

Mental Health Advisory Team (MHAT) V
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(b)(2)

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The results and opinions presented in this report are those of the Mental Health Advisory Team V members and do not necessarily represent the official policy or position of the Department of Defense, the United States Army, or the Office of The Surgeon General.

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25. EXECUTIVE SUMMARY

25.1 Introduction

The Mental Health Advisory Team (MHAT) V Operation Enduring Freedom (OEF) was established by the Office of the U.S. Army Surgeon General at the request of the Service Chief, Army Central Command (ARCENT).

The mission of MHAT V OEF was to:

4. Assess Soldier mental health and well-being in Afghanistan.
5. Examine the delivery of behavioral health care in Operation Enduring Freedom (OEF).
6. Provide recommendations for sustainment and improvement to command.

During October and November 2007, 699 Soldiers assigned to the (b)(2) (b)(2) completed anonymous Soldier Well-Being surveys. In addition, 190 Soldiers assigned to Task Force (b)(2) the unit conducting the Army Transition Team mission completed the same surveys. Finally, anonymous surveys were completed by 23 behavioral health, 40 primary care and 24 unit ministry team members.

During the period of 15 October to 30 November the MHAT V OEF team (a) processed and analyzed survey data, (b) examined secondary data sources, and (c) conducted focus group interviews with Soldiers, behavioral health personnel, and medical personnel. The MHAT V OEF team report and recommendations are based on these data sources.

25.2 OEF 2007 Central Findings: Soldiers

1. OEF 2007 Soldiers in Brigade Combat Teams (BCTs) reported combat levels comparable or higher to OIF 2007 Soldiers in BCTs. Combat levels are a key determinant of mental health status.
2. Deployment length and family separation were the top non-combat issues.
3. Soldier morale was similar to OIF but lower than OEF 2005.
4. OEF 2007 Soldiers had higher rates of mental health problems than OEF 2005 Soldiers and comparable or higher rates to OIF 2007 Soldiers.
5. Good leadership was a key factor in sustaining Soldier mental health and well-being.
6. OEF 2007 Soldiers reported more barriers to accessing behavioral health (BH) care than OIF 2007 Soldiers.
7. For OEF 2007 Soldiers with mental health problems, more reported receiving mental health care than OIF 2007 and OEF 2005 Soldiers.
8. Approximately 17% of OEF 2007 Soldiers reported taking mental health medications; one-half of those medications were sleep medications.

25.3 Summary of OEF Behavioral Health Personnel Findings

1. OEF BH personnel were predominantly Air Force (61%) and had significantly less time in theater than BH personnel in OIF.
2. OEF BH personnel supported more locations (30 vs. 9) and took more time to travel (including prep time) to locations (39 hrs vs. 8 hrs) than BH personnel in OIF.
3. OEF BH personnel conducted Combat & Operational Stress Control (COSC) outreach less often than OIF (conduct several times a week: OEF 17% vs. OIF 52%).
4. Major changes were made during and immediately following MHAT V OEF in terms of distribution of BH assets and conducting an aggressive outreach program. In addition, the CJTF-82 Command Surgeon appointed the CSC Commander as the BH Consultant.

25.4 Summary of OEF Primary Care (PC) Personnel Findings

1. OEF Primary Care personnel helped service members with MH problems as often as OIF PC personnel (40% at least weekly).
2. There was a trend toward PC personnel referring service members with MH problems more often than OIF PC personnel (38% vs. 26% at least weekly).

25.5 Summary of OEF Unit Ministry Team Personnel Findings

1. OEF UMT personnel supported more locations (28 vs. 18) than OIF UMT personnel.
2. OEF UMT personnel communicated less often with BH (OEF 17% frequently/always vs. 52%) and PC (62% frequently/always vs. 86%) personnel than OIF UMT personnel.

25.6 Summary of OEF Suicide Assessment

1. Since the beginning of OEF (DEC 2001), there have been 15 confirmed Army suicides. Theater rates of suicide have held steady, ranging from 16 to 22 per 100,000 since 2002 (except for 2003), and are higher than the total Army 10-year rate of 10.6 per 100,000.
2. There was no formal suicide prevention training program in OEF to ensure that Soldiers receive the latest standardized training.
3. There is no single, joint tracking system capable of monitoring suicide, mental health evacuations, and the use of mental health/combat stress control services in a combat environment.

25.7 Summary of TF (b)(2) (Transition Team) Findings

1. Compared to (b)(2) Soldiers, TF (b)(2) Soldiers were older, higher ranking, more likely to be married, and in theater fewer months. They reported fewer combat experiences and less concern about deployment stressors. These factors are related to better mental health.
2. Compared to (b)(2) Soldiers, TF (b)(2) Soldiers had higher morale, were less likely to report mental health problems, reported less stigma and barriers to BH care; rated their leadership less favorably, and had a higher number of Soldiers using alcohol while in theater.

25.8 Key Recommendations

25.8.1 *During Deployment*

1. Every 3 months and following significant events, rotate remote units back to more established FOBs for a minimum of 7 days (+ travel time) in order to allow them to re-set.
2. Re-structure R&R program to give priority to Soldiers working outside the basecamp.
3. Develop and monitor work cycles using Combined Arms Doctrine Directorate (CADD) Sleep Management guidance and encourage treatment seeking for sleep problems.
4. Follow MEDCOM policy on in-theater Battlemind Psychological Debriefings after deaths, serious injuries and other significant events.
5. Focus BH outreach on platoons with the highest levels of combat and conduct outreach using the Proximity, Immediacy, Expectancy and Simplicity (PIES) model.
6. Require BH providers from all services be qualified to travel throughout the theater in order to conduct outreach.
7. Mandate all combat medics and Chaplains receive Battlemind Warrior Resiliency (formerly Battlemind First Aid) Training before deploying to OEF or OIF.
8. Appoint BH consultant to the Command Surgeon who has knowledge of the theater and authority to assign BH personnel in an optimal configuration.

25.8.2 *Post-Deployment/Sustainment*

9. Tailor interventions to units based on their level of combat experiences.
10. To facilitate Soldiers reintegrating with their families and transitioning home, ensure Soldiers receive mandated Post-Deployment Battlemind Training.
11. Provide Spouse/Couples Battlemind Training to improve relationships and facilitate transitioning home.
12. Require NCO and Junior Officers receive Battlemind for Junior Leaders Training.
13. Educate and train NCOs and Officers about the important role they play in maintaining Soldier mental health and well-being and reducing stigma/barriers by including behavioral health awareness training in ALL leader development.
14. Hold leaders accountable for directly or indirectly demeaning Soldiers that seek behavioral health resources.

25.8.3 *Suicide Prevention*

15. Tailor suicide prevention training to the deployment cycle. Ensure training is scenario-based and includes buddy-aid and leader actions.

26. BACKGROUND AND LIMITATIONS

26.1 Background

This report presents findings from the Mental Health Advisory Team Operation Enduring Freedom (MHAT V OEF). The MHAT V deployed teams to Iraq and Afghanistan in October and November of 2007. This report presents the findings from the OEF Theater. The mission and scope of activities of the MHAT V OEF were approved by the Army Central Command (ARCENT) Service Chief. The MHAT V OEF members were assigned to (b)(2) (b)(2) and worked directly under the supervision and control of the Command Surgeon, (b)(2). Previous MHAT assessments (MHATs I-IV) have been conducted in Iraq since the beginning of Operation Iraqi Freedom (OIF). An additional MHAT assessment (MHAT IIb) was conducted in Afghanistan in 2005.

26.1.1 MHAT Mission

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

26.1.2 MHAT Scope of Activities

The MHAT is designed to:

1. Assess the mental health and well-being of the deployed force, and identify trends by comparing findings from OEF 2007 to those from OIF 2007 as well as the findings from OEF 2005.
2. Review behavioral health policies, programs, and structure to ensure optimal integration/utilization.
3. Review suicide prevention efforts.
4. Assess ethical issues faced by Soldiers to enhance future battlefield ethics training. This activity was included in a previous MHAT (MHAT IV) at the specific request of the CG, Multi National Forces-Iraq (MNF-I).

26.2 Limitations

MHAT recommendations are based upon many sources of information to include survey data from Soldiers and providers and focus groups. One of the primary sources for data comes from the anonymous Soldier Well-Being surveys collected as part of the effort. Soldier survey data are valuable because they provide a way to summarize responses from a large number of Soldiers and examine trends and patterns that would otherwise be impossible to detect. Despite these strengths, there are two limitations associated with the Soldier survey data that need to be highlighted – issues related to the validity of certain scales and the sampling scheme used to collect the data.

26.2.1 Scale Validity

Many of the constructs assessed in the survey are measured using validated scales. For instance, the items used to assess Post-Traumatic Stress Disorder (PTSD) are widely used in

civilian and veteran settings and have been subsequently validated in active-duty Army populations (Bliese, Wright, Adler, Cabrera, Hoge & Castro, in press). Validated scales have established norms that make it possible to state with some degree of certainty that a specific score (e.g., a score of 50 on the Post-Traumatic Stress Disorder Check List -- PCL) is an indicator of the clinical condition being measured (e.g., PTSD). In the current survey, however, validated measures were not available for all constructs. For instance, the measures of ethical issues developed for the previous MHAT missions have not been validated. The use of un-validated scales provides flexibility in assessing battlefield conditions; nonetheless, in cases where un-validated scales without established norms are used, the interpretation of the data is more subjective than in cases where validated norms exist.

26.2.2 Sampling Scheme

A second limitation with the survey data is that respondents were not sampled using a random sampling design. A commonly used sampling design is a stratified random sample where relevant sub-populations are identified (e.g., type of unit, gender or rank), and individuals are randomly selected from these sub-populations. While this design has many statistical advantages, it was considered logistically unfeasible to implement in a combat environment. In addition, this sampling design would require access to personally identifying information among deployed Soldiers and was not permitted under the current MHAT human use protocol because it would raise concerns about confidentiality.

Cluster sampling is an alternative random sampling design that is less precise but potentially feasible in a deployed setting. In this sampling strategy, all members of randomly selected groups provide data. The sampling scheme used for past and present MHATs had elements of a cluster sample. The MHAT V OEF data collection targeted Brigade Combat Teams (BCTs) as well as supporting Task Forces. Specifically, two BCTs, six supporting task forces and one Brigade Transition Team were sampled. Each BCT and Task Force was asked to provide 25 Soldiers from each of their companies. The specific companies and individuals within the companies, however, were selected by the local medical provider rather than by a predetermined random process; consequently, the sampling scheme cannot be considered random.

One issue associated with not having a random sampling scheme is the potential for sampling bias. That is, the individuals who selected the specific Soldiers to complete surveys could introduce bias by selecting either highly symptomatic or highly non-symptomatic Soldiers. While possible, the MHAT OEF team has no reason to believe that Soldiers were systematically picked in any way that would bias the results. It is common, for instance, to select individuals to complete surveys based on which specific platoon or platoons have down-time the day the survey administration is scheduled.

26.3 Mitigating the Limitations

26.3.1 Current Report

The current report compares responses on MHAT V OEF (2007) with MHAT IIB OEF (2005) and MHAT V OIF (2007). Throughout this report these MHAT sample populations will be identified and referred to as *OEF 2007*, *OEF 2005* and *OIF 2007*.

Comparisons between sample populations were made using unadjusted and adjusted values. In most cases, unadjusted values are presented. However, when unadjusted values differ from

adjusted values or when there are theoretical reasons to do so, such as the relationship between Soldier mental health and deployment length, adjusted values are also reported. In addition, to mitigate the limitations associated with both un-validated scales and non-random sampling, the MHAT V OEF report relied heavily on statistical modeling to draw inferences. That is, in addition to presenting unadjusted values, the analyses focused on whether responses to variables of interest are related to factors such as time in theater or the number of previous deployments.

The use of statistical modeling has two additional advantages. First, it provides a way to compare responses over time while adjusting for sample differences. Specifically, the current report compares responses from OEF 2007 with those from OEF 2005 and OIF 2007. All three theaters used virtually identical sampling designs, so it is reasonable to conclude that sampling bias (if it exists) would be comparable. In making comparisons, the analyses adjust for demographic sample differences in (1) gender, (2) rank, and (3) months deployed. This helps ensure that observed differences are not merely due to demographic differences in the two samples.

Second, by using statistical modeling, adjusted mean values can be used in figures to illustrate differences or similarities across years. The use of adjusted means effectively equalizes the OEF 2005, OEF 2007 and OIF 2007 samples on key demographic variables. In reporting adjusted means, we generally provide estimated values for a prototypical Soldier defined as a (1) male, (2) junior enlisted (3) deployed for nine months.

Adjusted means were estimated from either a logistic regression model or a linear regression model depending upon the nature of the dependent variable. 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). GLMMs were not used throughout because a fairly large percentage of Soldiers failed to provide their complete unit information and thus GLMM models had to be run on a sub-sample of those who provided complete unit information.

All analyses in this report were run in the statistical language R (R Core Development Team, 2007), and replicated by a second member of the research team using the Statistical Package for the Social Sciences program (SPSS).

26.3.2 Future MHAT Missions

Future MHAT missions should consider implementing a cluster sampling design. One way to do this would be to require all platoon members from 2 randomly selected platoons within each selected company to complete the survey (a census sample of randomly selected platoons). Using this alternative will eliminate the possibility of bias.

26.4 Data Handling Procedures

All surveys were distributed and collected through the medical chain of custody or by MHAT V OEF members. Respondents returned surveys in sealed envelopes to ensure anonymity and confidentiality. Procedures were put into place to ensure that datasets were adequately de-identified and that surveys were properly destroyed. A neutral third-party (the Army Audit Agency) observed the survey handling and database creation process (Appendix A).

27. OVERVIEW OF SOLDIER WELL-BEING

The MHAT V Soldier Well-Being survey contains the same core survey measures used in all previous MHATs. MHAT surveys are adapted from the Land Combat Study conducted by the Walter Reed Army Institute of Research (Hoge, Castro, Messer et al., 2004; Hoge, Terhakopian, Castro et al., 2007).

27.1 Soldier Combat & Well-Being Model

The MHAT V survey covers: (1) Risk Factors, such as combat and deployment experiences; (2) Protective Factors, such as training and willingness to seek care; and (3) Behavioral Health Status and Performance Indices (see Figure 1).

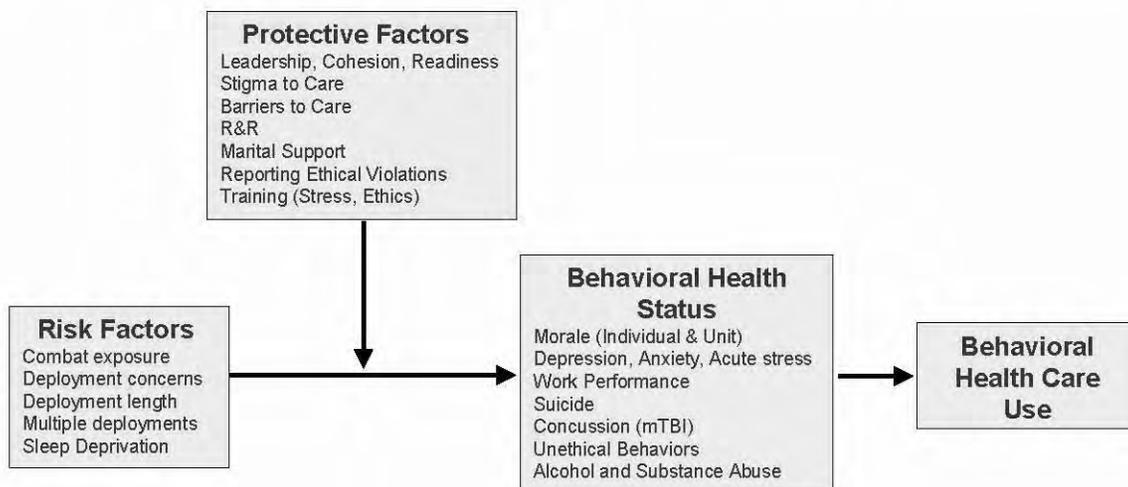


Figure 1. Soldier Combat & Well-Being Model (Adapted from Bliese & Castro, 2003).

27.1.1 Risk Factors

The model assumes that the behavioral health and performance of Soldiers is influenced by both environmental (e.g., exposure) and individual-level risk factors (e.g., sleep quality). One goal of the annual MHAT reports is to systematically evaluate changes in risk factors. A second goal is to determine whether new risk factors have emerged.

In this regard, the current OEF 2007 report will specifically examine the following:

6. Whether exposure to combat-related risk factors is significantly different when compared to OEF 2005 and OIF 2007.
7. Whether deployment concerns in OEF 2007 are significantly different from OEF 2005 and OIF 2007.
8. The degree to which reports of sleep deprivation are related to behavioral health and reports of sleep-related accidents and mistakes.

27.1.2 Protective 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 (protective factors). The current OEF 2007 report examines:

5. Whether there are systematic changes in protective unit variables such as perceptions of positive leadership, readiness and cohesion.
6. Whether willingness to seek care and access to care has changed, and how Soldiers might be encouraged to seek care.
7. Whether systematic changes in family support are evident when compared to OEF 2005 and OIF 2007.

27.1.3 Behavioral Health and Performance

Across the five years of MHAT missions, a consistent set of behavioral health status variables have been assessed. These include:

4. Individual and Unit Morale
5. Acute Stress (PTSD), Depression and Anxiety
6. Suicides and Suicidal Ideation

In addition to evaluating the indicators listed above, the current report also evaluates a series of variables related to either various aspects of well-being or performance to include:

5. Self ratings of the degree to which stress and emotional problems have impacted performance.
6. Use of alcohol and substance abuse in theater.
7. Soldiers' reports of unethical behaviors towards non-combatants.

Overall, these indicators provide a comprehensive assessment of the behavioral health status and performance of Soldiers deployed to Afghanistan.

27.2 OEF 2007 Soldier Sample and Methods

The OEF 2007 assessment of Soldiers focused on companies from brigade combat teams (BCTs) and supporting Task Forces (TFs) located primarily in the (b)(2)

(b)(2)

Brigade Combat Teams and Task Forces represented in the assessment are listed in Table 1. These units had Soldiers complete the Soldier Well-Being survey and provided individuals to complete the behavior health (BH), primary care (PC) or unit ministry team (UMT) surveys. In addition, selected units also provided Soldiers for focus group interviews.

(b)(2)

Table 1. Task Forces in OEF

27.3 Demographics and Comparison with MHAT OEF 2005 and OIF 2007

In the analyses detailed in this report, Soldier responses to the OEF 2007 survey (n=699) are compared to responses to the OEF 2005 survey (n=610) and the OIF 2007 survey (n=2195). For each of these assessments, the sampling strategy was virtually identical; nonetheless, there

were some demographic differences in the samples. Table 2 details key demographic variables across the three sample populations. The differences include:

1. Significantly fewer OEF 2007 respondents were active duty Soldiers (81%) compared to OIF 2007 (95%). However significantly more OEF 2007 respondents were active duty compared to OEF 2005 (72%).
2. Similar to OIF 2007, the majority of OEF 2007 respondents were junior enlisted, whereas OEF 2005 had a greater number of NCO respondents.
3. OEF 2007 Soldiers spent significantly less time in theater (7.7 months) at the time they completed the surveys compared to OIF 2007 (9.4 months) and OEF 2005 (9.6 months).

Although significant component differences exist between the three sample populations, analyses found no evidence of systematic differences in outcomes such as morale or mental health as a function of active versus reserve component, so this variable was not included as a control.

When drawing comparisons across the sampled populations, differences were evaluated using adjusted and unadjusted percents. When adjusted percents are reported, the demographic variables of gender, rank, and months in theater were statistically controlled to ensure that observed differences are not merely caused by demographic differences in the samples. For instance, when comparing combat experiences across samples, it is important to normalize the length of time Soldiers have deployed to determine whether there has been either a decline or escalation in combat intensity. Adjusted values are typically provided for male, E1-E4, in theater for nine months.

Table 2: Demographic Comparison - MHAT OEF 2005, OIF 2007 and OEF 2007

Demographic Variable	OEF 2005		OIF 2007		OEF 2007	
	n	Percent	n	Percent	n	Percent
Gender						
Male	528	86.8%	1983	90.3%	628	89.8%
Female	80	13.2%	206	9.4%	71	10.2%
Unknown	2	0.3%	6	0.3%	0	0.0%
Age						
18-19	18	3.0%	87	4.0%	25	3.6%
20-24	250	41.1%	1102	50.2%	316	45.3%
25-29	150	24.7%	539	24.6%	168	24.1%
30-39	144	23.7%	378	17.2%	145	20.8%
40+	46	7.6%	86	3.9%	44	6.3%
Unknown	2	0.3%	3	0.1%	1	0.1%
Rank						
E1-E4	275	45.1%	1315	59.9%	398	57.1%
NCO	295	48.4%	720	32.8%	250	35.9%
Officer / WO	38	6.2%	150	6.8%	49	7.0%
Unknown	2	0.3%	10	0.5%	2	0.3%
Component						
Active	437	71.6%	2091	95.3%	569	81.4%
Reserve	109	17.9%	49	2.2%	51	7.3%
National Guard	56	9.2%	44	2.0%	64	9.2%
Unknown	8	1.3%	11	0.5%	15	2.1%
Marital Status						
Single	229	37.5%	924	42.1%	291	41.6%
Married	331	54.3%	1076	49.0%	353	50.5%
Divorced	43	7.0%	132	6.0%	37	5.3%
Unknown/Widowed	7	1.1%	63	2.9%	18	2.6%
Time in Theater						
6 Months or Less	42	6.9%	456	20.8%	165	23.5%
6 to 12 Months	540	88.2%	1318	60.0%	478	68.2%
Over 12 Months	NA	NA	256	11.7%	10	1.4%
Unknown	30	4.9%	166	7.6%	48	6.8%

28. SOLDIER BEHAVIORAL HEALTH AND PERFORMANCE INDICES

In the conceptual model in Figure 1, Soldier behavioral health and performance are viewed as outcomes determined by risk factors and protective factors. This report begins by examining these outcomes, and uses subsequent chapters on risk factors and protective factors to interpret behavioral health and performance results. In most cases, health and performance indices for OEF 2007 are examined relative to data from OEF 2005 as well as OIF 2007. However, in OEF 2007, surveys were completed by BCT and supporting Task Force Soldiers whereas in OIF 2007, only BCT Soldiers completed surveys. There are differences in BCT Soldiers and supporting TF Soldiers both demographically and in the missions they complete. Therefore, in some cases, additional analyses were conducted comparing data from BCT Soldiers in OEF 2007 with BCT Soldiers in OIF 2007.

28.1 Individual and Unit Morale

28.1.1 Morale: OEF 2005, OIF 2007 and OEF 2007

Soldiers' ratings of individual morale were significantly lower in OEF 2007 compared to OEF 2005 but similar to ratings in OIF 2007. However, ratings of unit morale did not differ significantly for the three populations. The percentage of Soldiers reporting high or very high individual and unit morale are presented in Figure 2. When these percentages are adjusted to control for gender, rank and months in theater, then unit morale in OEF 2007 (9%) is significantly lower ($p < 0.05$) than unit morale in OIF 2007 (11.9%).

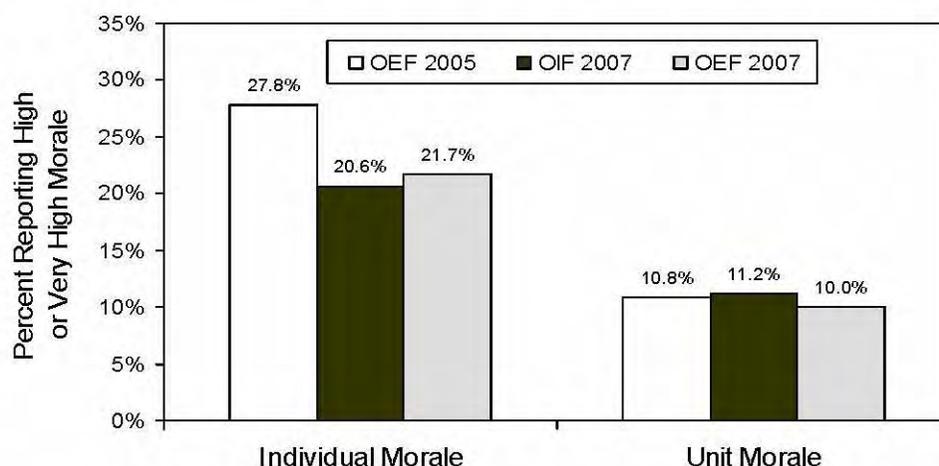


Figure 2: Unadjusted Rates for Individual and Unit Morale

28.1.2 Morale: Medium, High or Very High

An alternative way to look at morale is to examine the percent of Soldiers who rate morale as being medium, high or very high. Using this breakdown, a significantly lower percent ($p < 0.001$) of OEF 2007 Soldiers (57.4%) reported medium, high or very high individual morale compared to OEF 2005 (68.4%). Rates for individual morale for OEF 2007 were similar to OIF 2007 (57.3%). For unit morale, a significantly lower percent ($p < 0.01$) of OEF 2007 Soldiers (45.1%) reported medium, high or very high morale compared to OEF 2005 (52.5%) rates and significantly lower rates ($p < 0.05$) compared to OIF 2007 (49.7%). This pattern of differences was similar when demographic differences were controlled.

28.2 Behavioral Health: Acute Stress (PTSD), Depression and Anxiety

Soldiers' ratings of depression, generalized anxiety and acute stress (i.e., PTSD) were assessed using standardized, validated scales (Spitzer, Kroenke, & Williams, 1999; Weathers, Litz, Herman, Huska, & Keane, 1993). The scales were identical to the measures used in previous MHAT surveys, and have formed the basis of peer-reviewed publications from the Walter Reed Army Institute of Research (WRAIR) (e.g., Bliese, et al., 2007; Hoge et al., 2004; Hoge, et al., 2007). Details on scoring specific scales are available in previous MHAT reports.

28.2.1 Behavioral Health: OEF 2005, OIF 2007 and OEF 2007

Figure 3 presents the overall percents of Soldiers scoring positive for depression, generalized anxiety, acute stress or any of these three. Rates for depression, anxiety, acute stress and any mental health problem in OEF 2007 were significantly higher ($p < 0.001$) than those reported in OEF 2005. There was a tendency for Soldiers in OEF 2007 to report higher depression and anxiety values than Soldiers in OIF 2007; however, using a conventional criterion of $p < .05$, these differences were not statistically significant. If these percentages are adjusted to control for gender, rank and months in theater, then rates on all scales for OEF 2007 remain significantly greater than OEF 2005 and additionally the rate of depression in OEF 2007 (11.4% vs. 7.6%) was significantly higher than OIF 2007 ($p < 0.01$).

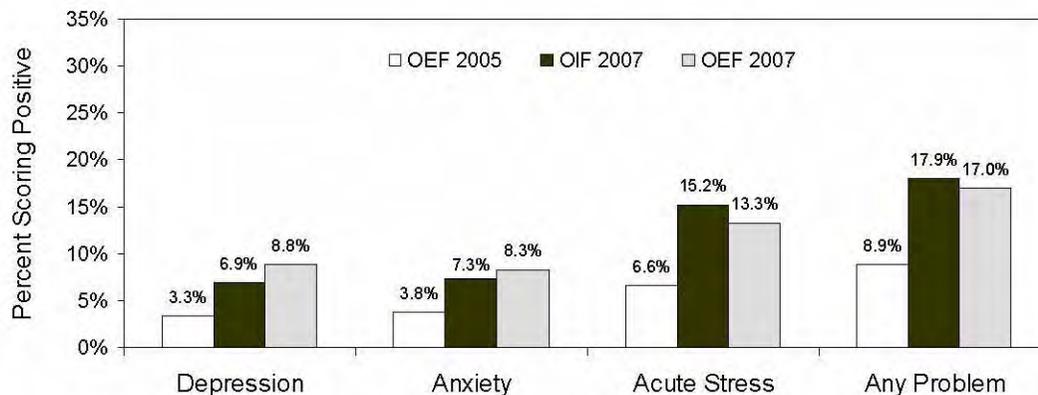


Figure 3: Unadjusted Rates for Behavioral Health

28.2.2 Behavioral Health 2007 Brigade Combat Teams Only

As previously stated, in OEF 2007, surveys were completed by Soldiers in supporting task forces as well as Brigade Combat Teams (BCTs). However, surveys in OIF 2007 were completed by Soldiers in BCTs only. Therefore additional analyses were run to compare OEF 2007 BCT Soldiers with OIF 2007 BCT Soldiers. These analyses are presented below in Figure 4. A significantly higher percent of OEF 2007 BCT Soldiers screened positive for depression compared to OIF 2007 Soldiers using both unadjusted ($p < 0.01$) and adjusted ($p < 0.001$) rates. Although unadjusted rates for anxiety and any mental health problem in OEF 2007 BCT Soldiers tended to be higher than OIF 2007 BCT Soldiers, these differences were not statistically significant. However, when controlling for gender, rank and time in theater, the OEF 2007 BCT Soldiers were more likely to screen positive for depression ($p < 0.001$), anxiety ($p < 0.01$) and any mental health problem ($p < 0.05$).

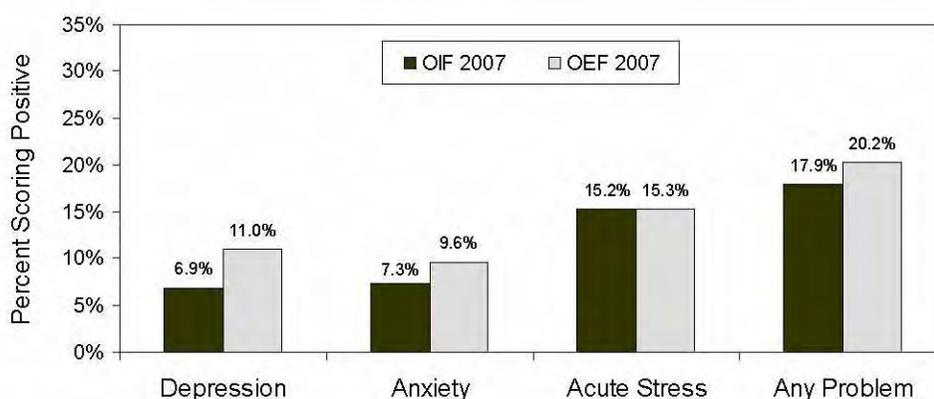


Figure 4: Unadjusted Rates for Brigade Combat Teams Only

28.3 Stress and Work Performance

There are a number of reasons to track mental health rates across deployments including the need to resource behavioral health care delivery. From an organizational perspective, however, mental health problems are also important to track because psychological well-being has been shown to be a direct pre-cursor of performance (Lang, Thomas, Bliese & Adler, 2007). In the Soldier Well-Being survey, work performance is assessed with three items where Soldiers indicate whether stress or emotional problems in the last four weeks have:

4. Limited your ability to do your job.
5. Caused you to do work less carefully than usual.
6. Caused your supervisor to be concerned about your performance.

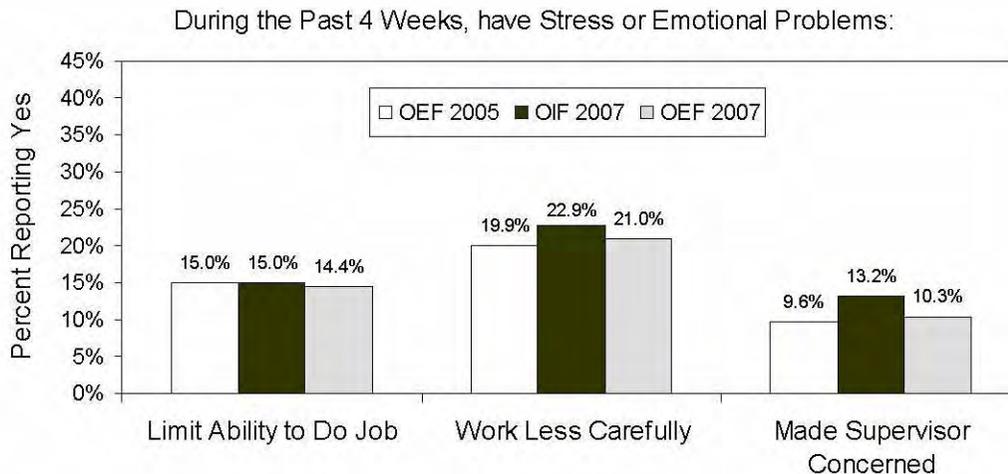


Figure 5: Unadjusted Rates

Figure 5 contrasts responses from OEF 2005, OIF 2007 and OEF 2007. No significant differences were found between the three populations on any of these three parameters using either adjusted or unadjusted rates.

28.4 Suicidal Ideation

Suicide rates in OEF have been above the Army 10-year average for every year except 2003; consequently, the current report contains a detailed section on suicide. Suicidal ideation, however, can also be examined using a single depression item on the Soldier Well-Being survey. This is the last item (item 9) of the PHQ-D (Spitzer, Kroenke, & Williams, 1999). This item 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. Responses range from "Not at all" to "Nearly every day"; any response other than "Not at all" is considered a positive response. A significantly higher percentage of OEF 2007 Soldiers ($p < 0.001$) indicated suicide ideation compared to OEF 2005 (15% vs. 8%) whereas suicide ideation was similar for both OEF 2007 and OIF 2007 (15% vs. 13%, respectively). When comparing these populations using adjusted values, the same pattern of significance was found. Furthermore, 87% of OEF 2007 Soldiers reported receiving suicide prevention training, however only 51% reported the training to be sufficient, indicating the need to ensure that Soldiers receive suicide prevention training that is applicable to a combat environment.

28.5 Social Relationships: Divorce

Another possible indication of behavioral health problems is the percentage of Soldiers who report that they intend to divorce. Significantly more Soldiers were planning to get divorced ($p < 0.01$) in OEF 2007 (19%) compared with OEF 2005 (13%). Soldiers' reports of their intent to divorce did not differ significantly when comparing OEF 2007 and OIF 2007 (19%). This pattern was the same using adjusted values.

28.6 Concussion (mTBI)

A series of questions evaluated whether Soldiers had experienced one of four possible head injuries, and whether they had been evaluated for a concussion by a medical professional. These questions are unique to MHAT V and therefore comparisons to OEF 2005 cannot be made. The specific questions were:

How many times during this deployment did you have an injury that involved the following (response options ranged from “never” up to “five or more times”):

- Injury to your head
- Being dazed, confused, or “seeing stars”
- Not remembering the injury
- Losing consciousness

During this deployment were you evaluated by a medical professional for a concussion? (yes /no)

Responses to the head injury questions were scored as “never” versus “one or more times”. Figure 6 shows the percent of Soldiers who reported receiving the specific injury at least once and the percent that were evaluated by a medical professional for a concussion. Figure 6 also shows the percent of Soldiers who met the criteria for screening positive for a mild Traumatic Brain Injury (mTBI). To screen positive for mTBI, Soldiers had to report having been injured and also report (a) being dazed and confused, (b) not remembering the injury or (c) losing consciousness. Note that the estimates in Figure 6 may be biased downward because a number of Soldiers have been evacuated from theater because of explosions. Overall, a slightly higher percentage of OEF 2007 Soldiers screened positive for mTBI compared to OIF 2007. However, a lower percentage of OEF 2007 Soldiers reported being evaluated for a concussion compared to OIF 2007 Soldiers.

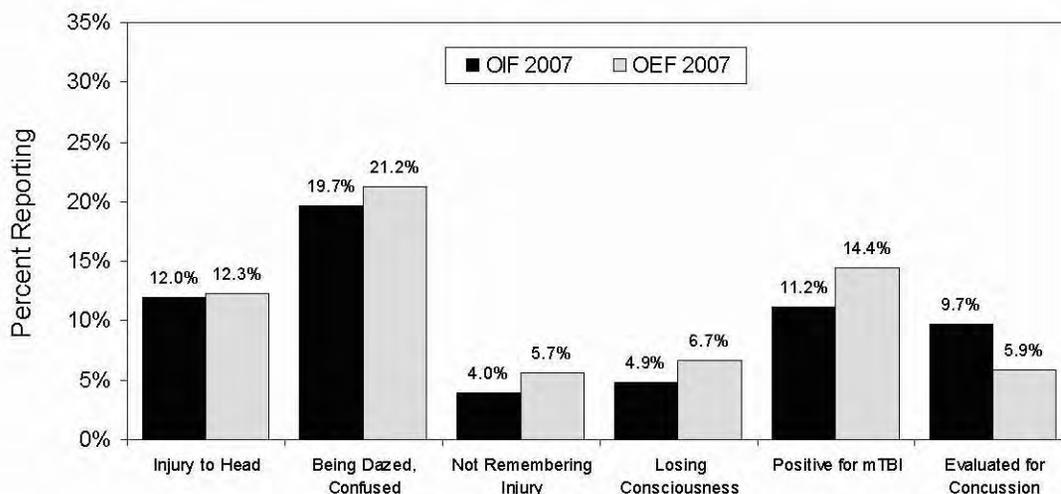


Figure 6: Unadjusted Rates for Head Injuries and Concussion

Figure 7 breaks down the percents in Figure 6 and shows the percent of Soldiers who reported head injuries who also reported being evaluated by a medical professional for a concussion in OEF 2007 compared to OIF 2007. For instance, 21.2% of the OEF 2007 Soldiers reported having an injury that involved “Being dazed, confused or “seeing stars” (Figure 6). Figure 7 shows that 4.4% of the 21.2% were evaluated for a concussion while 16.8% (not shown) of the 21.2% were not evaluated. Overall, Figure 7 shows that less than half of the Soldiers who

report mTBI also report being evaluated for a concussion. Also, despite having more OEF 2007 Soldiers screening positive for mTBI, a similar percent or lower were seen by a medical professional compared to OIF 2007 Soldiers.

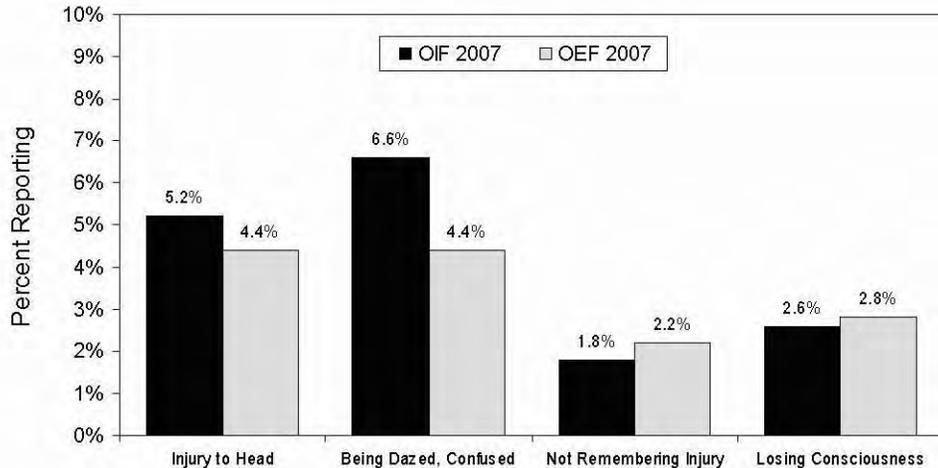


Figure 7: Evaluated for Head Injuries and Concussion (Unadjusted Rates)

28.7 Alcohol and Substance Abuse

The reported use of alcohol in OEF 2007 was significantly lower ($p < 0.01$) (7%) compared to OEF 2005 (12%). However, significant differences were not found when the values were adjusted for gender, rank and time in theater. Reported alcohol usage in OIF 2007 (8%) was similar to OEF 2007 (8%).

Reported use of illegal drugs or substances was significantly higher ($p < 0.05$) in OEF 2007 (2.6%) compared to OIF 2007 (1.4%). These statistical differences were also found when adjusting for gender, rank and time in theater. Rates of illegal drug use were similar in OEF 2007 and OEF 2005 (2.3%) using both adjusted and unadjusted values.

28.8 Unethical Behaviors

In 2006, ethical issues were included in the MHAT IV Soldier Well-Being survey at the request of the MNF-I Commander. The questions specifically addressed the issue of battlefield ethics and the adequacy of battlefield ethical training for preparing Soldiers to conduct combat operations in Iraq. As noted in the MHAT IV report, MHAT IV members and other military subject matter experts (SMEs) developed a set of unique survey questions. These questions assessed four dimensions:

5. Dimension 1: Attitudes Regarding the Treatment of Insurgents and Non-Combatants
 - a. Five questions, scored on a five-point scale ranging from Strongly Disagree to Strongly Agree.
 - b. A sample item is "All non-combatants should be treated with dignity and respect."

6. Dimension 2: Battlefield Ethical Behaviors and Decisions
 - a. Five questions scored on a scale from Never, One Time, Two Times, Three or Four Times to Five or More Times
 - b. A sample item is "Insulted and/or cursed non-combatants in their presence."
7. Dimension 3: Reporting Ethical Violations
 - a. Six questions scored on a five-point scale ranging from Strongly Disagree to Strongly Agree
 - b. A sample item is "I would report a unit member for the mistreatment of a non-combatant."
8. Dimension 4: Battlefield Ethics Training
 - a. Five questions scored on a "Yes" or "No" response scale
 - b. A sample item is "The training I received in the proper (ethical) treatment of non-combatants was adequate."

The four dimensions provide different information and fit into different parts of the conceptual model presented in Figure 1. Battlefield ethics training (Dimension 4) theoretically serves as a protective factor as does a Soldiers' willingness to report ethical violations (Dimension 3). They are protective because high responses to either Dimension 3 or Dimension 4 should be associated with a reduction in the number of unethical behaviors reported by Soldiers.

Attitudes regarding the treatment of insurgents and non-combatants (Dimension 1) may be influenced by training and may also be a pre-cursor to behavior. Social psychological literature indicates that the direct link between attitudes and actual behavior is quite weak (Fishbein & Ajzen, 1976); therefore in this report, we focus on modeling reported behavior (Dimension 2) rather than focusing on attitudes (Dimension 1).

One of the central findings from MHAT IV was that Soldiers and Marines were more likely to report they had engaged in unethical behavior if they had also screened positive for behavioral health problems such as depression, anxiety or acute stress or if they reported high levels of anger. Therefore, this section of the reports re-examines the relationship between unethical behaviors and behavioral health status. Below is an assessment of whether reports of unethical behaviors differ between OEF 2007 and OIF 2007. Questions relating to ethical behavior were not included in the OEF 2005 survey and therefore comparisons with that population are not made.

28.8.1 Reports of Unethical Behaviors Compared to OIF 2007

The incidence of unethical behavior is determined by whether Soldiers report:

6. They insulted and/or cursed non-combatants in their presence.
7. They damaged and/or destroyed private property when it was not necessary.
8. They physically hit/kicked a non-combatant when it was not necessary.
9. Unit members "modified" the rules of engagement in order to accomplish the mission.
10. Unit members "ignored" the rules of engagement in order to accomplish the mission.

As noted in the limitations section of this report, one of the potential limitations associated with interpreting the ethics questions is that it was necessary to use un-validated scales. As such, there are no established norms upon which to help interpret the items. As mentioned earlier,

these questions were not included in the OEF 2005 survey therefore the current report only presents comparisons for OEF 2007 relative to OIF 2007. Approximately 10% of OEF 2007 Soldiers reported damaging or destroying property when it was not necessary while almost 4% reported that they hit or kicked non-combatants when it was not necessary. The comparison of responses across theaters is presented in Table 3. Using the convention p-value of $p < .05$, the analyses reveal that for most questions, responses did not differ between the two theaters. The only significant difference ($p < 0.001$) was found for Question 1, in which 36.6% of OEF 2007 Soldiers reported they “Insulted and/or cursed non-combatants in their presence” compared to 29.6% of OIF 2007 Soldiers. This relationship was also significant for adjusted values ($p < 0.001$).

Table 3: Treatment of Non-Combatants (Unadjusted Percents).

Unethical Behavior Variable	Percent Reporting One Time or More		p-value
	OIF 2007	OEF 2007	
1. Insulted and/or cursed non-combatants in their presence.	29.6%	36.6%	0.00
2. Damaged and/or destroyed private property when it was not necessary.	11.9%	9.8%	0.12
3. Physically hit/kicked a non-combatant when it was not necessary.	5.0%	3.9%	0.24

28.8.2 Mental Health and Unethical Behaviors in OEF 2007

Earlier MHAT reports have identified a relationship between mental health and unethical behaviors. That is, Soldiers who screened positive for mental health problems of depression, anxiety or acute stress were significantly more likely to report engaging in unethical behaviors. This relationship was also found in OEF 2007. Specifically, Soldiers who screened positive for any mental health problem were more than twice as likely to report engaging in unethical behaviors as those who did not screen positive for a mental health problem (Table 4).

Table 4: Treatment of Non-Combatants as a Function of Mental Health Status (Unadjusted Percents).

Unethical Behavior Variable	Positive for Mental Health Problem		p-value
	No	Yes	
1. Insulted and/or cursed non-combatants in their presence.	31.7%	60.7%	0.00
2. Damaged and/or destroyed private property when it was not necessary.	7.2%	22.2%	0.00
3. Physically hit/kicked a non-combatant when it was not necessary.	2.5%	11.1%	0.00

This pattern was also found when evaluating reports of unethical behavior as a function of high anger levels (Table 5). This pattern of significance for both measures was also found using adjusted values. That is, reports of unethical behavior were significantly higher for Soldiers who screened positive for a mental health problem or had high levels of anger. These findings indicate that screening positive for mental health problems or high levels of anger is significantly associated with the likelihood that a Soldier will report engaging in unethical behaviors.

Table 5: Treatment of Non-Combatants as a Function of Anger (Unadjusted Percents).

Unethical Behavior Variable	Anger		p-value
	Low	High	
1. Insulted and/or cursed non-combatants in their presence.	21.5%	53.4%	0.00
2. Damaged and/or destroyed private property when it was not necessary.	5.0%	15.1%	0.00
3. Physically hit/kicked a non-combatant when it was not necessary.	1.1%	7.1%	0.00

28.9 Summary of Behavioral Health and Performance Indices

Overall behavioral health in OEF 2007 is significantly lower than in OEF 2005. Soldiers' ratings of individual morale in OEF 2007 were significantly lower than in OEF 2005. Significantly more OEF 2007 Soldiers reported planning to get a divorce compared to OEF 2005 Soldiers. Further, ratings of depression, generalized anxiety and acute stress were significantly higher in OEF 2007 compared to OEF 2005.

Ratings of individual and unit morale and behavioral health were similar for both OEF 2007 and OIF 2007. However, as mentioned earlier, the OEF 2007 sample included Soldiers in BCTs as well as supporting units whereas the OIF 2007 sample only included BCT Soldiers. Therefore, comparisons were made between OEF 2007 Soldiers in BCTs to OIF 2007 Soldiers in BCTs. When using adjusted values, Soldiers in OEF 2007 BCTs reported significantly more overall mental health problems than OIF 2007 Soldiers in BCTs. Self reports of drug use were higher in OEF 2007 than OIF 2007 and more OEF Soldiers reported insulting or cursing non-combatants.

There was also a significant relationship between reported treatment of non-combatants and high levels of anger or any mental health problem for Soldiers in OEF 2007. Soldiers were much more likely to report engaging in unethical behaviors if they had high levels of anger or screened positive for a mental health problem. These factors may serve as key markers for an increased propensity of Soldiers to engage in unethical or inappropriate behaviors.

29. SOLDIER RISK FACTORS

The examination of risk factors serves several purposes. First, it provides a theoretical basis from which to explain changes in Soldier behavioral health and reported performance indices. As noted earlier, Soldiers in OEF 2007 reported lower individual morale, and a greater number of mental health problems compared to OEF 2005. Based on these trends in health and performance outcomes, it would be reasonable to expect that risk factors are higher in OEF 2007 relative to OEF 2005. This expectation will be formally tested in this section. A second reason to examine risk factors is to specifically focus on those known risk factors that can be directly influenced by command and/or behavioral health providers. To this end, the final part of this section focuses on the relationship between sleep deprivation and behavioral and performance related problems.

29.1 Combat Experiences

Exposure to potentially traumatic experiences is one of the principal risk factors for behavioral health problems in combat settings (Fontana & Rosenheck, 1998). In the Soldier Well-Being Survey, combat experiences are measured with 33 items assessing experiences such as “Knowing someone seriously injured or killed” and “Being wounded/injured”. A combat experience score (ranging from 0 to 33) is created by summing the number of reported experiences.

Figure 8 displays the relationship between combat experiences and acute stress for Soldiers in OEF 2007. Soldiers were divided into low, medium and high combat experiences based on the number of combat events that they reported experiencing during the deployment. Soldiers with high levels of combat exposure were significantly more likely to screen positive for acute stress or any mental health problem.

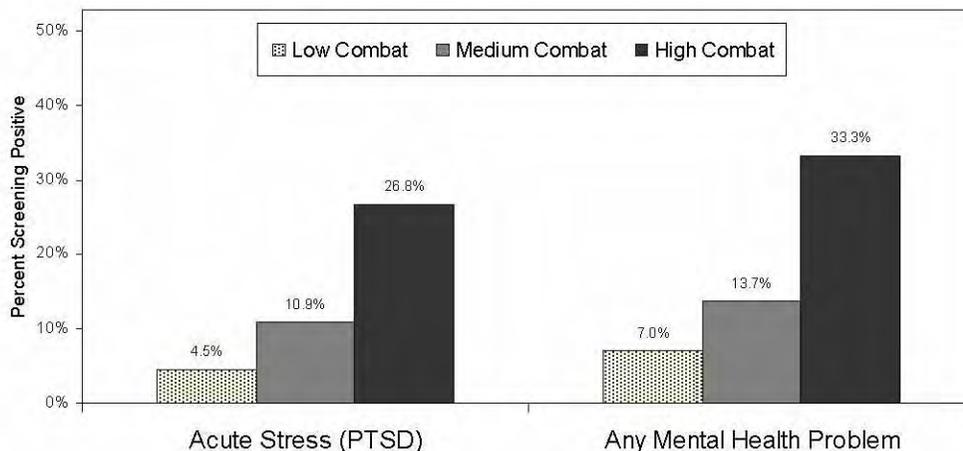


Figure 8: Unadjusted Rates for Combat Experience

Given the importance of combat experiences in terms of behavioral health, the following sections provide a detailed examination of differences between OEF 2007 compared to OEF 2005 and OIF 2007.

29.1.1 Combat Experiences for OEF 2007 Compared to OEF 2005

The following comparisons of combat experiences and Soldier concerns are based on adjusted values. One factor that can significantly impact combat experiences and Soldier concerns is time in theater. The average months in theater for OEF 2007 was 7.66 compared to 9.56 in OEF 2005 and 9.40 for OIF 2007. Therefore comparisons using adjusted values provide a more accurate indication of differences in the three populations and are presented here. Estimated values are provided for a male, junior enlisted Soldier deployed for nine months.

Table 6 provides the percents for items rated in OEF 2007 that significantly differed from OEF 2005. With a conventional p-value of .05, the large number of analyses (33 different tests) raises the possibility that one or two significant results would be observed simply because of the high number of tests conducted; therefore to adjust for the increase in the family-wise error rate, the table only list results with a p-value equal to or less than .01. By using this more stringent p-value, the differences represented in the table are more likely to represent meaningful differences.

Comparison across years indicates a significantly higher combat intensity in OEF 2007 compared to OEF 2005. However, some combat experiences have declined. The pattern of combat experiences reported by Soldiers reflects the changing nature of the war from one of static operations in 2005 to more of a counter-insurgency (COIN) nature in 2007. Additionally this provides evidence that Soldiers' exposure to potentially traumatic combat experiences has increased in OEF.

Table 6: Adjusted Percents for Male, E1-E4 in Theater 9 Months

Combat Experiences	Values		
	OEF 2005	OEF 2007	p-value
<u>Significantly Higher</u>			
Being attacked or ambushed.	49.6%	61.6%	0.00
Seeing dead bodies or human remains.	50.7%	59.2%	0.01
Seeing dead or seriously injured Americans.	44.7%	55.2%	0.00
Knowing someone seriously injured or killed.	65.9%	73.7%	0.01
Being in threatening situations where you were unable to respond because of the ROE.	34.6%	44.2%	0.00
Being wounded/injured.	5.5%	13.7%	0.00
Receiving incoming artillery, rocket or mortar fire.	71.3%	81.5%	0.00
Being directly responsible for the death of an enemy combatant.	13.3%	21.0%	0.01
Had a close call, was shot or hit but protective gear saved you.	3.0%	8.0%	0.01
<u>Significantly Lower</u>			
Seeing destroyed homes and villages.	63.3%	50.1%	0.00
Working in areas that were mined or had IEDs.	72.6%	64.3%	0.00
Disarming civilians.	42.7%	28.7%	0.00
Clearing/searching homes or buildings.	53.1%	32.3%	0.00
Clearing/searching caves or bunkers.	45.3%	31.2%	0.00
Seeing ill/wounded women and children who you were unable to help.	46.9%	33.3%	0.00

29.1.2 Combat Events for OEF 2007 Compared to OIF 2007

Table 7 provides the percents for items rated in OEF 2007 that significantly differed from OIF 2007. As outlined above, the table below only lists results with a p-value equal to or less than .01 in order to minimize the likelihood of overstating differences.

Table 7: Complete OEF 2007 Soldier Well-Being Sample (Adjusted Percents)

Combat Experiences	Values		
	OIF 2007	OEF 2007	p-value
<u>Significantly Higher</u>			
Being attacked or ambushed.	53.1%	59.5%	0.01
Seeing dead or seriously injured Americans.	46.1%	52.7%	0.01
Calling in fire on the enemy.	12.6%	21.1%	0.00
Clearing/searching caves or bunkers.	17.1%	29.8%	0.00
<u>Significantly Lower</u>			
Seeing destroyed homes and villages.	64.7%	51.3%	0.00
Receiving small arms fire.	60.2%	53.5%	0.00
IED/Booby trap exploded near you.	53.2%	39.1%	0.00
Disarming civilians.	35.2%	26.1%	0.00
Clearing/searching homes or buildings.	53.7%	32.3%	0.00
Having a member of your unit become a casualty.	55.3%	48.9%	0.01

These ratings indicate that OEF 2007 Soldiers are experiencing combat in Afghanistan at levels as high as in Iraq. As mentioned earlier, the OEF 2007 sample contained data from BCT units as well as supporting task forces whereas the OIF data were collected only from Soldiers in BCTs. Therefore additional analyses were run to compare combat experiences for Soldiers in OEF BCTs to those of Soldiers in OIF BCTs. Table 8 presents these values.

Table 8: BCT Soldier Combat Experiences (Adjusted Percents)

Combat Experiences	Percent		p-value
	OIF 2007	OEF 2007 BCTs	
Being attacked or ambushed.	52.2%	75.1%	0.00
Receiving small arms fire.	59.7%	70.3%	0.00
Seeing dead bodies or human remains.	60.8%	74.4%	0.00
Handling or uncovering human remains.	29.7%	44.8%	0.00
Witnessing an accident which results in serious injury or death.	37.0%	47.7%	0.00
Witnessing violence within the local population or between ethnic groups.	37.8%	46.2%	0.01
Seeing dead or seriously injured Americans.	46.3%	63.7%	0.00
Knowing someone seriously injured or killed.	72.3%	87.4%	0.00
Participating in demining operations.	22.2%	37.8%	0.00
Having hostile reactions from civilians.	45.6%	58.8%	0.00
Being in threatening situations where you were unable to respond because of the ROE.	41.8%	54.3%	0.00
Shooting or directing fire at the enemy.	38.5%	62.7%	0.00
Calling in fire on the enemy.	11.9%	31.0%	0.00
Clearing/searching caves or bunkers.	16.4%	51.2%	0.00
Being wounded/injured.	11.9%	24.4%	0.00
Receiving incoming artillery, rocket or mortar fire.	80.7%	91.6%	0.00
Being directly responsible for the death of an enemy combatant.	13.7%	32.8%	0.00
Observing abuse of Laws of War/Geneva Convention.	6.2%	11.2%	0.01
Having a member of your unit become a casualty.	54.5%	76.5%	0.00
Had a close call, dud landed near you.	25.0%	38.0%	0.00
Had a close call, equipment shot off your body.	4.6%	15.2%	0.00
Had a close call, was shot or hit but protective gear saved you.	6.4%	12.9%	0.00
Had a buddy shot or hit who was near you.	16.6%	24.6%	0.01
Informed unit members/friends of a Service Member's death.	10.5%	22.2%	0.00

Comparisons of these rates indicate a significantly higher level of combat activity for Soldiers in BCTs in OEF 2007 than for Soldiers in BCTs in OIF 2007. What this comparison shows is that although overall combat experiences are similar in OEF 2007 and OIF 2007, the level of combat in BCTs (the units most involved in direct combat), was actually higher in OEF.

29.2 Deployment Concerns

Combat experiences are intense events that put Soldiers at risk for mental health problems. From a behavioral health perspective, however, less dramatic chronic concerns related to being deployed have also been shown to negatively relate to health. Indeed, in some ways less dramatic, chronic concerns may have more of a negative influence on health than intense, vivid events (an argument made by Gilbert, Lieberman, Morewedge, and Wilson, 2004 in an article entitled "The Peculiar Longevity of Things Not So Bad").

All MHAT surveys capture less dramatic, chronic events with a series of eleven deployment concerns rated on a scale from 1 (very low trouble or concern) to 5 (very high trouble or concern). These eleven deployment concerns are listed below.

12. Being separated from family
13. Illness or problems back home

14. Boring and repetitive work
15. Difficulties communicating back home
16. Uncertain return date
17. Lack of privacy or personal space
18. Lack of time off, for personal time
19. Not having the right equipment or repair parts
20. Not getting enough sleep
21. Continuous operations
22. Long deployment length

29.2.1 Specific Concerns for OEF 2007 Compared to OEF 2005 and OIF 2007

To determine how OEF 2007 Soldier concerns differ from OEF 2005 and OIF 2007, a series of analyses similar to those for combat experience were conducted. As mentioned above in the combat experiences section, time in theater can significantly impact Soldier concerns.

Therefore the data for this section were evaluated with adjusted values and are presented below in Table 9. Asterisks (*) in the table indicate significant differences from the OEF 2007 sample. Because fewer comparisons were run (compared to the combat experiences section above), any test with a p-value of less than 0.05 is considered statistically significant.

These data indicate a significantly higher level of concerns raised by Soldiers in OEF 2007 compared to OEF 2005. Seven of the eleven items are significantly higher than 2005 and the remaining items were similar or slightly, but not significantly higher in 2007. Interestingly, comparisons between OIF 2007 and OEF 2007 indicate a high degree of similarity between the two theaters. Response rates were not significantly different for 9 of the 11 items. The only significant differences were a higher level of concern for privacy/personal space issues in OIF 2007 compared to OEF 2007 and higher rates of concern about poor equipment in OEF 2007 compared to OIF 2007. This mirrors reports noted in the focus groups. Soldiers often stated that they felt that resources, including equipment or repair parts, in OEF were lacking compared to those in OIF.

The rank order of items that were most concerning was similar for all three populations. In particular, long deployment length and engaging in boring and repetitive work were the top 2 ranked items on the list for all three theaters. In short, deployment length and family separation were the major concerns reported by the sample as a whole.

Table 9: Deployment Concerns (Adjusted Percents).

Trouble or Concern Caused By	Percent Rating High or Very High		
	OEF 2005	OIF 2007	OEF 2007
Being separated from family.	38.1%	43.2%	41.8%
Illness or problems back home.	23.8%	23.9%	24.0%
Boring and repetitive work.	39.3%*	44.4%	48.9%
Difficulties communicating back home.	17.3%*	22.6%	25.7%
Uncertain redeployment date.	29.3%*	42.3%	41.5%
Lack of privacy or personal space.	36.9%	44.0%*	38.8%
Lack of time off, for personal time.	35.7%	40.6%	40.6%
Not having the right equipment or repair parts.	21.6%*	25.5%*	31.2%
Not getting enough sleep.	21.1%*	31.9%	33.6%
Continuous operations.	24.9%*	34.7%	36.5%
Long deployment length.	51.4%*	59.0%	61.3%

* indicates statistically significant difference from OEF 2007

29.3 Effect of Multiple Deployments

Previous MHAT reports have identified multiple deployments as a risk factor for behavioral health problems. In the earlier reports, analyses have examined the effects of multiple deployments by comparing first-time deployers with those who had deployed at least one previous time. In presenting the results related to multiple deployments, values are presented for NCOs rather than for junior enlisted (E1-E4) Soldiers. This was done because Soldiers in the multiple-deployer group are predominantly NCOs. Specifically, in the first-time deployer group, 72% were junior enlisted, 21% were NCOs, and 7% were officers. For multiple-deployers, 26% were junior enlisted, 65% were NCOs, and 9 were officers.

For NCOs in OEF 2007, 9.8% of first time deployers screened positive for any mental health problem whereas 14.2% of NCOs who had previously deployed screened positive. This difference was significant (one tailed, $p < 0.05$). This is consistent with the findings from previous MHATs and identifies another risk factor that can affect the behavioral health of Soldiers.

29.4 Sleep Deprivation

Overall, 31% of OEF 2007 Soldiers reported high or very high concern that they weren't getting enough sleep. Nearly one-quarter of OEF 2007 Soldiers reported falling asleep during convoys. Additionally, 16% of OEF 2007 Soldiers reported taking mental health medications and approximately 50% of those were sleep medications.

29.4.1 *Sleep and Reports of Accidents and Mistakes*

In addition to health, sleep deprivation has a known negative link to performance. Indeed, even relatively small amounts of sleep deprivation show a cumulative performance decline over time (Belenky et al., 2003; Bliese, et al, 2006; Van Dongen et al., 2003). The relationship between sleep and performance can also be assessed by examining Soldiers' responses to the item "During this deployment, have you had an accident or made a mistake that affected the mission because of sleepiness?" Six percent (6%) of OEF 2007 Soldiers reported they had an accident or made mistakes during the deployment due to sleepiness.

29.5 Summary of Risk Factors

The intensity of combat in OEF 2007 was significantly higher than in OEF 2005. As a whole, Soldiers deployed to OEF in 2007 have clearly witnessed a high degree of intense combat and experienced significant levels of combat activity. Additionally, many of the reported rates for OEF 2007 are on par with the OIF 2007 theater. These rates are particularly significant when comparing rates from OEF 2007 Soldiers in BCTs to Soldiers in OIF 2007 BCTs. In fact, the rates for OEF 2007 BCT Soldiers are significantly higher than those of OIF 2007 on 24 of the 33 scale items and rates for the remaining 9 items were similar for both theaters.

There was also a significantly higher rate of non-combat, deployment related concerns raised by Soldiers in OEF 2007 compared to OEF 2005. Rates for the majority of items on this scale were significantly higher in OEF 2007 than OEF 2005 and the remaining items were similar or slightly higher. Interestingly, comparisons between OIF 2007 and OEF 2007 indicate a high degree of similarity between the two theaters on non-combat deployment concerns. Finally, there was a significant relationship between mental health problems and multiple deployments in the current sample. NCOs who had deployed more than one time were at increased risk for a mental health problem compared to those who were on their first deployment.

30. PROTECTIVE FACTORS

In the conceptual model used to guide this report, protective factors represent the area most amenable to intervention. In this section we examine unit social climate (leadership, readiness and cohesion), reducing stigma about behavioral health care, reducing barriers to behavioral health care, rest and relaxation (R&R), family and marital support, willingness to report ethical violations and training as protective factors.

30.1 Leadership, Readiness, and Cohesion

Social factors within platoons and companies presumably play a critical role in how well unit members respond to combat experiences. A memorable illustration of the importance of social factors in combat was recounted in Shils and Janowitz's (1948) description of the resiliency of the German *Wermacht* in World War II. Shils and Janowitz convincingly argued that the cohesion of the German units allowed them to maintain morale and performance under intense combat stressors.

Empirical evidence for Shils and Janowitz's proposition has been found in studies of Soldiers in both deployed and garrison settings. In military research, a common trend has been to deconstruct the social environment into separate components such as the leadership climate (Bliese & Castro, 2000) and training readiness (Jex & Bliese, 1999) and examine the protective effects of the separate climate dimensions. While this approach potentially pin-points relevant aspects of the social environment for specific situations, one limitation is that indices of social functioning tend to be highly related. For instance, units that have positive perceptions of unit leaders also tend to have high cohesion and high perceptions of readiness whereas units that are low in any one of these dimensions also tend to be low in the other dimensions.

One way to consider the inter-relationships among climate dimensions is to develop indices of social climate that encompass several different components. This approach is theoretically justified by research which suggests that separate ratings of the social climate load on a second-order factor described by whether individuals evaluate the work environment as personally beneficial or personally harmful (James & James, 1989).

In the current report, we examine the combined variables of cohesion, readiness and perceptions of NCO and officer leadership. All items were asked on five-point scales with three being a generally neutral response. To facilitate the presentation of results in the Tables, the combined climate measure is considered positive if the mean score was rated above "3".

Figure 9 shows that there was a decrease of 6 percentage points between OEF 2005 and OEF 2007 in ratings of positive climate for male E1-E4 Soldiers in theater for 9 months. While small in absolute terms, this value is statistically significant. There was no difference between OEF 2007 and OIF 2007.

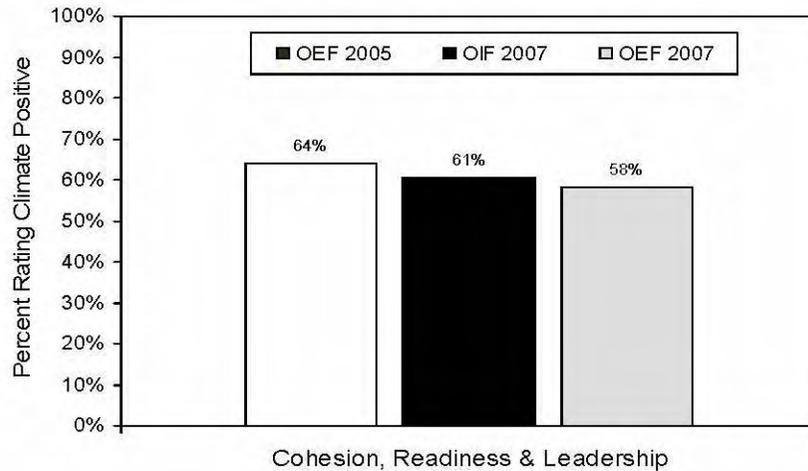


Figure 9: Unadjusted Rates for Social Climate

As mentioned earlier in the combat experiences section of this report, exposure to high levels of combat significantly increases the risk of reporting a mental health problem. Previous MHATs have found that good NCO leadership can, to some extent, limit the degree to which Soldiers screen positive for any mental health problem.

Figures 10 and 11 illustrate the importance of NCO and Officer leadership in terms of mitigating the effect of combat experiences on Soldiers' mental health. As Figure 10 illustrates, Soldiers who rate NCO leadership positively have lower levels of mental health problems than those who rate NCO leadership negatively regardless of the level of combat experiences. This pattern is also found when examining the impact of officer leadership on mental health rates, controlling for combat experiences (Figure 11). In summary, Soldiers who rate their leadership, both NCO and officer, highly are less likely to have mental health problems whether they experience high or low levels of combat.

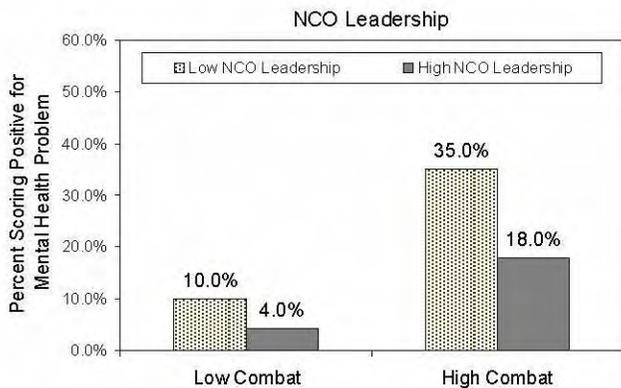


Figure 10: Unadjusted Rates for NCO Leadership

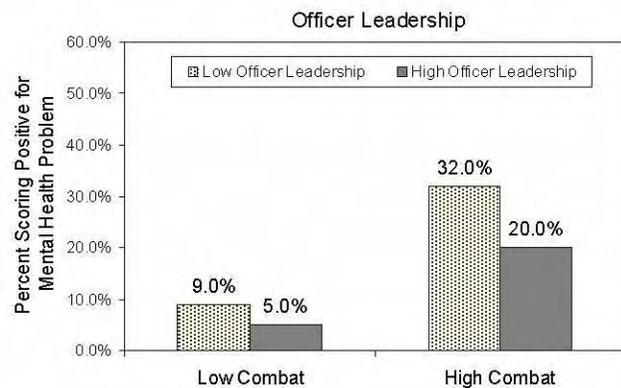


Figure 11: Unadjusted Rates for Officer Leadership

30.2 Willingness to Seek Care / Stigma

Another dynamic that is likely to serve as a protective factor is Soldiers' willingness to seek care, and a key impediment to seeking care is overcoming the stigma associated with receiving

behavioral health care. One of the challenges with providing behavioral health care is that stigma is strongest among individuals who screen positive for mental health problems (Hoge, et al., 2004). Therefore, when looking at changes in stigma, it is informative to examine those who screen positive for psychological problems. Table 10 provides the adjusted percents for male, E1-E4 Soldiers in theater 9 months who also screen positive for depression, anxiety or acute stress. Neither of the rates for OEF 2005 or OIF 2007 differed significantly from OEF 2007. The fact that rates have not changed significantly from 2005 suggests that more emphasis should be placed on outreach and education programs that emphasize reducing stigma.

Table 10: Stigma Concerning Behavioral Health Care for Soldiers Who Screen Positive for a Mental Health Problem (Adjusted Percents).

Factors that affect your decision to receive mental health services	Percent Agree or Strongly Agree		
	OEF 2005	OIF 2007	OEF 2007
It would be too embarrassing.	32.2%	32.0%	35.1%
It would harm my career.	37.4%	31.7%	31.2%
Members of my unit might have less confidence in me.	48.9%	44.9%	47.8%
My unit membership might treat me differently.	59.8%	53.7%	55.6%
My leaders would blame me for the problem.	43.7%	40.2%	43.9%
I would be seen as weak.	52.9%	52.2%	56.7%

30.3 Barriers to Care

Perceived barriers to care also vary depending upon whether a Soldier screens positive for a mental health problem such that those who screen positive typically report higher barriers to care. In the analyses comparing barriers across years and theaters, a number of perceived barriers are higher in the OEF 2007 sample compared to both OEF 2005 and OIF 2007. Table 11 provides the results using adjusted values. An asterisk (*) next to percentages for OEF 2005 and OIF 2007 indicates a statistically significant difference from the OEF 2007 sample. As the table indicates, perceived barriers to care have increased since 2005 and, in general, are higher in the present OEF theater than in OIF. The OEF theater has considerable transportation challenges that may contribute significantly to some of these findings. This limits the ability of behavioral health personnel to get to outlying posts as well as the ability of Soldiers to get back to behavioral health personnel at the larger FOBs. One recommendation from this report is to redistribute behavioral health personnel within OEF in order to increase BH contact with Soldiers located at smaller outposts.

Table 11: Barriers to Behavioral Health Care for Soldiers Who Screen Positive for a Mental Health Problem (Adjusted Percents).

Factors that affect your decision to receive mental health services	Percent Agree or Strongly Agree		
	OEF 2005	OIF 2007	OEF 2007
Mental health services aren't available.	21.4%	11%*	19.9%
I don't know where to get help.	17.2%	14.3%	15.1%
It is difficult to get an appointment.	17.4%*	21.3%	26.8%
There would be difficulty getting time off work for treatment.	43%*	43.4%*	56.3%
It's too difficult to get to the location where the mental health specialist is.	24.2%*	17.7%*	32.7%
My leaders discourage the use of mental health services.	19.5%*	21.8%*	33.0%

* indicates statistically significant difference from OEF 2007

30.4 Rest and Rehabilitation (R&R)

Rest and rehabilitation (R&R) is defined as a 3 or 4 day pass taken in theater or at an out of theater location (b)(2) R&R is different from the 2-week mid-tour leave that all Soldiers receive. Soldiers were also asked whether they had taken R&R during their deployment. Taking R&R can also serve as a protective factor for mental health problems. This question was not included in the OEF 2005 survey and therefore only comparisons between OEF and OIF 2007 are reported. In the 2007 sample, 68.5% of respondents in OIF 2007 reported not taking any R&R while 75.6% of OEF 2007 Soldiers reported not taking R&R. This difference was significant when comparing the raw values but when they were adjusted for gender, rank and time in theater the differences were not significant (73.4% for OIF and 71.0% for OEF). The average time in theater for Soldiers in OIF was almost 2 months longer than for Soldiers in OEF (9.4 vs. 7.7 months) which may significantly influence responses to this question and explain why the difference is not significant using adjusted values that include equaling the length of time in theater.

Interviews with Soldiers and behavioral health providers indicated that the immediate period after returning to theater from mid-tour leave was a difficult time for Soldiers both in terms of morale and mental health. Unfortunately, the survey does not ask specifically when mid-tour leave was taken relative to when the survey was completed. Future Soldier Well-Being surveys should consider asking both mid-tour leave and R&R dates in order to assess the length of time that has elapsed since the Soldier took mid-tour leave and R&R. By adding these items, it may be possible to model the effects of mid-tour leave and R&R on Soldier well-being.

30.5 Marital Satisfaction

Marital satisfaction may also be an indicator of overall behavioral health. In the behavioral science literature, social support from spouses and family members has often been found to be a protective factor in helping individuals cope with stress (Cohen & Wills, 1985). In addition, Soldiers' morale and well-being are affected by family issues back home. The Soldier Well-Being survey assesses Soldiers' perceptions of the quality of the marital relationship and Soldiers' perceptions of satisfaction with family support. Because family issues can be significantly influenced by deployment time, adjusted values are presented in this section. Overall reports of marital satisfaction were significantly lower in OEF 2007 than they were in

OEF 2005 (Table 12). Significantly fewer OEF 2007 Soldiers reported that they have “a good marriage”, that “my relationship with my spouse makes me happy”, and that “I really feel like a part of a team with my spouse” compared to Soldiers in OEF 2005. On these same questions, rates for OEF 2007 Soldiers were similar to OIF 2007 Soldiers.

Table 12: Marital Satisfaction (Adjusted Percents).

Marital and Family Support	Percent Agree or Strongly Agree		
	OEF 2005	OIF 2007	OEF 2007
I have a good marriage.	73.5%	66.8%	65.6%
My relationship with my spouse is very stable.	70.4%	63.5%	62.7%
My relationship with my spouse makes me happy.	75.8%	69.2%	67.7%
I really feel like a part of a team with my spouse.	73.3%	63.9%	63.6%

30.6 Reporting Ethical Violations

One of the potential deterrents against committing unethical behaviors is the degree to which Soldiers believe unethical behaviors will be reported by unit members. Soldiers’ willingness to report unit members for unethical behaviors almost certainly runs counter to the strong sense of bonding that occurs among unit members during the deployment. Questions about reporting ethical violations were first included in MHAT OIF 2006 and therefore this report does not include data from OEF 2005. As Table 13 indicates, the rates for OEF and OIF 2007 are not significantly different. Not surprisingly, Soldiers are reluctant to report the ethical violations of unit members and this reluctance is consistent across theaters. Unadjusted rates were consistent with adjusted values.

Table 13: Reporting Ethical Violations (Adjusted Percents).

Reporting Ethical Violations	Percent Agree or Strongly Agree		
	OIF 2007	OEF 2007	p-value
I would report a unit member for the mistreatment of a non-combatant.	33.9%	33.2%	0.77
I would report a unit member for injuring or killing an innocent non-combatant.	40.8%	43.0%	0.33
I would report a unit member for unnecessarily destroying private property.	30.4%	31.7%	0.53
I would report a unit member for stealing from a non-combatant.	34.7%	37.6%	0.19
I would report a unit member for violating the Rules of Engagement.	35.7%	34.7%	0.63
I would report a unit member for not following General Orders.	35.9%	35.1%	0.71

30.7 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. Soldiers were asked a series of questions about training including if they had received suicide prevention training within the last year. Slightly more Soldiers in OIF 2007 reported receiving this training (93.3%) compared to Soldiers in OEF 2005 (87.5%) or OEF 2007 (87.5%). Similarly, more Soldiers in OIF 2007 reported receiving training in managing the stress of deployment and/or combat prior to deployment (86.8%) than Soldiers in OEF 2007 (80.7%). Again, when asked about attending pre-deployment Battlemind training, slightly more OIF 2007 Soldiers reported receiving this (67.6%) compared to OEF 2007 (63.9%). These last two questions were not included in the OEF 2005 survey and, therefore, rates for these items are not available.

30.7.1 Training Adequacy for Deployment Stress and Suicide

As outlined above, a large majority of Soldiers reported receiving deployment stress and suicide prevention training. This section addresses the perceived effectiveness of training in these areas. Table 14 presents Soldiers' responses across years and theaters to questions about their perceived adequacy of suicide and deployment stress training. An asterisk (*) next to percentages for OEF 2005 and OIF 2007 indicates a statistically significant difference from the OEF 2007 sample. For all questions, rates for OEF 2007 were lower than either OEF 2005 or OIF 2007. The OEF 2007 rates were significantly lower than 3 of the 4 items in OEF 2005 and significantly lower than 2 of the 4 items in OIF 2007. The same significant differences were found with adjusted values. This finding points out the need for better suicide and deployment stress training for Soldiers deploying to OEF.

Table 14: Adequacy of Training (Unadjusted Percents).

Adequacy of Suicide and Stress Training	Percent Agree or Strongly Agree		
	OEF 2005	OIF 2007	OEF 2007
I am confident in my ability to help Service Members get mental health assistance.	79.5%*	66.0%	67.7%
The training in managing the stress of deployment and/or combat was adequate.	48.6%*	46.7%*	38.6%
I am confident in my ability to identify Service Members at risk for suicide.	60.6%	60.0%	59.1%
The training for identifying Service Members at risk for suicide was sufficient.	58.9%*	58.3%*	50.9%

30.7.2 Training Adequacy for Ethics

The final aspect of training evaluated in the Soldier Well-Being survey assessed ethics training both in terms of (a) whether the Soldier recalled having the training, and (b) whether the training was adequate. Adequacy was evaluated both by directly asking if it was adequate, and also by asking if the Soldier had encountered situations that were ethically difficult despite the training. Table 15 provides results from OIF 2007 and OEF 2007. Significantly fewer Soldiers in OEF 2007 reported having received the training and that the training was adequate. Additionally,

fewer Soldiers reported that training made it clear how they should behave towards non-combatants.

Table 15: Adequacy of Ethics Training (Adjusted Values)

Ethics Training	Percent Responding Yes		p-value
	OIF 2007	OEF 2007	
I received training in the proper (ethical) treatment of non-combatants.	81.1%	71.5%	0.00
The training I received in the proper (ethical) treatment of non-combatants was adequate.	79.9%	69.6%	0.00
I encountered ethical situations in which I didn't know how to respond.	28.1%	24.6%	0.11
I received training that made it clear how I should behave towards non-combatants.	84.4%	74.2%	0.00

30.8 Summary of Protective Factors

Both NCO and officer leadership were shown to be protective factors in mitigating the effect of combat on Soldiers' mental health. Alternatively, Soldiers reports of stigma and barriers to BH care were higher in OEF 2007 compared to OEF 2005 and OIF 2007. This may largely be due to transportation difficulties in Afghanistan. Additionally, fewer OEF 2007 Soldiers reported that the training they received in preparing them for the stress of deployment, the training in identifying Soldiers at risk for suicide, and the training in ethical treatment of non-combatatives were adequate compared to OIF 2007 Soldiers.

31. Behavioral Health Care Use

Interestingly, although OEF 2007 Soldiers reported higher stigma and barriers to receiving behavioral health care compared to OIF 2007 Soldiers, a higher percentage of OEF 2007 Soldiers sought help for their behavioral health problems. For individuals who screened positive for a mental health problem, significantly more OEF 2007 Soldiers (57%) reported receiving behavioral health care from a health care professional or Chaplain than Soldiers in OEF 2005 (43%) or OIF 2007 (40%). The breakdown of specialties that Soldiers who screened positive for a mental health problem sought care from is provided in Figure 12. Asterisks (*) in the figure indicate significant differences from the OEF 2007 sample.

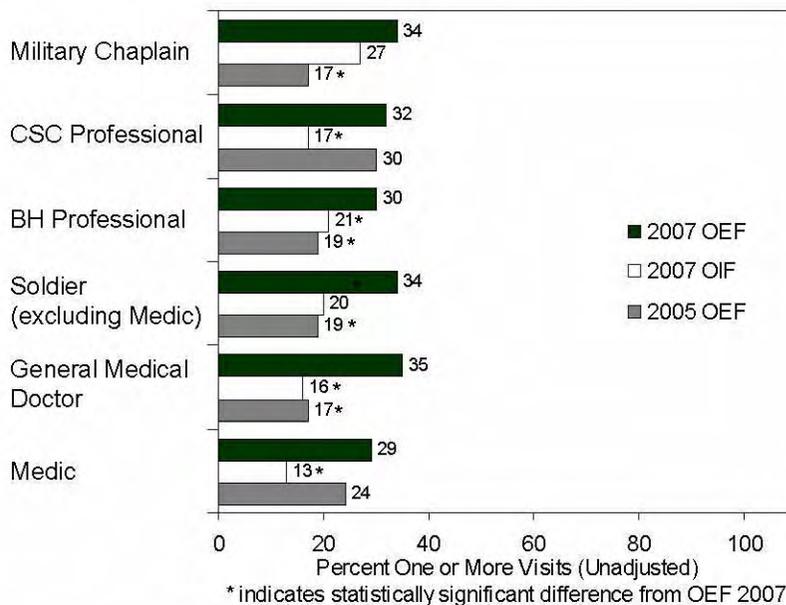


Figure 12: Behavioral Health Care Use During Deployment

32. Soldier Focus Groups

Ten focus groups were conducted with 51 Soldiers throughout the Afghanistan theater of Operations in October and November of 2007. Participants were informed that their participation was voluntary in that they did not have to answer any questions if they did not want to; that no personal identifying information was being gathered, and that their responses would be non-attributional with quotes attributed to "a Soldier/NCO". The focus groups followed a semi-structured interview schedule asking Soldiers about: quality of life, morale, coping with deployment stress (i.e., individual coping, buddy-aid and leader-aid in helping Soldiers through the deployment), families, the tour extension (if applicable to the unit participating in the focus group), perceptions of the mission, ethics training, behavioral health training, and recommendations for future training (ethics and mental health training). Typically, focus group interviews lasted from 60-75 minutes. At the conclusion, Soldiers were thanked for their participation and notes from the focus group session were typed up by the interviewers.

32.1 Quality of Life

Generally, quality of life problems were minimal but varied depending on the FOB/outpost. Although the U.S. Army has been in Afghanistan for nearly 7 years, there were Soldiers still living in non-hardened living quarters on some outposts. Soldiers reported this problem was getting better but there was difficulty getting contractors to come to the more remote FOBs due to the contractors expressing fear for their safety. This was especially true at the combat outposts (COPs) where contractors had been mortared and refused to stay at the location to complete the construction project. Additionally, Soldiers at one of the COPs reported needing heaters to warm their rooms during the cold winter months. Furthermore, units operating as embedded training teams (ETTs) noted that when living among the local Afghans, they had no electricity and no running water. Those who had previously deployed to Afghanistan said that "things are better this time around."

32.2 Morale

When focus group respondents were asked to rate their personal morale as very high, high, medium, low, or very low, the majority of responses were on the low or very low end of the scale. A typical answer was that morale was "double thumbs down" or "very low". Soldiers cited many reasons, including the continual occurrence of casualties in the unit, long deployment length, high OPTEMPO, family issues at home, and boredom. However, one unit reported high morale due to being near their time to go home.

Many Soldiers reported that morale was low due to being in Afghanistan compared to Iraq and it being "the second class citizen war." Iraq was referred to as the "media darling" and Afghanistan as the war that nobody cares about. One Soldier told us that a fellow Afghanistan veteran was home in a bar when a person asked where he had returned from; when the Soldier responded "Afghanistan", the person asked "what part of Iraq is that?"

32.3 Coping with Deployment/Job Stress

When asked what they did to maintain their morale and/or cope with the stress of the deployment, nearly all Soldiers said that they frequently spent time working out in the gym. Another common response was that Soldiers joked with each other and made fun of each other

to cope with the stress. Other ways to cope included: movies, attending religious services, playing cards and games, computer gaming (X-box), music, sleep, playing practical jokes, organized sports such as team softball, basketball, and “just bull-shitting with each other.” Communication back home was often cited, but some Soldiers reported that talking to their spouse sometimes made things worse and added more stress. Soldiers on the more remote COPs reported a lack of MWR facilities.

“Garrisonized environment takes away from personal time. We are already working 10-15 hour days, and then we have to wake up at 0500 to do organized PT. It makes no sense.” Alternatively, one battalion reported how morale was much better due to leadership cutting out some of the “bullshit stuff” such as allowing Soldiers to buy (& the unit paid for) any kind of boot they wanted in order to make their feet comfortable while walking in the mountains every day.

When Soldiers were asked what they did to look out for each other, common responses were: making sure they use MWR and having them keep contact with loved ones. Soldiers also reported that they talked with each other to maintain morale. One group reported “we are part of a team and the team looks out for each other.” NCOs were also asked what they did to take care of their subordinates, some NCOs went to the gym with their Soldiers, one NCO said he took his Soldiers to lunch about once a week; another NCO reported simply “I encourage them.”

Soldiers and NCOs were also asked what, if anything, their leaders could do to help Soldier morale during the deployment. Communication and information-flow were often mentioned as things that leaders could do better to help Soldiers. Additionally, Soldiers want their leaders to know what jobs their Soldiers were doing and ask about their families. Soldiers would like to have more time to do “personal stuff” and some downtime. It was not uncommon for Soldiers to say they did not have a single day to themselves in 6 months. This was reported mainly by Soldiers at the remote FOBs/COPs. As previously mentioned, Soldiers requested that “garrison environment” things such as “washing trucks that are going to get dirty right away” and “mandatory PT like in garrison when this is not garrison be eliminated.”

32.4 Families

In the focus groups, interviewees were also asked about how their families were doing. Some Soldiers reported that their families did not understand what was going on in Afghanistan. One Soldier reported that he believed that “most people lie to their families about what’s going on here” and added “how do you explain this?”

Spouses were described as “stressed”. An extreme example of this was one Soldier who reported “My wife cried every time I called for an entire year.” Alternatively, some Soldiers reported their families were doing well and that they got “good support back home.” One Soldier stated that the deployment was tough on his children saying “my kids wonder where their daddy is everyday.”

A general theme expressed by Soldiers at the remote FOBs/COPs was that spouses were depressed and scared due to the high number of casualties. The death notification process was raised as an issue in several groups with Soldiers expressing horror when a Spouse was mistakenly told her husband had been killed.

At (b)(2) communicating back home is not a problem for Soldiers. One Soldier there said “I look forward to calling home everyday.” However, some

Soldiers talked about the communication paradox, reporting that “contact with family is good and bad though. Hearing about issues but not being there to help is a problem.”

32.5 Tour Extensions

Among those in units affected by the tour extension while already deployed, there was near total consensus among focus group interviewees that the tour extensions had placed a significant burden on everyone: themselves, their colleagues, Soldiers, leaders and on their families. A Soldier simply stated that “we found out we were extended to 15 months after we got here. It hurt. I would rather have known before.” Another Soldier added “basically after we were here for 3 months we were told to reset the clock to zero.” The tour extension was reported to be especially hard on the families.

One junior enlisted Soldier summarized what many in the focus groups thought when he said “when I saw the Secretary of Defense on TV announce that deployments were going to be 15 months, I felt like throwing the TV out the window. Last year we were here (in Afghanistan) and 12 months was too much. We got 3 extra days of leave and \$3,000 more; that’s a joke. We didn’t get any of the incentives like \$500 per month; that was cancelled.” This sentiment was echoed by a senior officer who said that “that quote could come from anyone from the most junior private to all the colonels.”

The result of the tour extension was shown by one NCO who reported “I hate the Army; the Army doesn’t take care of me.” Another NCO said “two weeks before we left, we found out it was 15 months. It may be possibly 18 months. I think it will be 18 months. I wanted to kill myself. Eighteen months out here and I’ll go crazy.” Alternatively, a few Soldiers expressed ambivalence, saying “some don’t care; some are affected.”

32.6 The Mission

When asked about their mission, most Soldiers responded with their frustration about fighting a counter-insurgency war and lack of communication about the mission. One Soldier reported “they say we’re getting the job done but we don’t see it. We’re fighting an enemy more than 800 meters away. Recently it’s closer. We’ve only positively identified 3 people (we killed). We don’t see the enemy. If you take out the head guy somebody else takes over the next day and they’re hitting us again.” Another Soldier echoed the lack of knowledge of mission success by saying “Is the mission successful? Yes, but we don’t know what is going on outside the wire.” This was further stated by an NCO who said “don’t know how the mission is going, we just do our job.” In terms of how the mission is going, our ‘intel is no tell’. The command does not give any information to us about how the mission is going.”

Another theme was the unexpected nature of the mission and the difficulty of the size of the area of operations (AO). An NCO, talking about the mission, reported “it’s a little different, worse because of where we’re at. The activity and size of the AO is not what we expected.” Another NCO stated that “the original mission is not what we are doing now.”

Many Soldiers reported frustration with the local Afghan population. One Soldier said “the locals are just lazy with poor attention spans. A few want to learn but most don’t. They just want to sleep. We are turning the country into a bunch of beggars.” This was echoed by a NCO who stated “we should be teaching instead of babysitting.” A junior enlisted Soldier reported “As soon as we leave they (the locals) will go back to the way they were.” Finally, a common response when asked if the mission was a success was simply “no.”

Additional frustration was reported in reference to the rules of engagement. One junior enlisted Soldier reported “We have so many restrictions that even if when we have solid intel about an enemy, we are not allowed to do anything about it until the enemy starts taking shots at us.” Another Soldier stated “it’s hard to get creative when you have ROE restraints.”

32.7 Ethics and Future Training

Soldier focus group members were asked about ethical situations that they encountered during their tour. As mentioned previously, many Soldiers reported difficulty identifying combatants from non-combatants. One junior enlisted Soldier said “you know what separates the fighters from the non-fighters? A weapon in their hands. It’s hard to distinguish the enemy from everyone else. We can only engage if they have a weapon.”

The results were mixed when it came to whether the units had received ethics training. Many Soldiers said they had received training that was basically ‘death by PowerPoint’ training. The training was often deemed inadequate or a waste of time. One Soldier commented “a class isn’t going to tell me what is right and wrong.” Another junior enlisted Soldier added “it doesn’t really help; it’s all just there to cover their asses anyways. Choices will be made by the individual regardless of the class.” An NCO reported that the training was minimal and “I feel like it did not apply to me or the mission here.” Some Soldiers did not care for the presentation method, saying “the presentations and classes are done in such a way that they are not value added.”

Some units reported they were trained for a deployment to Iraq, not Afghanistan. Soldiers in one unit stated “we were trained for Iraq. The last training we got was for going through villages.” Another Soldier commented “training and briefings are Iraq focused.”

There was also continued concern about ROEs and UCMJ, as one Soldier said “training covered how to act and what you can do but handcuffed us. I had to fire a warning shot once and all I could think about was whether or not I was going to get an Article 15 for doing it.”

32.8 Behavioral Health Training

Focus group members were asked if they had received any behavioral health training prior to leaving on the deployment. The responses varied from “we got all the stuff” to “no.”

When asked if they had received any behavioral health training during the deployment, most indicated they did not. A fairly common theme among the brigade combat team Soldiers was a lack of training and lack of faith in the behavioral health system, but faith in the unit members taking care of each other. One Soldier reported “there was no training since being here. The Brigade Psychologist is always out there. He goes to where the casualties are. No one wants to talk to the other mental health guys. The hardest part is to talk to them. What’s it going to do? They just give medication. The best thing is the ability to communicate. They’re (psych) not going to accomplish anything. We’re out there all the time. You don’t want to leave your buddies. This company is like family.”

Nearly all Soldiers indicated that they had received suicide prevention training but the adequacy was questioned. One Soldier reported “the Chaplain gives suicide prevention classes. We had to do PTSD/TBI training. It was terrible. Training should be given by people who care. It was a waste of our time.” Finally, another Soldier stated “it’s hard to recognize the signs for suicide, since most people exhibit a lot of them after being here for a month or so.” This was further

echoed by an NCO who commented "Most of the signs are the same as depression. If you paid attention to the warning signs you would think that everyone is suicidal that is depressed."

When asked what might be done in future mental health training to better prepare Soldiers to face challenges of the deployment. A Soldier stated that the units "need transition issues to focus on reintegrating back into the life we left." Some Soldiers reported that the training was too narrow and did not address Reserve Component Soldier issues. One Soldier responded that "PTSD is not the only issue we are dealing with. National Guard especially have different issues compared to Active Duty Soldiers. When we return we go back to different jobs and work with people that have no idea what we have been through. AD still have their unit when they go back. The transition for NG is very tough. The training is tailored to AD, not NG. Another Soldier said "classes help you ID issues but don't do anything to prevent or solve them. They only provide you a door to go to."

Another concern was that future training is futile. One NCO stated "You can't prepare for what we've seen." A unit in one of the most dangerous areas of Afghanistan reported that "the unit coming in needs to know this is a shit-show and worse than Iraq. (b)(2) (b)(2) The next guys are going to get fucked up. It's a stand up brigade; they need to know the first day, the shit's on."

A final comment on the transition back home after the deployment focused on the increased need for behavioral assistance; "fifteen months is too long (b)(2) Those who make it out will be doing drugs and drinking. The problems will come when we get back. When we can sit back, the problems will be in the whole battalion and with families. There's going to be discipline problems when guys think they're so bad after having been here." When asked for a solution, the Soldier responded "they did a good job with mental health after the last deployment but they're not ready for the number of dudes. They only have 2 helpers and there will be twice as many this time. They need at least 5 people. For the first 90-180 days they need a designated team to sift through this shit. It will be better after 3-4 months." An NCO further offered the idea of positioning behavioral health assets in Afghanistan prior to the end of the deployment. This NCO said "you need to get people out here who we can get to know now so we can open up to them when we get back. They need to be part of the team."

33. BEHAVIORAL HEALTH CARE SYSTEM ASSESSMENT

This section of the report discusses: (1) current behavioral health staffing and distribution in OEF 2007, (2) behavioral health survey methodology and results, and (3) behavioral health provider interview results.

33.1 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 and re-deployment, 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 in OEF as of OCT 2007.

Nonetheless, the overall ratio of military personnel to Behavioral Healthcare (BH) personnel in the OEF 2007 theater in OCT 2007 was 1: 651. This ratio is significantly higher than the ratio for OEF 2005 which was 1:1756 and slightly higher than the OIF 2007 theater which was 1:734. In terms of absolute numbers, the 29 BH personnel in OEF 2007 represents a significant increase since OEF 2005 (9 BH personnel).

Table 16 (below) provides the distribution of BH personnel by occupational specialty and branch of service for OEF 2005, OIF 2007, and OEF 2007. Although occupational specialties fluctuate across rotations, there has been an increase in the contributions of Navy and Air Force BH personnel to both the OIF and OEF theaters. In 2005 the Navy and Air Force had no BH assets in either theater. In 2007 they are providing support in both theaters and are the lead providers of BH in OEF. It is notable that the majority of BH personnel in OEF 2007 were Air Force personnel (62%) compared to OIF 2007, where the Air Force only provides 14% of the BH personnel. Although BH personnel from sister services have added significant resources to providing in-theater behavioral healthcare to OEF, there are cultural differences and a much shorter deployment time (6 months for Air Force vs. 15 months for Army) that affect the services provided. Prior to October 2007, the majority (approximately 38%) of BH personnel were located at (b)(2). However, in November 2007, under the direction of the (b)(2) Command Surgeon and the Combat Stress Control (CSC) Commander, the distribution of BH personnel throughout the Afghanistan theater was readjusted to provide far forward BH support to FOBs and outposts previously not supported.

Table 16: Distribution of BH specialties in OEF 2005, OIF 2007 and OEF 2007 by Corps.

ARMY			
SPECIALTY	OEF 2005	OIF 2007	OEF 2007
Psychiatrist	2	21	0
Occ. Therapist	0	4	0
Behavioral Sciences	0	2	0
Psychiatric Nurse	0	13	0
Social Worker	1	25	2
Psychologist	1	21	1
OT Specialist	0	1	0
BH Specialist	5	96	7
TOTAL	9	183	10
NAVY			
Psychiatrist	0	6	0
Psychiatric Nurse	0	0	1
Social Worker	0	0	0
Psychologist	0	3	0
BH Specialist	0	10	0
TOTAL	0	19	1
AIR FORCE			
Psychiatrist	0	7	3
Psychiatric Nurse	0	3	1
Social Worker	0	4	3
Psychologist	0	4	4
BH Specialist	0	15	7
TOTAL	0	33	18
Theater Total	9	235	29

33.2 Behavioral Health Survey

This section of the report compares Behavioral Health (BH) survey responses for the OIF 2007 and OEF 2007 theaters. Comparisons between OEF 2007 and OEF 2005 were not drawn because the survey questions were not equivalent. The BH survey items for OIF and OEF were identical and therefore comparisons between these two populations are presented below.

In all, 23 BH surveys were completed and returned by OEF 2007 behavioral health providers. This represents a sampling rate of 79%. The rate for OIF 2007 was lower with 131 of the 235 BH providers in theater completing a survey (56%). Behavioral Health survey items focused on demographics, standards of practice, coordination of services, BH services provided, skills and training in relation to BH services, perceived stigma and barriers to BH care, methods to address Soldier BH needs, and personal well-being. Additionally, each survey also had a qualitative section for all respondents to write in the equipment / resources / supplies that would have improved their ability to complete their mission.

33.2.1 OEF 2007 Behavioral Health Survey Demographics

Demographics for BH personnel responding to the survey are shown in Table 17. There are notable demographic differences between OEF 2007 and OIF 2007. OEF 2007 BH personnel have been in theater significantly less time than OIF 2007 BH personnel (3.9 months vs. 8.9

months). When asked on the survey “approximately how many service members does your team support” the reported numbers were similar for OEF 2007 and OIF 2007 (5,597 vs. 5,396).

Table 17. Demographic list of surveyed BH Personnel in OEF 2007.

Behavioral Health Survey Demographics	
Sample Size	n = 23
Age (Mode)	30-39 years old*
Gender (Mode)	55 % Male
Rank (Mode)	61% Officer
Branch of Service (Mode)	61% Air Force
Component (Mode)	87% Active Duty
Average Months Deployed since 9/11	8.17
Average Number of Service Members supported by team	5,597
Average Hours spent per Week Outside FOB	2.91
Average Days per Month Living Outside FOB	4.91
Average Number of Locations your BH/COSC Team Supports	30.17

*Multiple modes exist. The median value is shown

33.2.2 Behavioral Health Survey Results

Results from the behavioral health survey indicate that there are significant differences between the two theaters (Table 18). The number of locations supported by OEF BH personnel and the time to travel to those locations is significantly different than OIF BH personnel. On average, BH teams in OEF support more locations than OIF BH teams. Additionally, it takes significantly more time to get to those locations in Afghanistan than in Iraq. As a result, 52% of OEF BH personnel reported having to cancel a mission due to the inability to travel compared to 28% of OIF BH personnel. Conversely, a similar percentage (30% vs. 25%) of BH personnel in OEF and OIF reported there were adequate BH assets in theater to cover the mission.

Table 18: Behavioral Health Locations

	OIF 2007	OEF 2007	p-value
How many locations does your BH/COSC team support? (Mean)	9	30	0.001
On average, how many hours does it take to travel to the locations you support? (Mean)	8	39	0.001

One likely factor contributing to differences in travel hours between the two theaters is the geography of Afghanistan. This theater presents a significant challenge for ground movement due to the numerous mountain ranges and lack of road infrastructure. Therefore, air assets are the primary means of transportation and access to these are limited. Scheduling limitations and route changes for air travel rarely allow for short notice transportation arrangements between locations.

Due to the small number of BH providers in the OEF theater, statistical comparisons of many BH survey questions between OIF 2007 and OEF 2007 were limited. Therefore, theater specific responses to selected survey items in Table 19 are presented as descriptive percentages only.

Table 19: Significant differences between OIF 2007 and OEF 2007 of Behavioral Health Personnel Surveyed
 Respondents: OIF (n = 131), OEF (n=23)

	OIF 2007	OEF 2007
STANDARD OF CLINICAL CARE (Percent Agree or Strongly Agree)		
The standards of BH care are clear.	52%	61%
The standards for clinical documentation are clear.	42%	30%
The standards for records management are clear.	43%	26%
Commanders are satisfied with the amount of information I can provide	72%	61%
STANDARD OF CLINICAL CARE (Percent Agree or Strongly Agree)		
RESOURCES FROM COMMAND (Percent Agree or Strongly Agree)		
My higher HQ (command) provides us with the resources required to conduct our mission.	34%	52%
My higher HQ (command) encourages us to provide feedback/comments to theatre/AO BH/COSC policies	31%	61%
We coordinate/integrate our BH/COSC activities with primary care/med personnel in the battalion aid stations/medical companies.	77%	91%
WELL-BEING (Percent Agree or Strongly Agree)		
My ability to do my job is impaired by the stressors of depolyment/combat.	19%	4%
My mental well being has been adversely affected by the events I have witnessed on this deployment.	26%	13%
PSYCH MEDS AVAILABILITY (Percent Agree/ Yes)		
Level II Forward Support Medical Company.	71%	50%
COMBAT & OPERATIONAL STRESS		
I attended the pre-deployment COSC training course (Percent Yes)	52%	44%
I received adequate training pre-deployment to prepare me for COSC duties (Percent Agree/Strongly Agree)	31%	45%
DOING THEIR JOB (Percent Frequently or Always)		
Conduct command consultation.	71%	61%

33.2.3 Standards of Care / Combat and Operational Stress Control (COSC)

Although a higher percentage of OEF 2007 BH personnel reported that the standards of BH care were clear, fewer OEF BH personnel reported that the standards of clinical documentation and record management were clear compared to OIF 2007 BH personnel. During interviews with BH personnel, they reported there was no standardized reporting system for tracking BH workload such as the US Army COSC Workload and Activity Reporting System (COSC-WARS). When asked on the survey, only 13% of OEF BH personnel reported being confident in their ability to use COSC-WARS. These findings may be due to differing documentation requirements of the Air Force versus the Army. Additionally, the lack of clarity on documentation and record management may have been compounded by the fact that fewer of OEF BH personnel reported they attended the COSC Course.

33.2.4 Resources

Overall, support from higher headquarters was viewed in a positive light by OEF BH personnel. A higher percentage of OEF 2007 BH survey respondents reported that their higher headquarters provided enough resources to conduct the mission compared to OIF 2007 BH personnel. Similarly, more OEF 2007 BH personnel reported being encouraged by higher

headquarters to provide feedback on BH policies compared to OIF BH personnel. Additionally, more OEF 2007 BH personnel reported coordinating their BH activities with medical personnel and talking with unit medical personnel than OIF BH personnel.

33.2.5 Well-Being

As with primary care personnel, there has been a lot of concern about BH personnel burnout and decreased well-being. Across the board, BH personnel in OEF 2007 reported less burnout and better well-being. Thirteen percent (13%) of OEF 2007 BH personnel reported that their well-being was adversely affected by the events they had witnessed during the deployment compared to 26% of OIF 2007. Only 4% of OEF 2007 BH personnel agreed that their ability to do their job had been impaired by the stressors of the combat deployment compared to 19% of OIF 2007 BH personnel. Similarly, a greater percent of OEF BH personnel reported high morale (65% vs. 39%), high energy (44% vs. 31%), high motivation (74% vs. 39%) and lower burnout (17% vs. 33%) compared to OIF 2007 BH personnel. This may be primarily due to OEF BH personnel being deployed an average of 4 months compared to 9 months for OIF BH personnel.

In order to gain more fidelity in the assessment of provider well-being and functioning, future BH (and Primary Care) surveys should include additional items. These include items about the number of deployments, duty and time at remote outposts, whether or not personnel are organic to their unit or PROFIS (Professional Officer Filler Information System) replacements, and the degree to which BH personnel are operating as one or two-person teams in supporting FOBs and multiple outposts.

33.2.6 Behavioral Health Functional Work

Survey responses revealed differences in the way BH care was delivered in OEF 2007 versus OIF 2007. OEF 2007 BH personnel reported that they conducted more (91% vs. 80% at least weekly) one on one BH counseling at the BH unit but less (32% vs. 39% at least weekly) BH counseling at the Service Members' worksites. Similarly, OEF 2007 BH personnel conducted COSC outreach less frequently (30% vs. 57% at least weekly) compared to OIF 2007 BH personnel. Additionally, fewer OEF 2007 BH personnel reported conducting command consultations (61% vs. 72% frequently/always) and fewer developed prevention and early intervention plans (36% vs. 49% frequently/always).

As previously mentioned, OEF BH personnel were predominantly Air Force whereas OIF BH personnel were predominantly Army. The pattern of the delivery of BH care reported above may be a reflection of the difference in the philosophy of the Air Force BH community compared to the Army BH community. Traditionally, the Air Force espoused a model of providing BH care on the base when their clients returned from missions. The Army BH care model pushes BH care forward to outlying areas where the Soldiers are located.

In sum, the picture as of November 2007 was one of OEF BH personnel conducting their missions mainly out of their CSC office, doing a limited number of command consultations and generally little BH outreach. Additionally, there was only a part-time BH consultant to the (b)(2)

(b)(2) Command Surgeon and this consultant did not have any authority to make changes in the delivery of BH care in OEF. However, beginning in late November and December of 2007 and continuing through the time of this report, major changes have been made in how BH personnel conduct their mission. The CSC Commander developed and mandated an increased outreach program, formulated and implemented an early intervention program, implemented combat and operation stress control-workload and reporting system (COSC-WARS) to assist in managing

client information and as noted previously, realigned BH resources to cover more locations. Additionally, the (b)(2) Command Surgeon appointed the CSC Commander as the BH consultant and together they are working to optimize the delivery of BH care in OEF.

33.2.7 Equipment and Supplies Needed to Conduct the BH Mission

BH personnel were also asked to provide written comments on equipment or supplies that they were lacking that would improve their ability to conduct the mission. The most commonly requested resources were: (1) more personnel, (2) laptops, (3) vehicles, (4) office space, (5) cellular or satellite phones and (6) pamphlets.

33.2.8 Psychiatric Medications

It is not possible to conduct meaningful comparisons between OEF 2007 and OIF 2007 on the availability of psychiatric medications due to having only 3 OEF 2007 psychiatrists who could prescribe to the survey population. When asked about the availability of psychiatric medications at the three levels of care, 2 of 3 OEF 2007 psychiatrists reported that there was adequate availability at Level I (Battalion Aid Station) facilities and 1 of 2 (1 did not answer) at Level II (Forward Support Medical Company) and Level III (Combat Support Hospital). Finally, 2 of 3 psychiatrists reported that there was adequate availability of psychiatric medications in the area of operations (AO).

33.3 Behavioral Health Provider Interview Results

Interviews were conducted with five BH personnel. In general, the themes that emerged from interviews underscore the BH survey findings and also add depth and context to the survey results. The key content discussed included the role of the behavioral health specialist, common problems of Service Members seen by BH personnel, and Service specific issues. Additionally, there was one issue that was unique to Air Force BH personnel; CSC personnel do not always train together prior to a deployment. Finally, Battlemind Psychological Debriefings were not being conducted in OEF.

The role of the mental health specialist includes administrative tasks, NCO duties, front desk, triage, psychosocial histories, briefings, and classes (relaxation, cognitive skills, etc.). Techs that are forward (at FOBs) do "walk-arounds". Some are certified alcohol and drug addiction counselors.

It was reported that some mental health specialists do therapy but may not have the training to do so. One senior BH provider stated "It would be helpful if they could do it (therapy) but need more training. They can learn to do it for substance abuse, why not for other therapy." When behavioral health specialists conduct therapy, the supervision and clinical oversight were done by a Ph.D. or MD officer. Some providers felt that training MH specialists to do therapy is oftentimes based on individual characteristics or capabilities of the specialist. Some may not be suited for that level of responsibility.

The most frequently identified problems reported by BH personnel varied by location and type of unit supported. For those (b)(2) who supported predominantly large FOB-based units, the most frequently seen problems were relationship issues with family members and unit leadership, and anger. For BH personnel at the more remote FOBs who supported the line units, the most common problems were Anxiety Disorder NOS (Not Otherwise Specified), and Combat Stress (PTSD). One provider reported "Soldiers stay functional but have symptoms.

Most common ranks seen are E5-E7, captains and majors. I also see Soldiers with Silver and Bronze Stars with valor.” Additionally, a significant percentage of BH personnel reported that they were seeing Service Members with sleep problems and nightmares.

When asked if there were many evacuations for BH issues, a provider stated “yes, quite a few for psychotic breakdowns, chronic PTSD. Many of these Soldiers are sent to Afghanistan despite a doctor saying they shouldn’t go or leaders knowing they shouldn’t deploy. Some bipolar patients and Soldiers having their first psychotic episode, such as Schizophrenia have to be evacuated.” Another provider stressed how important it was that he “screened” his Soldiers for mental health issues before deploying and that his leadership supported his recommendations to not allow Soldiers at high risk (personality disorders or Axis I diagnoses) to deploy. Alternatively, another BH Provider reported her surprise at “the amounts of people deployed who shouldn’t have. Doctors recommend they don’t deploy or commanders know they shouldn’t deploy. Soldiers have to fight for their health – they have chronic PTSD after 5 deployments. They are sent back to Landstuhl, Germany, and then sent to Fort Hood where they are sent back to Afghanistan. Soldiers want to be with their unit but can’t do their job.”

As noted earlier, service specific issues among the Army and Air Force were identified, such as the difference in philosophy of forward placement of BH assets. Additionally, shorter deployment length for Air Force BH personnel meant less time for Soldiers to learn to trust the Air Force BH personnel. One Psychologist reported “My dream would be to have the CSCs on the same rotations; we will go through 3 sets of teams and it takes time to get trust.” The lack of a common culture among Army and Air Force personnel was identified by a provider who stated “the only problem is that the Air Force doesn’t understand the Army system; need to understand Battle Space and how the Company Commander “owns the dirt”.”

One senior Air Force BH provider identified a few issues that were unique to the Air Force BH personnel. “I would like the whole team (CSC) to train together prior to arriving in theater. Also have positions established before arriving in theater. Air Force has a policy in which 3 of the Air Force mental health are on 4 month rotations instead of the 6 month rotation the rest of the CSC is on. I would like them all to be on the same rotation schedule/length. Also, enforce the requirement that all Air Force personnel get combat skills training prior to arriving in theater so they can go outside the wire. As is, at least 1 provider does not go outside the wire. Non-combat skills trained Airmen can volunteer to go outside the wire but are not required to.”

One additional area identified was the need for the theater BH consultant to the (b)(2) Surgeon to be formally defined. There was agreement among senior BH personnel and (b)(2) (b)(2) Command Surgeon staff that the role of BH consultant was unclear.

Finally, Battlemind Psychological Debriefings have been dictated as best clinical practice by the AMEDD Center & School and are the recommended form of debriefing when appropriate. However, OEF 2007 BH personnel were not conducting them as of NOV 07. Some BH personnel reported doing CISDs while others said they use more education following traumatic events. For instance, one BH provider stated “I don’t use CISD, don’t use that structure. I do psychoeducation and gathering of common trauma. Let Soldiers guide it. I work with the Chaplain. Let the Soldiers know the purpose. It depends on how long after (the event), may do a defusing. Work on anything they are stuck on. I do more individual therapy after.” In summary, there was no standardized psychological debriefing policy in OEF. However, in JAN 08, as part of the new CSC Policy, the CSC Commander mandated that Battlemind Psychological Debriefings be done whenever debriefings are appropriate.

34. PRIMARY CARE SURVEY

34.1 Primary Care Survey Methodology

A census sampling design was employed for the Primary Care (PC) survey. That is, surveys were sent to Primary Care personnel throughout the OEF theater of operations and each was given an equal opportunity to complete and return surveys. Forty (n= 40) PC surveys were returned of the 50 distributed. The OEF 2007 sample size was lower than OIF 2007 (n = 135).

The OEF 2007 PC survey items were identical to OIF 2007 PC survey items. Survey items focused on demographics, standards of practice, coordination of services for BH cases skills, training and practice in relation to BH services, availability of psychiatric medications, and personal well-being. Additionally, each survey had a qualitative section for all respondents to write in the equipment / resources / supplies that would have improved their ability to complete their mission.

As with the BH surveys, chi-square tests of independence were calculated to see whether the percentages differed significantly between OIF 2007 and OEF 2007. Differences were deemed significant using the standard $p < .05$ cut-off.

34.2 Primary Care Survey Demographics

Demographics from the Primary Care survey are listed in Table 20.

Table 20: Demographics of Primary Care Personnel in OEF 2007.

	Primary Care Survey Demographics
Sample Size	n = 40
Age (Mode)	30-39 years old
Gender (Mode)	78% Male
Rank (Mode)	63% Officer
Branch of Service (Mode)	70% Army
Component (Mode)	83% Active Duty
Average Months Deployed since 9/11	11.53
Average Number of Service Members supported by team	1,991
Average Hours spent per Week Outside FOB	14.72
Average Days per Month Living Outside FOB	5.13

Of note is that OEF 2007 PC personnel reported being in theater significantly less time than OIF 2007 PC personnel (5 months vs. 11 months). However, OEF PC personnel reported spending more days per month (5 vs. 2) living at Forward Operating Bases (FOBs) and spending more hours per week (15 vs. 6) outside the wire than did OIF PC personnel.

34.3 Primary Care Role in Mental Health

OEF 2007 Primary Care (PC) personnel reported no significant differences from OIF PC personnel on questions assessing their role in providing behavioral health care. For example,

approximately 40% of PC personnel in OEF and OIF reported helping Service Members with mental health problems at least weekly. There was a trend toward OEF PC personnel referring Service Members with mental health problems more often than OIF PC personnel (37% vs. 25%). However, this difference was not significant.

Table 21: Role of Primary Care Providers in Behavioral Health (Unadjusted Percents).

	OIF 2007	OEF 2007
COMBAT AND OPERATIONAL STRESS CONSULTING (Percent Agree or Strongly Agree)		
<i>During this deployment how frequently did you:</i>		
Help Service members with a mental health problem weekly.	40%	40%
Refer Service Members with problems to mental health personnel weekly?	25%	37%
PSYCH MEDS (frequency of event)		
During this deployment how frequently do you prescribe meds for depression (monthly).	64%	63%
During this deployment how frequently do you prescribe meds for sleep problems (weekly).	52%	56%
During this deployment how frequently do you prescribe meds for anxiety (monthly).	60%	63%

34.4 Provider Well-Being and Burnout

There were very few significant differences in OEF 2007 PC personnel well-being (as assessed through the survey) when compared to OIF PC personnel well-being. In general, morale, mental well-being, and job impairment due to deployment stress/experiences, and perceptions of burnout remained unchanged compared to OIF PC personnel. One exception is that OEF PC personnel reported higher levels of motivation (55% high/very high motivation vs. 33% in OIF).

As with the survey of Behavioral Health personnel, future Primary Care surveys should include items such as the number of deployments, duty and time at remote outposts, whether or not personnel are organic to their unit or PROFIS (Professional Officer Filler Information System) replacements. Moreover, coordination with other MEDCOM organizations studying provider fatigue and burnout should occur so that richer data may be collected in order to best inform policy and best-practice decisions.

34.5 Psychiatric Medication in OEF

Primary Care personnel in OEF 2007 reported some ambiguity in the logistics of psychiatric medications. Thirty-five percent (35%) of OEF PC personnel vs. 59% of OIF PC personnel reported that the procedures for ordering and replenishing psychiatric medications in the Afghanistan theater of operations were clear.

34.6 Resources

Primary Care respondents also wrote in comments regarding equipment or supplies they felt would have improved their mission. Key concerns are summarized: (1) better functioning and connectivity to MC4 computers, (2) better X-ray capabilities, (3) fully stocked pharmacies, (4) more behavioral health personnel, (5) various medical equipment such as defibrillators, (6) better troop medical clinics (TMCs), (7) more training, and (8) more PC providers.

35. UNIT MINISTRY TEAM SURVEY

35.1 Unit Ministry Team Survey Methodology

A census sampling design was employed for the Unit Ministry Team (UMT) survey. That is, surveys were sent to Unit Ministry Team personnel throughout the OEF theater of operations and each was given an equal opportunity to complete and return surveys. Twenty-four (n= 24) UMT surveys were returned out of 25 distributed. The OEF 2007 sample size was smaller than the OIF 2007 sample (n = 83). All comparisons in this section will be made to OIF 2007. UMT data were not collected in OEF 2005 and therefore comparisons to this population are not included here.

OEF 2007 UMT survey items were identical to OIF 2007 UMT survey items. Survey questions focused on demographics, coordination of services, religious activities, skills and training, service member needs, and personal well-being. Additionally, each survey also had a qualitative section for all respondents to write in the equipment / resources / supplies that would have improved their ability to complete their mission.

As with the BH and PC surveys, chi-square tests of independence were calculated to see whether the percentages differed significantly between OIF 2007 and OEF 2007 UMT survey responses. Differences were deemed significant using the standard $p < .05$ cut-off. Unit Ministry Team demographics are presented in Table 22.

Table 22: Demographics of Unit Ministry Team Personnel in OEF 2007.

Unit Ministry Team Survey Demographics	
Sample Size	n = 24
Age (Mode)	40+ years old
Gender (Mode)	91% Male
Rank (Mode)	50% Officer
Branch of Service (Mode)	71% Army
Component (Mode)	67% Active Duty
Average Months Deployed since 9/11	15.35
Average Number of Service Members supported by team	807
Average Hours lived per Week Outside FOB	23
Average Days per Month Living Outside FOB	5

35.2 Unit Ministry Team Results

Although on average, OIF 2007 UMT members reported on the survey that their team supported more Soldiers (2,178 vs. 807) than OEF 2007 UMT members, OEF 2007 UMTs supported more locations (24 vs. 11). In addition, during interviews, both Chaplains and Chaplain Assistants reported having great difficulties traveling to the more remote locations they supported.

Significant percentage differences between OIF 2007 and OEF 2007 UMT items are displayed below in Table 23.

Table 23: Unit Ministry Team Coordination

	Percent Frequently or Allways		p-value
	OIF 2007	OEF 2007	
COORDINATION WITH UNIT PERSONNEL (% Frequently or always)			
Talk with units behavioral health/COSC personnel	52%	17%	0.01
Talk with units medical personnel.	86%	63%	0.05

Overall, there were very few significant differences between responses reported in OIF 2007 and OEF 2007. This may be due to the small number of UMTs surveyed in OEF 2007. However, a pattern emerges in which the level of coordination between UMT personnel and both behavioral health personnel and medical personnel is significantly lower in OEF. The percentage of respondents in the OEF 2007 UMT survey who reported that they frequently or always talked with the behavioral health personnel was significantly lower than in OIF 2007. Similarly, the percentage of respondents in the OEF 2007 UMT survey who reported that they frequently or always talked with the medical personnel was significantly lower than in OIF 2007. These data highlight the need for UMT personnel to communicate more frequently with leadership and medical personnel when conducting their mission.

Unit ministry team personnel in OEF 2007 reported significantly higher (75% vs. 43% high or very high) levels of energy than OIF 2007 UMT personnel. Additionally, OEF UMT personnel reported lower (17% vs. 25%) rates of burnout than OIF 2007 personnel. These findings suggest that Chaplains may have the necessary reservoir of energy and low burnout needed to do a greater amount of coordination as recommended above.

36. MILITARY TRANSITION TEAMS MENTAL HEALTH AND WELL-BEING

The OEF 2007 MHAT surveyed 190 Soldiers from Task Force (b)(6), (b)(2)

(b)(2)

Task Force (b)(2) Soldiers were older than (b)(2) BCT Soldiers with 59% of TF (b)(2) being over 30 years old compared to 15% of (b)(2) BCT Soldiers. They had a higher percentage of NCOs (44%) compared to the (b)(2) BCTs (31%). Additionally, a higher percent were married (54% vs. 39%). Finally, TF (b)(2) Soldiers had been in theater less time (5.5 months vs. 7.7 months), reported fewer combat experiences than (b)(2) BCT Soldiers (i.e. 57% had received incoming artillery, rocket or mortar fire compared to 84% of (b)(2) BCT Soldiers) and reported less concern about non-combat deployment stressors (i.e. 33% high or very high concern about long deployment length compared to 64% of (b)(2) BCT Soldiers). These factors are normally associated with better mental health.

TF (b)(2) Soldiers had higher individual morale (42% vs. 19%) and unit morale (17% vs. 12%) compared to (b)(2) BCT Soldiers. A higher number of TF (b)(2) Soldiers reported using alcohol while in theater (10% vs. 5%). Overall, TF (b)(2) Soldiers were less likely to screen positive for a mental health problem than other (b)(2) BCT Soldiers (7% vs. 20%). Fewer TF (b)(2) Soldiers reported symptoms of depression (4% vs. 11%), anxiety (4% vs. 10%), and acute stress (5% vs. 15%) than (b)(2) BCT Soldiers. Additionally, few TF (b)(2) Soldiers reported stigma and barriers to receiving behavioral health care. For example, 17% of TF (b)(2) reported having difficulty getting time off work for treatment compared to 35% for (b)(2) (b)(2) BCT Soldiers.

Ratings of officer and NCO leadership were lower in TF (b)(2) compared to (b)(2) (i.e. 30% vs. 41% reported that their leadership often or always treated all members of the unit fairly). For example, a significantly lower percentage (46% vs. 57%) of TF (b)(2) Soldiers reported their officers were concerned about their safety compared to (b)(2) Soldiers. Similarly, a lower percentage (35% vs. 45%) of TF (b)(2) Soldiers reported their NCOs exhibited clear thinking and reasonable action under stress compared to (b)(2) Soldiers. Both officer and NCO leadership were identified in interviews as areas that Soldiers thought showed room for improvement. This is especially important considering the finding that TF (b)(2) Soldiers who reported they had good officer leadership were significantly less likely (3% vs. 11%) to screen positive for a mental health problem compared to those who reported they had poor leadership.

During interviews with BH and PC personnel several common themes emerged. First was the lack of support from their higher headquarters. (b)(2)

(b)(2)

(b)(2)

The higher headquarters did not require nor receive any

medical or mental health reports, delegated all medical decisions, and did not provide any behavioral health support.

Although absolute rates of combat experiences and mental health problems in TF (b)(2) were lower than in (b)(2) BCTs, there were significant events experienced that included 15 killed in action (KIAs) within the first 6 months. That number is twice as high as the number of KIAs in the brigade that served as the previous transition team in OEF had in their entire year-long deployment. Another issue identified was the lack of a relief in place (RIP) overlap time with the previous brigade and that brigade did not identify any plan for providing behavioral health care.

Having sister service (non Army) providers working in an Army Brigade Combat team also presented challenges for the delivery of behavioral health to TF (b)(2). One provider voiced major challenges by saying "this (TF (b)(2)) is an Army world. I had no prior training on how to provide mental health in an Army environment. It's problematic, Army paperwork for Command Evaluations, drugs, Article 15s. Soldiers have to go to (b)(2) for command evals. I didn't know any of the Army paperwork or terminology; it's been a steep learning curve."

When asked about the adequacy of BH staffing in TF (b)(2) one of the BH personnel responded with "we're grossly under resourced. TF (b)(2) has about (b)(2) we need more than 3 (behavioral health personnel). Need one at each of the major FOBs and the regional corps headquarters needs behavioral health also. We need 6 teams of 2 each." Due to the shortage of personnel, one provider reported "I haven't been able to do any prevention; I had it as a priority." TF (b)(2) providers agreed with the (b)(2) BH staffs' comments about the difficulty traveling to the FOBs where TF (b)(2) Soldiers lived and worked. It was also very difficult to provide BH support to Embedded Training Team Soldiers as they spend a majority of their time living with Afghan National Army or Afghan National Police. Due to the shortage of BH providers, one mental health specialist was functioning in the role of a social worker, doing case management, described as handling adjustment reactions, financial concerns, and relationship issues.

One provider commented about the effects of combat on the behavioral health of Soldiers stating "there is a poor understanding of the significance of mental health to performance in the field. Mental health is the #1 reason for poor performance and leaving the field is stressful. We need commanders to understand this; it's a numbers game. The Army is driven by Infantry; driven by charging the hill without question even if you die. There is more demand for individual initiative in the Air Force and Navy. They have a tech focus – it's a grunt (Army) vs. hardware manager (AF and Navy). The Army is chewing people up. Soldiers may have PTSD but they won't tell their commanders. Commanders will rip them a new one if they have a mental health problem. That's got to change. It will keep more men in the field."

37. THEATER SUICIDE AND SUICIDE PREVENTION

37.1 Theater Suicide Rates

Although the raw number of suicides in Afghanistan is small, suicide continues to be a problem. Since the beginning of OEF, there have been 15 confirmed Army suicides. There were 3 confirmed suicides for 2007 as of 30 OCT 07, producing an annualized rate in theater of approximately 20/100,000³. Theater rates of suicide have held steady between 16 to 22 per 100,000 since 2002, and remain elevated compared to both the total Army rate and rates observed in the civilian population. This pattern did not exist in 2003 when the rate was significantly lower (8.3%). This section will discuss in detail what is known about the problem, and the present status of prevention efforts.

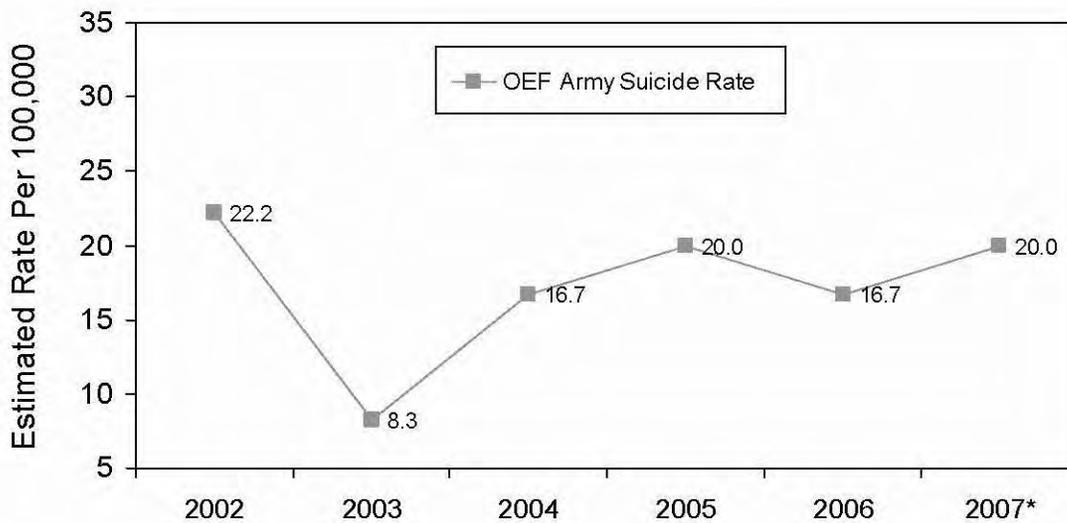


Figure 13: OEF Army Suicide Rates

*Estimated Rate as of 30 OCT 2007

The 10 year rate for suicide and average rate for the entire active duty Army suicide is presented in Table 24. There is no reliable method in place to collect and report Reserve and National Guard suicide data when personnel are not serving on active duty. As such, our discussion of these components is limited to their behavior when on active status.

The Army-wide suicide rate has been trending upward in recent years, driven in part by the increase in theater suicides. The total Army rate was 17.3 per 100,000 in 2006, up from the rate of 9.8/100,000 observed at the beginning of hostilities in 2001 (Table 24). The ten year average has thus been adjusted upward from the 11.6/100,000 number reported in MHAT IV to a 12.2/100,000 number for MHAT V.

³ Calculated as of 30 OCT 07, based on the 3 OEF confirmed suicides this year to date. Estimates use an OEF average day "boots on the ground" total of 20,000 forces.

Table 24: US Army Suicide Rates -
Ten Year Average (1997-2006)

Calendar Year	Rate per 100,000
1997	10.6
1998	12
1999	13.1
2000	12.1
2001	9.8
2002	11.3
2003	12.4
2004	10.8
2005	12.8
2006	17.3
Average 1997-2006	12.2
US Average	10.9*

*NIMH Population Average for 2004
(Latest Year Available)

37.2 Army Verses Total Forces Data

A great deal of information is available for Army suicides in Afghanistan. The Suicide Risk Management and Surveillance Office (SRMSO) at Fort Lewis, WA, collects detailed information on all Army Suicides via the web based Army Suicide Event Report (discussed below), and presents this information in a readily searchable format. The Army MEDCOM Suicide Prevention Office (SPO) at Fort Sam Houston has also performed detailed analysis of Army Suicides. The Army G-1 publishes weekly Suicide Updates which break out Army suicides in the Afghanistan theater of operation, and gives the status of confirmed versus probable cases.

37.3 Suicide Prevention Programs

The previous MHATs have reviewed the status of the OIF theater's suicide prevention and surveillance program, including an analysis of completed suicides. The MHAT V OEF conducted a similar review of (b)(2) prevention and surveillance program and a detailed analysis of completed suicides.

37.4 Suicide Prevention Structure

Unlike MNF-I, (b)(2) does not have a formalized Suicide Prevention Committee nor a standardized suicide prevention training package. Therefore, those responsible for conducting suicide prevention training, mainly Chaplains, are using a wide variety of training tools. These range from senior Chaplains doing Suicide Prevention Training with no materials other than "my 20+ years of working with Soldiers" to detailed briefs including one that uses a non-validated suicide intervention assessment tool. When asked about the effectiveness of the suicide prevention program in OEF, one BH provider responded "effective as it's ever been. Prevention – don't know how effective. It's ad nauseum. Soldiers don't need any more briefs. They could use interactive training, hands-on at the lowest level."

37.5 Theater Suicide Review

A summary of Army OEF theater suicides for 2007 was conducted by the MHAT V OEF team. As has been consistently true for reviews going back as far as 20 years (Rock, 1988), military suicide is most often precipitated by the loss of a relationship--either a spouse or other intimate partner.

**Table 25. Profile of Confirmed OEF 2007 Soldier Suicides
(As of 30 OCT 2007)**

Date of Suicide	Age	Rank	MOS	Comp	Gender	Race/Ethnicity	Marital	Method
(b)(6)								

N = 3

A distant second cause implicated in suicide is loss of career, usually through UCMJ or other criminal charges. For the Active Army as a whole, people who committed suicide in 2007 are, on average, older and higher ranking than in previous years. For the first time in at least a decade, the majority of Army suicides (54%) were of rank E-5 or higher (although this was not the case for OEF 2007).

37.6 Army Suicide Event Report (ASER)

The primary tool for surveillance of Army suicide remains the Army Suicide Event Report (ASER); a reporting and tracking mechanism for completed suicides and non-lethal suicide events that result in hospitalization and/or evacuation. The ASER was developed and initial validation conducted by the U.S. Army Medical Research Unit-Europe, as a means to track suicides in near real-time and suicidal behaviors of Army personnel within the U.S. Army, Europe (USAREUR) (Dolan, Schroeder, Wright, Thomas, & Ness, 2003).

Following the recommendation of the first Mental Health Advisory Team (MHAT I) in 2003, the U.S. Army Medical Command issued a policy directing that the ASER be used throughout the Iraq and Afghanistan Theaters of Operations. The Suicide Risk Management & Surveillance Office (SRMSO) located at Fort Lewis, WA, has operational oversight of the ASER, conducts routine data analyses and publishes reports of these findings. The SRMSO also has responsibility for updating the ASER, with the latest update in the spring of 2007.

The SRMSO has issued guidance for completing ASERs. The ASER should be completed for all fatalities, hospitalizations, and evacuations when the injury or injurious intent is self-directed. It is not intended to replace the psychological autopsy, which is limited to fatalities in which the manner of death is uncertain (b)(5)

Quality control of ASERS in theater has remained problematic, both in submittal tracking and quality. This is due in large part to the mechanism of data entry, which is unique to the ASER. ASER information is directly entered into database fields using a web page based at Fort Lewis,

after which data automatically enters the ASER database. Once entered, auditing or editing submissions is not possible. Further, there has in the past been substantial difficulty in communication between the SRMSO office and theater.

Previous MHATs have reported that this issue has been corrected; therefore continued monitoring of the effectiveness of theater surveillance is warranted. Ideally, the ASER should be a component of AHLTA (Armed Forces Health Longitudinal Technology Application) and AHLTA-T (Armed Forces Health Longitudinal Technology Application - Theater), rather than a free standing web site. In this case, data could be inputted directly as medical information, which would allow quality control, auditing and review that is not presently possible in the current system.

37.7 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 (CDC) and are used to organize the discussion of suicide in Afghanistan.

37.7.1 Risk Factors

Risk Factors most relevant to Army suicide in Afghanistan are presented below:

6. **Loss (relational, social, work, or financial).** This has consistently been the key variable associated with suicide. It appears that long tour durations, in itself, do not increase rates of suicide. Rather, tour length serves as a secondary factor in provoking marital disruption and in kindling the loss of relationships. Aggressive efforts to strengthen families and improve communication are a logical remediation to this problem, as well as psychological resiliency training aimed at better weathering these break ups.
7. **Isolation, a feeling of being cut off from other people.** The Soldier survey assesses this directly by asking whether Soldiers are "Feeling Distant or Cut off from People". Results reveal that 47.2% of all Soldiers surveyed in OEF 2007 have experienced these feelings of isolation at least somewhat in the past month. Efforts by MWR to deliver mail, as well as enhance internet and phones, have probably helped in this dimension. However, this variable should continue to be monitored over time, and efforts to keep Soldiers feeling engaged in what is going on "back home" (e.g. Superbowl parties in theater) should be encouraged.
8. **Barriers to accessing behavioral health treatment.** As noted in the Soldier Well-Being section of this report, stigma to receiving behavioral health care, such as being seen as weak and barriers to receiving care, such as difficulty getting time off work for treatment were higher in OEF 2007 compared to OEF 2005 and OIF 2007. Ensuring that the climate promotes behavioral health care seeking and facilitates access to care may help get care for those who are having suicidal ideation.

37.7.2 Protective Factors

Protective factors for suicide buffer individuals from suicidal thoughts and behavior. To date, protective factors have not been studied as extensively or rigorously as risk factors. Identifying

and understanding protective factors are, however, equally as important as researching risk factors. Protective factors which act to reduce suicide probability in Afghanistan are listed below.

6. **Lack of Intoxicants:** Alcohol is a known risk factor for military suicides. The relative lack of availability of intoxicants in theater should therefore act to lower the rate of suicide. It has long been known that intoxicants make the act of suicide more likely through disinhibition effects. The National Violent Death Reporting System examined toxicology tests of those who committed suicide in 13 states. Postmortem tests of these cases revealed that 33.3% tested positive for alcohol; 16.4% for opiates; 9.4% for cocaine; 7.7% for marijuana; and 3.9% for amphetamines (Karch et al. 2006).
7. **Easy access to a variety of clinical interventions and support for help seeking.** Recent redistribution of troops in the battlespace calls for equally agile shifts in behavioral health support, which is a strong argument for locating the Theater BH Consultant at the (b)(2) Command Surgeon level. This also calls for increased efforts at destigmatization of seeking behavioral health care services.
8. **Family and community support.** Efforts to strengthen family and unit bonds should be encouraged, and the definition needs to be broadened to include significant others regardless of marital status (fiancée support).
9. **Skills in problem solving, conflict resolution.** Relationship enrichment and training, at both the Soldier and the Family Readiness Group (FRG) level, designed to improve communication will assist in re-integration and strengthening relationships. All available evidence supports stabilizing relationships as the single most effective suicide prevention intervention.

37.8 Surveillance

Each service uses its own unique tool for tracking suicides. The Air Force uses a system called the SESS, the Navy uses the DON SIR and the Coast Guard presently has no centralized reporting system. An effort is presently underway to expand the ASER from an Army system to a tri-service tool, to be called the DoDSER, which would greatly enhance surveillance.

38. SUMMARY, DISCUSSION, AND RECOMMENDATIONS

This section of the report first summarizes the key findings and then makes a series of recommendations.

38.1 Summary of OEF 2007 Soldier Well-Being Survey Findings

The summary of findings from the Soldier Well-Being survey are presented below.

1. OEF 2007 Soldiers in Brigade Combat Teams (BCTs) reported combat levels comparable to or higher than OIF 2007 Soldiers in BCTs. Combat levels are a key determinant of mental health status.
2. Deployment length and family separation were the top non-combat issues.
3. Soldier morale was similar to OIF 2007 but lower than OEF 2005.
4. OEF 2007 Soldiers had higher rates of mental health problems than OEF 2005 Soldiers and comparable or higher rates to OIF 2007 Soldiers.
5. Good leadership was a key factor in sustaining Soldier mental health and well-being.
6. OEF 2007 Soldiers with mental health problems reported more barriers to accessing behavioral health (BH) care than OIF 2007 Soldiers.
7. For OEF 2007 Soldiers with mental health problems, more reported receiving mental health care than OIF 2007 and OEF 2005 Soldiers.
8. Approximately 17% of OEF 2007 Soldiers reported taking mental health medications; one-half of those medications were sleep medications.

38.2 Summary of OEF Behavioral Health Personnel Findings

1. OEF BH personnel were predominantly Air Force (61%) and had significantly less time in theater than BH personnel in OIF.
2. OEF BH personnel supported more locations (30 vs. 9) and took more time to travel (including prep time) to locations (39 hrs vs. 8 hrs) than BH personnel in OIF.
3. OEF BH personnel conducted Combat & Operational Stress Control (COSC) outreach less often than BH personnel in OIF (conduct several times a week: OEF 17% vs. OIF 52%).
4. Major changes were made during and immediately following MHAT V OEF in terms of distribution of BH assets and conducting an aggressive outreach program. In addition, the (b)(2) Command Surgeon appointed the CSC Commander as the BH Consultant.

38.3 Summary of OEF Primary Care Personnel Findings

1. OEF PC personnel helped service members with MH problems as often as OIF PC personnel (40% at least weekly).

2. There was a trend toward OEF PC personnel referring service members with MH problems more often than OIF PC personnel (38% vs. 26% at least weekly).

38.4 Summary of OEF Unit Ministry Team Personnel Findings

1. OEF UMT personnel supported more locations (28 vs. 18) than in OIF.
2. OEF UMT personnel communicated less often with BH (OEF 17% frequently/always vs. 52%) and PC (62% frequently/always vs. 86%) personnel than OIF UMT personnel.

38.5 Summary of OEF Suicide Assessment

1. Since the beginning of OEF (DEC 2001), there have been 15 confirmed Army suicides. Theater rates of suicide have held steady between 16 to 22 per 100,000 since 2002 (except for 2003), and are higher than the total Army 10-year rate of 10.6 per 100,000.
2. There was no formal suicide prevention training program in OEF to ensure that Soldiers receive the latest standardized training.
3. There is no single, joint tracking system capable of monitoring suicide, mental health evacuations, and the use of mental health/combat stress control services in a combat environment.

38.6 Summary of TF (b)(2) Transition Team) Findings

1. Compared to (b)(2) Soldiers, TF(b)(2) Soldiers were older, higher ranking, more likely to be married, and in theater fewer months. They reported fewer combat experiences and less concern about deployment stressors. These factors are related to better mental health.
2. Compared to (b)(2) Soldiers, TF(b)(2) Soldiers had higher morale, were less likely to report mental health problems, reported less stigma and barriers to BH care; rated their leadership less favorably, and had a higher number of Soldiers using alcohol while in theater.

38.7 Discussion and Recommendations

Combat experiences and the resultant mental health problems in OEF 2007 were as high or higher than in OIF 2007 and generally higher than in OEF 2005. This is especially true for Soldiers in the Brigade Combat Teams who are doing the majority of the fighting. The OEF Theater of Operations has changed a great deal since OEF 2005. Based on what was observed in Afghanistan during OEF 2007 and what is being reported on the news, this trend of increased combat activity can be expected to continue. The fighting in Afghanistan became more intense in OEF 2007 as the war changed from static operations in OEF 2005 to the current counter-insurgency mission.

(b)(2)

(b)(2) There greater dispersement of troops and an increase in the number of locations where units are located. The increased number of Soldiers in OEF 2007 was not matched by an increase in the number of aviation assets needed to move Soldiers as well as get BH personnel out to the Soldiers.

Having more Soldiers and more locations with limited aviation assets makes it challenging to provide behavioral health care to Soldiers. Compounding this is the fact that OEF 2007 Soldiers report higher psychological stigma and organizational barriers to receiving behavioral health care than Soldiers in OIF 2007. Many of these barriers were related to transportation difficulties and the time required to get a BH provider out to the Soldiers or to get the Soldier in to the BH personnel. Additionally, there are service differences in the way BH care is being delivered in OEF 2007 compared to OIF 2007. Fortunately, the leadership at both the (b)(2) and the CSC were aware of these issues before MHAT V OEF mission and used the findings from MHAT V OEF to serve as a tool to make changes to BH care delivery in theater.

In making recommendations to optimize behavioral health we must assume (a) Soldiers will continue to be exposed to potentially traumatic events, (b) deployments will continue to be long, and (c) many Soldiers will be required to deploy to Afghanistan or Iraq multiple times during their military careers. MHAT V OEF recommendations are presented according to the phase of the deployment cycle in which they occur (i.e. During deployment or post-deployment/sustainment).

38.7.1 During Deployment:

An Infantry battalion that was located in one of the most dangerous areas of Afghanistan initiated a program in which Soldiers at the most remote Combat Outposts (COPs) rotated, as a unit, back to a more established FOB in order to re-set. This re-setting process allowed Soldiers time to get their equipment repaired, settle financial and/or personnel problems, do laundry, use internet and phones to communicate home, get hot showers, and have uninterrupted sleep. Additionally, Chaplains and behavioral health providers were available to talk to any Soldier who desired to do so. The key component of this re-setting program was that the Soldiers remained with their unit in a relatively safe place and did not have to pull their own security. Leaders, medical personnel, Chaplains and Soldiers all hailed this program as something that was valuable for their mental health and well-being.

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

Overall, very few Soldiers were able to get R&R and those that did were primarily from the major FOBs where the combat level and mental health rates were low. R&R is a 3 or 4 day pass and is separate from mid-tour leave. Thus, those who were experiencing the highest levels of combat and therefore in most need of R&R, were the least likely to get it. This was due to many factors, including OPTEMPO in the line units, and difficulty getting Soldiers to and from R&R locations. Some units reported that a Soldier was normally away from the unit for 2 weeks so he or she could take 4 days of R&R due to transportation problems. Another reason few line Soldiers took R&R was they were unwilling to leave their buddies behind.

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

Many Soldiers reported sleep problems including difficulty getting to sleep and having nightmares. Additionally, some Soldiers reported making mistakes due to sleepiness. Finally, half of all the medications being given to OEF 2007 Soldiers were sleep medications. As a result, sleep problems were identified as an important risk factor for

behavioral health and performance problems. Unlike other risk factors which may be largely unavoidable in combat settings (such as combat exposure), sleep deprivation and sleep problems are manageable either through work cycle management or medical treatment. In addition, seeking treatment for sleep problems may serve as an effective mechanism for Soldiers to receive care for a variety of mental health problems such as depression or acute stress because Soldiers report low stigma associated with sleep problems.

Appendix B presents the Combined Arms Doctrine Directorate (CADD) on sleep management. This document provides detailed information summarizing the research on sleep deprivation and performance and provides practical guidance on sleep management.

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

Traumatic events such as the death of a unit member have been shown to have the potential for causing mental health problems. Following the recommendation in MHAT IV, the Army Medical Command (MEDCOM) directed that the best practice for mental health debriefings following traumatic events was Battlemind Psychological Debriefings. Research conducted by the US Army found that Battlemind Psychological Debriefings immediately after a deployment resulted in reports of fewer symptoms of mental health problems in units that experienced high levels of combat.

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

Both in past research and in OEF 2007, the level of combat experiences has been shown to be the major factor in Soldiers' mental health problems. Therefore, the units with the highest level of combat experiences are most likely to need early intervention in order to mitigate the effect of those experiences on Soldiers in those units.

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

US Air Force policy requires all personnel who travel outside the wire complete Combat Skills Training. This training includes convoy operations, IED detection and other important combat skills. However, if an Airmen is not able to complete the training, they are still able to deploy but are not required to leave the base camp in which they are assigned. The choice of whether an Airmen who did not receive Combat Skills Training goes outside the wire is left up to that Airmen. During OEF 2007, some Air Force BH personnel who had not completed the training refused to leave their base camp. This resulted in Service Members who needed BH care not getting that care.

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

Soldiers reported during focus groups and interviews that they sought behavioral health care from Chaplains and medics at a rate similar to the rate that was reported for BH personnel. As of 31 October 2007 there were only 29 BH personnel in OEF 2007. BH personnel are assigned at the brigade level. However, the US Army modified Table of Organization and Equipment (mTOE) has one Chaplain in every battalion and a medic in every platoon.

Therefore there are many more Chaplains than BH personnel and an even greater number of medics in OEF 2007. They are often the conduits by which Soldiers enter the behavioral health system. However, many Chaplains and medics report having little or no formal behavioral health training. Battlemind Warrior Resiliency Training (formerly called Battlemind First Aid Training) was developed by the Walter Reed Army Institute of Research (WRAIR) to educate medics in identifying signs and symptoms of mental health problems and proper referral techniques for getting Soldiers behavioral health care.

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

In September 2007 at the request of the (b)(2) Command Surgeon, the senior BH provider from the CSC (b)(2) was appointed as the Behavioral Health Consultant to the (b)(2) Command Surgeon. It was identified that the BH Consultant should be in a position with authority and knowledge of the OEF theater in order to relocate BH assets to areas of highest need. Previously the senior provider was not in a position to authorize reassignments. Immediately following the MHAT V OEF mission, the (b)(2) Command Surgeon implemented recommendation 8 by appointing the CSC Commander as the BH Consultant.

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

38.7.2 Post-Deployment/Sustainment

As previously noted, the level of combat that a Soldier experiences is the most important factor in whether that Soldier develops mental health problems. Research conducted by the Walter Reed Army Institute of Research (WRAIR) has shown that training such as Battlemind may be most effective in some units with high levels of combat experiences than in others with fewer combat experiences.

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

There is evidence that resiliency training works. This evidence comes from large randomly controlled experiments of Battlemind Training (Adler et al., in review; Thomas et al., 2007). Therefore, the current MHAT supports the existing Battlemind resiliency training programs (many of which were recommended in MHAT IV and subsequently implemented by the Army).

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

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

One of the key protective factors for sustaining the mental health and well-being of the deployed force lies with developing junior leaders so that they recognize the important role they play in sustaining the morale and mental well-being of their Soldiers and reducing the stigma and barriers to seeking BH care. Soldiers who rate NCO leadership positively have lower levels of mental health problems than those who rate NCO leadership negatively

regardless of the level of combat experiences. This pattern is also found when examining the impact of officer leadership on mental health rates, controlling for combat experiences. Those leader behaviors that have been shown to be effective for sustaining morale, well-being, and mental health in combat need to be taught at the Warrior Leader Course and the Officer Basic Course.

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

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

Educating leaders about their role in setting a climate that supports seeking behavioral health care is very important. Additionally, leader evaluations should include benchmarks to assess the degree to which they (as leaders) set a climate that is conducive to receiving BH care or one that promotes stigma and barriers to care.

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

38.7.3 Suicide Prevention

There was no formalized suicide prevention training in OEF 2007. Additionally, the training that was being provided was not necessarily designed for the deployment phase of the Deployment Cycle Support System.

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

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