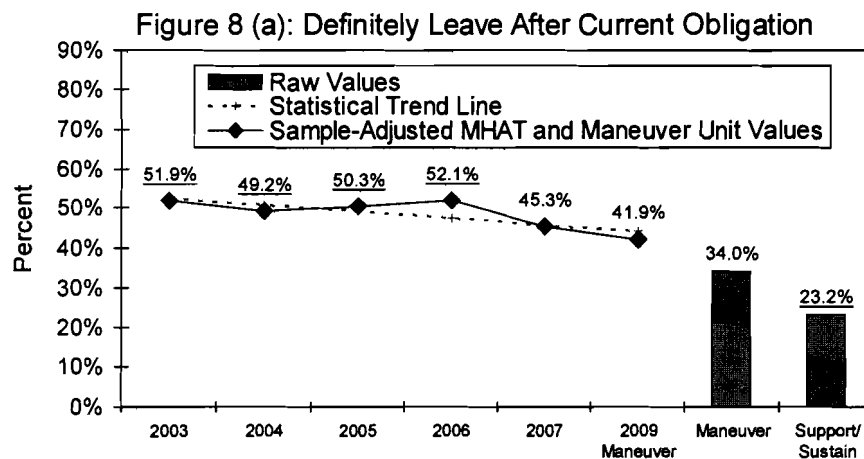
5. SOLDIER RISK FACTORS

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

5.1   Combat Experiences

Section 4.2.2 detected significant declines in reports of acute stress in the Maneuver Unit sample relative to MHAT V in 2007. 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 decreases in combat-related risk factors relative to other MHAT data.

In the Soldier Well-Being Survey, 30 combat experience items have been consistently assessed since MHAT II in 2004 (items used in MHAT I did not include references to IEDs, so MHAT I is omitted from the current analyses). 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 9 shows the relationship between the combat experiences score and acute stress scores. 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 9: Combat Experiences and Acute Stress

Combat Experiences Score
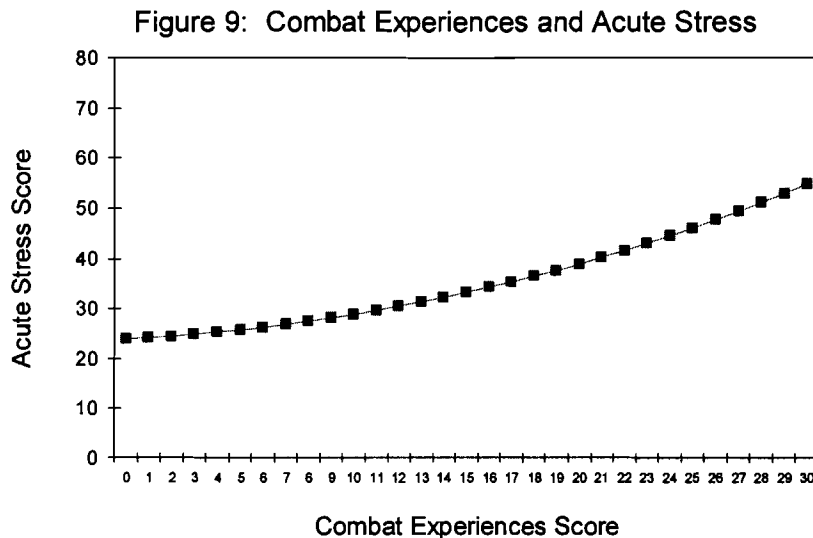
5.1.1 *Combat Experiences*

Figure 10 provides a comparison of levels of mean total combat experiences from MHAT II to MHAT VI. Notice that the overall levels of combat experiences reported in MHAT VI are significantly lower than every year except 2004. The overall difference between the MHAT VI Maneuver Unit sample and MHAT V is relatively small (though statistically significant). The

levels of combat exposure reported by Soldiers in Support and Sustainment Units are dramatically lower than rates reported by those in Maneuver Units.

Figure 10: Mean Total Combat Experiences
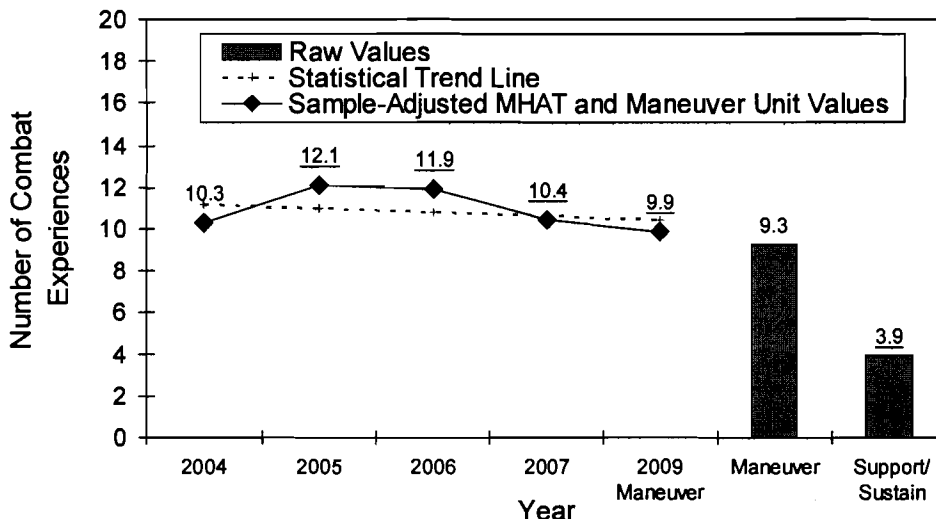
Table 4 provides a breakdown of all the items that significantly differed between MHAT VI (Maneuver Unit sample) and MHAT V. The Table also provides comparisons to MHAT IV in 2006. All values are sample-adjusted for male E1-E4s in theater 9 months. With a conventional p-value of .05, the large number of analyses comparing MHAT VI to MHAT V (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 list results with a p-value equal to or less than .01 in the MHAT VI and MHAT V comparison.

Table 4 shows that 25 of the 30 combat experiences significantly changed from MHAT V to MHAT VI (Maneuver Unit). Nine of these changes represented increase (values above the dotted line), and the remaining 16 represented decreases. A number of the increases are almost certainly due to changes in the sampling and the large number of respondents in MHAT VI that are living outside of the FOBs (see section 3.4). For instance, it is doubtful that the percent of war-fighters clearing/searching homes or buildings has increased from 50.2% (MHAT V) to 78.8% (MHAT VI). Much more likely is that the MHAT VI Maneuver Unit sample contains a high percentage Soldiers engaged in direct combat.

Even with the changes in sampling that led to increases in some variables, it is clear that levels of combat exposure have significantly declined from MHAT V to MHAT VI. The reduction in combat experiences is particularly dramatic when MHAT VI values are compared to MHAT IV values from 2006. Notice that rates for the current MHAT are often half as high as the rates reported in the previous MHATs. These findings are even more dramatic when we consider that the MHAT VI Maneuver Unit sample is comprised entirely of war-fighters whereas other MHATs had a mix of war-fighters and those in support and sustainment roles.

Table 4: Adjusted Percents for Male, E1-E4 Soldiers in Theater 9 Months.

|	Percent			p-values	
Combat Experiences	MHAT IV 2006	MHAT V 2007	MHAT VI (Maneuver) 2009	2009 versus 2007	2009 versus 2006
Witnessing an accident which results in serious injury or death.	41.8%	35.7%	41.9%	0.00	0.96
Witnessing violence within the local population or between ethnic groups.	38.8%	35.4%	42.3%	0.00	0.10
Participating in demining operations.	26.9%	21.4%	25.8%	0.01	0.55
Working in areas that were mined or had IEDs.	75.1%	63.1%	76.0%	0.00	0.63
Having hostile reactions from civilians.	55.8%	43.5%	49.9%	0.00	0.01
Disarming civilians.	33.8%	30.9%	41.6%	0.00	0.00
Clearing/searching homes or buildings.	48.1%	50.2%	78.8%	0.00	· 0.00
Clearing/searching caves or bunkers.	18.0%	15.1%	20.0%	0.00	0.24
Seeing ill/injured women or children who you were unable to help.	39.3%	33.6%	46.9%	0.00	0.00
Being attacked or ambushed.	66.4%	50.7%	34.0%	0.00	0.00
Receiving small arms fire.	67.2%	58.0%	36.7%	0.00	0.00
Seeing dead bodies or human remains.	64.9%	59.0%	47.4%	0.00	0.00
Handling or uncovering human remains.	30.1%	28.9%	18.1%	0.00	0.00
Seeing dead or seriously injured Americans.	46.1%	46.4%	34.1%	0.00	0.00
Knowing someone seriously killed or injured.	71.7%	71.8%	57.1%	0.00	0.00
Shooting or directing fire at the enemy.	45.8%	36.1%	24.1%	0.00	0.00
Calling in fire on the enemy.	10.5%	11.6%	5.3%	0.00	0.00
Receiving incoming artillery, rocket or mortar fire.	88.1%	78.3%	56.9%	0.00	0.00
Being directly responsible for the death of an enemy combatant.	15.0%	12.3%	9.0%	0.00	0.00
Having a member of your own unit become a casualty.	59.3%	54.6%	45.4%	0.00	0.00
Had a close call, dud landed near you.	32.3%	23.8%	14.0%	0.00	0.00
Had a close call, equipment shot off your body.	4.6%	4.4%	2.2%	0.00	0.00
Had a close call, was shot or hit but protective gear saved you.	6.9%	6.1%	2.2%	0.00	0.00
Had a buddy shot or hit who was near you.	15.3%	15.6%	8.4%	0.00	0.00
Informed unit members/friends of a Service Member's death.	10.5%	11.2%	7.7%	0.00	0.02

The five combat experiences that did not significantly change compared to MHAT V [MHAT V, MHAT VI] were:

1. Seeing destroyed homes and villages [62.7%, 64.1%].
2. IED/booby trap exploded near you [51.6%, 48.3%].
3. Being in threatening situations where you were unable to respond because of the rules of engagement [40.4%, 38.1%].
4. Engaged in hand-to-hand combat [4.4%, 4.7%].
5. Being wounded/injured [10.8%, 8.4%].

5.1.2 *Platoon-Level Variation in Combat Exposure*

While the theater as a whole reported a decline in levels of combat, Soldiers' responses to the combat experiences scale vary significantly by platoon. Figure 11 shows the average ratings of combat experiences across platoons from the Maneuver Unit sample. The solid line represents a random distribution (with 95% error bars) expected if combat experiences were random across platoons. Notice that there are a number of platoons where members, on average, reported 15 or more experiences. Statistically, this clustering by platoons can be summarized by noting that the Intraclass Correlation Coefficient 1 or ICC(1) value is 0.43 (43% of a Soldier's combat exposure score can be explained by platoon membership – see Bliese, 2000). These analyses highlight that specific platoons may be experiencing high levels of combat even if the theater as a whole has generally seen a decrease. The findings emphasize that for certain groups of Soldiers, the theater remains a tough, demanding combat environment.

Figure 11: Average Levels of Combat Exposure in Platoons Compared to Random Expected Value
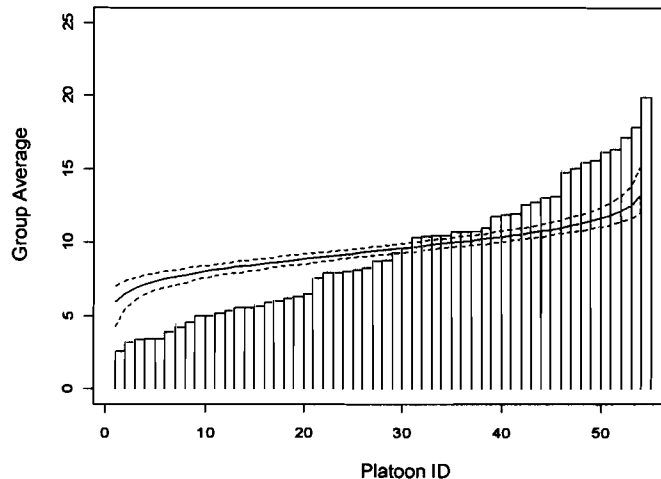
5.2   OPTEMPO Factors: Deployment Length

Months deployed was identified as a risk factor of behavioral health outcomes in MHAT IV and MHAT V. The MHAT VI Maneuver Unit sample is smaller than the MHAT V sample; like MHAT V, however, the MHAT VI Maneuver Unit sample contains an excellent range of months deployed. Figure 12 provides two different ways to visualize months deployed. The density plot clearly shows that the data has three groups clustering around 4 months deployed, 9/10 months deployed and 13 months deployed.

Figure 12: Density and Mosaic Plots of Months Deployed in the Maneuver Unit Sample

Density Plot of Months Deployed

N = 1207   Bandwidth = 0.8323

Number of Surveys by Months Deployed
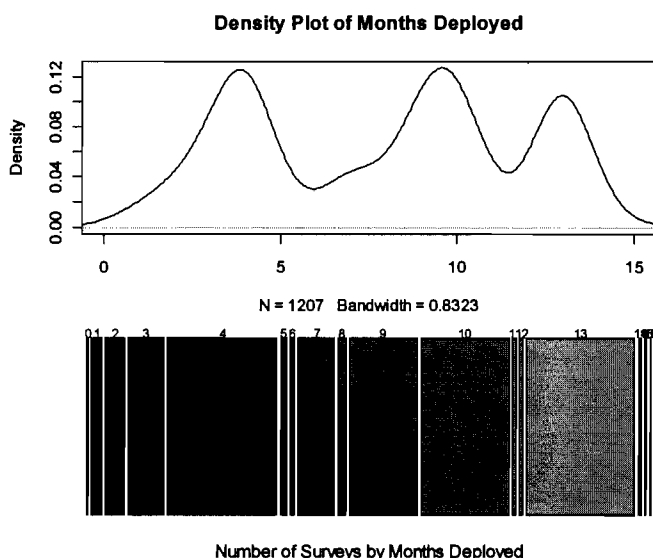
In MHAT V, the relationship between months deployed and morale was in the form of a "U". For behavioral health problems, the form of the relationship was an "∩". These relationships were generally replicated in MHAT VI. For instance, Figure 13 illustrates the relationship between months deployed and unit and individual morale detected in the MHAT VI Maneuver Unit sample – a relationship which is similar to that reported in MHAT V. Given that MHAT V detailed the relationship between months deployed and outcomes, and the results from MHAT VI are generally consistent with those findings, we do not detail all these relationships in MHAT VI. We simply reiterate that months deployed is a significant risk factor and that the mid-point of a deployment may be a particularly high risk period. There was less evidence of these findings in the Support and Sustainment sample; however, fewer Soldiers were surveyed in the final months of the deployment making it more difficult to detect curvilinear effects.

Figure 13: Sample-Adjusted Levels of Morale by Month in Theater for E1-E4 Male Soldiers in Maneuver Units

27
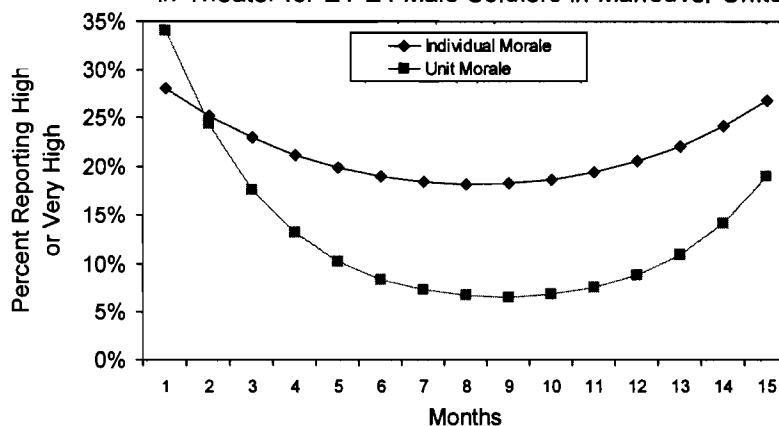
5.3   OPTEMPO Factors: Multiple Deployments

The last three MHATs have identified multiple deployments as a risk factor for mental health problems. In 2007, the sample contained enough Soldiers on their third or fourth deployment to Iraq to create three deployment groups: first-time deployers (68.2%), second-time deployers (24.5%), and third/fourth time deployers (5.9%). In the MHAT VI Maneuver Unit sample, the percents were 60.2%, 29.4%, and 9.3%: in the Support and Sustainment sample, the percents were 62.3%, 27.1% and 9.0% both of which represent higher percents of multiple deployers relative to 2007.

As in previous years, Soldiers in the multiple-deployer group are predominately NCOs. Specifically, NCOs constitute 12.2% of the first-time deployer group, 66.0% of those on their second deployment and 86.3% of those on their third or fourth deployment. Figure 14 presents the relationship between rank and multiple deployments for the Maneuver Unit sample.

Figure 14: Mosaic Plot of the Relationship Between Rank and Multiple Deployments to Iraq
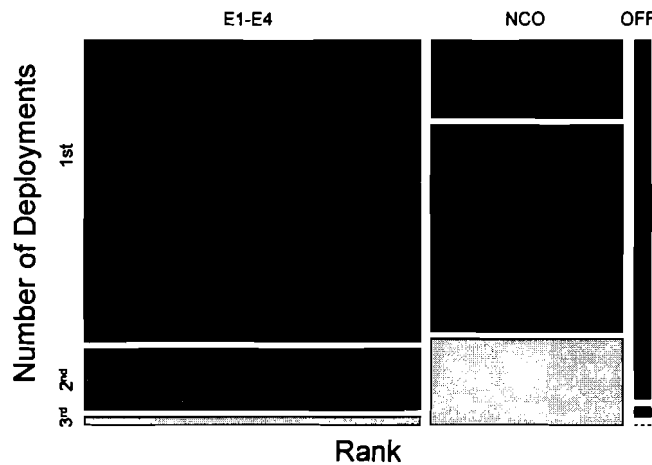
5.3.1 *Morale: Maneuver*

Figure 15 shows sample-adjusted rates of morale for male NCOs deployed for 9 months. As in previous MHAT data there is a clear multiple deployment effect though the difference between 26.4% and 32.4% for individual morale is not statistically significant.

Figure 15: Sample-Adjusted Values for Male NCOS in Theater 9 Months (Maneuver Unit)
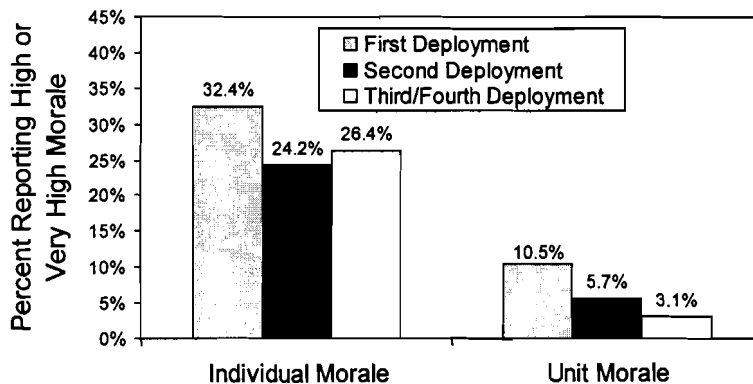
5.3.2 Behavioral Health: Maneuver

The multiple deployment effects on behavioral health are less pronounced than in MHAT V. Nonetheless, Figure 16 shows evidence of a multiple deployer effect for those on their second deployment.

Figure 16: Sample-Adjusted Values for Male NCOS in Theater 9 Months (Maneuver Unit)
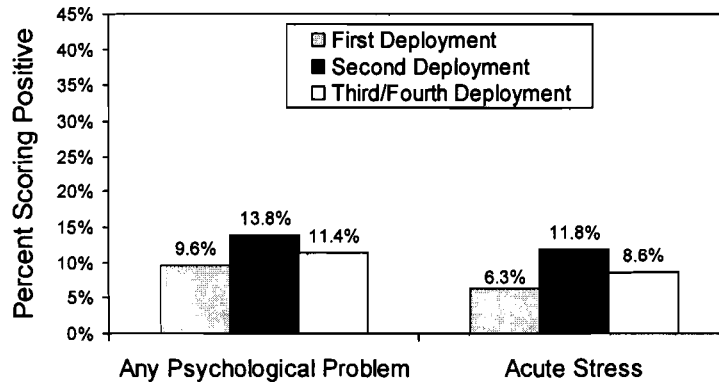
5.3.3 Suicide Ideation and Divorce: Maneuver

As with MHAT V, Soldiers' reports of suicide ideation or intent to divorce were unrelated to the number of deployments. The finding related to divorce may reflect the observation that focus groups were inconsistent. Some focus groups suggested that multiple deployments were having a negative effect on families, while other focus group members reported that even with multiple deployments their marriages were stronger than ever. In this latter case, Soldiers reported that spouses had gotten used to the Soldier being deployed. Nonetheless, this inconsistent finding warrants further investigation.

5.3.4 Morale: Support/Sustain

Evidence of multiple deployment effects on individual and unit morale were detected for the Support and Sustainment sample. The effects were weaker than those in the Maneuver Unit sample and revealed that those deployed the second time had lower morale than those deployed the first time. Differences between first and third/fourth time deployers were not significant.

5.3.5 Behavioral Health: Support/Sustain

Figure 17 shows that multiple deployment effects were particularly pronounced in the Support and Sustainment sample. Those Soldiers on their second deployment or third/fourth deployment were significantly more likely than those on their first deployment to be positive for combined mental health outcome of acute stress, depression, or anxiety (Any Psychological Problem). The right side of Figure 17 shows that the effect detected in the combined measure is driven by acute stress scores. Indeed, subsequent analyses revealed no evidence of a multiple-deployer effect for either depression or anxiety. These results suggest that Soldiers in Support and Sustainment roles may not have recovered from the experiences of previous deployments a sentiment expressed by one Soldier who wrote "ask more questions about previous deployments. Current deployment is uneventful, but previous ones were stressful and experienced loss, fatigue, and frightfulness." The issue of the impact of previous deployments is also examined in terms of dwell-time effects in section 5.4.

Figure 17: Sample-Adjusted Values for Male
NCOS in Theater 9 Months (Support/Sustain)
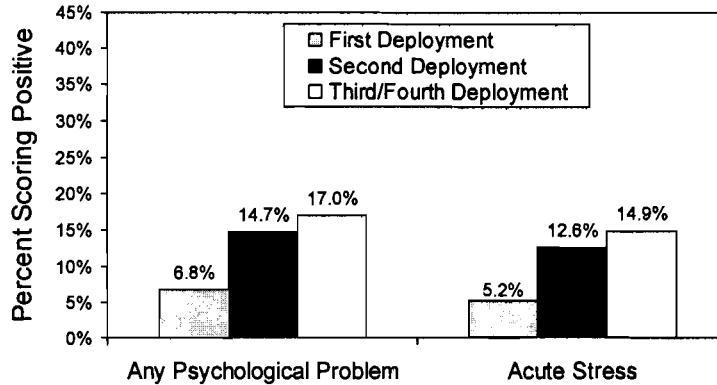
5.3.6 *Suicide Ideation and Divorce: Support/Sustain*

The Support and Sustainment sample showed no relationship between number of deployments and either suicide ideation or divorce/separation intentions.

5.4   OPTEMPO: Dwell-time

The MHAT VI survey collected information about the timing of previous deployments and was, therefore, able to estimate dwell-time. In the Maneuver Unit sample, 517 of the Soldiers (41.0% of the sample) provided some value for the dwell-time estimate. The median dwell-time value was 17 months. In the Support and Sustainment sample, 451 Soldiers (38.2% of the sample) provided a dwell-time value. The median dwell-time was 21 months.

We examined the relationship between dwell-time and a variety of outcomes (morale, mental health, intent to divorce, and intent to leave the military). The statistical models included the covariates of (1) months deployed, (2) rank, and (3) total months deployed since 2001 in addition to dwell-time. In the Maneuver Unit sample, dwell-time was found to account for unique variance in the combined mental health measure and in the intent to leave the military (Figure 18). A near return to garrison rates of mental health problems (approximately 10% -- see Hoge et al., 2004) occurs around 24 months with full return around 30 to 36 months of dwell-time.

Figure 18: Sample-Adjusted Values for NCOs
(Maneuver Unit Sample)

Months of Dwell-Time Between Deployments

30
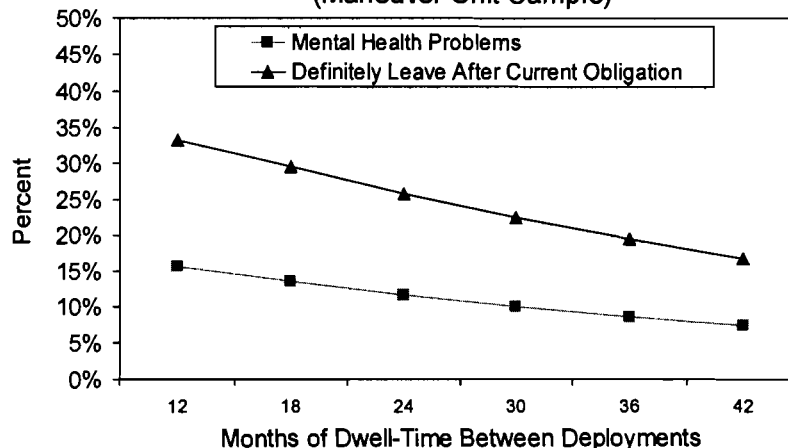
In the Support and Sustainment sample, the same directional trends for mental health problems and career intentions were observed, but the effects were not statistically significant. In contrast, the effect for individual morale was significant and is presented in Figure 19.

Figure 19: Sample-Adjusted Values for NCOs (Support and Sustainment Sample)
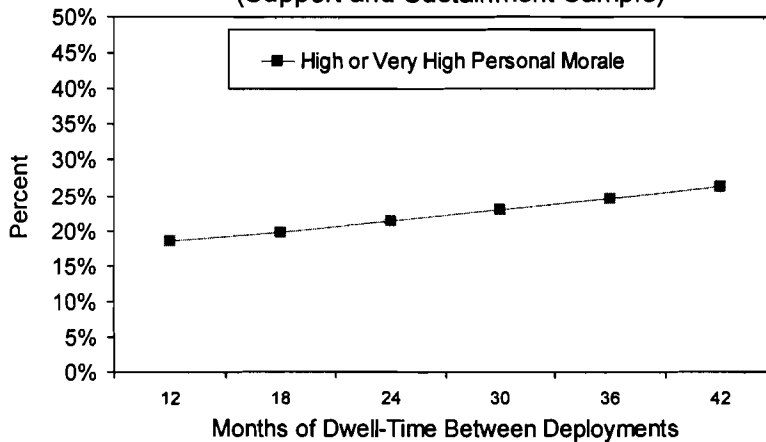
5.5 Deployment Concerns

As noted, due to an error in the survey, only Soldiers who had completed mid-tour leave completed the deployment concerns items. For this reason, we do not attempt to conduct statistical analyses comparing responses to previous years nor do we provide point estimates (percents). Figure 20, however, provides a visual representation of values across all MHATs. The figure shows that deployment concerns were at their highest levels during OIF 1 in 2003 and have generally been constant between 2004 and 2009. Interestingly, the graph shows drops in concerns about long deployment lengths and concerns about being separated from family in the 2009 sample. This, however, may reflect the fact that respondents (by having been on mid-tour leave) are nearing the end of the deployment. Importantly, the data generally show that MHAT VI values are in line with previous years except 2003.

Figure 20: Deployment Concerns over Time

31
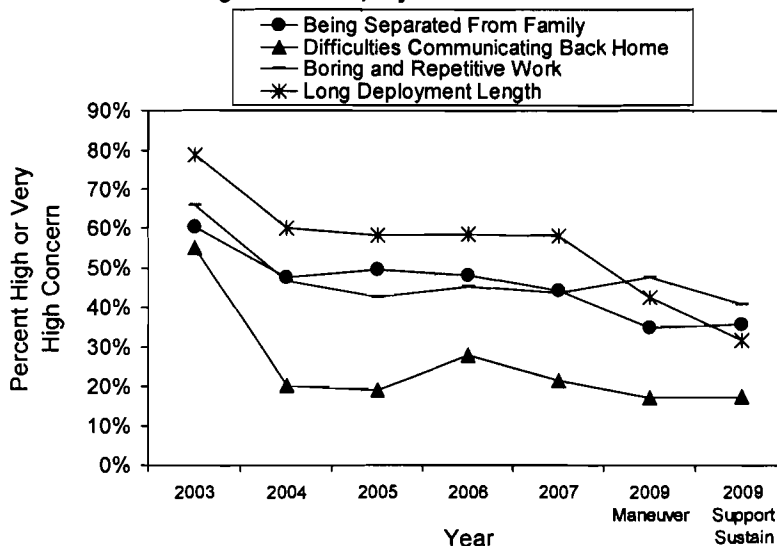
In focus groups several other concerns were noted by junior enlisted Soldiers and NCOs. The most consistent concerns were: low job satisfaction and under-prepared NCOs. Low sense of purposefulness was frequently reported as a reason for low job satisfaction. The concern with under-prepared NCOs was a similar concern to that raised in MHAT V, and reflected a sense that NCOs have been promoted "so quickly they don't know how to do their jobs" or even being "pushed into leadership positions" before they are qualified.

6. SOLDIER RESILIENCE FACTORS

Resilience factors are the third broad category of factors in the conceptual model of Soldier 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 impacted by multiple factors to include small unit leadership, individual coping skills, family support, the willingness and ability to seek care.

Statistically, resilience can be demonstrated by showing that a resiliency factor interacts with a challenge. Specifically, an interaction demonstrating resiliency is one in which those high on the resiliency factor have a reduced reaction to a challenge while those low on the resiliency factor show a typical negative reaction to the challenge. Several examples of this interaction will be illustrated in this section.

6.1 Small Unit Leadership

The ability of small unit leadership to serve as a resiliency factor is well-illustrated using the MHAT VI Maneuver Unit sample. Figure 21 shows the relationship between a Soldier's combat exposure (the challenge) and his acute stress score for the first 29 platoons in the sample. The typical relationship is for acute stress score to increase as combat exposure increases (see section 5.1.1); however, Figure 21 shows that this relationship is not consistent across platoons. For instance, platoon 27 has a number of Soldiers reporting relatively high levels of combat exposure with only a slight elevation in acute stress while those in platoon 3 have a much more typical relationship with roughly equal amounts of combat exposure. In other words, Soldiers in platoon 27 appear resilient.

Figure 21: Platoon-Level Variation in the Relationship Between Combat Exposures and Acute Stress
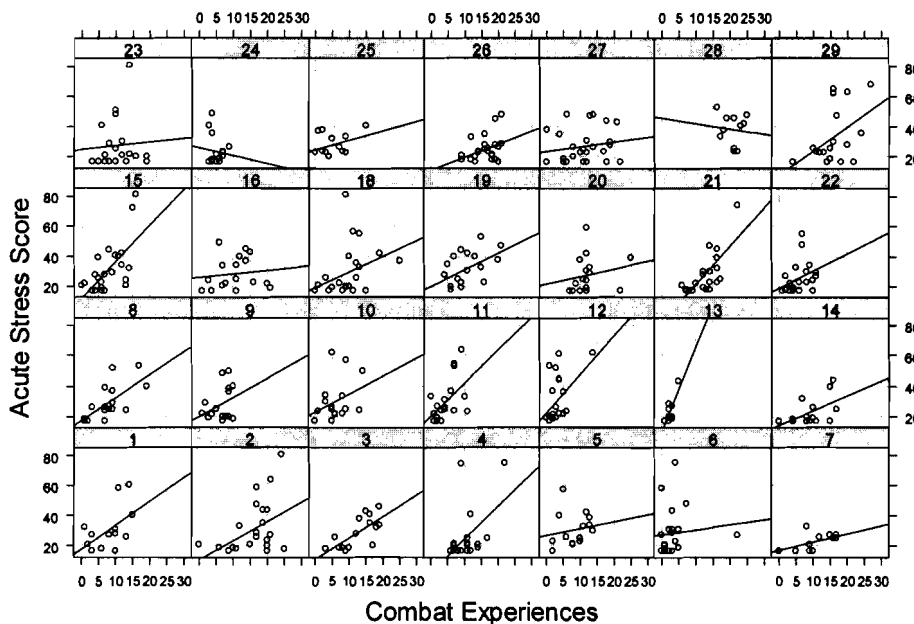
Statistical models indicate that the slope variation between combat experiences and acute stress across platoons is too great to occur by chance, and suggest some characteristic of the platoon is producing resilient Soldiers. An examination of a number of factors to include unit cohesion, ratings of platoon-level NCO leadership, and ratings of company-level officer leadership revealed that collective ratings of officer leadership in the company played a strong role in promoting resilience. Platoons that collectively rated officers positively were more resilient than platoons that rated officers negatively. This relationship is illustrated in Figure 22. Under low combat, acute stress is low regardless of how the platoons rate company leadership. Under high combat, acute stress is still low if officers are rated positively, but high if officers are rated negatively.

Figure 22: Officer Leadership, Combat and Acute Stress
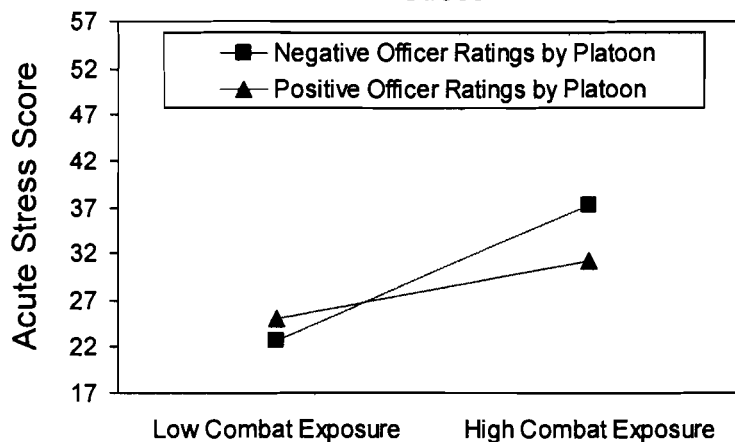
Focus group comments help explain how leadership can either amplify or suppress the effects of combat stressors. Junior enlisted Soldiers and NCOs consistently reported that garrison standards were being inconsistently implemented by senior ranking leadership and that garrison-type standards were a major contributor to their deployment stress. In contrast, the positive leadership was praised by Soldiers. Soldiers and NCOs commented that their leaders "go out and do stuff with Soldiers" and make Soldiers "feel like they are in a family."

6.2   Coping Skills

One of the unique goals of MHAT VI was to examine Soldiers, coping strategies and to identifying strategies that appear to be the most effective in maintaining resiliency. The analyses identified three positive strategies and one negative strategy for coping with combat experiences in the Maneuver Unit sample. Resilient Soldiers were those who (a) tried to see things in a positive light, (b) had learned to accept things, (c) were keeping their sense of humor and (d) avoided blaming or criticizing themselves. As Figure 23 shows, each of these factors interacted with combat exposure in a protective manner.

Figure 23: Resiliency Effects of Four Coping Methods

Looking for Positives

Acceptance

Humor

Self Criticism
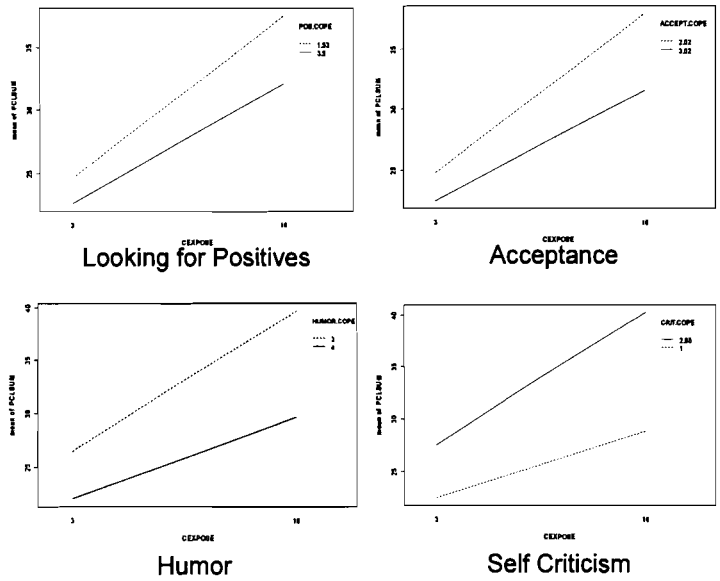
6.3   Stigma

At an organizational level, one way to enhance Soldier resilience would be to encourage Soldiers to seek care before problems escalate. From this perspective, low levels of stigma could be considered a resiliency factor. Figure 24 shows that stigma, does indeed, serve a moderating role. Those with high levels of stigma about mental health care tend to have high rates of psychological problems and they also react more strongly to high levels of combat exposure (a steeper slope).

Figure 24: Stigma, Combat Stress and Any Psychological Problems
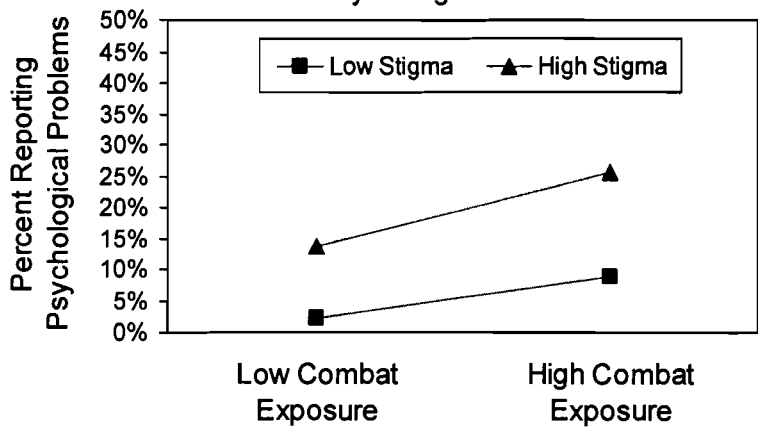
Table 5 provides sample-adjusted values comparing MHAT VI (Maneuver Unit sample and the Support and Sustainment sample) to MHAT V for Soldiers reporting mental health problems. Notice that four of the six stigma values from the Maneuver Unit sample are significantly higher

than values reported in 2007 (the shaded cells). In contrast, the values from the Support and Sustainment sample are all lower than MHAT V in 2007 with four being significant. The last column shows that every item in the Support and Sustainment sample is significantly lower than the values reported in the Maneuver Unit sample. It is not clear why stigma values are lower among the Support and Sustainment sample. It is possible, however, that stigma may be related to the availability of care (see section 6.4) and that stigma is lower when care is easily available and can be unobtrusively obtained. Indeed in the Maneuver Unit sample, statistical models detect a significant positive relationship between levels of Stigma and the average number of days a month spent off of the FOB.

Table 5: Sample-Adjusted Percents for Male, E1-E4 Soldiers in Theater 9 Months who Screen Positive for a Mental Health Problem.

	Percent Agree or Strongly Agree			p-value		
Factors that affect your decision to receive mental health services	MHAT V 2007	MHAT VI (Maneuver)	MHAT VI (Support/ Sustain)	Maneuver vs 2007	Support vs 2007	Support vs Maneuver
It would be too embarrassing.	31.8%	37.1%	28.5%		0.22	
It would harm my career.	31.6%	34.4%	26.2%	0.20		
Members of my unit might have less confidence in me.	42.7%	48.8%	37.4%			
My unit leadership might treat me differently.	51.1%	54.4%	45.4%	0.12		
My leaders would blame me for the problem.	37.5%	42.9%	32.0%		0.06	
I would be seen as weak.	47.9%	52.6%	39.9%			

Figure 25 combines the stigma items in Table 5 into a scale and compares values across all years of the MHAT. Values for the Maneuver Unit sample are significantly higher than stigma values in MHAT V (2007) and MHAT III (2005). It is worth reiterating that some of the increase observed in the MHAT VI Maneuver Unit sample almost certainly reflects the fact that the MHAT VI Maneuver Unit sample contains no Support and Sustainment elements whereas previous MHAT data contains at least some Support and Sustainment elements. In addition, the Maneuver Unit sample has a much larger percentage of Soldiers living off FOBs than did the sample in MHAT V, and rates of stigma increase as time spent off the FOB increases.

Figure 25: Sample-Adjusted Stigma Values for E1-E4 Male Soldiers Reporting Mental Health Problems
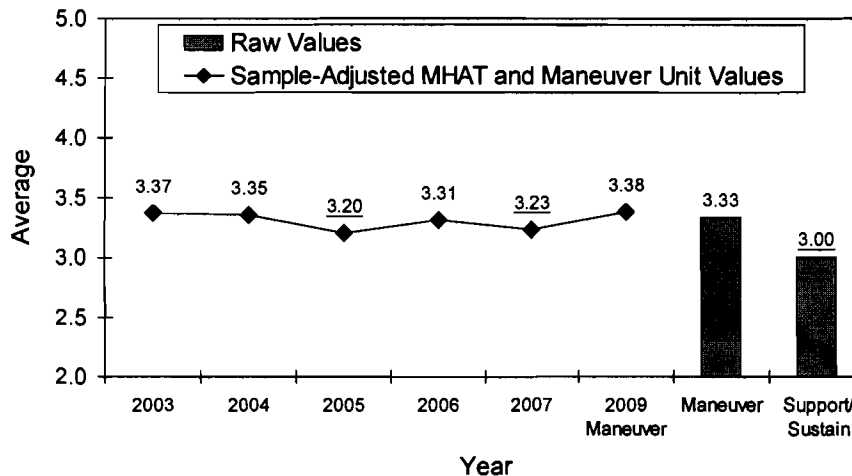
6.4   Barriers to Care

Barriers to care in the Maneuver Unit sample showed an increase relative to MHAT V.   Table 6 provides sample-adjusted rates of barriers to care for Soldiers with mental health problems. Notice that for the Maneuver Unit sample, every barrier to care item except the second ("I don't know where to get help") is significantly higher than (1) MHAT V in 2007, and (2) the MHAT VI Support and Sustainment sample.   In contrast, the Support and Sustainment sample reports lower barriers to care on all items relative to MHAT V in 2007 although only one of the differences reached statistical significance.

Table 6: Sample-Adjusted Percents for Male, E1-E4 Soldiers in Theater 9 Months who Screen Positive for a Mental Health Problem.

Factors that affect your decision to receive mental health services	Percent Agree or Strongly Agree			p-value		
	MHAT V 2007	MHAT VI (Maneuver)	MHAT VI (Support/ Sustain)	Maneuver vs 2007	Support vs 2007	Support vs Maneuver
Mental health services aren't available.	9.0%	15.3%	7.1%		0.25	
I don't know where to get help.	11.8%	11.9%	13.4%	0.93	0.44	0.51
It is difficult to get an appointment.	19.0%	28.8%	15.5%		0.17	
There would be difficulty getting time off work for treatment.	39.6%	49.6%	36.2%		0.23	
It's too difficult to get to the location where the mental health specialist is.	14.7%	28.8%	8.8%			
My leaders discourage the use of mental health services.	18.8%	23.9%	14.6%		0.13	

Figure 26 combines the six barriers to care items into a scale and examines trends across all MHATs for the Soldiers who report having mental health problems.   Notice that barriers to care in the Maneuver Unit sample are significantly higher than every year except 2003.   Also notice, however, there is a small, but significant trend for barriers to have decreased since 2003 even with the increase in MHAT VI (dotted line).

Figure 26: Sample-Adjusted Barriers to Care Values for E1-E4 Male Soldiers Reporting Mental Health Problems
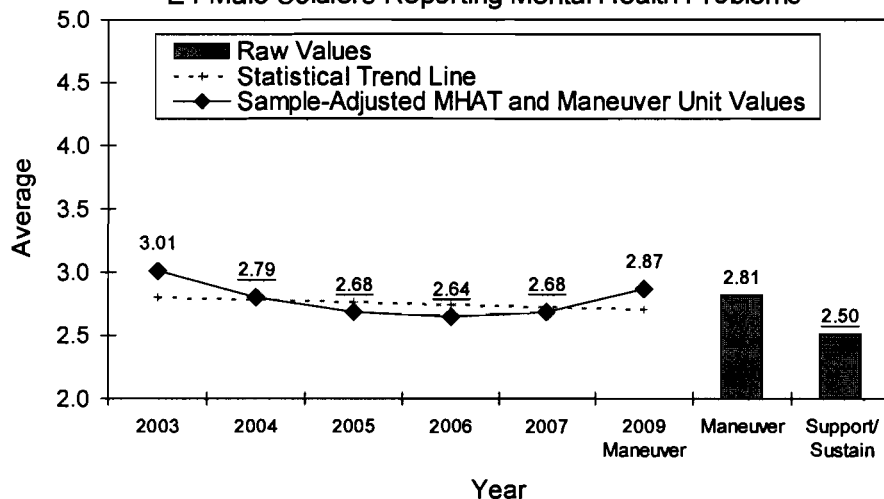
We emphasize that increases in barriers in the Maneuver Unit sample relative to 2007 are NOT evidence that the behavioral health care system has significantly deteriorated in its ability to provide care. Rather, the changes reflect differences in the sampled populations (see section 3.4). At the same time, however, the results do make clear the challenges associated with providing care to maneuver units under conditions of high troop dispersion – a situation of relevance to both Iraq and Afghanistan. This challenge is clearly highlighted by examining yearly responses to the item "It's too difficult to get to the location where the mental health specialist is." Figure 27 provides responses to this item among those who were positive for mental health problems. Notice the dramatic increase in the Maneuver Unit sample and the low rates in the Support and Sustainment Sample. When looking at this item alone instead of the combined scale in Figure 26, the slope related to time indicates a significant increase in barriers over time.

Figure 27: Sample-Adjusted Values for E1-E4 Male
Soldiers Reporting Mental Health Problems
Difficult to get to location where mental health specialist is
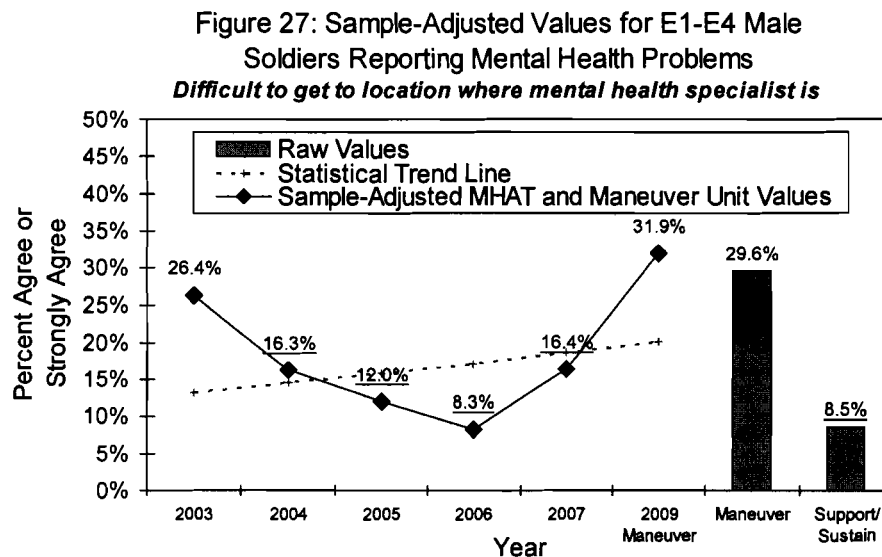
6.4.1 Platoon-Level Characteristics of Barriers to Care

Further evidence that the increase in barriers to care is a result of the new sampling plan and troop dispersion can be found by looking at the degree of consistency in responses among members of the same platoon. Table 7 provides the intraclass correlation coefficients (ICCs) for each of the barriers items. ICC(1) values indicate the percent of variance in an individual response that can be explained by group membership, and ICC(2) values at or near .70 provide evidence of reliable mean differences among groups (Bliese, 2000).

The value with the highest ICC(2) value is "It's too difficult to get to the location where the mental health specialist is." The value with the lowest ICC(2) value is "My leaders discourage the use of mental health services." The high ICC(2) values for location indicate a high degree of consistency among platoon members. These results highlight that barriers associated with getting mental health assets to Soldiers is a localized issue that can be addressed by focusing on difficult to reach platoons. In contrast, the question about whether leaders discourage mental health has very low unit-level properties indicating that Soldiers respond to this item based more on personal characteristics than on anything systematically done by that unit leaders. While not shown, the ICC(2) values for stigma items are also very low indicating that responses to these items are based primarily on Soldiers' personal characteristics.

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Table 7: Platoon-Level Characteristics of Barriers to Care

Factors that affect your decision to receive mental health services	ICC1	ICC2
Mental health services aren't available.	0.06	0.60
I don't know where to get help.	0.04	0.48
It is difficult to get an appointment.	0.04	0.47
There would be difficulty getting time off work for treatment.	0.05	0.54
It's too difficult to get to the location where the mental health specialist is.	0.09	▮▮▮▮
My leaders discourage the use of mental health services.	0.01	0.15

6.5 Soldier Focus Group Comments about Stigma and Barriers

Focus groups yielded only a few comments about stigma; nonetheless, these comments revealed that stigma is still prevalent. One Soldier participating in unit suicide training described the training atmosphere as one that breeds stigma because the leaders conducting the training were joking and making fun of those that may need help. Another Soldier commented that stigma also exists at a peer level in that confidentiality does not hold and persons seeking behavioral health help should have a "compassionate reassignment" to avoid harassment by peers.

When focus groups were asked about the location and function of behavioral health services, a majority of participants knew where the services were located. Additionally, focus groups conveyed positive perceptions of behavioral health services, although none of them professed to having utilized services for personal needs. Some Soldiers and NCOs recounted experiences in helping other military personnel get behavioral health care through their leadership or directly through health providers. Others relayed the positive approaches of their chaplains and behavioral health providers such as engaging in routine consultation and education in which the provider would leave the clinic and go talk and encourage Soldiers to get help if needed.

6.6 Mid-Tour Leave

In previous focus groups, Soldiers had indicated that a difficult time of the deployment had been the period following return from mid-tour leave. Consequently, the MHAT VI survey contained several questions related to mid-tour leave. Analyses of a number of relevant outcomes (individual morale, depression and acute stress symptoms) failed to find any consistent significant effects associated with either having taken mid-tour leave or with the timing since having taken leave. In the analyses we examined whether mid-tour leave variables were directly related to outcomes and also whether mid-tour leave interacted with combat exposure.

6.7 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). Trends in marital satisfaction are illustrated in Figure 28. Notice the strong decline in marital satisfaction for the male E1-E4 population. The decline for NCOs is also significant though less extreme. No decline in marital

satisfaction was detected among Officers. On a year-by-year basis, the declines have been minor. For instance, the MHAT V report failed to find a decline in comparing values between 2007 and 2006. Over six years, however, the decline is noticeable and results in a large decline of roughly 20 percentage points. These results are congruent with the intent to divorce analyses conducted in section 4.5.

Figure 28: Sample-Adjusted Trends in Response to Item "I have a good marriage"
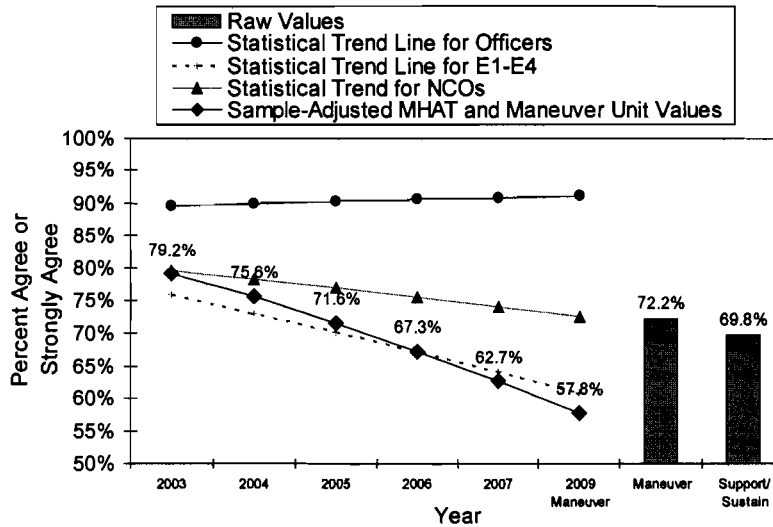
6.8 Training

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

6.8.1 *Training Adequacy for Deployment Stress and Suicide*

Table 8 compares across years Soldiers' responses to whether they agreed that they had received adequate training for deployment stressors and suicide. Notice that there were significant improvements in perceptions of training adequacy for three of the four items. It is important to note that all the data from the Maneuver Units and most of the data from the Support and Sustainment sample were collected before the theater-wide suicide stand-down in March of 2009. Some of the increases may have reflected the theater-wide implementation of a the *Warrior Resiliency and Thriving Training* program (see section 8.3).

Table 8: Sample-Adjusted Percents for Male, E1-E4 Soldiers in Theater 9 Months.

	Percent Agree or Strongly Agree			p-value		
Adequacy of Suicide and Stress Training	MHAT V 2007	MHAT VI (Maneuver)	MHAT VI (Support/ Sustain)	Maneuver vs 2007	Support vs 2007	Support vs Maneuver
I am confident in my ability to identify Service Members at risk for suicide.	54.2%	57.3%	54.4%	0.11	0.93	0.22
I am confident in my ability to help Service Members get mental health assistance.	55.5%	61.9%	64.0%			0.38
The training for identifying Service Members at risk for suicide was sufficient.	53.4%	57.1%	56.7%		0.13	0.87
The training in managing the stress of deployment and/or combat was adequate.	44.4%	52.9%	53.5%			0.79

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7. BEHAVIORAL HEALTH CARE SYSTEM ASSESSMENT

7.1 Behavioral Health Survey and Interviews

A census sample of theater BH personnel was conducted in January and February of 2009 and 159 BH surveys were returned. The MHAT VI BH survey was identical to the previous MHAT V 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

Logistic regression was used to identify significant differences between MHAT V and VI items using months in theater and rank as controls. Survey results were augmented with focus group interviews. In total, interviews were conducted with 40 behavioral health personnel using a structured interview.

7.1.1 Behavioral Health Survey Demographics

Demographics for BH personnel responding to the survey are shown in the Table 9. Relative to MHAT V, MHAT VI had significantly fewer males, fewer Army personnel, more active duty personnel, fewer months deployed since 9/11and fewer months in theater. To be consistent with the analyses of the Soldier data, subsequent results are presented as sample-adjusted values controlling for differences in rank and time in theater. Sample-adjusted values are provided for officers.

Table 9. Demographics of Surveyed Personnel.

	MHAT V	MHAT VI
Sample Size	n = 131	n = 159
Age (Mode)	30-39 y.o.	30-39 y.o.
Gender (Mode)	73% Male	58% Male
Rank		
Jr. Enlisted (E1-E4)	29%	22%
NCO (E5-E9)	29%	31%
Officers / Warrant Officers	40%	47%
Branch of Service (Mode)	93% Army	76% Army
Component (Mode)	58% Active	79% Active
Average Months Deployed since 9/11	13.51	9.84
Months Deployed at the Time of the Survey	7.68	6.38
Average Number of Service Members supported by your team	5396	5487
Average Hours spent per Week Outside FOB	10.09	6.95
Average Days per Month Living Outside FOB	1.9	1.51
Average Number of Locations your BH/COSC Team Supports	9	11

7.1.2 Behavioral Health Survey Results

Table 10 lists significant differences between the MHAT V and MHAT VI. Appendix A provides a list of the non-significant changes.

Table 10: Significant Changes in Behavioral Health Survey

	MHAT V	MHAT VI	p-value
IMPAIRMENT (% Agree)			
My ability to do my behavioral health job is impaired by the stressors of deployment or combat	19.8%	9.2%	0.03
My mental well-being has been adversely affected by the events I have witnessed on this deployment	30.8%	12.9%	0.00
Since this deployment, I have become less sensitive to the needs of the Service Members I serve or support	20.9%	11.1%	0.02
COMBAT AND OPERATIONAL STRESS COURSE TRAINING (% AGREE)			
I received adequate training pre-deployment to prepare me for my COSC duties	28.7%	47.9%	0.00
I feel confident in my ability to perform clinical evaluation and treatment of Iraqi civilians	29.9%	19.3%	0.04
STANDARDS OF CLINICAL CARE (% AGREE)			
The standard of BH care in this theater or Area of Operations are clear	42.3%	57.7%	0.02
The standards for clinical documentation in this theater or Area of Operations are clear	36.3%	66.6%	0.00
The standards for records management in this theater or Area of Operations are clear	37.3%	51.1%	0.03
The standards for transfer of clinical BH information between levels of care in this theater or Area of Operations are clear	21.9%	37.5%	0.01
RESOURCES FROM COMMAND (% ARGEE)			
My higher headquarters provides us with the resources required to conduct our BH or COSC mission	30.0%	50.9%	0.00
My higher headquarters encourages us to provide feedback/comments to theater/Area of Operations BH or COSC policies	34.1%	52.5%	0.00
COMBAT AND OPERATIONAL STRESS (CONSULTING (% Agree))			
During this deployment how frequently did you:			
conduct Battlemind psychological debriefings (monthly)	41.9%	19.7%	0.00
conduct psychological debriefings (CED/CISD; monthly)	48.5%	17.8%	0.00
provide one-to-one BH counseling with Service Members at their worksite (weekly)	33.0%	18.0%	0.01
provide one-to-one COSC services with Service Members at their worksite (weekly)	43.8%	30.8%	0.04
COORDINATION (% AGREE)			
We coordinate or integrate our BH or COSC activities with the Unit Ministry Teams in our Area of Operations	67.2%	53.9%	0.03
STIGMA AND BARRIERS TO CARE (% AGREE)			
Traveling to supported units is too dangerous	22.6%	7.3%	0.01
BH or COSC personnel are not available due to performing non-BH or COSC missions	12.0%	4.8%	0.02

Compared to 2007, behavioral health personnel report:

1. Less impairment
2. A higher sense that pre-deployment training is adequate
3. Clearer clinical standards of care
4. Better resources and interaction with command
5. More personnel resources and less dangerous travel
6. A reduction in providing counseling and COSC services at Soldiers' worksites

Below, we comment on these findings and integrate both survey results and interview notes.

7.1.3 Training Adequacy

The findings related to pre-deployment training adequacy did not entirely corroborate the interview results. In at least two of the interviews, behavioral health officers had been deployed without any specific COSC training, and in one case the provider was deployed after having completed only the Officer Basic Course (OBC). In the latter case, the officer had deployed without receiving the two week specialized track for behavioral health officers commonly provided during OBC. In this officers' case, training was limited to what was provided in theater and the officer appeared to be performing well; however, it should not be the responsibility of theater assets to provide basic training.

The interviews also provided insight into how COSC training course could be improved. A consistent theme was a perceived need to continue updating the course as the demands in the theater continue to change.

7.1.4 Standards of Care

It was clear from the interviews that higher-level command (task-force BDE and MNC-I level) had emphasized consistency in standards of care, and these efforts were reflected in responses in Table 10.

Even with the increase in consistency of standards of care, interviews produced several useful suggestions for further facilitating consistency. For instance, one provider suggested that consistency and lessons-learned could be facilitated by having the theater mental health consultant (or designee) conduct a weekly phone conference modeled after the phone conferences conduced by the Joint Theater Trauma System (JTTS). This phone conference would involve providers in theater, Landstuhl, and CONUS with the goal of tracking evacuated patients and improving delivery and continuity of care.

7.1.5 Personnel Resources and Travel

With respect to personnel resources few, if any, of the interviewed behavioral health personnel complained about extremely high workloads. Our impression based on the interviews was that personnel resources were sufficient to meet the demand (see also section 7.2). While travel was rated as less dangerous, interviews revealed that it was still difficult to travel within theater. Personnel recounted stories about how short trips could extend across multiple days due to weather and other impediments. One provider described his frustrations by saying:

> "You need to submit travel 72 hours before you plan to leave, and travel must be BDE approved. Then once you leave there is one less man at the clinic to see patients, and once you finally arrive at your destination your patients are often sleeping or on a

mission due to shifts. Basically, travel produces a lot of down time that could be used seeing patients."

7.1.6 *Consulting with Soldiers at Worksite*

As noted earlier, Table 10 showed that behavioral health personnel report conducting significantly less counseling and one-on-one COSC services with Soldiers at their worksites than did behavioral health personnel in MHAT V. Part of this may reflect lowered demand. Recall section 4.2.1 showed reports of mental health problems were low in MHAT VI relative to other MHATs. The decline, however, may also reflect less outreach and could partially explain the high barriers to care reported by Soldiers in the Maneuver Unit sample (see section 6.4). Again, it is worth reiterating that most of the difference in barriers relative to MHAT V is almost certainly due to changes in the sampling strategy (see in particular section 3.4); nonetheless, the current results highlight the challenges associated with providing care with a highly distributed force.

Interviews with behavioral health providers generally confirmed the findings from the Behavioral Health survey. One provider stated that "Soldiers (on outposts) are not getting what they need, while the Soldiers on this FOB are able to use the clinic." Several of the providers interviewed suggested that behavioral health assets needed to be organized so that there was always a minimum of two mental health providers. In a BCT, this would mean task-organizing assets from CSC teams such that at least one provider is attached to each Brigade Support Medical Company (BSMC) to augment the organic BH provider. While this type of task organization is discussed in FM 4-02.51 (Combat and Operational Stress Control), it is not highlighted as a Course of Action (COA) for the modular force nor the asymmetrical battlespace.

7.2   Behavioral Health Staffing and Distribution

Within the theater of operations, personnel numbers for both behavioral health providers and 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 March 2009.

Table 11 provides a breakdown of the behavioral health personnel by branch of service. The bottom of the table provides the ratio of behavioral health personnel to military personnel (overall staffing ratio). The ratio for MHAT VI is estimated to be 1:627 which is within the accepted range observed in previous MHATs and previously derived staffing models. The bottom of the table also provides an estimate of the ratio of independent practitioners to the total population (1:1424). These values roughly indicate that there is a behavioral health personnel for every battalion-sized unit in theater, and one independent practitioner for every two battalion-sized units.

Table 11 shows that the OIF provider/personnel ratio is lower than the previous two years (meaning more providers are available per Soldier) even though Soldiers' reports of barriers to care increased. These results reinforce the idea that increases in barriers reported in section 6.4 primarily reflect changes in the sampling design rather than a decline in mental health personnel.

Table 11. Distribution and Ratio of MH specialties across OIF rotation

| | ARMY | | | | | |
SPECIALTY	MHAT I OIF I	MHAT II OIF II	MHAT III OIF 04-06	MHAT IV OIF 05-07	MHAT V OIF 06-08	MHAT VI OIF 07-09
Psychiatrist	-	15	17	18	21	14
Psychologist	-	17	21	14	21	16
Soc Worker	-	27	30	23	25	24
Psych Nurse Practitioner*	-	12	21	12	13	7
Psych Nurse	-	-	-	-	-	7
MH Specialist	-	123	120	84	96	83
Occ. Therapist	-	8	9	11	4	7
OT Tech/Medic	-	13	12	12	1	10
TOTAL	-	215	230	174	181	168
	NAVY					
Psychiatrist	-	-	-	4	6	4
Psychologist	-	-	-	2	3	8
Soc Worker	-	-	-	-	-	2
Psych Nurse Practitioner*	-	-	-	-	-	2
Psych Nurse	-	-	-	-	-	0
MH Specialist (Psyc Tech)	-	-	-	7	10	11
Occ. Therapist	-	-	-	-	-	0
OT Tech/Medic	-	-	-	-	-	0
TOTAL	-	-	-	13	19	27
	AIR FORCE					
Psychiatrist	-	-	-	-	7	4
Psychologist	-	-	-	1	4	6
Soc Worker	-	-	-	2	4	5
Psych Nurse Practitioner*	-	-	-	-	3	1
Psych Nurse	-	-	-	-	-	1
MH Specialist (Tech)	-	-	-	-	15	15
Occ. Therapist	-	-	-	-	-	0
OT Tech/Medic	-	-	-	-	-	0
TOTAL	-	-	-	3	33	32
	MULTI-NATIONAL FORCES					
Total	-	-	-	190	233	227
Overall Staffing Ratio	836	387	448	668	734	627
Indep Practitioner Ratio	-	-	-	-	-	1424

* Psychiatric Nurse Practitioners and Psychiatric Nurses were not differentiated in MHAT I to MHAT V

Interpreting raw staffing ratios does not specifically address the adequacy of mental health care coverage. Most models of staffing adequacy are based on assumptions about (1) rates of mental health problems and (2) workloads associated with the rates of problems. An alternative way to estimate staffing ratios is to rely on reported workload data. In practice, there are some limitations with estimating ideal staffing ratios from workload data in OIF. Specifically, in a highly dispersed population, the workload may be under-reported if troop dispersion is high and time traveling to and from remote locations is not recorded. Nonetheless, during OIF 07-09, the Task Force Medical Brigade Mental Health Staff Officer used COSC-WARs data to estimate personnel requirements and based on the workload data concluded that current levels of staffing were sufficient. Workload and footprint analysis showed that one provider was sufficient for a basecamp population of approximately 2K. Indeed, the analysis indicated a slight excess in behavioral health care strength suggesting that existing capability could be directed towards outreach for Soldiers at remote locations without seriously degrading the ability to provide care at large FOBs. As one provider noted, "it is not an exaggeration to say that it is harder for many Soldiers to get appointments in CONUS than it is for them in Baghdad."

8. THEATER SUICIDE AND SUICIDE PREVENTION

8.1 Theater Suicide Rates

Military suicide continues to be an issue in Iraq. Since the beginning of OIF, there have been 162 confirmed suicides in the ITO of which 132 have been Army. For 2008, MNF-I is tracking 34 suicides producing an annualized theater rate of 21.5 per 100k US service members (see Table 12). This section discusses the problem and the status of education and prevention efforts. Much of this material is drawn from the MNC-I suicide review.

Table 12 shows that the Army-wide suicide rate has continued to trend upwards from 2004. The theater suicide rate for 2008 (21.5 per 100k) is not statistically different from the previous year (24.8 per 100k) or the pending Army rate (23 per 100k); however, it is the first year since 2004 that the theater-wide has not increased relative to the previous year.

Table 12: Suicides in Iraq Theater of Operations 2003 to 2008

	Year					
	2003	2004	2005	2006	2007	2008
SERVICE						
Army	22	11	20	22	31	26
Marine	0	6	3	4	6	6
Navy	1	1	0	0	1	0
Air Force	0	0	0	0	0	0
Coalition	Unk	Unk	Unk	Unk	Unk	2
TOTAL OIF	23	18	23	26	38	34
US OIF Rate (per 100k)	21.1*	13.5	15.8	19.5	24.8	21.5
All Army Rate	12.4	10.8	12.8	17.2	19.2	20.2**

* Reflects annualized rate
** Does not include pending suicides; final rate expected to increase up to 23

OIF trends for the theater and Army are provided in Figure 29. Both rates show a stabilization of rates.

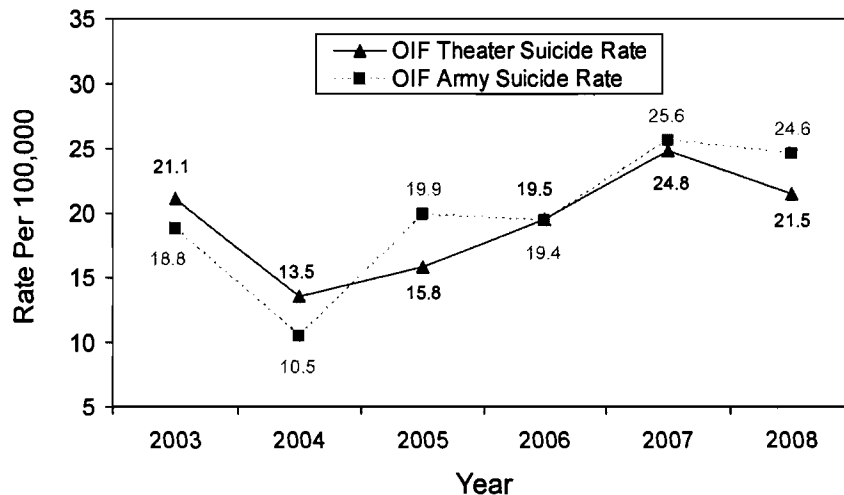*Figure 29: OIF Army and Theater OIF Suicide Rates*

Table 13 provides basic demographic information about individuals who committed suicide for each year of OIF. It is clear from the table that the majority of suicides occur among junior service members and that the method of suicide is predominately via firearms.

Table 13: Demographic Characteristics of Confirmed Suicides in OIF (Percent)

	Year					
	2003	2004	2005	2006	2007	2008
Firearm	95	100	95	91	91	94
Male	91	100	95	100	100	91
Age <30	82	91	80	86	83	84
E-1/E-4	68	82	65	77	61	75
Married	41	0	35	18	32	41
Non-white	43	20	10	14	18	28

8.2 Suicide Prevention Programs

Across the Army, the high rates of suicide have resulted in expanded prevention and awareness programs and new approaches to reduce the rate of attempted and completed suicides. As with any significant public health issue, awareness and education are important factors, and the Army has devoted tremendous resources to expanding traditional didactic educational programs. An interactive learning and decision-making software program called "*Beyond the Front*" has been developed. This program is designed to realistically depict deployment setting and Army cultural norms to better reach the intended audience of recently deployed Soldiers. Additionally, as directed by the Army's Chief of Staff, a bottom-line upfront step-by-step program known as "ACE" (Ask, Care, and Escort) has been developed. ACE augments and reinforces the concepts learned through the "Beyond the Front" software; both ACE and *Beyond the Front* are significant components of the Army's Suicide Stand-Down training that was being conducted in the ITO during March of 2009. There is significant command emphasis from the top to bottom of the leadership structure to execute these Army suicide prevention programs.

8.3 Theater Suicide Prevention Structure

Within MNF-I and MNC-I, it is clear that leaders at every level are engaged in a robust suicide education and prevention program. MNF-I continued to execute a quarterly Suicide Prevention Committee until April 2008 when it merged with the MNC-I Suicide Prevention Board. Prior to the merger, the committee was chaired by the Chief of Medical Clinical Operations for MNF-I and the charter of the committee continued to (a) review suicide policies and procedures within MNF-I, (b) assess trends in suicides and suicidal behaviors within theater and (c) advise Commanders and Leaders in the prevention of suicides through training and education. The committee met quarterly from August 2006 to April 2008.

The currently merged MNF-I Suicide Prevention Committee and MNC-I Suicide Prevention Board now executes an expanded Suicide Prevention Review Board (SPRB). The board is chaired by the MNC-I Deputy CG. The MNC-I Surgeon is the proponent for the board. It meets quarterly (March, June, September, December) to plan, review trends, implement changes, and manage suicide prevention efforts in theatre. Membership on the board in addition to MNC-I Deputy CG and MNC-I Surgeon consists of MNC-I CSM, C-1, MND/MSC representative, TF MEDCOM Behavioral Health Consultant, Chaplain, Provost Marshal (PM), Staff Judge

Advocate (SJA), Inspector General (IG), Public Affairs Officer (PAO), and the Criminal Investigation Division (CID).

In December the Suicide Prevention Review Board approved and released for distribution and implementation the 2008 MNC-I Suicide Prevention Action Plan (SPAP) (Appendix B). The MNC-I SPAP has a strong focus on training and awareness, utilizing suicide prevention education, resiliency training, the Army Suicide Intervention Skills (ASIST) program, and unit intervention as pillars of the plan. The MNC-I Chaplain functions as the teaching and training arm of the program utilizing Ask, Care, Escort (ACE) card in conjunction with the ASIST Program train-the-trainer model, along with a strong emphasis on *Warrior Resiliency and Thriving Training*, use of the buddy system and unit intervention. The program of instruction utilizes Warrior Ethos concepts, Army leadership principles, Rational Emotive Behavior Therapy strategies, and inspirational examples of POW and survivor resiliency to supplement pre-deployment resilience training and reduce barriers to care.

Over the last 14 months the SPRB has developed, implemented and reviewed several initiatives; of note:

- Based on OPORD 08-01, each division within the ITO has established Suicide Risk Management Teams that function down to the battalion level
- Selection and ordering of Suicide Prevention Risk Factor Assessment Cards for unit leaders
- Development and approval of a theater-wide Suicide Prevention Action Plan
- Rapid implementation of the phases inherent to the Army's Suicide Prevention Stand-Down
- Phased implementation and tracking of *Warrior Resiliency and Thriving Training*
- Including Unit Suicide Prevention Programs into the Organizational Inspection Program (OIP)

It is worth noting that as a direct result of OPORD 08-01, MND-B developed an initiative coined as the "Suicide Elimination Program". In 06-08, MND-B had 19 suicides for an approximate rate of between 38 and 76 per 100k (the exact population size is unknown so the range is estimated based on a wide population range of 25,000 to 50,000). The approximate 95% confidence interval for the expected number of suicides in a population of 50,000 with an annual rate of 23.1 per 100k (the OIF rate in 2008) is [6 and 18] based on the simulation method described in Bliese, Wright, Adler and Hoge (2007). Consequently, even with a large MND-B population estimate of 50,000 the rate of 19 is significantly higher than what would be expected by chance. In 07-09, 5 suicides were reported for a rate of approximately 18 per 100k (in this case the population was known) and none of these suicides occurred in the final 7 months of the deployment. This represents a significant drop from the 06-08 rate, but a non-significant difference from the annual rate of 19.4 per 100k reported in 2008. Obviously, there is no causal way to establish that the initiates executed by MND-B were associated with the decline, and it is important to note that the rates in 06-08 were significantly inflated. Nonetheless, the decline in suicides is noteworthy.

The "Suicide Elimination Program" adopted a number of recommendations made by previous MHAT reports and is a creative application of COSC doctrine reflected by pushing outreach activities into sector and establishing temporary clinical outposts away from larger FOBs. This program worked to address the issues of stigma by developing and implementing a Behavioral Health Advocate Program designed to train NCOs in the early recognition of indicators related

to behavioral health issues. Although these activities have been performed throughout the OIF and OEF theaters by multiple Brigade Behavioral Health Sections (BBHS) and CSC teams over the course of the GWOT, the significance of this initiative is the coordinated and focused effort across the ITO.

As a function of reviewing the theater Suicide Prevention Structure, a section of the MHAT VI team was invited and attended the 27 February 2009 MNC-I Suicide Prevention Review Board. This was the last meeting with current leadership prior to the Transfer of Authority (TOA) to I Corps. Emphasis was placed on the idea that suicide prevention is a commander's issue and affects all services and the need to bring in outside assistance to ensure all possible solutions are examined.

The committee discussed the Army's suicide prevention stand-down requirement and noted that MNC-I is on track to execute mission requirements and meet the end state. The 1st Quarter 2009 suicide summary and case-by-case analysis was presented and reviewed. The five 1st Quarter 2009 suicide cases were reviewed and discussed. The implementation of the four phases of the *Warrior Resiliency and Thriving Training* was discussed with updates about phase status completion. The MNC-I Chaplain and his complete theater Chaplain Team is fully engaged in the successful mission accomplishment of this course. They stressed the importance of turning personal stressors and obstacles into opportunities for personal thriving and growth. The DCG MNF-I made closing comments where he expressed concerns about future OIF theater changes and dynamics and how behavioral health support and personnel will be used and coordinated as the theater draws down.

The MNC-I Chaplain and his complete theater Chaplain and Chaplain Assistant Team of 255 Chaplains and 261 Chaplain Assistants, has fully embraced all aspects of suicide prevention. Near the end of 2008 the Chaplain Team received *Warrior Resiliency and Thriving Training* and in the beginning of 2009 the Chaplain Assistants and the Behavior Health Team received the training. They have taken a proactive approach to suicide prevention and resiliency training during pre-deployment and continued throughout the deployment cycle. Redeployment training is occurring simultaneously in theater and back at home station in preparation for the reintegration of Service Members and their Families. As per regulation, the deployment cycle support tasks of Reunion Training, Communication Training, Suicide Awareness, and Marital Assessment (as required) are being executed.

8.4   Theater Suicide Review

Among the positive initiatives outlined above regarding the development, refinement and utilization of the Suicide Prevention Review Board (SPRB) process, one significant feature is the real-time analysis of completed suicides in the ITO. This process assists in crafting the Theater Suicide Prevention Structure allowing prevention outcomes to be relevant and instep with issues relevant to ITO. An analysis process is completed on each case utilizing the Defense Casualty Information Processing System (DCIPS), the Department of Defense Suicide Event Report (DoDSER), the individual's Medical Record and information gathered as a result of mandatory the AR 15-6 investigation. This sequence is repeated for all completed suicides. The primary factors that are focused on include the individual's demographic information, psychosocial issues, e.g., UCMJ, relationship or work problems, previous behavioral health treatment, number of combat tours and time spent in theater.

The SPRB revealed the following contributing factors in 2008: 28 out of 32 suicides (88%) had identifiable psychosocial concerns; 13 of 32 (41%) had work related problems with recent

reprimands, counseling event or an adverse action; 10 of 32 (31%) had a interaction with Behavioral Health Services (BHS) prior to deployment; 7 of 32 (22%) had pending UCMJ action; 18 of 32 (56%) had two or more of the above factors. This case by case analysis of the 2008 OIF suicides revealed 26 of 32 (81%) had local access to Behavioral Health Services; 8 of 32 (25%) received a Behavioral Health (BH) evaluation or treatment in the ITO; 10 of 32 (31%) had a pre-deployment BH treatment history, 8 of those received follow up actions on the part of theater BHS. Of the 8 that had contact with BHS in the ITO, 4 were command referrals, 3 were treated for substance abuse and 3 had a disproportionate number of visits in a condensed time period. Importantly, all 8 denied having suicidal thoughts prior to the suicide event highlighting the tremendous challenge of predicting suicide.

8.5   Discussion

The US Public Health Service (1999) considers suicide risk and prevention in terms of relative *Risk Factors* and *Protective Factors for Suicide*. These factors have been adopted by the Centers for Disease Control and Prevention (CDC). In addition, the National Institute of Mental Health (NIMH) (2004) also conducted research into risk factors for suicide. The CDC and NIMH factors are used to organize the discussion of suicide in Iraq.

8.5.1 *Risk Factors*

Risk factors relevant to Army suicides in Iraq have not changed since previous MHATs. The factors include:

1. Loss (relational, social, work, or financial)
2. Isolation, a feeling of being cut off from other people
3. Barriers to accessing mental health treatment
4. Easy access to lethal methods
5. Unwillingness to seek help because of the stigma attached to mental health
6. Feeling of hopelessness
7. Impulsive or aggressive tendencies
8. Physical illness
9. Depression and other mental disorders or substance-abuse disorder (often in combination with other mental disorders)

The NIMH reported two significant risk factors: Depression and other mental disorders or substance-abuse disorder (often in combination with other mental disorders) and stressful life events in combination with other risk factors such as depression. The report stated more than 90% of people who die by suicide have these risk factors and suicide and suicidal behavior are not normal responses to stress. While many people have these risk factors, few are suicidal (Moscicki, 2001).

Figure 30 presents the probable contributing factors leading to the suicides in OIF in 2007 and 2008. Relationship-related problems continue to be the most frequent contributing factor.

Figure 30: Probable Contributing Factors in OIF
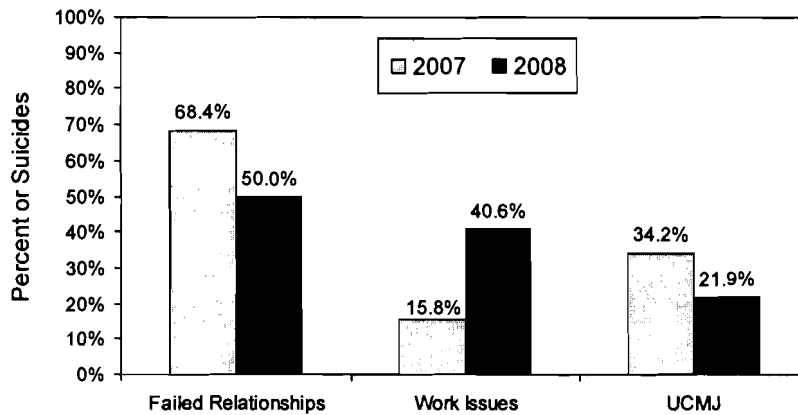
8.6   Soldier Focus Groups

In the focus groups, many junior enlisted Soldiers and NCOs reported knowing about the increase in Army suicide rates. One Soldier recounted his experience with behavioral health services when a fellow Soldier in his unit committed suicide saying "behavioral health showed up and offered their services if anyone needed it, but it would have been more effective if the group had been smaller." Most focus group participants also described the new interactive suicide training such as *Beyond the Front* as "great", "effective" and "good" stating that "PowerPoint gets old". Other Soldiers postulated that resiliency training, as opposed to suicide training is needed, because suicide training only teaches one "how to kill himself."

When the focus group discussion addressed the causes of suicide, most mentioned unfaithful spouses and girlfriends. When the factor of unfaithful spouses was examined as a risk factor for suicide ideation in the results from the Soldier data, the statistical models revealed a significant link between the two variables. In the Maneuver Unit sample, 11.6% of married Soldiers reported that infidelity had been a problem with 16.1% saying they were unsure. In the Support and Sustainment sample, the corresponding percents were 11.8% and 14.2% unsure. Other factors mentioned in the focus groups were poor leadership and a drop in recruitment standards.

8.7   Summary

MHAT V recommended developing a comprehensive suicide action plan throughout the deployment cycle. It was also recommended that suicide prevention products be developed that are effective and useful at the small unit level. Actions taken by the Army, ITO and at the ITO regional levels over the last year go a long towards addressing these recommendations.

Changes made to the Theater Suicide Prevention Program have allowed for a targeted and focused approach when identifying and developing strategies that increase awareness of the specific factors. This has contributing to increased awareness down to the small unit level and its leaders. This in concert with the Army's Suicide Stand Down featuring programs such as the "Shoulder to Shoulder" interactive video, the development of and phase implementation of the ACE program, and the ASIST are all tools that dovetail well and functionally address the comprehensive deployment cycle recommendation. The SPRB process provides a way to monitor, modify and disperse suicide prevention programs throughout the ITO.

9. 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 ITO thereby providing quick feedback. In recent years, in-theater medical assets at the Corps and Medical Brigade Task-Force level have provided excellent support with survey distribution and collection. This active involvement by in-theater medical assets has generated large numbers of surveys, and allowed the MHAT team 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 predominately contain members with specialized skills in data analyses.

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.

9.1   Nature of Recommendations

9.1.1 *Army-Wide Recommendations*

While MHAT data is quite comprehensive, Army-wide 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 IV recommended the Army adopt Battlemind Training; however, the authors knew Battlemind had been subjected to a group randomized trial that had demonstrated efficacy of the program (Adler et al, in review). With evidence from the MHAT showing a need for mental 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 nonetheless play in policy decisions. For instance, MHAT V provided detailed analyses the effects of OPTEMPO-related stressors such as months deployed and multiple deployments. These findings were briefed to senior Army and DoD leadership (to include the Joint Chiefs), and provided information that may have influenced the decision to return to 12-month deployments. In this way, the results likely play a role in Army-level policy. For a discussion of the role of the MHAT V report see the April 6, 2008 *New York Times* article "Army Is Worried by Rising Stress of Return Tours to Iraq" by Thom Shanker.

9.1.2 *Behavioral Health Care and Product Development*

Most MHAT recommendations focus on behavioral health care delivery and product development. Product development recommendations emerge because MHAT teams have typically had several researchers from labs within the US Army Medical Research and Material Command (USAMRMC) and these researchers rely on MHAT results to help inform product development. MHAT team members have historically had considerably less expertise in the area of theater-based behavioral health care delivery. Specifically, with the exception of one

team member in MHAT VI, the MHAT teams have never deployed with a team member who has served as a direct health care provider to Iraq.

Previous MHATs have made important recommendations even without team members who have been direct providers in Iraq; 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. In the ideal situation, focus groups are conducted after data have been analyzed. In that way, MHAT team members can query behavioral health personnel about ways to solve issues that emerge in the data analyses.

In MHAT VI, we were fortunate to be able to follow this model because data were immediately available to process and analyze. Consequently, many of the focus group interviews occurred after we had analyzed a large portion of the Maneuver Unit sample, and we were able to ask the experts – the providers who grapple with issues of health care delivery – for ideas about how to solve issues evident in the data. The MHAT team is ultimately responsible for deciding which recommendations to emphasize, but wish to acknowledge the source of the ideas. We also note that some of the recommendations are not directly tied to the empirical data from either the Soldier or Behavioral Health Survey, but emerged in the focus groups and are included because we believe they will facilitate care.

9.2   Recommendations versus Additional Considerations

As part of the MHAT process, it has become clear that recommendations are often used as benchmarks. The media, rightly so, is interested in how many of the recommendations are adopted. Unfortunately, the implication with focusing on the number of implemented recommendations is that failure to adopt a recommendation can be interpreted as a lack of responsiveness by the Army. In many cases, however, a failure to adopt a recommendation is because further examination produced additional information that led to a logical decision not to implement the recommendation.

For these reasons, far fewer recommendations are made in the current report relative to the last two reports. The report, however, does provide "Additional Considerations". The Additional Considerations include ideas that we believe warrant further examination and may ultimately be adopted; however, due to the complexity of the behavioral health care system we do not formally propose them as recommendations. In this way, the report can give visibility to good ideas generated from providers in the field without requiring that ideas be implemented before receiving a thorough review.

9.3   MHAT VI Recommendations

In MHAT VI, the largest issue was the high perceptions of barriers to care reported by Soldiers in Maneuver units. Although the increase in barriers relative to 2007 was largely driven by differences in sampling, there are nonetheless challenges associated with providing care to highly dispersed Soldiers. In Iraq, this issue is likely to resolve as the drawdown continues and personnel are increasingly moved to large FOBs. Even so, the broader issue of providing coverage to highly dispersed Soldiers will remain a key issue in Afghanistan (see MHAT V report on Afghanistan).

9.3.1 *Recommendation 1: Implement Dual Provider BCT Model*

The first recommendation is that personnel allocation be modified to institute a "Dual Provider BCT Model" that reflects the current modular BCT-centric Army structure. Such a configuration

would result in each Brigade Support Medical Company (BSMC) having two dedicated behavioral health providers to support their Brigade Combat Team (BCT). This configuration provides the ability for providers to share coverage of both outlying areas and the FOB and helps provide access to care for the entire BCT.

The intent of the recommendation is NOT a request for an increase in the number of providers in theater or a change to the BCT M/TOE. Indeed, current staffing ratios (see section 7.2) indicate that there is roughly one independent provider for every two Battalions suggesting the Dual Provider BCT model could be achieved with existing resources. Rather, the intent of the recommendation is to re-allocate or re-mission existing resources. Specifically, the intent of the recommendation is to establish Behavioral Health teams that are tailored to fill access gaps in situations where service members are highly dispersed.

In-Theater Implementation. Examine the current support relationships and consider re-missioning elements of COSC teams to a direct support (DS) relationship instead of a general support relationship. The benefit of a DS relationship is that the gaining unit establishes the priorities of the team and can relocate the team within its operating environment. This DS relationship could be achieved by utilizing a Request For Forces (RFF). For example, a BCT could submit a RFF requesting a 73B (Psychologist) if the BSMC has a 73A (Social Worker) or vice versa.

Garrison and Pre-Deployment Implementation. For future deployments we proposed that the dual provider model be considered in mission planning and incorporated into their deployment manning process. With this approach, a BCT (or BDE without behavioral health assets such as an CAB) may identify in their behavioral health concept of support the need to submit a RFF for COSC assets to be attached and deploy with the BCT/BDE throughout its deployment. This strategy is consistent with the modular medical force as depicted in the recently approved (as of 2 JAN 08) AMEDD Modularity Initiative (AMI) for CSC detachment reconfiguration.

To further expand this modular concept, the COSC unit would arrive in theater, conduct a theater assessment, and based on this assessment would provide direct support to existing brigades. In addition, under this proposal COSC commanders in CONUS would have the ability to cross-level unit assets and create dwell-time patterns for their individual teams, thereby allowing all of the Army COSC Detachments and Companies to be a constant resource for mission tasking. The proposal outlined above is only to serve as an example of a potential solution to fill the gaps in care identified in this report; however, it is recommended that a review of how behavioral health assets are deployed move from a legacy style model and align more effectively with the modular force.

The proponent for doctrinal change is the AMEDDC&S DCDD (Directorate of Combat and Doctrine Development). Theater is the proponent for requiring needs assessments and establishing direct support relationships.

9.3.2 *Recommendation 2: Create and 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.

The proponent for this recommendation is DA and AMEDDC&S DCDD.

9.3.3 *Recommendation 3: Explore Ways to Provide Maneuver Unit Soldiers Greater Opportunities to Discretely Seek Care.*

Soldiers in maneuver units reported high barriers to care and significantly higher stigma than Soldiers in support and sustainment units. To some degree, this may reflect the fact that it would be very difficult for a Soldier located at a remote outpost to discretely seek behavioral health care. Therefore, we recommend that theater consider ways to help maneuver-unit Soldiers discretely seek care. For instance, it may be possible to increase the amount of reset time Soldiers receive when they come into the main FOB from remote outposts. Recall that over 30% of the maneuver unit sample reported spending 29 or more days a month outside of the FOB. In this way, Soldiers would potentially have more time to stop by behavioral health if needed.

The proponent for this recommendation is MNC-I.

9.3.4 *Recommendation 4: Quarterly Review of BCT BH Assignment Gaps*

Make filling the Brigade Behavioral Health Officers positions a priority, refrain from filling the brigade positions using a PROFIS model. By assigning BH officers for a normal assignment cycle it will allow the individual assigned to integrate more effectively and to identify any gaps in their ability to apply their skill set to the tactical setting. This would also enable unit leaders to increase their understanding and fully develop effective utilization of their BH asset across the complete deployment cycle.

MHAT V also made this recommendation; nonetheless, interviews have indicated that BCT's continue to have their Brigade Behavioral Health Officer unfilled in garrison. With the continued burden of BH issues Brigade Commanders are looking for their organic subject matter expert to help guide their decision-making process. Units that have their assigned BH officer in place have proven to be in a better position in maintaining oversight on unit BH issues. The status of Brigade BH Officer slots in garrison need to be tracked and reported to MEDCOM on a quarterly basis to ensure those positions are filled.

The proponent for this recommendation is MEDCOM Combat and Operational Stress Control Program Management Office.

9.3.5 *Recommendation 5: Review Standards for Deployment and Develop System to Provide Continuity of Care*

On at least three occasions, interviews with providers raised concerns with the current medical standards for determining deployment eligibility. One provider noted that "by relying on 90 days of stability without new or significant changes to psychotropic medications, the standards prevent CONUS providers from starting or changing medications during that period b/c they know that the Soldier can and, in most cases, wants to deploy. Clinical condition and function should be the determinant of deployability."

A related concern is the need to develop a system that informs MNC-I when waivers are provided to ensure continuity of care. That is, there is a need for formal notification when waivers are granted so that providers in theater can ensure service members receive follow-up.

The proponent for reviewing the Mental Health Standards for Deployment and developing a system to inform theater of service members on waivers is Health Policy & Services. However, the Office of the Assistant Secretary of Defense/Health Affairs (OASD/HA) owns the governing policy, Policy Guidance for Deployment Limiting Psychiatric Medications and Conditions.

9.3.6 *Recommendation 6: Revise the Unit Needs Assessment*

In MHAT VI, providers reported conducting significantly less outreach and consulting. While not statistically significant, MHAT VI mental health personnel reported conducting 10% less unit needs assessments. Interviews with providers consistently revealed that providers found the current Unit Needs Assessment instrument too complex and in need of updating.

The proponents for revising and implemented a revised version of the Unit Needs Assessment are CHPPM, WRAIR and the AMEDD Center and School.

9.3.7 *Recommendation 7: Develop, Revise, Validate, and Integrate Resiliency and Life-Skills Training*

Focus on resiliency training in order to increase Soldiers' skills in meeting the psychological demands of combat deployment. Resiliency training such as the Army's Battlemind Resiliency Training system offers a promising way to help build resiliency in Soldiers, and such training can be informed by findings such as those related to coping (see Section 6.2).

The efficacy of Battlemind Training has been demonstrated in several studies, and several efforts are underway to develop and test additional training as part of the integrated system. The Army's Battlemind resiliency training program has two major types of training: Life Cycle Training products to teach resilience as part of career courses, and Deployment Cycle products to target mental health training for the appropriate phase of the Deployment Cycle. Research is being conducted to develop and test interventions to strengthen pre-deployment, during deployment, post-deployment and spouse Battlemind resiliency training. These research programs should continue to be prioritized and recommendations fast-tracked for implementation. Implementation should be conducted pro-actively with the use of mobile training teams and quality control procedures should be established to ensure training is conducted according to standard.

Approaches to resiliency training such as MNC-I's *Warrior Resilience and Thriving Training* demonstrate a perceived gap in terms of Army resiliency training within the deployed setting. Training designed to fill perceived gaps is important; however, such training needs to be (a) tested for efficacy as acknowledged in the MNC-I for Phase IV of the *Warrior Resiliency and Thriving Training* implementation plan and (b) ultimately integrated within the Army's resiliency training program. Indeed, as a general rule the Army should require evidence of efficacy as a prerequisite for implementing resiliency training programs as programs are all too often implemented without evidence of efficacy or even a plan to test for efficacy. Program developers should be responsible for establishing efficacy.

Finally, it is important to note the implementation of the Army's Comprehensive Soldier Fitness program. This program is designed to assess and provide training in five areas of fitness: Financial, Family, Spiritual, Emotional and Physical. It is important that training products

developed for the Comprehensive Fitness program be tested for efficacy and integrated with Battlemind.

The proponents for developing and evaluating training are MNC-I (*Warrior Resiliency and Thriving Training* evaluation); WRAIR for Battlemind training and the Comprehensive Soldier Fitness program for fitness programs.

9.3.8 *Recommendation 8: 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.

The proponent is the Battlemind Transition Office, WRAIR, the Comprehensive Soldier Fitness program and TRADOC.

9.3.9 *Recommendation 9: Continue Behavioral Health Teleconference*

On average, the ITO evacuates approximately 40 Service Members a month for every 100k Service members in theater (Lewis, 2009). On 27 January of 2009, the Behavioral Health Consultant in theater began a weekly teleconference between providers at OIF, OEF, Landstuhl Regional Medical Center, and CONUS to ensure continuity of care of patients evacuated from theater. This teleconference was modeled after the system developed and maintained by the Joint Theater Trauma System (JTTS). The teleconference provides a way to track patients, ensure continuity of care, and provide lessons learned and should be supported by providers across CONUS who receive patients evacuated from theater.

The proponent is the Theater Mental Health Consultant or designee.

9.3.10 *Recommendation 10: Continue Suicide Prevention Review Board (SPRB) process*

The SPRB process detailed in Appendix B provides a way to monitor, modify and disperse suicide prevention programs throughout the ITO. We recommend this process be continued.

The proponent is the MNC-I Surgeon or designee.

9.3.11 *Recommendation 11: 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.

In MHAT VI, the inclusion of a Support and Sustainment Sample was highly valuable; however, the changing nature of Support and Sustainment populations across deployments makes it difficult to ensure that equivalent samples can be drawn across different deployments. For this reason, comparisons of trends should be based upon maneuver unit data and the collection of data from other groups (e.g., Support and Sustainment) may not be necessary each time an MHAT is requested. Future MHATs may consider targeting special groups (e.g., transition team members, or Combat Aviation Brigade Members) based upon in-theater configuration and need to augment the maneuver unit sample.

The proponent is the WRAIR.

9.3.12 Recommendation 12: COSC Course Instructors Conduct Regular Course Evaluation Interviews with Deployed Behavioral Health Personnel and Consider Specialized Instruction

Behavioral health personnel deploying into theater are required to attend the Combat Operational Stress Control (COSC) Course. In focus groups, the behavioral health personnel provided numerous suggestions about ways to keep the COSC Course relevant and current; however, the system of MHAT members recounting these recommendations to COSC Course developers is inefficient. The MHAT recommends, therefore, that COSC Course members regularly interview graduates of the course either in theater (e.g., during an in-theater Behavioral Health Conference) or following the deployment to modify and update the COSC course.

A related recommendation is to explore providing alternative versions of the COSC course for specific groups. For instance, there may be value in developing a quarterly COSC course for division psychiatrists and incorporating elements of Behavioral Health Care into Brigade and Division Surgeon courses.

The proponent is the AMEDD Center and School.

9.4   Additional Considerations

9.4.1 Consideration 1: Develop a Way-Forward for Electronic Capture of Workload and Management of Patients

Several MHAT V recommendations focused on system shortfalls for the electronic capture of behavioral health workload data. While some progress has been made, the systems continue to frustrate both unit-level providers and BH staff members tasked with documenting workload. While it is unlikely that resolution of these issues will occur prior to the next MHAT, a way forward needs to be identified.

In garrison, the primary platform being launched is the Automated Behavioral Health Clinic (ABHS). Consider, therefore, creating an operational component to ABHS. In doing so, it is critical that the platform be capable of recording demographic data, the number of contacts made during consultation and education, along with the capability to record formal clinical notes and streamline the push of data to higher echelons.

The proponent for developing a way-forward is DHIMS.

9.4.2 *Consideration 2: BH Case Manager to Track Mental Health Evacuations*

As noted, in an average month the ITO evacuates approximately 40 Service Members for every 100,000 Service members in theater (Lewis, 2009 BH Conference); however, there is no particular person who is responsible for tracking patients across echelons to ensure that (1) they are moved to where the care is most appropriate and (2) the receiving provider knows the history of the patient. One solution to this problem would be create a BH case manager at LRMC whose function is to ensure that patients (and their histories) are managed in transit. This case manager can connect with units, families, patient and provider and ensure that the patient is taken care of across the continuum of care as they go from theater to LRMC, to WRAMC, etc. until they eventually arrive home.

The proponent for considering this position is MEDCOM.

10. STATUS OF MHAT V RECOMMENDATIONS

This section reviews the status of MHAT V recommendations. Recommendations are evaluated in terms of status (red, amber, green). In addition to providing an implementation status summary, we also provide some critical evaluation of the merits of MHAT V recommendations. Specifically, we note cases where recommendations were seen as having been particularly helpful, and we also note cases where recommendations appear to have lacked merit upon further consideration.

10.1 Theater Behavioral Health

Recommendation BH1: Modify the MTOE to move the Division psychiatrist from the Sustainment Brigade to the Division Surgeon cell.

Green. This has largely been seen as being helpful it helping facilitating care within the theater.

Recommendation BH2: Change the MTOE to move the Brigade Mental Health Officers from the BSB to the Brigade Surgeon cell.

Red. This recommendation has been considered; however, it is not clear that making this change would facilitate care. Currently Mental Health Officers are still assigned to the BSB.

Recommendation BH3: Prioritize the assignment of Behavioral Health Officers to Brigades to allow sufficient time for the behavioral health officer to train with the unit. Avoid PROFIS assignment when possible.

Amber. Competing demands for behavioral health personnel continue to make this recommendation hard to implement.

Recommendation BH4: Revise the COSC Course to increase its relevance to Division and BCT behavioral health assets.

Amber. The COSC course continues to be updated; however, efforts need to be made to keep the course relevant and the Battlespace and role of the behavioral health provider change.

10.2 Optimizing Theater Assets

Recommendation TH1: Assign the Theater Mental Health Consultant and senior Mental Health NCOIC to MNC/F -I Surgeon's office.

Amber. The future CORP's MTOE has a behavioral health staff officer assigned to the Surgeon's cell. Logical arguments can be made for keeping the position at the Medical Brigade level as this level has direct control over a large amount of behavioral health assets in theater.

Recommendation TH2: Have each MND Mental Health Consultant (typically the division psychiatrist) work with the Theater Mental Health Consultant to address MND-level mental health issues.

Green. The current Mental Health Consultant views this recommendation as having been successful in facilitating care.

Recommendation TH3: Hold a quarterly ITO behavioral health conference. Goals are to enhance networking, communication, coordination, increase BH personnel morale and well-being, and offer Continuing Medical Education (CME) (MNF/C-I).

Green. The current Mental Health Consultant views this recommendation as having been successful in facilitating care; however, the mental health consultant has suggested modifying the recommendation to include local conferences within each MND twice a year and theater-wide conferences twice a year.

Recommendation TH4: Enforce use of the Combat and Operational Stress Control Workload and Activity Reporting System (COSC-WARS) throughout the ITO (MNF/C-I).

Green. COSC-WARS is being widely used and is providing useful data to the theater Mental Health Consultant.

Recommendation TH5: Develop and implement an improved version of COSC-WARS leading to a joint service behavioral health workload reporting tool (MNF/C-I).

Green. COSC-WARS was recently revised by the theater Mental Health Consultant is being used jointly within theater.

Recommendation TH6: Revise the current electronic medical record (AHLTA-T) to capture individual data-points currently reported in COSC-WARS and revise the current coding options for psychiatric diagnoses to be consistent with current Diagnostic and Statistical Manual of Mental Disorders. In addition, modify the Joint Medical Electronic Workload System (JMEWS) to permit direct input of combat operational stress control aggregate data such as the number of command consultations, prevention classes, and Battlemind debriefings. Any working group addressing potential mental-health related revisions of AHLTA-T should include mental health providers who have deployed to the ITO and are experienced using AHLTA-T.

Amber. Automated medical record and workload reporting systems are still unable to effectively capture the range of mental-health activities conducted in theater; however, MEDCOM is working on getting COSR recognized by ICD thereby allowing documentation in the Electronic Medical Records (EMR).

Recommendation TH7: Ensure that there is one electronic medical record computer terminal for each mental health provider in the ITO.

Green.

Recommendation TH8: Incorporate training on Theater EMR into the curriculum of the Pre-Deployment Combat and Operational Stress Control Course.

Green.

Recommendation TH9: Provide an opportunity for additional instruction at reserve unit mobilization sites and/or Kuwait for reserve units.

Green. All incoming MED units receive MC4 training.

<u>Recommendation TH10</u>: Implement a policy for behavioral health leadership to conduct quality assistance visits at locations that have BH providers.

Green. An SOP for this has been developed and is being executed.

10.3 Addressing Reported Shortages of Mental Health Personnel

<u>Recommendation PS1</u>: Develop mechanism to fill CSC teams with GS or contracted psychologists or social workers.

Amber. A mechanism is in place; however, efforts could be made to recruit to fill positions.

<u>Recommendation PS2</u>: Cross-train selected 68W to allow them to augment 68X using Battlemind First-Aid.

Green. Battlemind First-Aid has been renamed "Battlemind Resilience Training" for medics and has been officially incorporated into the 68W schools.

<u>Recommendation PS3</u>: Upgrade the MTOE of Aviation Brigades to include a Behavioral Health Officer and Behavioral Health NCO in Aviation Brigades. Have the Behavioral Health Officer co-located with BDE (Flight) Surgeon.

Red. Upon further consideration, it is probably more logical to have Aviation Brigades and other Brigades without organic Behavioral Health Officers modify their Deployment Manning Document (DMD) to include a Behavioral Health Officer based upon the specific mission rather than to change the MTOE.

10.4 Leadership and Reducing Stigma

<u>Recommendation RS1</u>: Have senior leaders encourage subordinate leaders at the BN and CO level to read material such as the NATO guide – "A Leader's Guide to Psychological Support Across the Deployment Cycle" – a document that recounts the experiences of a number of senior operational leaders (as well as leaders from other Nations) in terms of providing mental health support.

Green. Incorporated as part of the MNC-I Suicide Prevention Program

<u>Recommendation RS2</u>: Enhance training for NCOs at the Warrior Leader Course, BNCOC and ANCOC on their role in reducing Soldier stigma through counseling & mentorship training.

Green. Battlemind training for leaders has been integrated into NCO courses. This training emphasizes the role of leadership in helping reduce stigma.

<u>Recommendation RS4</u>: Place one 68X or cross-trained 68W in each Battalion to serve as a unit behavioral health representative.

Green. Incorporated as part of the MNC-I Suicide Prevention Program.

10.5   Sleep Management

Recommendation SLP1: Ensure leaders at all levels develop and monitor work cycle programs that provide adequate sleep time based on the Combined Arms Doctrine Directorate (CADD) on Sleep Management.

Amber. No specific policy regarding the CADD in theater. Much of this material is being incorporated into NCO and Officer courses. In addition, the need to monitor sleep and rest cycles is part of the Suicide Prevention Action Plan (SPAP, see Appendix B).

Recommendation SPL2: Ensure leaders at all levels encourage Soldiers to seek treatment for sleep problems.

Green. The importance of sleep management has been incorporated into leadership courses to include Senior Leader Battlemind.

Recommendation SLP3: Ensure officers know that sleep deprivation is cumulative and that their cognitive performance is highly susceptible to the effects of sleep deprivation.

Green. The importance of sleep management has been incorporated into leadership courses to include Senior Leader Battlemind.

Recommendation SP4: Conduct research on the role of sleep and sleep problems in behavioral health problems such as acute stress and PTSD.

Amber. Work in this area is being funded and conducted by the Medical Research and Materiel Command (MRMC), but has not been completed.

Recommendation SP5: Conduct research on ways to unobtrusively monitor sleep and provide performance estimates for individuals and groups.

Amber. Work in this area is being funded and conducted by the Medical Research and Materiel Command (MRMC), but has not been completed.

Recommendation SP6: Investigate the efficacy of sleep aids as well as agents that might be used to safely maintain performance under short-term periods of sleep deprivation.

Amber. Work in this area is being funded and conducted by the Medical Research and Materiel Command (MRMC), but has not been completed.

10.6   Results Related to Providing Care

Recommendation PC1: Continue to implement the MHAT-IV recommendation of focusing behavioral health resources on units in theater between six to ten months. Emphasize (a)Time-driven Battlemind debriefing after 6 months in theater for high combat exposure units and (b) Unit Behavioral Health Needs Assessments after 6 months in theater for at risk units.

Amber. Interventions are being provided based on units' requests. BH/COSC providers continue to recommend services throughout the deployment cycle. The BH survey results, however, indicated some significant declines in consulting services.

Recommendation PC2: Behavioral health and primary care providers need to be aware of the symptoms of inhalant abuse among Soldiers seeking care. Details on inhalants are provided in Lacy and Ditzler (2007).

Green. Training has been conducted at the Behavioral Health Conference.

10.7 NCOs and Multiple-Deployments

Recommendation NCO1: Give NCOs who have deployed multiple times priority for TDA assignments.

Amber. Efforts have been made to spread deployments across Soldiers; however, the results of MHAT VI indicate higher percentages of Soldiers are on multiple deployments in 2009 than in 2007.

Recommendation NCO2: Ensure NCOs (and all Soldiers) have adequate reset time. Previous research indicates that one-year dwell-time may not be adequate to reset the force.

Amber. The length of dwell-time is recognized as an issue and efforts have been made to provide adequate dwell-time.

Recommendation NCO3: Determine the number NCOs who have been unable to attend required leadership courses and consider developing shortened in-theater courses that would meet the requirements.

Red.

10.8 Validated Training

Recommendation TR1: Units should continue to implement Battlemind training across all phases of the deployment cycle. Materials for all phases are available at www.battlemind.org.

Green. This has been incorporated as part of the MNC-I Suicide Prevention Program.

Recommendation ET1: Revise and validate ethics training for Soldiers

Amber. No specific theater training. All service members receive ethics pre-deployment. Various initiatives are underway to revise training materials including a detailed effort by the 3rd ID following the release of MHAT V.

10.9 Theater Suicide Prevention Program and Suicide Action Plan

Recommendation S1: Develop a suicide prevention action plan at the operational and tactical level.

Green. MNC-I has developed and implemented a comprehensive suicide prevention plan.

Recommendation S2: Adopt Automated Suicide Evaluation Report as DOD-level Surveillance Tool / Integrate ASER into AHLTA and AHLTA-T

Green.

Recommendation S3: Replace or augment proprietary suicide prevention products (ASIST) with Army owned/no cost training packages.

Green. The Center for Health Promotion and Preventive Medicine (CHPPM) has developed a product referred to as ACE that incorporates similar aspects of ASIST and has begun a phased roll out in conjunction with the recent Army Suicide Stand Down event.

Recommendation S4: Tailor suicide prevention training packages to the phase of deployment and focus on building psychological resiliency. Use real-world examples from a combat environment.

Green. The Army's adoption of the Shoulder to Shoulder video product and the many initiatives locally and by MEDCOM to develop resiliency training and centers are clear demonstrations of actions taken to address these concerns.

Recommendation S5: Enhance relationship Support (see section 10.11).

Amber.

Recommendation S6: Provide a detailed instruction manual for completing the ASER.

Amber.

10.10 Theater Concussion (mTBI) Assessment and Screening Program

Recommendation TBI1: Develop consistent policies for evaluation after a concussive event and standards for return to duty.

Green. Policy has been developed and medical providers receive training prior to entering Kuwait. Policy IAW DVBIC CPG. In addition, research validation studies of TBI screens are being conducted in theater.

10.11 Strengthening Military Families.

Recommendation SMF1: Amend TRICARE rules to cover marital and family counseling as a medical benefit under TRICARE Prime.

Amber. The Army has funded and hired 46 Marriage and Family Therapists, but marital and family counseling is not a TRICARE benefit.

Recommendation SMF2: Increase the number of Family Life providers to work with spouses and families.

Green.

Recommendation SMF3: Conduct research examining spouses and family well-being across the deployment cycle.

Green. The Army has contracted with RAND to provide a 3-year family study. In addition, the Medical Research and Material Command (MRMC) has an ongoing program conducting and funding this research, but the work has not been completed.

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12. APPENDIX A: COMPLETE BH SURVEY RESULTS

Complete BH Results (non-significant changes)

	MHAT V	MHAT VI	$p < .05$
WELL-BEING (% Agree)			
My spiritual well being has been adversely affected by the events I have witnessed on this depl	5.2%	4.0%	0.63
My ability to do my job is impaired by listening to the combat experiences of Service Members I	15.5%	8.1%	0.17
Rate your personal morale	44.4%	53.2%	0.17
Rate your energy level	33.4%	37.2%	0.52
Rate your level of burnout	35.8%	32.5%	0.63
Rate your motivation	43.0%	45.5%	0.69
COMBAT OPERATIONAL STRESS TRAINING (% Agree)			
I feel confident in my ability to:			
use the COSC Workload and Activity Reporting System (COSC-WARS)	65.0%	72.3%	0.21
help Service Members adapt to the stressors of combat or deployment	93.3%	94.8%	0.58
evaluate and manage Service Members with suicidal thoughts or behaviors	92.4%	95.4%	0.29
evaluate and manage Service Members with substance Abuse or Dependence	75.6%	76.1%	0.92
evaluate and treat Combat and Operational Stress Reaction	95.6%	95.7%	0.99
evaluate and treat acute Stress Disorder or PTSD	90.3%	87.1%	0.38
evaluate and treat victims of sexual assault	72.4%	74.0%	0.78
perform clinical evaluation and treatment of detainees	22.8%	15.8%	0.11
perform clinical evaluation and treatment or Iraqi Security Force personnel	33.6%	26.0%	0.18
STANDARDS OF CLINICAL CARE (% AGREE)			
The standards of COSC services in this theater or Area of Operations are clear	42.5%	53.6%	0.09
Commanders are satisfied with the amount of information I can provide	78.3%	75.4%	0.57
I encountered situations involving medical ethics in this AO to which I did not know how to resp	32.1%	30.1%	0.75
The standards of how much patient information I can share with commanders is clear	61.1%	64.0%	0.65
RESOURCES FROM COMMAND (% ARGEE)			
We coordinate or integrate our BH or COSC activities with primary care medical personnel in th	81.3%	82.7%	0.75
COMBAT AND OPERATIONAL STRESS (CONSULTING (% Agree))			
During this deployment how frequently did you:			
provide COSC outreach services (weekly)	55.5%	49.3%	0.34
conduct educational classes (weekly)	49.1%	47.1%	0.75
consult with unit leaders (weekly)	82.3%	79.1%	0.46
conduct systematic unit needs assessments (every 2-3 months)	41.0%	30.6%	0.11
conduct Suicide Prevention Training (monthly)	28.6%	32.8%	0.47
provide one-to-one BH counseling with Service Members at the BH/COSC unit location (weekly	85.1%	82.0%	0.47
provide one-to-one COSC services with Service Members at BH/COSC unit location (weekly)	80.5%	77.1%	0.49

COMBAT AND OPERATIONAL STRESS COURSE TRAINING (% AGREE)

I attended pre-deployment COSC Training Course (e.g. AMEDD)	80.5%	77.1%	0.49

DOING THEIR JOB (% Agree)

How often do you:

talk informally to the Service Members	97.3%	98.2%	0.49
conduct focus groups with Service Members	67.8%	62.7%	0.41
talk with the chaplains	95.6%	93.1%	0.26
talk with the units commander	95.2%	96.2%	0.62
talk with the units medical personnel	97.4%	97.0%	0.76
use validated surveys or instruments	64.7%	75.1%	0.08
use locally developed surveys or instruments	56.4%	56.6%	0.97
develop a BH or COSC unit prevention and early intervention plan	68.0%	69.9%	0.76
conduct Command Consultation	92.7%	88.7%	0.20

STIGMA AND BARRIERS TO CARE (% AGREE)

The medical leadership does not support BH/COSC outreach	9.2%	5.3%	0.32
The supported units leadership does not support BH or COSC outreach	12.0%	13.7%	0.70
There is inadequate transportation to conduct outreach activities	30.2%	31.0%	0.90
There is inadequate communication between BH or COSC and supported units	25.4%	27.3%	0.74
Service Members feel uncomfortable talking to BH or COSC personnel about their problems	23.7%	32.1%	0.17
BH or COSC personnel are unfamiliar with supported unit leadership and Service Members	8.6%	9.6%	0.75
Arranging convoys to supported units is too difficult	33.9%	32.7%	0.85
The inability to arrange convoys has led to mission cancellations	29.8%	30.9%	0.86
BH or COSC personnel do not like to perform outreach services	13.1%	8.3%	0.26
BH or COSC personnel are not trained to conduct outreach services	21.6%	12.9%	0.11
BH or COSC personnel do not think preventive outreach activities are effective	21.9%	12.2%	0.08
Commander's support BH provider recommendations for medevac out of theatre	49.4%	55.6%	0.33
Commanders respect patient confidentiality when it comes to mental health issues	51.1%	46.4%	0.46
There are sufficient BH assests in theatre to cover the mission across the AO	23.1%	29.7%	0.23

PSYCHE MEDS (% Agree)

The procedures for ordering or replenishing psychiatric medications in this theater or Area of O	50.5%	57.4%	0.52
In general, there has been adequate availability of appropriate psychiatric medications in the ar	82.5%	91.9%	0.10
There has been adequate availability of appropriate psychiatric medication at Level I (Battalion	46.9%	60.2%	0.25
There has been adequate availability of appropriate psychiatric medication at Level II (Forward	71.7%	82.8%	0.23
There has been adequate availability of appropriate psychiatric medication at Level III (Combat	90.8%	98.1%	0.05

13. APPENDIX B : SUICIDE PREVENTION ACTION PLAN (SPAP)

MULTI-NATIONAL CORPS- IRAQ

Suicide Prevention Action Plan

Version 3.1
December 1, 2008

Purpose

To establish an effective suicide prevention program for the Soldiers, Sailors, Airmen, and Marines and their leaders serving within the Multi-National Corps-Iraq and equip these personnel with the right tools to help indentify, prevent, and assist in the treatment of behavioral health issues experienced by their teammates.

Teammates take care of Teammates

You Can Do Something...Intervention Can Save a Life

"One Suicide is one too many"

For more information see your unit leadership, chaplain, healthcare provider or visit

https://mnci.intranet.iraq.centcom.mil/C1

Plan Overview

Objective: To Implement and Maintain a Viable Suicide Prevention Program in the Iraq Theater of Operation (ITO) that Seeks to Eliminate or Reduce Suicidal Behavior

Suicide Action Plan Goals

- Develop positive life coping skills that eliminate suicide as an option in a teammate's mind

- Encourage a "help-seeking" environment and remove barriers to care for all teammates

- Raise teammates' awareness and vigilance towards suicide prevention

- Reinforce the idea that "Teammates take care of Teammates"

- Get all teammates involved with suicide prevention throughout the entire deployment cycle; not just after a successful or attempted suicide occurs

- Empower teammates with the tools to deal with a suicide event should it arise

Background

Based on the Army's 2007 Mental Health Advisory Team (MHAT) V conclusions, the current Army Suicide Prevention Program is not designed for the contemporary combat/deployed environment. The MHAT further believed that the Army's program needs to provide more realistic training packages focused on the phases of deployment and aimed at building psychological resiliency. The Army's suicide rate has been increasing for the past four years especially in the Iraq Theater of Operation (ITO). It is critical that an action plan be maintained and emphasized at the lowest levels if we are to positively influence and prevent suicides by military service members in Iraq.

Since 1 January 2008, there have been a total of 28 completed suicides. While an increasing number of service members are on subsequent deployments, the majority of successful suicides were committed by first-time deployed service members. This upward trend in completed or attempted suicides in the Iraq Theater of Operations must be reversed.

Current Site Picture

Currently, several MNC-I staff agencies are working efforts in suicide prevention. Other efforts are being undertaken by the behavioral health networks, Combat Stress, and other counseling services that are available and making a difference in our efforts to eliminate or reduce suicide in Iraq. The training, treatment, tracking, and regular maintenance of the program need to be coordinated and synchronized to ensure no member is left behind. Additionally, each of the Multi-National Divisions and Major Subordinate Commands all have individual programs that they maintain.

The MNC-I Suicide Prevention Action Plan takes a three-pronged approach with a keen focus on training and awareness: suicide prevention education; resiliency training; Army Suicide Intervention Skills (ASIST) program; and Unit intervention. As of 1 January 2008, the Department of Defense Suicide Event Report (DODSER), is being be used to report completed suicides and attempts resulting in hospitalization for all MNC-I service members.

The MNC-I Chaplain functions as the teaching and training arm of the program using the Ask, Care, Escort (ACE) training model (train- the-trainer), along with the ASIST Program. ASIST training is comprised of three tiers:

Tier 1 Gatekeeper (Buddy level) focuses on awareness and intervention training annually spearheaded by the Chaplain.

Tier 2 Gatekeeper is the Leader level (supervisors, green tabbers, etc).

Tier 3 Gatekeeper is the Intervention level. The ASIST Program requires 1 in every 50 soldiers be trained on the procedures associated with intervention. In addition to being the theater ASIST proponent, the Chaplain also tracks and reports numbers of counseling and referrals for suicide related matters.

Behavioral Health specialists can also provide resiliency training to individuals, units, leaders and families during the pre-deployment, deployment and post-deployment phases of the operation.

Way Ahead

As is often the case, suicide is a high profile act that gains our attention only after there is a trend identified by an outside agency, or the general public. For prevention to be effective, it must begin before a team member deploys. Suicide is not a pleasant topic and some leaders think the more you talk about it, the more you will "plant the seed" in people's mind that it is a viable option. Actually, the more that suicide is talked about, the more barriers can come down and lessen the associated stigma. Leaders who stand up early and address negative indicators that can often lead to more disruptive and life-threatening behavior will improve not only the overall readiness of their organization, but will do more to ensure every teammate in distress seeks help, and makes it back home to their loved ones.

Suicide prevention training should be incorporated into every facet of the deployment cycle: pre-deployment, deployment, re-deployment, and re-integration; and it includes all members of the team: leaders, behavioral health professionals, chaplains, service members, family members and significant others. The training must be relevant, realistic, and useful to team members or it will not be internalized. Just as units prepare to combat IEDs or insurgents, they must prepare to combat the battle in the mind against negative behaviors that can lead to demise and combat ineffectiveness. We must be deliberate in our suicide prevention efforts to ensure that first-line leaders and commanders are equipped with the tools needed to identify and recognize the warning signs in their team members. They must also be familiar with the methods and procedures on how best to get them help and what resources exist to aid in this effort.

Awareness and training are the keys to preventing suicide. Teams who synchronize the elements of command emphasis, training, communication, early detection, intervention, and treatment, have the best chances of eliminating or reducing the occurrences of suicides and attempts within their organizations.

MNC-I Strategy

❖ Implement Theater-level Suicide Prevention Action Plan

❖ Execute Quarterly Theater-level Suicide Prevention Review Boards (SPRB) to review lessons learned and current trends

❖ Publish and Enforce the MNC-I Suicide Prevention Policy focused on:

✓ Resiliency Training

✓ Leadership Emphasis

✓ Education

✓ Awareness

✓ Suicide Awareness Training

✓ De-Stigmatization of Seeking Behavioral Health Services

✓ Vigilance

❖ Distribute leader and service member suicide prevention pocket references down to unit level

❖ Use a unit behavioral health survey as a risk assessment tool at unit level (consult local Combat Stress personnel for which specific tool to use)

MNC-I Approach

❖ Begin Suicide Prevention and Resiliency Training during pre-deployment and continue throughout deployment cycle

❖ Emphasize prevention at the first-line leader level (NCO's have hand on pulse)

❖ Integrate all players (leaders, commanders, ministry teams, medical teams, teammates, family members) in entire process

❖ Reduce barriers to care by removing stigma for those who seek help

❖ Leaders need to ensure that new teammates are integrated into the team before and during deployment. New teammates arriving during deployment should be integrated as soon as practicable

❖ Analyze situations (UCMJ, casualties, "Dear John" letters) that could set in motion suicidal behavior and counter with intervention

❖ Command emphasis from top-to-bottom

❖ Keep talking to troops but also listen to them!

When team members feel they are valued members of the team, they feel obligated to stay in the fight and not do anything that would cause undue burdens on their comrades. This process should start from a teammate's arrival.

The buddy concept should be used as extensively as possible in our efforts to combat suicidal behaviors in our ranks. The first-line leader, the NCOIC/ squad leader, has an optimal vantage point of a team member's behavioral health especially in the deployed environment. What's easier to hide in garrison can become prevalent during a lengthy deployment. It is imperative that all leaders become very familiar with suicide prevention and intervention tools such as ACE to make a difference. Commanders must also ensure that their units have the requisite number of Soldiers trained in Army Suicide Intervention Skill Training (ASIST).

A leader should never discount how a team member views his or her situation. If it's a big deal to them, it should be seen accordingly to leaders. A team member who is preoccupied with home front issues or other stressors will not be fully engaged in execution of their duties and could become a liability, rather than a force multiplier, in combat. The leader who is attuned to his or her subordinates will know when something is wrong. The goal of this suicide prevention action plan is to ensure that teammates look out for one another and knowing what to do when one of their own exhibits the signs that could lead to suicidal behavior.

Suicide Prevention & the Deployment Cycle

The time to conduct suicide prevention training is well before the deployment ever begins and must continue throughout the entire deployment cycle.
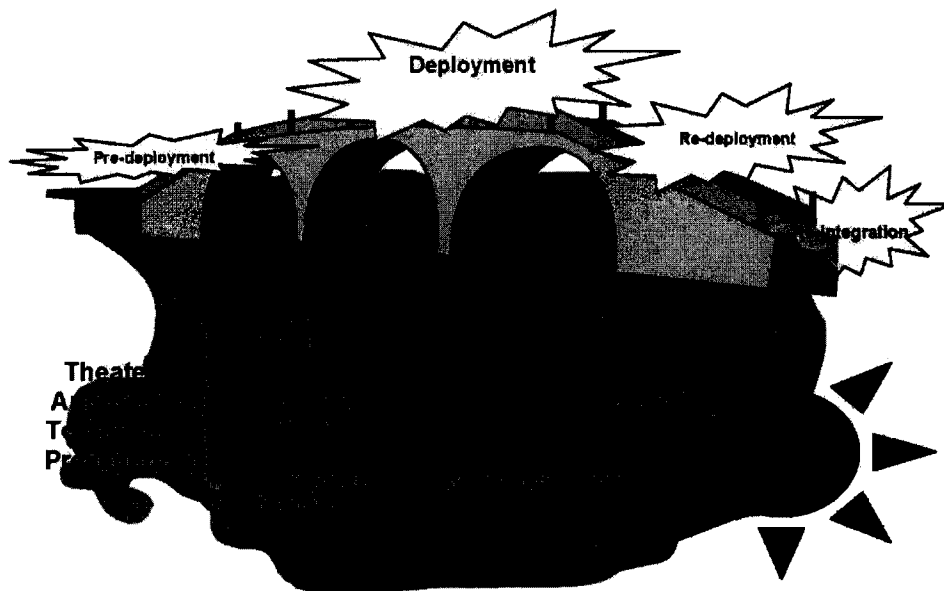
Pre-deployment

The pre-deployment phase of the Suicide Prevention Plan incorporates three areas: (1) Prevention/Training; (2) Intervention/Early Identification; (3) Pre-deployment screening.

During pre-deployment, a unit has many training requirements. Suicide prevention training should be approached just as energetically as gunnery, an MRE, or an MRX. Suicide prevention and resiliency training shouldn't be the same old PowerPoint slide presentation that is shown during quarterly training just to meet a QTB requirement, but rather, effective training

that instructs the participants by engaging them in learning. Role playing, testimonials, short high-energy videos (10-15 minutes) that set up expectations for the deployment and what team members may realistically face should help ease the anxiety of a deployment. One of the MHAT recommendations was for all leaders to read the NATO's *"Leader's Guide to Psychological Support Across the Deployment Cycle"* throughout all the phases of the deployment.

Prevention/Training During Pre-deployment

For All

- ❖ Training focuses on recognizing risk factors and early warning signs

- ❖ Emphasizes how to seek/get assistance

- ❖ Useful, relevant, and honest training not "same old slide packet" and 1-hour brief

- ❖ Use role playing and testimonials when possible

- ❖ Involve family members

- ❖ Chaplains take lead

- ❖ All service members complete as part of pre-deployment training

- ❖ Battlemind training and similar programs are key steps in building psychological resiliency.

For Medical Personnel

Train on recognition and management of:

- ❖ Combat Operational Stress (COS)

- ❖ Post Traumatic Stress Disorder (PTSD)

- ❖ Sleep disorders

- ❖ Depression

- ❖ Coping with stress

- ❖ Battle drills for responding to critical incidents in combat

- ❖ Pairing up with unit ministry teams to work in concert in field environment

<u>For Leaders</u>

Commander and Senior Leader conferences to discuss:

❖ Wellness

❖ Self care

❖ Warrior resilience

❖ Importance of leader involvement

❖ Command referrals

❖ Recognizing risk factors/warning signs of suicidal behavior

❖ Remove barriers to care by reducing stigma to getting help

Intervention/ Early Identification

Intervention and early identification of behavioral health issues prior to deployment can help leaders focus their efforts and posture their commands for challenges that may arise during the deployment. By conducting this early assessment, commanders are better armed with information to know which team members are at risk and may require additional attention during the deployment. Commanders may also begin addressing a team member's behavioral health problems before the deployment starts and adjustments can be made which will better accommodate the team member and the mission.

Minimum Behavioral Health Standards for Deployment

➢ Service members with significant behavioral health problems must show three months of stability prior to deployment

➢ Service members currently being treated for psychosis or bipolar disorder are not deployable

➢ Service members who are taking medications which require laboratory monitoring such as lithium or valproic acid are not deployable

➢ Service members who are taking antipsychotic medications to control psychotic, bipolar, or chronic insomnia conditions are not deployable

➢ The continued use of psychotropic medications clinically and operationally problematic during deployments including short half-life benzodiazepines and stimulants should be balanced between the necessity for successful functioning in the theater of operations and the ability to obtain the medication, the potential for withdrawal, and the potential for abuse

➢ If a Service member is placed on a psychotropic medication within three months of deployment, then he/she must be improving, stable, and tolerating the medication without significant side effect to deploy

Pre-deployment Behavioral Health Screening

Legend:
- ▨ Completed at SRC by unit provider
- ▨ Completed by behavioral health provider
- ☐ Completed by Unit Surgeon

Once a team member has been identified as needing assistance through the screening process, they then enter a network of behavioral healthcare professionals who are available to assist:.

Behavioral Health Clinics

❖ Provide behavioral health to service members

❖ Command Directed Evaluations

❖ Monitor trends in units

❖ Can work in concert with unit medical professionals before deployment for continuity of care

An optional, and highly encouraged initiative for Brigade level commands, is to develop a Suicide Risk Management Team (SRMT) of multi-disciplinary members from the Brigade and unit command and staff. The SRMT can track throughout the deployment team members identified as "high risk" during the pre-screening process or identified as "high risk" later in the deployment. The SRMT can help coordinate and focus the efforts of the subject matter experts within the unit and gives the command team a good conduit to work through with each team member's individual case.

Deployment

Suicide prevention efforts must not end upon arrival into theater. Training must occur at all levels; especially in the squad/platoon-sized elements. Training should be tailored to the current phase of the deployment and the contemporary issues of the team. These issues may include home front issues, UCMJ, heavy casualties or combat losses, etc. During this training, commanders should ensure that all Soldiers (buddy teams), especially first-line NCOs are looking out for the early warning signs they learned to detect issues during pre-deployment training. First-line leaders will need to emphasize the importance of buddy maintenance and will need to assist team members in this effort. Training should be targeted for the 6th-10th months of the deployment, as these are the critical points, statistically, when most suicidal ideations, gestures, or incidents occur.

Resilience training strengthens psychological health by teaching individuals, families and teams techniques for stress reduction, post traumatic growth, self mastery and team building. Specific Warrior Resilience Training (WRT) courses are available from theater CSC and BH teams. The WRT program of instruction utilizes Warrior Ethos concepts, Army leadership principles, Rational Emotive Behavior Therapy strategies, and inspirational examples of POW and survivor resiliency to supplement pre-deployment resilience training and reduce barriers to care.

Another very important aspect of deployment and the management of healthy lifestyle habits is the establishment and enforcement of work/rest cycles. Everyone needs "down time"—even leaders. In fact, one of the most effective means for leaders to convey similar practices in their subordinates, is to exercise it themselves when the mission and conditions allow. A unit R&R plan should be established early to build predictability for team members. There are other in-theater Fighter Management Plans like Freedom Rest or the Qatar Pass Program that are options for team members to take R&R, as well as other MWR options. Leaders should remain vigilant for "tracer burn out" in their teammates. When fatigue is high, individual defenses are down and those who are already susceptible to suicidal tendencies will only become more so.

A tool that can help commanders identify systemic issues within their unit is the Unit Behavioral Health Needs Assessment Survey (UBHNAS). This survey was developed by the Walter Reed Army Medical Center and is meant to sample 10 percent of a unit, anonymously, to identify trends. It is not a clinical assessment or screening tool, but can be an invaluable tool to help the commander identify larger issues his/her unit may be dealing with. This will assist the commander in better tailoring training and other prevention options.

While deployed, team members may encounter problems and will need to develop healthy ways of working through them. The buddy system is a great network that teammates can use to looking out for each other. However, sometimes personal problems move beyond the scope and abilities of a friend to handle and will require professional assistance. Today's leaders have a variety of options available to them to assist their subordinates in attaining help. Some service members feel more comfortable with a representative from the Unit Ministry Team, while others may need more sophisticated treatment and should be referred through the unit physician to Combat Stress units. Another avenue to explore is the use of Unit Behavioral Health Advocates. This concept is very much what we have in place in units with Sexual Assault Victim Advocates. Each battalion would have a mid-level NCO (E6-E7) that would serve as the battalion advocate. They would be another available asset to work with the unit's medical and command teams as a liaison for the team members. They can help decrease the

stigma associated with getting help, help identify "at risk" team members, and assist in teaching and prevention efforts.

Suggested Medical Health Care While Deployed

- ❖ Level 1 (Battalion Aid Station)
- ❖ Level 2 (Outpatient Clinic)
    - ➤ Physicians & PAs – first line care and intervention
    - ➤ Psychiatry consults
- ❖ Combat Stress Clinics
    - ➤ Located throughout OE
    - ➤ Improves accessibility
- ❖ Outreach at Patrol Bases
    - ➤ Highest risk for Combat and Operational Stress due to exposure
- ❖ Debriefings
    - ➤ Event Driven
    - ➤ Time Based

Finally, the unit needs a plan on how to deal with team members who contemplate, attempt or succeed in harming themselves – a postvention plan. Reporting suicidal events through the Department of Defense Suicide Event Report (DODSER) is already an MNC-I requirement. It is DoD's standardized reporting apparatus for any successful event or ideation/behavior resulting in evacuation or hospitalization. This is to be done within 60 days of a completed suicide or within 30 days of an ideation/behavioral event and forwarded through the service member's chain of command to the Theater Behavioral Health Consultant located in the Task Force Medical Command.

As of 1 January 2008, the Combat and Operation Stress Control Workload and Activity Reporting System (COSC-WARS) are used to uniformly collect and record behavioral health information. This numerical worksheet is completed monthly by medical providers and can help track suicide attempts and rates of Combat Operational Stress Reactions versus Mood Disorder.

The last piece of postvention is the review process. Each brigade level unit should conduct a Suicide Review Board for all successful suicides to identify lessons learn, and take measures to prevent or reduce future occurrences.

Redeployment

Much like the pre-deployment and deployment phases, redeployment involves training, early identification/ intervention, and treatment. The major difference with the redeployment phase is that the source of anxiety for a team member may have shifted to what awaits them back at home station rather than the battlefield. These fears can manifest themselves in many ways and the unknown or pending conflict that many may experience can be too overwhelming when coupled with the fatigue of a long combat tour. One of the tools the Department of Defense has implemented to mitigate this is the Post-Deployment Health Assessment (PDHA). This assessment is completed before a service member redeploys. This assessment tool provides a commander with a good idea of which members of their unit could potentially experience problems upon re-deployment. Commanders can determine, with the advice of behavioral health professionals, which members need treatment and to what degree. If it's determined, after consultation with Behavioral Health, that a team member is a high risk to themselves or others, commanders can take appropriate measures upon arrival at home station. Service members assessed at a lower risk can be scheduled for treatment or continue treatment if started in theater.

Redeployment preparation should simultaneously occur in theater, and back at home station, to prepare service members and their families for reintegration. Rear detachment elements should work to involve family members in reintegration classes and workshops that will assist them in receiving their loved one back into the home. Family services and other applicable agencies should attempt to make families aware that the service member completed could have been life-changing. Resiliency training strengthens psychological health by teaching individuals, families and teams techniques for stress reduction, post traumatic growth, self mastery and team building.

While in theater, there are certain regulatory Deployment Cycle Support (DCS) tasks that must be completed prior to re-deployment. Each individual is required to complete a DCS checklist which includes the PDHA (DD 2796) and other required briefings (Medical Threat, Pre-Battlemind training) that address behavioral health/traumatic brain injuries issues. A complete list of the DCS requirements can be found on the MNC-I C1 SIPR website under "DCS CONPLAN/REDEPLOYMENT."

Required DCS Briefings

- Reunion Training (Chaplain)

- Communication Training (Chaplain)

- Soldier and Family Resilience (Behavioral Health)

- Suicide Awareness (Chaplain)

- Marital Assessment (Chaplain – as required)

- Finance Re-deployment Info (Finance)

- SCRA & USERRA (SJA)

- Theater Medical Threat (Medical)

- Behavioral Health (Medical)

- Post-Deployment Health Assessment (PDHA) (Medical) *NET 30 days before redeployment*

- Mild Traumatic Brain Injury (MTBI) and PTSD (Medical)

- Tricare Benefits (Medical)

- Post-Deployment Battle Mind Video (Unit Leadership)

- Unit Risk Reduction (Unit Leadership)

- Sexual Assault Prevention and Response (Unit Leadership)

- Substance Abuse Prevention (Unit Leadership)

*Briefings will be completed NET 90 days prior to redeployment unless otherwise noted.

The PDHA, which is completed in theater no earlier than 30 days before redeployment by unit providers, is used to identify any potential health issues, including behavioral health. Service members who screen positive on the PDHA for potential behavioral health issues will be categorized as low, medium, or high risk. Brigade-level surgeons should track service members requiring follow-up and consults can be completed at the PDHA website. All soldiers are also screened for Traumatic Brain Injuries (TBI) with the Defense and Veterans Brain Injury Center (DVBIC) question-four screen.

PDHA Risk Stratification

❖ Low

> Normal reactions to abnormal stressors

> Does not require further evaluation

> Recommend to seek care upon return to home

> No further outreach taken

❖ Medium

> Those who need behavioral health care, but do not present high risk for harm to themselves or others

> Advanced list sent to home station behavioral professionals to help prepare for intake before release for 2-day pass

> Outreach from local behavioral health professionals to schedule follow-up shortly after return

> Can't force into treatment, but will conduct aggressive outreach as they are in greater need

❖ High

> Those who present a significant risk upon return

> List is sent to commanders with pre-completed command directed evaluation packets

> Recommend that command closely monitor these individuals at unit level

> Will complete emergency command directed evaluation prior to release upon return to home station

Re-integration

Upon re-deployment, service members will finalize the PDHA (DD 2796) at their home station as part of their DSRP. This is conducted in accordance with the DCS task timeline before service members are released for block leave. The DSRP may also identify behavioral health issues and service members should be tracked and followed by the command in much the same way they were in theater only they should have greater access to care.

Flight Reception	Pass	Days 1-10 Do Not Include Weekend Days

Decompression and Initial Post-Deployment Tasks
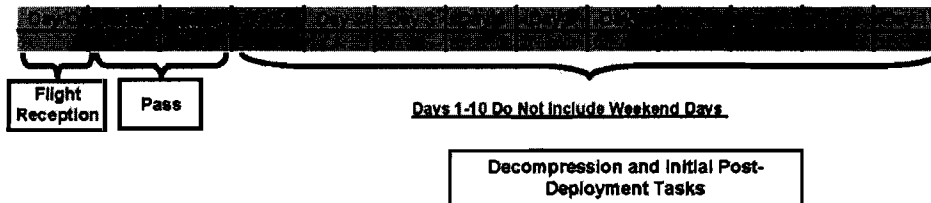
At the 90-day post-deployment mark, a follow-up assessment will be conducted on all service members. This follow-up assessment is designed to capture issues that have arisen since the re-deployment. The initial weeks back, the "honeymoon phase," are usually uneventful but once the re-deployed service member resumes his "normal routine", problems are more apt to surface.

Suicide Prevention/Review Board (SPRB)

The MNC-I Surgeon is the proponent for the Suicide Prevention Review Board. It meets quarterly (March, June, September, December) to plan, review trends, implement changes, and manage suicide prevention efforts in theater. The team can be assembled more frequently by the Commanding General if warranted. These memberships should not rotate due to the sensitivity of information discussed.

a. MNC-I Deputy CG, Chair

b. MNC-I CSM

c. C-1

d. MND/MSC representative (1)

e. TF MEDCOM Behavioral Health Consultant

f. Chaplain

g. Surgeon

h. Provost Marshal (PM)

i. Staff Judge Advocate (SJA)

j. Inspector General (IG)

k. Public Affairs Officer (PAO)

l. Criminal Investigation Division (CID)

Board Responsibilities:

(1) Reviews trends suicide trends since last SPRB and calendar year cumulative statistics and demographics

(2) Coordinates program activities and suicide prevention activities for MNC-I and its subordinate units.

(3) Evaluates the program's needs and makes appropriate recommendations to the command.

(4) Review and refine the program based on continuous evaluation of needs.

(5) Develops awareness training concerning MNC-I suicide prevention activities and identifies appropriate forums for training.

(6) Evaluates the impact of the pace of combat operations and other stressors on the behavioral health of service members.

(7) Recommends command policy guidance for training and operations issues to ensure service members and leaders have sufficient opportunity for quality of life and family life.

(8) Reviews publicity generated with respect to suicides in the military community.

(9) MNC-I DCG chairs the board and coordinates the efforts of the committee members, providing overall staff guidance for the board.

Suicide Prevention Pocket Reference Cards

**SUICIDE PREVENTION RISK
FACTOR
ASSESSMENT CARD
(Green Tab)
(Front)**

**SUICIDE PREVENTION RISK
FACTOR
ASSESSMENT CARD
(Green Tab)
(Back)**

ACE
CARD
(All Service Members)
(Front)

ACE
CARD
(All Service Members)
(Back)

Training Resources

The chaplains in theater have the lead on suicide prevention training at the unit level. Unit Ministry Teams can use no-cost effective training such as ACE to train small unit leaders on suicide prevention and intervention skills. These leaders, in turn, can train others leaders and service members (a train-the-trainer method). To be effective, all suicide prevention efforts must include everyone.

There are numerous stock briefs located at the Army G-1 website as well as others listed in the references. The keys to effective training are consistency, relevancy, and the ability to inspire team member participation. Additionally, training should be tailored to the service member's phase of deployment. It should lead the member through expectation management for future phases, warning signs to look for in themselves and others, and coping skills when frustrations arise. Role playing, testimonials, and short-videos (10-15 minutes of high energy) with respected or credible representatives are much more effective and better received than the non-interactive PowerPoint brief typical of many standardized training programs.

Resources

A referral to these resources can be either command directed or self-referred.

- **In Garrison:**

    ✓ Family Life Chaplains

    ✓ Army Community Services

    ✓ Medical Services

    ✓ Marriage and Family Counselors

    ✓ Post Deployment Centers

- **During Deployment:**

    ✓ Combat Stress Control Teams

    ✓ Medics

    ✓ Battalion Aid Station

    ✓ Chaplain

        All returning Soldiers from OIF or OEF can contact the Military One Source @ https://www.militaryonesource.com

Summary

- ❖ Suicide prevention begins before the deployment orders are published and never stops

- ❖ First-line leaders are the First-line of defense

- ❖ Positive life coping skills and resiliency training will reduce negative behaviors

- ❖ Removing barriers to care opens up opportunities to heal

- ❖ Awareness and vigilance, identification and intervention can knock down suicide as a target

- ❖ Teammates take care of Teammates.
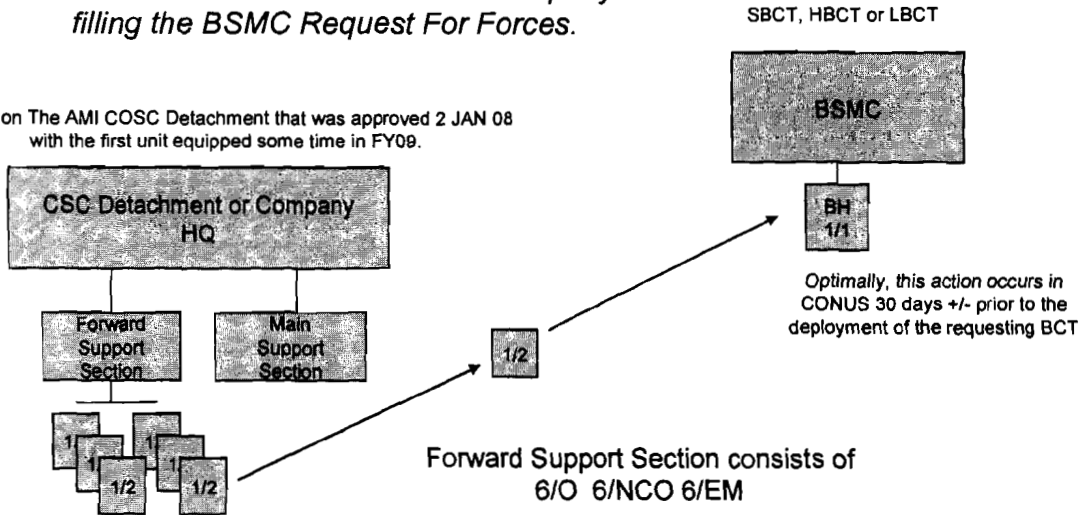
    "One suicide is one too many."

References

- ❖ The Army Suicide Prevention Program, prepared by The American Association of Suicidology & The U. S. Army Center for Health Promotion and Preventive Medicine

- ❖ AR 600-63, Army Health Promotion, dtd 7 May 07

- ❖ DA Pam 600-24, Suicide Prevention and Psychological Autopsy, dtd 30 Sep 88

- ❖ Suicide Prevention Manual: A Resource for the United States Army, prepared by the U. S. Army Center for Health Promotion and Preventative Medicine (USACHPPM), dtd 2007

- ❖ Warrior Resiliency Training: Jarrett, T. Warrior Resilience Training in OPERATION IRAQI FREEDOM: Combining rational emotive behavior therapy, resiliency and virtue ethics. *The AMEDD Journal*, Jul-Sep 2008: 30-36.

- ❖ NATO Leader's Guide to Psychological Support Across the Deployment Cycle, dtd 19 Jan 07

- ❖ MNC-I OPORD 08-01 (Tab A to Appendix 8 to Annex Q), Army Suicide Prevention Program

- ❖ Army G1 website: http://www.armyg1.army.mil/hr/suicide/default.asp

- ❖ Hooah4Health website: http://hooah4health.com/default.htm

- ❖ Suicide Prevention Resource Center website: http://www.sprc.org/

- ❖ LivingWorks.Net website: http://www.livingworks.net/

14. APPENDIX C: DUAL-PROVIDER MODEL

Illustrates a CSC Detachment or Company
filling the BSMC Request For Forces.

SBCT, HBCT or LBCT

Based on The AMI COSC Detachment that was approved 2 JAN 08
with the first unit equipped some time in FY09.

BSMC

CSC Detachment or Company
HQ

BH
1/1

Optimally, this action occurs in
CONUS 30 days +/- prior to the
deployment of the requesting BCT

Forward
Support
Section

Main
Support
Section

1/2

1/2

1/2

Forward Support Section consists of
6/O 6/NCO 6/EM

FM 4-02.51, 2-27 states that prevention teams are flexibly task organized in variety combinations to meet any fluid COSC threat.
The combination for a RFF from an EAC or ASMC may differ from a SBCT or a CAB.