Mental Health Advisory Team (MHAT-III)

Operation Iraqi Freedom 04-06

REPORT

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Office of the Surgeon
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I. EXECUTIVE SUMMARY

A. Introduction

The Office of The Surgeon General (OTSG) established the Mental Health Advisory Team III (MHAT III) at the request of the Commanding General, Multi-National Force-Iraq (MNF-I). MHAT III continued the precedent of deploying advisory teams to Operation Iraqi Freedom (OIF) in order to assess behavioral healthcare requirements of Soldiers. MHAT I and MHAT II conducted their assessments in September and October of 2003 and 2004, respectively. MHAT III deployed to OIF 04-06 during October and November 2005.

The MHAT III charter (Appendix B) was developed in coordination with the MNF-I Surgeon to address the following questions.

1. Behavioral Health of Soldiers. What is the behavioral health status of Soldiers? How does it compare to Soldiers who deployed during Operation Iraqi Freedom I (OIF-I) and Operation Iraqi Freedom II (OIF II)? Has behavioral health been affected by multiple deployments?

2. Behavioral Healthcare System. What is the status of the behavioral healthcare system? What are the systemic factors which need to be addressed in order to ensure Soldiers are receiving the best care?

3. Future Focus. What are the planning and resource factors which must be considered to care for Soldiers engaged in future deployments to Iraq? As the Iraqi area of operations changes, what can MNF-I do to prepare to meet the behavioral health needs of Soldiers?

B. Methods

Data were collected using (a) Soldier surveys, (b) Soldier and behavioral health provider focus groups, (c) provider surveys, and (d) other data sources. Behavioral health factors assessed included Soldier well being, knowledge and utilization of behavioral health resources, suicide event data, and suicide prevention activities. The issues raised by previous MHAT reports were also examined. MHAT III collected data from Brigade Combat Teams (BCTs) and Soldiers assigned to the Multinational Security Transition Command-Iraq (MNSTC-I), a unit advising and training Iraqi forces. MNSTC-I results (Appendix A) are presented separately from the BCT findings because these Soldiers were demographically different (older and higher rank) than the BCT Soldiers.

C. Key Findings

1. Combat Stressors

Soldiers in OIF 04-06 were significantly more likely than OIF II Soldiers to report knowing someone seriously injured or killed and having an improvised explosive device (IED) or other ordnance explode near them. Forty-five percent (45%) of OIF 04-06 Soldiers as compared to 39% of OIF II Soldiers reported being in life-threatening situations where they were unsure how to respond based on the rules of engagement. Soldiers in OIF 04-06 reported significantly lower exposure to artillery, rocket, and/or mortar fire than did Soldiers in OIF II.

2. Non-Combat Stressors

Deployment length and family separation were the top two non-combat stressors for both Active Duty (AD) and Reserve Component (RC) Soldiers. Multiple deployers reported significantly higher concerns about deployment length.

3. Personal Morale Similar to Other OIF Data and Unit Morale Higher

Ratings of personal morale in OIF 04-06 were similar to ratings reported in OIF II. Ratings of unit morale were significantly higher than those from OIF I or OIF II. Personal morale among AD Soldiers did not differ between first-time and multiple deployers. Multiple deployers were more likely than initial deployers to rate unit morale as low. RC Soldiers reported higher personal morale than did active duty Soldiers. Unit morale was the same across component.

4. Behavioral Health in OIF 04-06

Fourteen percent (14%) of OIF 04-06 Soldiers endorsed screening items indicating acute stress, and 17% endorsed screening items reflecting a combination of depression, anxiety and acute stress. These findings were similar to the 16% acute stress and 19% combined measure rates from OIF I. In OIF II, the rates were 11% for acute stress and 13% for the combined measure. The OIF 04-06 rate of 17% for the combined measure was significantly higher than the rate of 13% in OIF II. RC Soldiers reported similar acute stress, but significantly lower levels of depression and anxiety than did AD Soldiers.

5. Multiple Deployers Reported Higher Levels of Acute Stress

Soldiers who had at least one prior deployment to Iraq reported significantly higher levels of acute stress (18.4%) than those on their first deployment (12.5%).

6. Suicide and Deployment to OIF

The Armed Forces Medical Examiner reported a calendar year 2005 suicide rate for the OIF area of operations of 19.9 per 100,000 Soldiers. This rate is similar to OIF I rate of 18.8 per 100,000 Soldiers and should be considered in the context of the overall Army rate of 13.1 per 100,000.

7. Suicide Prevention and Deployment Training

Soldiers received training prior to, and during, deployments on suicide prevention and managing the stresses of deployment and combat. There were significant declines from OIF II in the number of Soldiers who endorsed that this training was adequate and/or sufficient, and had made them confident in their abilities to help their peers.

8. Stigma Declines and Access to Behavioral Healthcare Improves

The stigma concerning accessing behavioral healthcare continued to decrease. A number of stigma items such as avoiding mental health for fear of being seen as weak significantly decreased from OIF I to OIF 04-06. Results of provider surveys reinforced this finding. Perceptions of availability of care were positive with only 5% reporting that it was too difficult to get to mental health specialists. During OIF I and OIF II these rates were 15% and 7% respectively. The fact that 30% of the OIF 04-06 Soldiers versus 23% of OIF II Soldiers surveyed reported receiving behavioral health services while deployed, lends additional support to improved access to care and a decreased stigma.

9. Status of the Behavioral Healthcare System

Behavioral Health (BH), Primary Care (PC) and Unit Ministry Team (UMT) participants who were surveyed had deployed an average of 300 days over the past two years. Each BH team supported an average of 5,000 Soldiers at 5 Forward Operating Bases (FOBs) and deployed for 10 months. Each UMT supported an average of 700 Soldiers at 3 FOBs and had been deployed for 7 months. BH providers were confident in their ability to treat combat and operational stress reactions among Soldiers. Fewer (21%) of the BH providers reported understanding the standards for the transfer of clinical information between levels of care as compared to 35% of providers in OIF II. Fifty-five percent (55%) of BH providers reported conducting unit BH needs assessment at least once every 2-3 months. However, no standardized needs assessment instrument was available until MHAT III provided the Unit Behavioral Health Needs Assessment Survey to a combat stress control detachment.

10. Soldier Focus Groups

First-time deployed Soldier focus groups reported easy access to communication to home, excellent dining facilities, high job satisfaction, an appreciation for behavioral health services and good access to morale support activities. Negative aspects of the deployment cited included the perception that the enemy was more lethal and unpredictable with the frequent use of Improvised Explosive Devices (IEDs). Tour lengths for Soldiers were reported as too long, and the differences in length among the services were viewed negatively.

In the multiple deployer focus groups, participants were asked to compare positive and negative aspects of this deployment with a prior deployment. They reported that they were better prepared due to improved pre-deployment training and knew what to expect. They reported more stress on families and not enough time between

deployments. They also described the combat environment as more dangerous due to IEDs and difficulty dealing with being in a defensive posture.

11. Status of MHAT II Issues

Eight of fourteen issues specific to the OIF area of operations are now green. Five are amber, and one is red. A standardized Unit Behavioral Health Needs Assessment (UBHNA) was fielded to a CSC unit by MHAT III.

D. Recommendations

1. Implement a MNF-I BH Policy. Appendix D outlines a series of behavioral health issues, recommendations, and a structure to meet the needs of coalition forces.

2. Designate a MNF-I BH Consultant to serve as the principal staff officer to the MNF-I Surgeon in conjunction with duties as the MNC-I BH Consultant. Designate Regional Behavioral Health Consultants to address issues throughout the area of operations.

3. Continue to emphasize the reduction of stigma and barriers to behavioral healthcare for Soldiers and increase emphasis on suicide and deployment stress training.

4. Implement the standardized Unit Behavioral Health Needs Assessment Survey (UBHNAS) fielded by MHAT III for use by all combat stress control detachments and BCT organic BH personnel.

5. Continue to Integrate Behavioral Health staff with Primary Care providers to help reduce stigma and barriers to behavioral healthcare for Soldiers.

6. Continue research targeted at enhancing Soldier well-being with a particular focus on Soldiers who have deployed multiple times.

7. Provide theater suicide surveillance through service-specific suicide event reports to include the Army Suicide Event Report (ASER) for Soldiers.

8. Establish policy for the transfer of behavioral health information between providers.

9. Ensure distribution of behavioral health resources consistent with unit requirements.

10. Establish a theater-wide behavioral health performance improvement program.

11. Recommend that proponent for Army Suicide Prevention Training assess the requirements for a suicide prevention program with elements specific to the OIF area of operations.

II. INTRODUCTION

At the request of the Commanding General, Multi-National Forces-Iraq (MNF-I), the Office of The Surgeon General (OTSG) established the Mental Health Advisory Team III (MHAT III) to assess behavioral healthcare requirements of Soldiers deployed to OIF 04-06. MHAT III was the continuation of the decision by the Army to deploy Mental Health Advisory Teams to OIF I and OIF II. MHAT I and MHAT II assessed OIF I and OIF II in September and October of 2003 and 2004, respectively. MHAT III conducted its assessment of OIF 04-06 during October and November 2005.

A. Background Information

Combat and operational stress has been repeatedly documented as a factor contributing to the overall effectiveness and operational readiness of military units (see FM 4-02.51 Draft). MHAT III continued the command emphasis on the importance of identifying factors contributing to the stress and psychological well being of Soldiers in operational environments. As a follow up to MHAT I and MHAT II, MHAT III examined the behavioral health status of deployed Soldiers. One of the unique aspects of OIF 04-06 relative to OIF I and OIF II is that continued operations provided the opportunity to examine the effects of multiple OIF deployments on Soldier psychological well-being.

MHAT I and MHAT II collected data from Soldiers engaged in direct combat and the units that supported them. Brigade Combat Teams (BCTs) were the focus of MHAT III. MHAT III also surveyed and interviewed Soldiers engaged in advising and training Iraqi forces. These Soldiers are assigned to the Multinational Security Transition Command – Iraq (MNSTC-I). The unique aspect of their training mission and the fact that many of these Soldiers are serving in potentially high stress assignments warranted their inclusion in this MHAT assessment. Results of this assessment are at Appendix A. Due to the unique nature of the demographics of the MNSTC-I sample (older and higher rank), the data from MNSTC-I is included only in the appendix and omitted from the rest of the OIF 04-06 analysis.

B. Statement of the Problem

MHAT III operated under a charter from the Office of The Surgeon General (see appendix B). This charter was developed in coordination with the MNF-I Surgeon and posed the following questions.

1. Behavioral Health of Soldiers. What is the behavioral health status of Soldiers? How does it compare to Soldiers who deployed during Operation Iraqi Freedom I (OIF-I) and Operation Iraqi Freedom II (OIF II)? Has behavioral health been affected by multiple deployments to OIF?

2. Behavioral Healthcare System. What is the status of the behavioral healthcare system? What are the systemic factors that need to be addressed in order to ensure that Soldiers are receiving the best care?

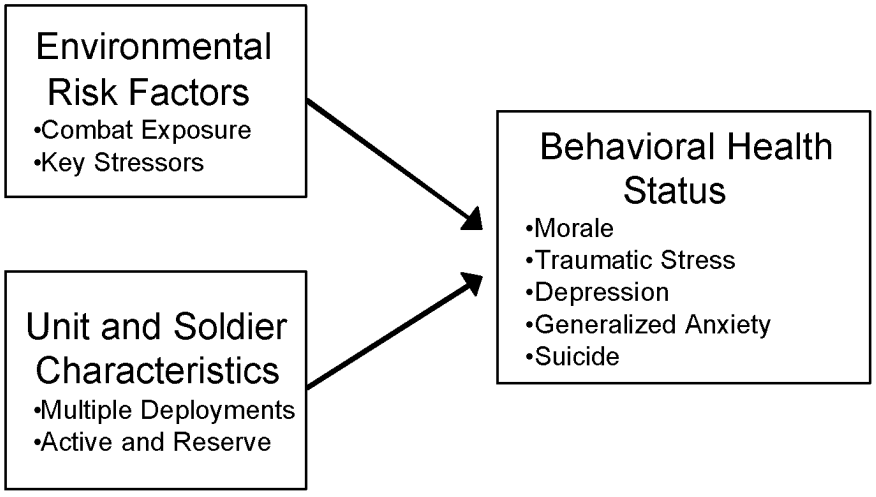
3. Future Focus. What are the planning and resource factors that must be considered to care for Soldiers engaged in future deployments to Iraq? As the Iraqi area of operations changes, what can MNF-I do to prepare to meet the behavioral health needs of Soldiers?

C. Overview of Design, Methods, and Data Collection

In order to answer these questions, data were collected using Soldier surveys, Soldier and provider focus groups, provider surveys, and other data sources. Behavioral health factors assessed included Soldier well-being, knowledge and utilization of behavioral health resources, suicide event data, and suicide prevention activities. The status of issues from previous MHAT reports was also examined to address any systemic issues affecting their implementation. The MHAT III report presents these findings and provides recommendations for the development of behavioral health policy for Soldiers serving in Iraq.

1. Soldier Survey

The Soldier Survey is a comprehensive instrument containing validated screening measures of behavioral health risk factors and health status. The elements of the survey covered in this report are (1) Environmental Stressors and Risk Factors, (2) Unit and Soldier Characteristics, and (3) Behavioral Health Status. The specific elements of the domain areas examined are listed in the figure below. All of these elements (with the exception of suicide) were examined using the Soldier Survey.



The basic assumption underlying analyses of the Soldier Survey is that behavioral health is determined by environmental risk factors as well as unit and Soldier characteristics. To understand the behavioral health status in OIF 04-06, the context of the combat environment and the characteristics of the Soldiers engaged in combat must be understood. For example, do first-time deployers and multiple deployers or active versus reserve component Soldiers show differences in behavioral health concerns? How have combat and non-combat stressors changed from OIF I to OIF II to OIF 04-

06? How have ratings of morale, traumatic stress, depression and anxiety changed from OIF I to OIF 04-06?

2. Soldier and Provider Focus Groups

To augment the Soldier survey, Soldiers were divided into two types of focus groups consisting of Soldiers who deployed for the first time and those who had previously deployed to OIF I and/or OIF II. In addition, focus groups were conducted with behavioral health providers and a limited number of primary care providers to augment the provider surveys. The focus group questions are at Appendix C.

3. Provider Surveys

Surveys assessing various aspects of behavioral health were administered to primary care providers, behavioral healthcare providers, and unit ministry team members. The surveys focused on the standards of care, coordination and integration with Soldier support activities, services provided, skills and training of providers, Soldier needs, the personal well-being of providers, and stigma and barriers to care. Questions also addressed the availability and use of psychiatric medications. Input from providers was viewed as essential for comparisons with Soldier survey data in order to develop a comprehensive assessment of the OIF 04-06 behavioral healthcare system.

4. Other Data Sources

Other data sources included information on the types and distribution of behavioral healthcare providers, the numbers and distribution of units and Soldiers, suicide reports, types and volume of behavioral health services, and workload reports.

D. Report Overview

In the following sections, methods and results are presented for the Soldier survey, the provider surveys, focus groups, and other data sources. These sections are followed by a review of suicide prevention, status of MHAT II recommendations, discussion of the results, and recommendations.

III. SOLDIER SURVEY

A. Soldier Survey Methods

Prior to collecting data, a sampling strategy was developed to ensure that the MHAT III sample represented the OIF 04-06 Army Forces in Iraq. The sampling strategy was closely coordinated with operational planners, and pre-selected units provided a set number of Soldiers for surveys and focus groups. A total of 1,124 Soldiers from 9 BCTs located at 13 Forward Operating Bases (FOBs) and associated units throughout Iraq participated in the MHAT III assessment.

1. Quality Control

The MHAT III team scanned and performed quality control on the Soldier Survey data in theater which permitted the data to be used for out-briefs to commanders and other

senior leaders. In the final Soldier Survey quality control review, 55 surveys from the total sample of 1,124 surveys were selected (5% random sub-sample), and team members conducted a 100% verification of all fields. Team members found 12 errors within 16,170 entry fields, for an overall error rate of approximately .0074%. These 12 errors represented random error as they were not systematically related to any one field.

2. Demographic Characteristics of OIF 04-06 Sample

The table below provides demographic details of the OIF 04-06 sample. National Guard and Reserve components comprised 29% and 2% respectively of the sample. In subsequent analyses, these two categories were combined and referred to as "reserve component" Soldiers.

Gender:	Female	14% (n= 158)
	Male	86% (n= 964)
Age:	18-24	44% (n=491)
	25-29	26% (n=296)
	30-39	23% (n=254)
	40+	7% (n=81)
Ethnicity/ Race:	White	60% (n= 656)
	African-Am	18% (n= 200)
	Hispanic	10% (n= 115)
	Asian	7% (n= 80)
	Other	5% (n= 51)
Rank:	Jr. Enlisted	60% (n=670)
	NCO	31% (n=353)
	Sr. NCO	3% (n=35)
	Officer/WO	6% (n=65)
Education:	H.S./ GED	45% (n=502)
	Some College	36% (n=398)
	Assoc. Degree	7% (n=80)
	Bachelor's	9% (n=96)
	Master's/Ph.D.	2% (n=24)

Median years in military:	4 years
Median months in unit:	18 months
Median months deployed in last 4 years:	11 months
Percent married:	54% (n =582)
Median years married:	4 years
Soldiers with children:	50% (n = 539)
Percent Reserve:	2% (n = 21)
Percent National Guard:	29% (n = 330)

The table below contrasts demographic information from active-duty Soldiers who previously deployed to Iraq (N=329) with active-duty Soldiers on their first deployment to Iraq (N=403). Reserve component Soldiers were omitted from the table and from subsequent analyses involving multiple deployments because only 15 reserve component Soldiers had previously deployed to Iraq. Multiple deployers tended to be older, higher rank, and more likely to be married. On average, those who had previously deployed to Iraq had been there a total of 20 months in the last four years. In contrast, first-time deployers had deployed an average of 10 months reflecting the current length of the OIF 04-06 deployment at the time of the survey.

Multiple Deployed (n = 329)		
Age:	18-24	34% (n=112)
	25-29	38% (n=124)
	30-39	25% (n=82)
	40+	3% (n=10)
Rank:	Jr. Enlisted	42% (n=138)
	NCO	49% (n=162)
	Sr. NCO	3% (n=11)
	Officer/WO	5% (n=17)
Percent Married :		63% (n=198)
Avg. Months Deployed Last 4 years:		20

First Deployment (n = 403)		
Age	18-24	62% (n=249)
	25-29	23% (n=92)
	30-39	13% (n=54)
	40+	2% (n=7)
Rank:	Jr. Enlisted	77% (n=310)
	NCO	15% (n=59)
	Sr. NCO	1% (n=4)
	Officer/WO	8% (n=30)
Percent married :		47% (n=185)
Avg. Months Deployed Last 4 years:		10

3. Demographic Characteristics of OIF I and OIF II

As noted in the introduction, many of the results from OIF 04-06 will be interpreted in comparison to the OIF I and OIF II samples. The MHAT I and MHAT II collected data in Kuwait and Iraq. In contrast, the MHAT III mission in support of OIF 04-06 collected data only in Iraq. Therefore, to ensure comparability, the OIF I and OIF II samples used in all comparisons omit the respondents from Kuwait.

OIF I: In total, 577 Soldiers deployed to Iraq participated in the Soldier Surveys. The demographic characteristics of the 577 Soldiers are provided in the table below.

Gender:	Female	13% (n=73)
	Male	87% (n=502)
Age:	18-24	57% (n=324)
	25-29	24% (n=137)
	30-39	14% (n=83)
	40+	5% (n=29)
Ethnicity/ Race:	White	65% (n=373)
	African-Am	16% (n=92)
	Hispanic	10% (n=59)
	Asian	4% (n=20)
	Other	5% (n=28)

Rank:	Jr. Enlisted	63% (n=362)
	NCO	28% (n=158)
	Sr. NCO	2% (n=14)
	Officer/WO	7% (n=41)
Median years in military:		3 years
Reserve:		9% (n=50)
National Guard:		3% (n=15)

OIF II: During MHAT II, 1,595 Soldiers in Iraq completed the Soldier Survey. The demographics of the Soldiers are listed in the table below.

Gender:	Female	13% (n=203)
	Male	87% (n=1383)
Age:	18-24	45% (n=722)
	25-29	21% (n=333)
	30-39	24% (n=387)
	40+	9% (n=150)
Ethnicity/ Race:	White	68% (n=1072)
	African-Am	14% (n=228)
	Hispanic	10% (n=160)
	Asian	4% (n=55)
	Other	4% (n=58)

Rank:	Jr. Enlisted	55% (n=879)
	NCO	33% (n=524)
	Sr. NCO	4% (n=67)
	Officer/WO	8% (n=122)
Median years in military:		5 years
Reserve:		11% (n=168)
National Guard:		35% (n=556)

4. Demographic Differences in OIF Samples Controlled in Analyses

The comparison of demographics across OIF I, OIF II and OIF 04-06 revealed several important differences. Specifically, the OIF II sample contained fewer junior enlisted (55%) than did OIF I (63%) and OIF 04-06 (60%). In addition, the OIF II sample contained a higher percentage of reserve component Soldiers (46%) than did OIF I (12%) and OIF 04-06 (31%). Both of these factors (rank and component) are potentially related to variables examined in the report, and are therefore controlled when testing for statistical significance in the logistic regression tests conducted in the report.

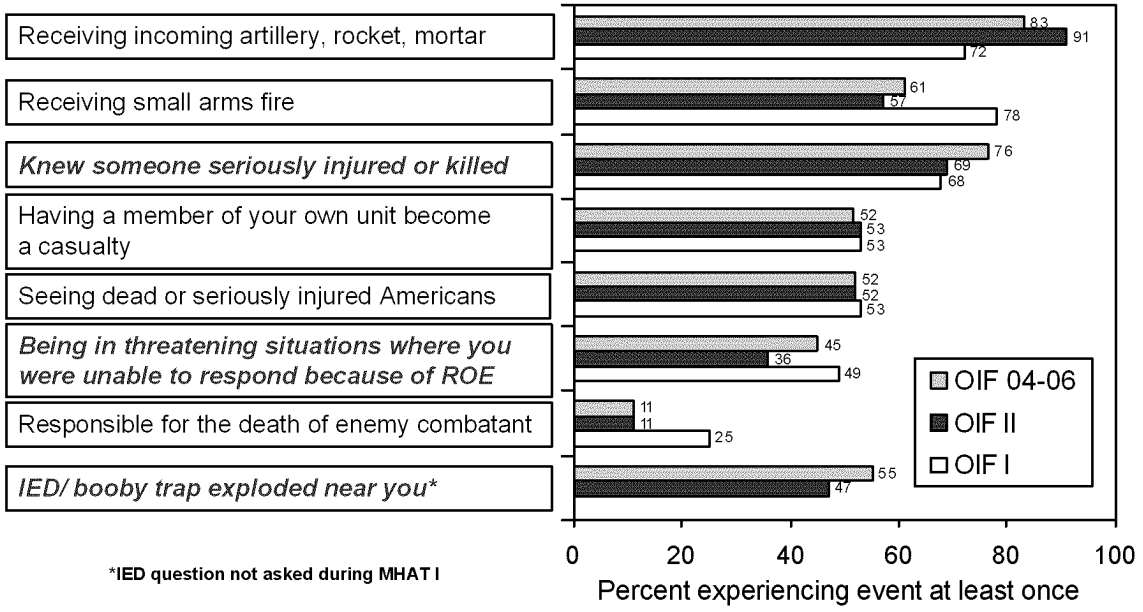
B. Soldier Survey Results

1. Combat Stressors

As in the previous two MHAT surveys, Soldiers were asked about specific combat experiences during this deployment. In general, combat experiences for Soldiers in OIF 04-06 were more similar to those of OIF II Soldiers than to those reported during OIF I. See the figure below for selected experiences. Soldiers in OIF 04-06 reported significantly lower exposure to artillery, rocket, and/or mortar fire than did Soldiers in OIF II (z-value = -6.04, $p<.001$). Soldiers in OIF 04-06 were significantly more likely than OIF II Soldiers to report:

(a) Knowing someone seriously injured or killed (z-value = 3.84, $p<.001$)
(b) Being in threatening situations where they were unable to respond because of rules of engagement (z-value = 4.51, $p<.001$)
(c) Having an IED or booby trap explode near them (z-value = 4.45, $p<.001$).

Focus group interviews reinforced these findings. Soldiers who had deployed during OIF I and deployed again for OIF 04-06 noted the defensive nature of OIF 04-06 operations and reported finding it more stressful than the OIF I offensive phase.



2. Combat Stressors: Multiple Deployers

A central theme of this report is a comparison of behavioral health status between those who previously deployed to Iraq (multiple deployers) and those who did not (first-time deployers). In trying to understand differences between these two groups, it is important to consider the possibility that multiple deployers and first-time deployers might have had different combat experiences during the current deployment. For instance, if multiple deployers were routinely assigned more dangerous missions because of their experience, then these differences in exposure to combat stressors might lead to higher levels of traumatic stress or other behavioral health symptoms.

The results of the comparisons between the combat experiences of active duty first-time and multiple deployers identified only one statistically significant difference in the seven combat exposures listed above. The difference was that 77% of those who had previously deployed reported receiving incoming artillery, rocket, or mortar fire. In contrast, 85% of the first-time deployers reported experiencing this event at least once. This difference was statistically significant even after accounting for possible rank differences between the two groups (z-value = -2.88, $p<.01$). This finding may reflect the possibility that multiple deployers are better able to differentiate artillery, rocket, or mortar fire from munitions demolition or range fire than first-time deployers.

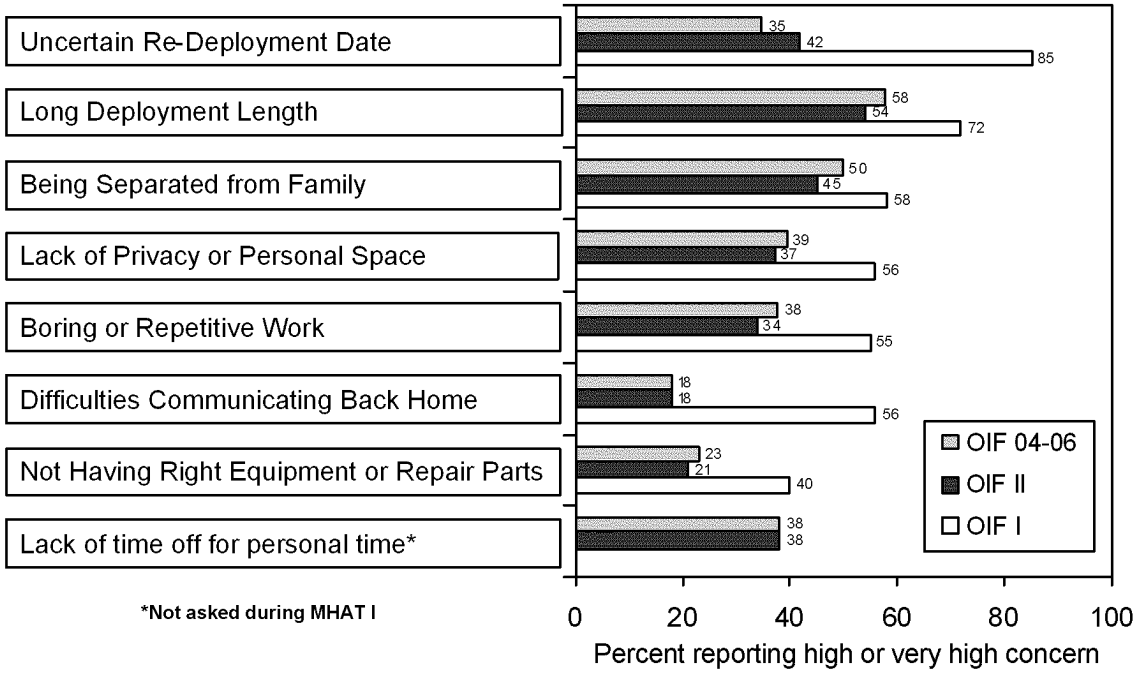
3. Combat Stressors: Reserve Component Soldiers

As a whole, reserve component Soldiers tended to report combat experiences with somewhat lower frequency than active duty Soldiers. In rank-adjusted analyses contrasting reserve component Soldier responses with first-time deployed active component Soldier responses, reserve component Soldiers reported significantly lower exposure to:

(a) Knowing someone seriously injured or killed (z-value = -4.54, p<.001). Reserve component Soldiers endorsed this experience 66% of the time; Active component Soldiers endorsed it 82% of the time.
(b) IED / booby trap exploding near them (z-value = -4.64, p<.001). Reserve Soldiers endorsed this experience 45% of the time; Active 63% of the time.
(c) Having a member of their unit become a casualty (z-value = -3.02 p<.01). Reserve Soldiers endorsed this experience 44% of the time; Active 56% of the time.
(d) Being in threatening situations where they were unable to respond because of rules of engagement (z-value = -3.44, p<.001). Reserve Soldiers endorsed this experience 38% of the time; Active 51% of the time.

4. Non-combat Stressors

Soldiers also rated how much concern had been caused by a list of non-combat stressors. The figure below shows that Soldiers' perceptions of non-combat deployment stressors during OIF 04-06 were similar to concerns reported in OIF II. The only statistically significant difference between OIF II and OIF 04-06 is that Soldiers in OIF 04-06 reported lower concern about uncertain re-deployment dates than did Soldiers in OIF II (z-value = -5.14, p<.001). Fewer Soldiers reported concern associated with these stressors during OIF 04-06 and OIF II than was the case in OIF I. In all comparisons, the values for OIF I are significantly higher than those for OIF 04-06.



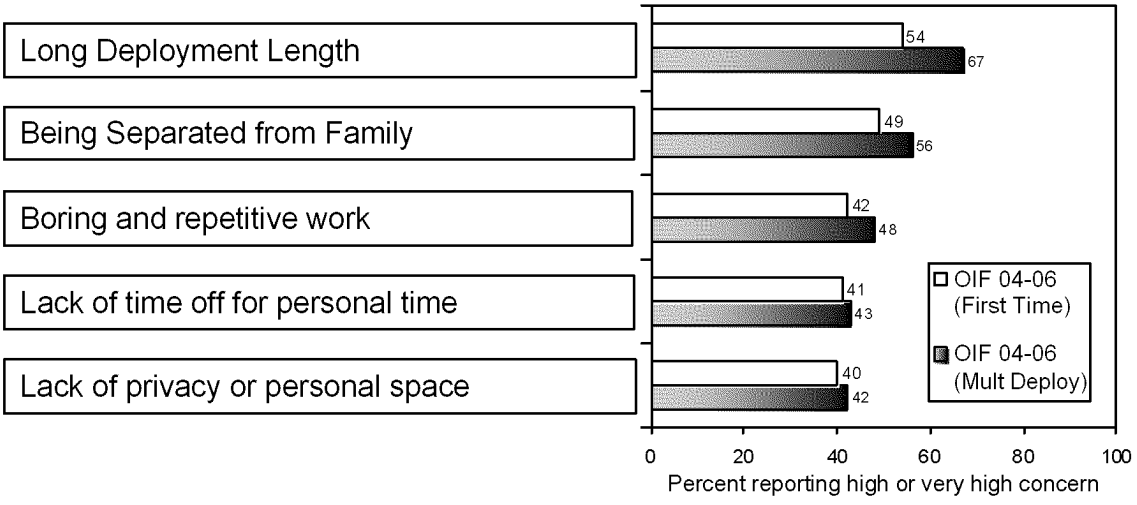
5. Non-combat Stressors: Multiple Deployers

To determine whether active-duty multiple deployers and first-time deployers reported similar concerns, the analyses presented below examined the top five non-combat stressors for each group. Active Component first-time deployers and multiple deployers

reported the same top five concerns in the same order of importance. Overall, however, multiple deployers reported more concern about each of the dimensions.

Statistical tests were conducted on each dimension to determine if the values reported by the multiple deployers were significantly higher than the values reported by the first-time deployers. Differences in rank between the two groups were controlled as rank is often related to perceptions of the military and deployments. As noted, demographics of multiple deployers included higher rank than first-time deployers. After controlling for rank differences, significant differences between the first-time deployers and multiple deployers were found for:

(a) Deployment length (z-value = 3.18, p<.01).
(b) Family Separation (z-value = 1.63, p<.10, one-tailed)
(c) Boring and repetitive work (z-value = 1.96, p=.05)



The differences in first-time and multiple deployers' concerns about being separated from their family did not reach statistical significance using the two-tailed .05 level of significance. However, these concerns are important because Soldiers in focus groups consistently reported that multiple deployments exacted a high toll on families.

6. Non-combat Stressors: Reserve Component Soldiers

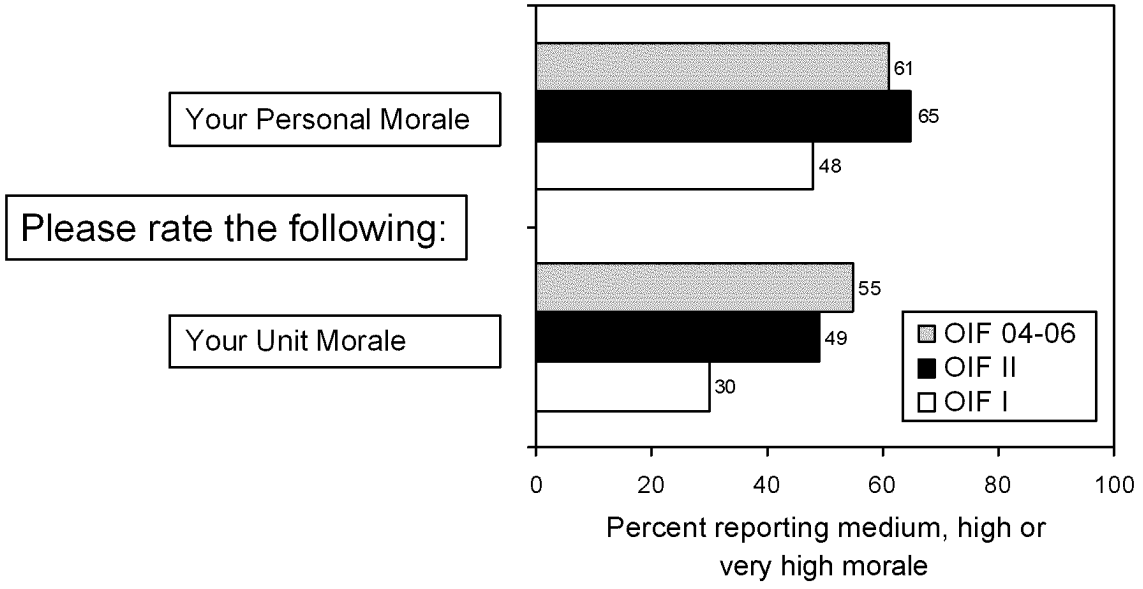
An examination of the top five non-combat stressors for reserve component Soldiers revealed that long deployment length and family separation remained the top two concerns. Fifty-three (53%) and 46% of Soldiers respectively reported high or very high concern about separation. Reserve component Soldiers also identified lack of personal privacy as a top five concern (36%) as did active duty respondents. Among reserve component Soldiers, rumors and uncertain re-deployment dates emerged as top five concerns; however, responses to rumor and redeployment date concerns (40% and 32%, respectively) were not significantly different from rates reported by first-time active duty Soldiers (37% and 33%).

7. Individual and Unit Morale

Soldiers' ratings of personal and unit morale in OIF 04-06 were similar to or higher than ratings of morale reported in OIF II. The figure below reveals that 61% of OIF 04-06 Soldiers rated personal morale as medium, high or very high. While this value is lower than OIF II, the difference between 61% and 65% is not statistically significant.

In contrast to personal morale, Soldiers in OIF 04-06 reported significantly higher ratings of unit morale than Soldiers in either OIF I or OIF II. Specifically, 55% of OIF 04-06 Soldiers rated unit morale as medium, high or very high, while the corresponding values for OIF II and OIF I were 49% and 30%.

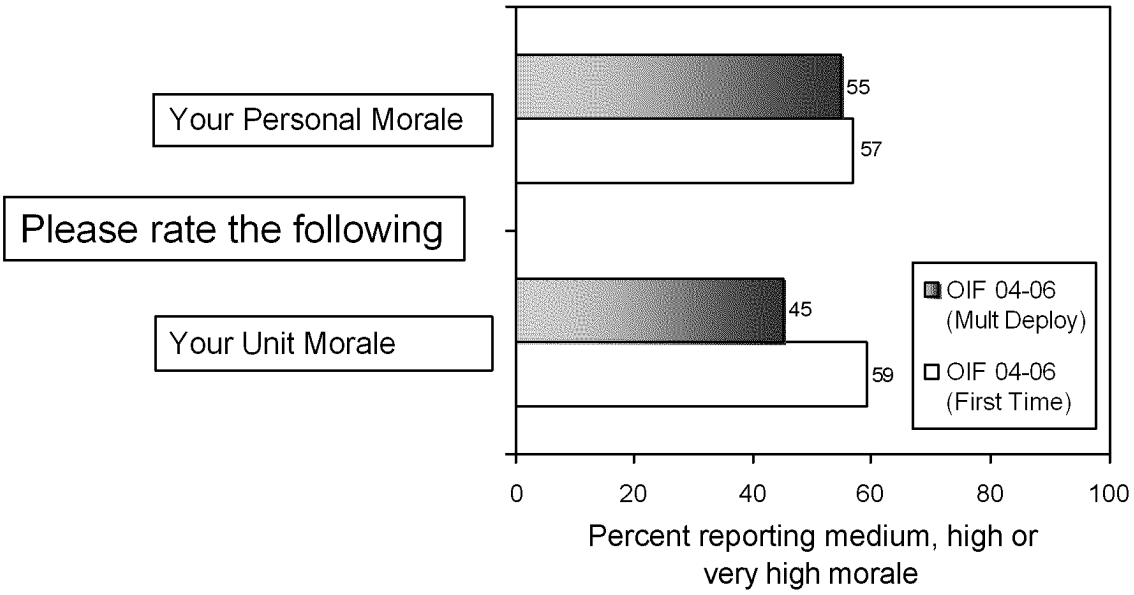
When demographic differences among OIF samples (rank and component) are statistically controlled, the OIF 04-06 sample still continued to report significantly higher levels of unit morale than either OIF II (z-value = 3.50, p<.001) or OIF I (z-value = 9.85, p<.001).



8. Morale: Multiple Deployers

Ratings of personal morale among active duty Soldiers did not differ between first-time and multiple deployers. In all, 57% of first time deployers rated personal morale as medium, high or very high. For multiple deployers, the value was 55%.

In contrast, there was a pronounced difference between first-time and multiple deployers in ratings of unit morale. Fifty-nine percent (59%) of first-time deployers rated unit morale as medium, high or very high. In contrast, only 45% of multiple deployers rated unit morale as medium, high or very high. This difference is statistically significant even when rank differences between the two groups were controlled (z-value = -2.48, p<.05).



9. Morale: Reserve Component Soldiers

Reserve component Soldiers reported higher personal morale than active duty Soldiers even when adjusting for rank differences (z-value = 3.57, p<. 001). For example, 68% of lower enlisted reserve component Soldiers reported medium, high or very high personal morale. In contrast, 55% of the active duty lower enlisted first-time deployers reported medium, high or very high personal morale. No differences were observed for ratings of unit morale.

10. Behavioral Health: OIF Comparison

Soldiers were asked about their current mental health functioning in the areas of depression, generalized anxiety and post-traumatic stress. Post-traumatic stress symptoms reported by Soldiers in a combat zone are referred to as acute stress or combat stress. In order to score positive for one of these three areas, established clinical guidelines were met at the levels of "more than half the days in the past four weeks" for depression and anxiety or at a "moderate" level for acute stress/combat stress. On the traumatic stress symptom scale, Soldiers were positive only if they met two conditions. They had to score positive on the three Post Traumatic Stress Disorder (PTSD) symptoms of avoidance, hyperarousal, and intrusive thoughts as described in the Diagnostic and Statistical Manual of Mental Disorders IV-TR (DSM IV-TR). They also had to receive a total score of at least 50 on a scale of 17 to 85 on the PTSD Checklist-PCL (Blanchard, et al.,1996). On the depression and anxiety scales, Soldiers were positive only if they met both the DSM IV-TR criteria for the disorders and endorsed functional impairment at the "very difficult" or "extremely difficult" level. The functional impairment item asked whether symptoms had made it difficult to do work or get along with others. The use of the functional impairment item for depression and anxiety and the total score of 50 for traumatic stress established conservative estimates

of those at high risk for possible mental disorders consistent with previous studies (Hoge, et al., 2004; Spitzer, et al., 1999; Blanchard, et al., 1996).

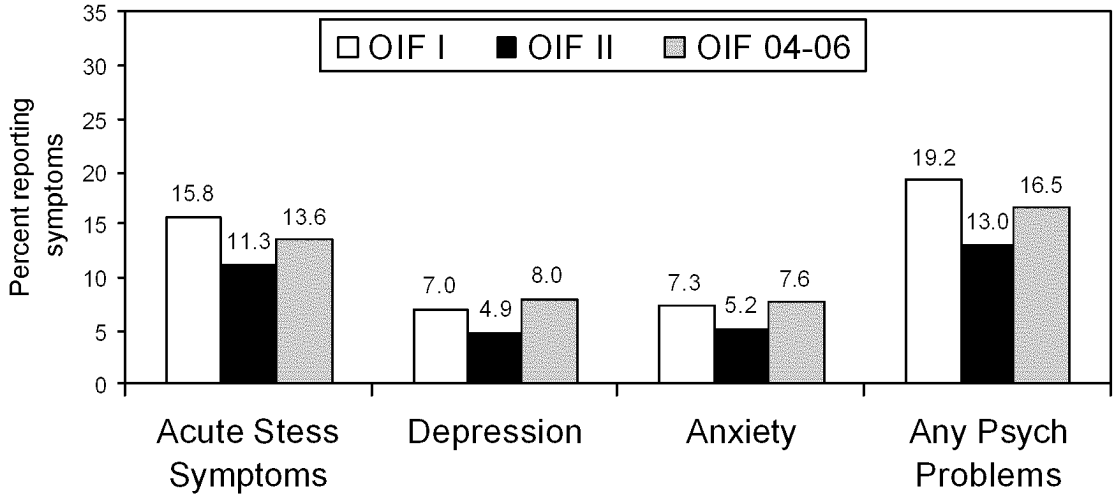
The figure below reveals that all three mental health indices (and the combined summary of any psychological problems) were higher in OIF 04-06 than in OIF II. The largest differences between OIF II and OIF 04-06 were for depression (a 3.1% difference) and the combined measure of any psychological problem (a 3.5% difference).

When demographic differences among OIF samples (rank and component) were statistically controlled, OIF 04-06 was significantly higher than OIF II for the two measures with the largest differences:

(a) Depression (z-value = 2.52, p<.05)

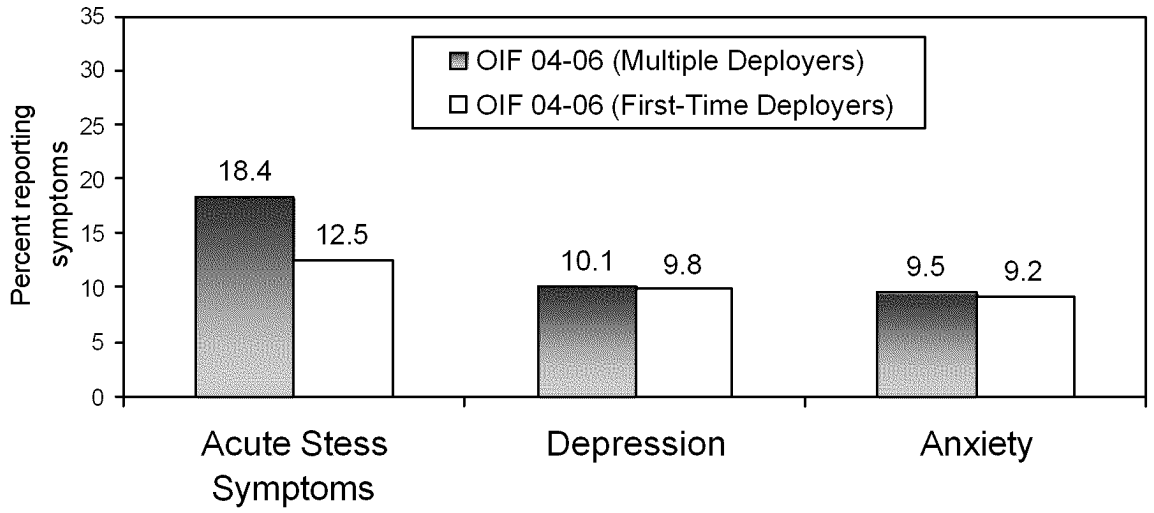
(b) Any Psychological Problems (z-value = 1.96, p=.05)

In addition, the 2.4% difference in anxiety between OIF II and OIF 04-06 was significant using a more relaxed p-value of .10 (z-value of 1.89, p=.06). OIF 04-06 did not differ from OIF I for any of the mental health indices.



11. Behavioral Health: Multiple Deployers

To determine whether the behavioral health status of multiple deployers differed from that of first-time deployers, the responses from the 403 active duty first-time deployers were compared to the responses from the 329 active duty Soldiers who had previously deployed to Iraq. Results displayed in the figure below reveal that the two groups are virtually identical in terms of depression and anxiety; however, multiple deployers show higher levels of acute stress symptoms. Analyses adjusted for rank revealed that the differences in acute stress symptoms between the two groups remained statistically significant (z-value = 3.02, p<.01).



12. Behavioral Health: Reserve Component Soldiers

In OIF 04-06, Reserve Component Soldiers reported levels of acute stress similar to active Component Soldiers. Reserve Component Soldiers, however, reported significantly lower levels of depression and anxiety than did active duty first-time deployed Soldiers. These differences held even when rank differences between the active and Reserve Component Soldiers were controlled (z-value= -2.53, $p<.05$ for depression; z-value= -2.72, $p<.05$ for anxiety). An example of the magnitude of the differences was reflected by the fact that 6.5% of the active duty first-time deployed NCOs met the criteria for depression while 3.3% of the reserve NCOs met the criteria. These results suggested that active duty NCOs are over twice as likely to meet the criteria for depression as are their Reserve Component counterparts. The comparable results for anxiety are 6.5% for active duty NCOs, and 4.2% for reserve component NCOs.

13. Reported use of Medications for Behavioral Health

The comparative analysis of medication use between OIF 04-06 and OIF II was based on a yes or no response to the question: "Have you taken any medication for a mental health, combat stress, or sleep problem during this deployment?" If the answer was yes, the Soldier was asked to identify the medication.

A total of 151 (14%) of the 1,124 Soldiers surveyed answered yes to this question indicating use of medication at least once during their deployment. The OIF 04-06 figure was higher than the rate of 8% reported in OIF II even after controlling for rank and service component differences between the two samples ($z=4.54$ $p<.01$). Medication usage was not surveyed during OIF I resulting in no comparative data for that deployment. Data from OIF 04-06 and OIF II did not identify if the Soldiers were receiving medication prior to their deployment, how long they used the medication or if any changes were made to the medication regimen.

To clarify medication usage among OIF 04-06 Soldiers, MHAT III coded the names of the medications each Soldier reported. Of the 151 Soldiers, 114 provided information that could be coded. Soldiers' reports included over-the-counter (OTC) medications sometimes used for sleep problems, unnamed medications, and in one case a Soldier reported using a device which was prescribed as an aid for a sleep problem. Some Soldiers reported the use of more than one medication.

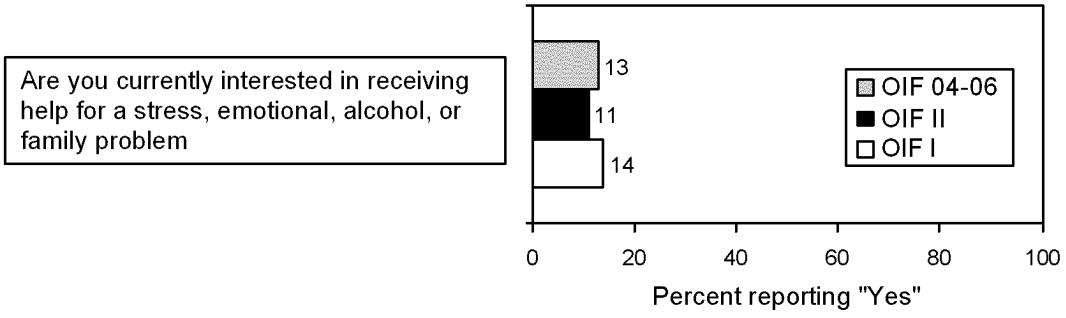
In OIF 04-06, 60 Soldiers (5.3%) reported taking medication that may be used to treat a behavioral health issue to include combat stress. However, as discussed below, these medications also have other therapeutic uses which should be considered in interpreting these findings. Sleep medications were analyzed separately because they are routinely used to treat sleep disturbances unrelated to behavioral health. For example, they are prescribed to aid in adjusting to time zone changes and shifts in work schedules. The number of Soldiers using sleep medications was 43 (3.8%). After identifying Soldiers who reported using both sleep and psychotropic medications and excluding 3 receiving stimulant medication as this medication is not used to treat deployment related issues, a total of 92 Soldiers (8.2%) were found to have reported using psychotropic medications, sleep medications, or both. There were 22 reporting unspecified analgesics or OTC medications. Differences in the way medications were coded made it impossible to compare specific medications between OIF II and OIF 04-06.

There are a series of factors which must be considered in evaluating these findings. The reason that the medication was prescribed can not be determined. This is important in that some medications have established efficacy in treating several conditions or alleviating multiple symptoms. For example, it is inaccurate to assume that all anti-depressant medications were prescribed for depression. Low dosages of some anti-depressant medications are routinely used for brief periods to treat sleep problems which are not uncommon in a combat environment or during the initial stages of deployment. Anti-depressants can also be used to prevent migraine headaches and as adjunctive therapy for pain. The length of time that the person was taking medication is important as it is not unusual for some medications to be prescribed for brief intervals to alleviate symptoms, especially sleep difficulties. Thus, if a person took a sleep medication and/or used an OTC medication once to assist them in going to sleep, they will be included in the data reported above.

Finally, two findings from this report offer additional interpretations of the medication usage rate. The fact that there is better access to BH care and Soldiers reported decreased stigma associated with this care suggests that treatment to include medication may be occurring more frequently. The fact that primary care providers reported increased confidence in managing combat stress may also be reflected in any changes in the number of Soldiers who reported use of medication. Decreased stigma concerning care and increased access is likely to have a positive effect on Soldiers. The use of medication alone should not be interpreted as evidence of a severe combat stress reaction.

14. Interest in Receiving Help

While there were differences in levels of mental health symptoms, the percentage of Soldiers reporting interest in receiving help was consistent across OIF deployments. Just over 10% of Soldiers in each of the three samples reported interest in receiving help.



No significant differences in response to this item were evident between first-time and multiple deployers, or for Active versus Reserve Component Soldiers.

15. Reported Utilization of Mental Health Services

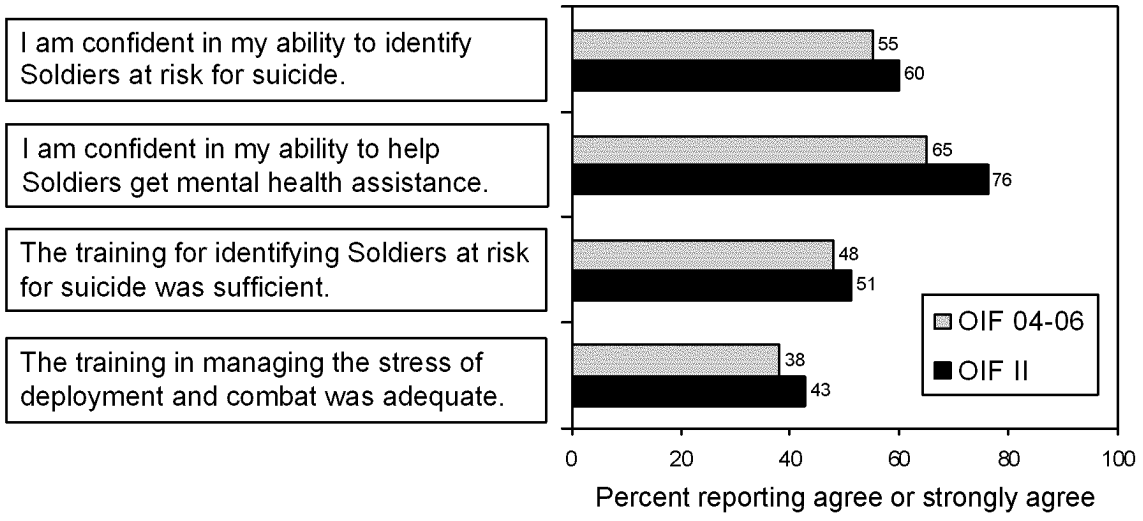
While Soldiers' interest in receiving help remained constant, their reports of actually receiving care in OIF 04-06 increased relative to OIF II. In both OIF II and OIF 04-06, Soldiers reported whether they had received counseling or mental health services at least once during the deployment from any of five professional sources: a mental health professional, a combat stress control professional, a general medical doctor, a military chaplain or a medic in their unit. In OIF II, 23% reported receiving care. In contrast, in OIF 04-06, 30% reported receiving care. This difference was statistically significant even after adjusting for rank and component differences (z-value = 3.85, p<. 01).

No significant differences in response to mental health service utilization were evident between first-time and multiple deployers, or for Active versus Reserve Component Soldiers.

16. Training for Suicide Prevention and Deployment

Prior to and during deployments, Soldiers are provided training on suicide prevention and on managing the stresses of the deployment and combat. An examination of Soldiers' responses to four items evaluating the adequacy of training showed a decline in perceptions of training adequacy from OIF II to OIF 04-06. The values are presented in the figure below. These differences remained statistically significant even when demographic differences between OIF II and OIF 04-06 were controlled (z-value = -2.43, p<.05 for identifying Soldiers at risk; z-value = -5.58, p<.01 for helping Soldiers get mental health assistance; z-value = -2.22, p<.05 for suicide training; z-value = -3.08,

p<.01 for managing deployment stress). Note that the large sample sizes increased the ability to detect statistical significance with small differences between these groups.

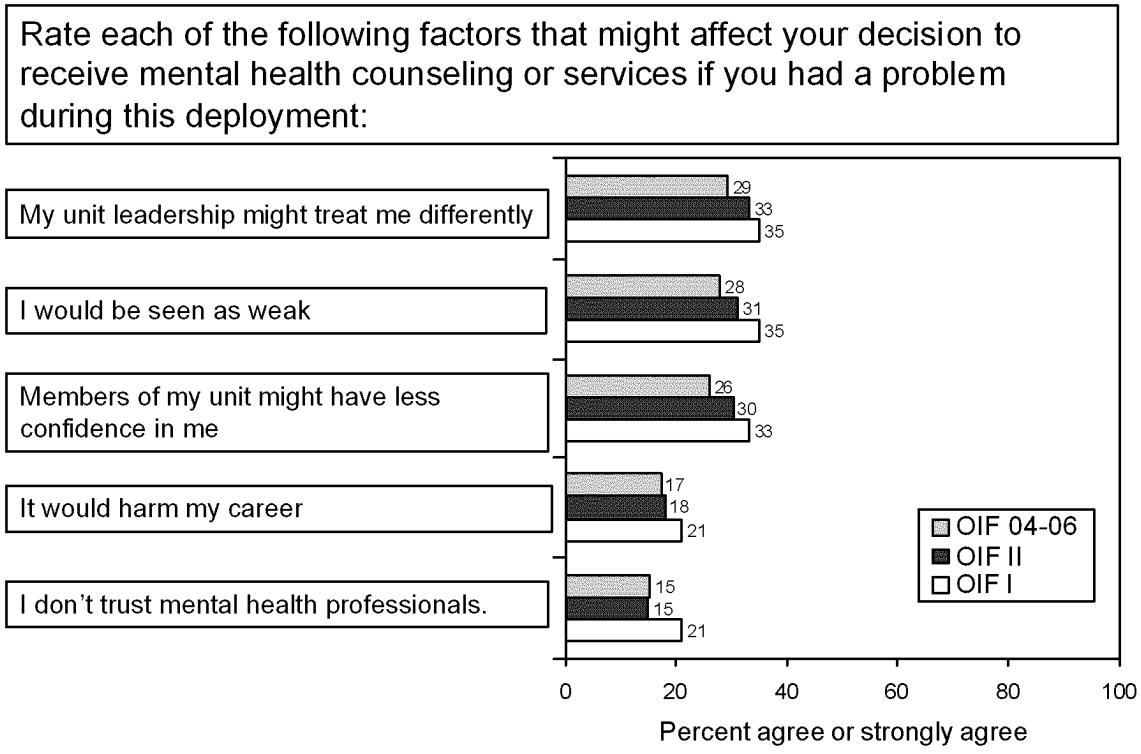


No significant differences in response to any of these four items were evident for first-time deployers versus multiple deployers or for Active versus Reserve Component.

17. Stigma Associated with Seeking Behavioral Healthcare

The figure below shows that reports of stigma across OIF samples is decreasing. Reports of stigma in OIF 04-06 were lower than or equal to those in OIF I and OIF II. Stigma associated with seeking behavioral healthcare was significantly lower for perceptions that:

(a) Unit leadership would treat the Soldier differently. OIF 04-06 is significantly lower than OIF II (z-value = -2.43, p<.05) and OIF I (z-value = -2.22, p<.05).
(b) The Soldier would be seen as weak. OIF 04-06 is significantly lower than OIF II (z-value = -2.30, p<.05) and OIF I (z-value = -2.74, p<.01).
(c) Members of the Soldiers' unit might have less confidence in the Soldier. OIF 04-06 is significantly lower than OIF II (z-value = -2.17, p<.05) and OIF I (z-value = -2.76, p<.01).
(d) Mental health professionals cannot be trusted. OIF 04-06 is significantly lower than OIF I (z-value = -3.04, p<.01).



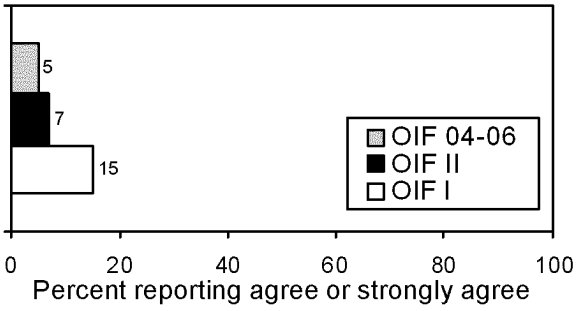
In OIF 04-06, individuals who met the criteria for acute stress symptoms, depression and anxiety reported significantly higher levels of stigma than did those who did not meet any of the criteria. For example, 53% of those who met the criteria for mental health problems thought they would be seen as weak, whereas in the figure above which included respondents not meeting the criteria, the value was 28%. The finding that those with problems report higher stigma was previously noted (Hoge et al, 2004). No significant differences in perceptions of stigma were evident between first-time and multiple deployers, or for Active versus Reserve Component Soldiers.

18. Soldiers' Perceptions of Access to Behavioral Healthcare

A downward trend in reported problems accessing behavioral healthcare is evident across OIF rotations. Fifteen percent (15%) of OIF I Soldiers reported that it was difficult to get to a location where they could meet with a BH provider. This rate decreased to 7% in OIF II and to 5% among OIF 04-06 Soldiers. The difference between OIF I and OIF 04-06 is statistically significant (z-value = 5.97, $p<.001$) as is the difference between OIF I and OIF II (z-value = 4.64, $p<.001$). The difference between OIF II and OIF 04-06 is <u>not</u> significant.

Rate factors that affect your decision to receive mental health counseling or services during this deployment:

It's too difficult to get to the location where the mental health specialist is



IV. PROVIDER SURVEYS

A. Provider Survey Methods

The following describes the methods used to collect data from Behavioral Health (BH), Primary Care (PC), and Unit Ministry Teams (UMT). Data were collected through written and electronically-completed surveys and focus groups. All providers were asked to complete the survey and most providers completed an electronic version of the survey. Structured focus group interviews were also conducted.

MHAT III used the same anonymous questionnaire as MHAT II. BH personnel surveyed included psychiatrists, occupational therapists, psychiatric nurses, social workers, clinical psychologists, occupational therapy assistants and mental health specialists. The PC personnel surveyed included primary care doctors, nurse practitioners, physician assistants, and medics. UMT personnel surveyed included chaplains and chaplain assistants.

Survey questions focused on demographics, standards of practice, coordination of services, BH services provided, skills and training in relation to compliance and understanding of BH services, perceived stigma and barriers to mental healthcare, and personal well-being. Where possible, questions were standardized across the three groups of providers. Space was provided for participants to make comments regarding equipment/supplies needed as well as any additional comments.

1. Demographics: Behavioral Healthcare Providers

A sample of 115 BH surveys was collected. The table below depicts the military occupational specialty/area of concentration (MOS/AOC) of the BH staff. Fifty-nine

percent (59%) were Reserve Component Soldiers, and 41% were Active Component. Fifty-six percent (56%) of the respondents were age 30 or older and 66% were male. Junior enlisted Soldiers were 20%, NCOs were 42%, and officers were 38% of the sample. Participants were deployed an average of 300 days over the past two years and 93% of those surveyed reported currently working in their primary specialty. Each BH team supported an average of 5,000 Soldiers, five FOBs, and had been deployed for 10 months. The OIF 04-06 BH teams traveled an average of one hour by convoy to perform outreach support.

MOS or AOC

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Psychiatrist (60W)	6	5.2	5.3	5.3
	Occ Therapist (65A)	7	6.1	6.1	11.4
	Psych Nurse (66C)	6	5.2	5.3	16.7
	Social Worker (73A)	12	10.4	10.5	27.2
	Clin Psychologist	11	9.6	9.6	36.8
	OT Specialist (91 WN3)	9	7.8	7.9	44.7
	MH Specialist (91X)	56	48.7	49.1	93.9
	Other	7	6.1	6.1	100.0
	Total	114	99.1	100.0	
Missing	System	1	.9		
Total		115	100.0		

2. Demographics: Primary Care Providers

MHAT III collected 172 PC surveys. The table below depicts the MOS/AOC of the PC staff that completed the survey. Nineteen percent (19%) were Reserve Component Soldiers and 81% were Active Component Soldiers. Sixty-three percent (63%) of all respondents were age 30 or older; and 90% were male. Junior enlisted Soldiers were 34%, NCOs were 17%, and officers were 49% of the sample. Participants were deployed on average 300 days over the past two years and 93% of those surveyed reported currently working in their primary specialty.

MOS or AOC

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Emerg Med (61B)	3	1.7	1.8	1.8
	Family Practice (61H)	23	13.4	13.5	15.3
	Flight Surgeon (61N)	3	1.7	1.8	17.1
	GMO (62B)	1	.6	.6	17.6
	PA (65D)	32	18.6	18.8	36.5
	Nurse (66B)	1	.6	.6	37.1
	Medical Specialist (91W)	85	49.4	50.0	87.1
	Other	22	12.8	12.9	100.0
	Total	170	98.8	100.0	
Missing	System	2	1.2		
Total		172	100.0		

3. Demographics: Unit Ministry Team Members

MHAT III collected 94 UMT surveys. The table below depicts the UMT staff represented in the survey. Thirty percent (30%) were Reserve Component Soldiers and 70% were Active Component Soldiers. Eighty-three percent (83%) of the respondents were age 30 or older; 92% were male. Junior enlisted Soldiers represented 8%, NCOs 27%, and officers 65% of the sample. Participants were deployed an average of 300 days over the past two years and 97% of those surveyed reported currently working in their primary specialty. Each UMT team supported an average of 700 Soldiers, 3 FOBs, and had been deployed for 7 months.

MOS or AOC

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Chaplain (56A)	62	66.0	66.0	66.0
	Chaplain Assistant (56M)	31	33.0	33.0	98.9
	Other	1	1.1	1.1	100.0
	Total	94	100.0	100.0	

B. Provider Survey Results

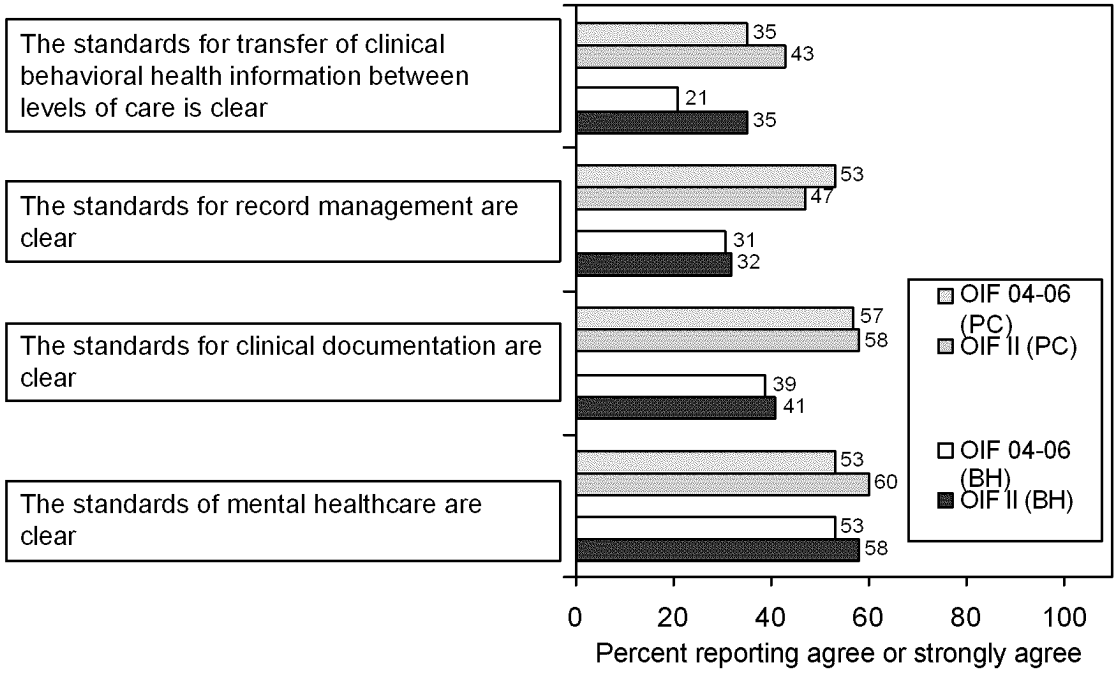
1. Standards of Care

Although most BH and PC providers agreed that the standards for medical and behavioral healthcare in the area of operations (AO) were clear, they also indicated that standards for transferring mental health (MH) information between levels of care and providers were not clear. Note that in this entire section Chi-square values are reported for statistically significant differences between groups.

The figure below shows ratings of the standards of care for both BH and PC providers across OIF II and OIF 04-06. Fifty-three percent (53%) of BH providers in OIF 04-06

reported that the standards of behavioral healthcare were clear. This is comparable to OIF II, where 58% of the BH providers reported that the standards were clear. While not shown in the figure below, BH provider perceptions of the standards surrounding Combat and Operational Stress Control (COSC) services were also similar between OIF II and OIF 04-06 (53% versus 50%, respectively). Thirty-nine percent (39%) of BH providers reported that standards for clinical documentation were clear versus 41% in OIF II, and 31% indicated that medical records management in the theater of operations was clear versus 32% in OIF II. A significantly lower percentage of BH providers in OIF 04-06 (21%) reported that the standards for the transfer of clinical MH information between levels of care were clear compared to 35% of providers in OIF II (Chi-square = 5.03, $p < .05$).

PC providers had significantly more positive ratings of the standards of clinical documentation, record management and transfer of information than did BH providers (Chi-square = 8.08, $p<.01$; Chi-square = 12.18, $p<.01$; and Chi-square = 5.88, $p<.05$, respectively). There were, however, no significant differences in PC provider ratings across OIF II and OIF 04-06. For example, although 53% of PC providers reported that the standards of behavioral healthcare in the theater of operations were clear compared to 60% in OIF II, this difference was not statistically significant. Similarly, the difference between 35% in OIF 04-06 and 43% in OIF II regarding information transfer was not statistically significant, although the trend mirrored the significant drop observed in the BH sample.

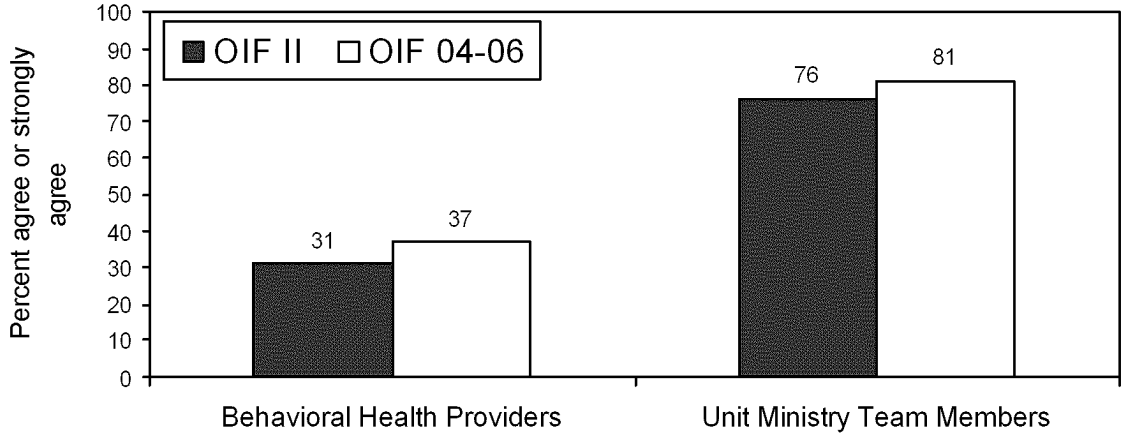


2. Primary Care Coordination and Support

PC providers rated their coordination and support of behavioral services similar to OIF II ratings. Fifty-one percent (51%) of PC providers reported they coordinated their activities with UMT members compared to 46% in OIF II. Likewise, 74% of PC providers reported that BH personnel provided information about where to refer Soldiers with mental health problems (78% in OIF II), and 70% indicated that BH staff provided information about the mental health services provided to Soldiers (75% in OIF II). Finally, PC providers reported coordinating and integrating mental health activities with mental health personnel in their AO at the same rates as during OIF II. Specifically, sixty percent (60%) of PC providers in OIF 04-06 indicated that they coordinated behavioral health activities compared to 62% in OIF II.

3. Resources from Command

Thirty-seven percent (37%) of BH providers reported that their higher HQs provided them with the resources needed to do their mission, compared to 31% in OIF II. In contrast, 81% of UMT staff reported that their command provided them with the correct resources to conduct UMT activities, compared to 76% in OIF II. Neither of these differences is statistically significant across OIF missions.

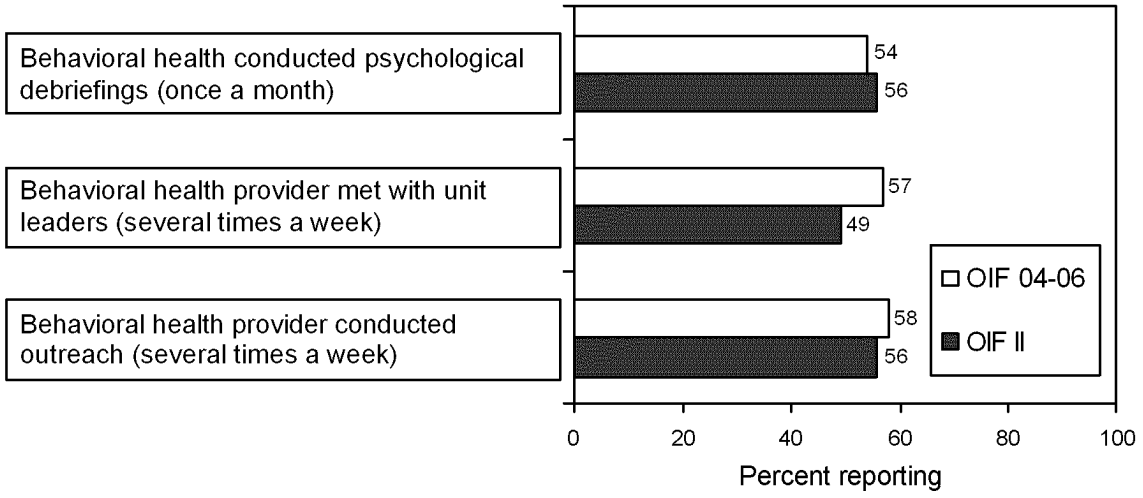


Satisfaction with resources from higher headquarters

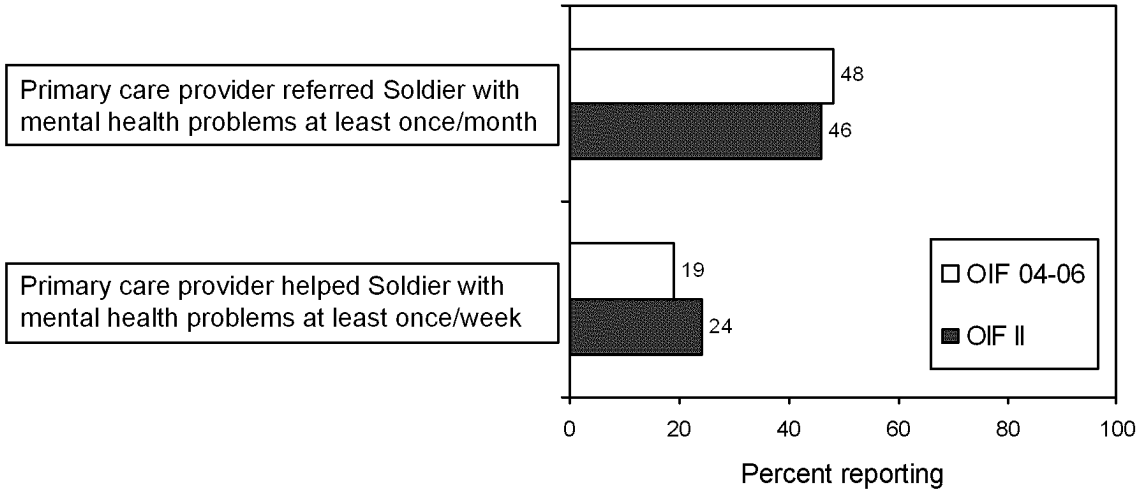
4. Frequency of Conducting Behavioral Health Outreach Work

The frequency of conducting behavioral health work remained consistent across OIF deployments. Fifty-eight percent (58%) of the BH providers indicated they conducted outreach services to Soldiers "several times a week" compared to 56% in OIF II. The BH providers stated that they consulted with unit leaders "several times a week" (57% compared to 49% in OIF II). Fifty-four percent (54%) of BH providers reported that they conducted psychological debriefings at least "once a month" compared to 56% in OIF II. In terms of suicide prevention training (not presented in the figure), 72% of BH providers

provided suicide prevention training "at least once during this deployment" compared to 66% in OIF II.



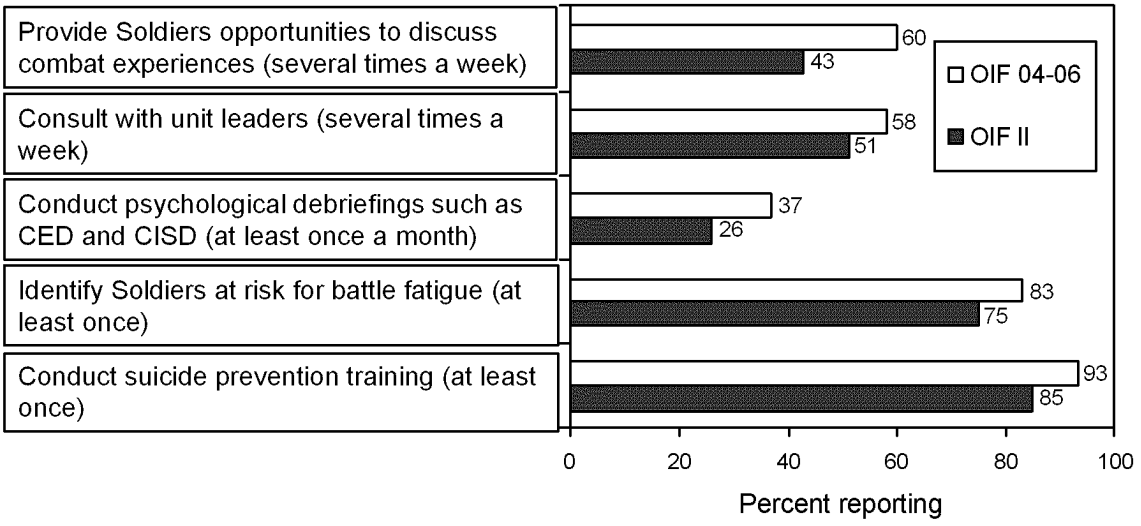
With regard to PC providers conducting BH care, 48% of PC providers indicated that they referred Soldiers with mental health problems to BH providers at least once a month compared to 46% in OIF II. Nineteen percent (19%) of PC providers reported helping Soldiers with mental health problems at least once a week compared to 24% in OIF II.



5. UMT Involvement in Suicide Prevention and Behavioral Healthcare

The figure below shows that UMT staff members are the primary personnel conducting suicide prevention training. Ninety-three percent (93%) of UMT members conducted suicide prevention training "at least once during this deployment" compared to 85% in OIF II (Chi-square = 4.58, $p < .05$). Eighty-three percent (83%) of UMT members

reported identifying Soldiers at risk for Battle Fatigue "at least once during this deployment" compared to 75% in OIF II. UMT members played a large role in psychological debriefings with 37% stating they had conducted debriefings "at least once a month", compared to 26% in OIF II (Chi-square = 3.96, $p < .05$). Fifty-eight percent (58%) of UMT members consulted with unit leaders "several times a week" compared to 51% in OIF II. Sixty percent (60%) of UMT members afforded Soldiers the opportunity to discuss their combat experiences "several times a week," compared to 43% in OIF II (Chi-square = 4.98, $p < .05$)



6. Confidence in Skills and Training

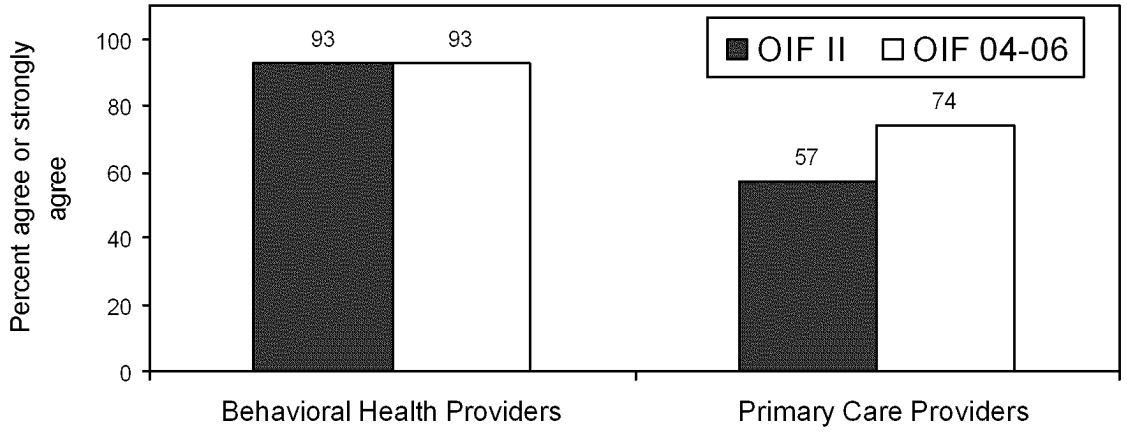
BH providers remain confident in their ability to treat combat and operational stress reactions among Soldiers.

Ninety-three percent (93%) of the BH providers reported confidence in their skills to help Soldiers adapt to stressors of combat deployment (94% in OIF II), 93% reported confidence to evaluate and treat suicidal behavior (94% in OIF II), and 93% reported confidence to treat all combat and operational stress reactions (93% in OIF II). Eighty-five percent (85%) reported confidence in their ability to evaluate and treat acute stress disorder or PTSD compared to 90% in OIF II. Sixty-five percent (65%) of the BH providers reported confidence in their ability to evaluate and treat victims of sexual assault which was similar to BH provider reports in OIF II (63%). There was a decrease in BH providers reporting confidence in being able to evaluate and treat Soldiers with substance abuse or dependence from 71% in OIF II to 61% in OIF 04-06. This difference was not statistically significant.

Eighty percent (80%) of PC providers reported having confidence to help Soldiers with mental health issues during deployment compared to 73% in OIF II. Sixty-one percent (61%) of the PC providers reported confidence in their ability to treat and evaluate Soldiers with substance abuse problems compared to 46% in OIF II (Chi-square = 12.79, $p < .05$). Seventy-four percent (74%) were confident in their ability to treat

combat and operational stress reactions compared to 57% in OIF II (Chi-Square = 11.45, $p < .05$). Fifty-five percent of the PC providers reported having confidence in their ability to evaluate and treat acute stress disorder or PTSD versus 45% OIF II (Chi-square = 4.38, $p < .05$). Forty-six percent (46%) of PC providers reported having confidence in their ability to evaluate and treat victims of sexual assault compared to 39% in OIF II.

The figure below shows BH and PC providers' reports of confidence in their ability to evaluate and treat Soldiers with combat and operational stress reactions across OIF II and OIF 04-06. As noted previously, the change from OIF II to OIF 04-06 for PC providers represents a significant increase.



Have Confidence in ability to treat combat and operational stress reactions

UMT members reported increases in their ability to help Soldiers cope with operational stress. Ninety-seven percent (97%) of UMT members reported having confidence in their ability to conduct suicide prevention classes or training compared to 83% in OIF II (Chi-square = 10.76, $p < .05$). Ninety-five percent (95%) of UMT members reported having confidence in their skills to help Soldiers adapt to stress of combat versus 82% in OIF II (Chi-square = 7.14, $p < .05$). Ninety-three percent (93%) of UMT members reported having confidence in their abilities to identify combat and operational stress reactions versus 79% in OIF II (Chi-square = 9.34, $p < .05$).

7. Provider Well-Being and Burnout

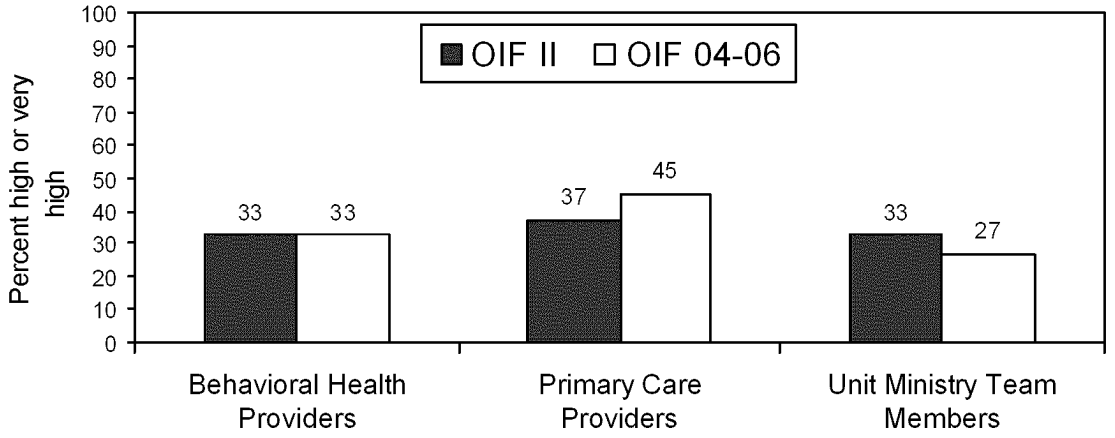
Nine percent (9%) of BH providers reported that their ability to perform their job was impaired by the stressors of combat deployment compared to 15% in OIF II. Thirty-three percent (33%) of BH providers reported their burnout level as high or very high, which was equivalent to the 33% reported by BH providers in OIF II.

Nine percent (9%) of PC providers reported that their ability to perform their job was impaired by the stressors of combat deployment compared to 14% in OIF II. Forty-five

percent (45%) of PC providers reported their burnout level as high or very high compared to 37% in OIF II.

Five percent (5%) of the UMT members reported that the ability to do their job had been impaired by the stressors of combat deployment as compared to 15% in OIF II (Chi-square = 5.91, $p < .05$). Twenty-seven percent (27%) of UMT members reported their burnout level as high or very high compared to 33% in OIF II.

The figure below shows burnout across providers and deployments. During OIF 04-06, the PC providers reported higher levels of burnout compared to UMT (Chi-square = 7.47, $p < .05$) and BH providers (Chi-square = 4.10, $p < .05$).

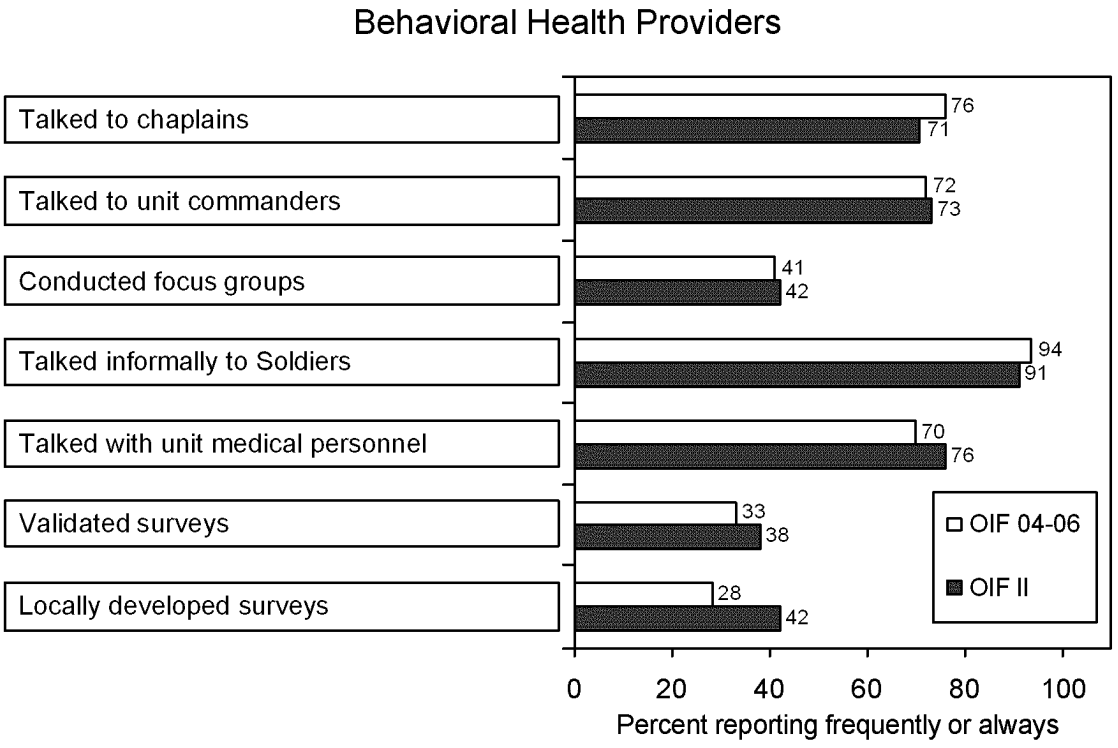


Providers' perceptions of burn-out

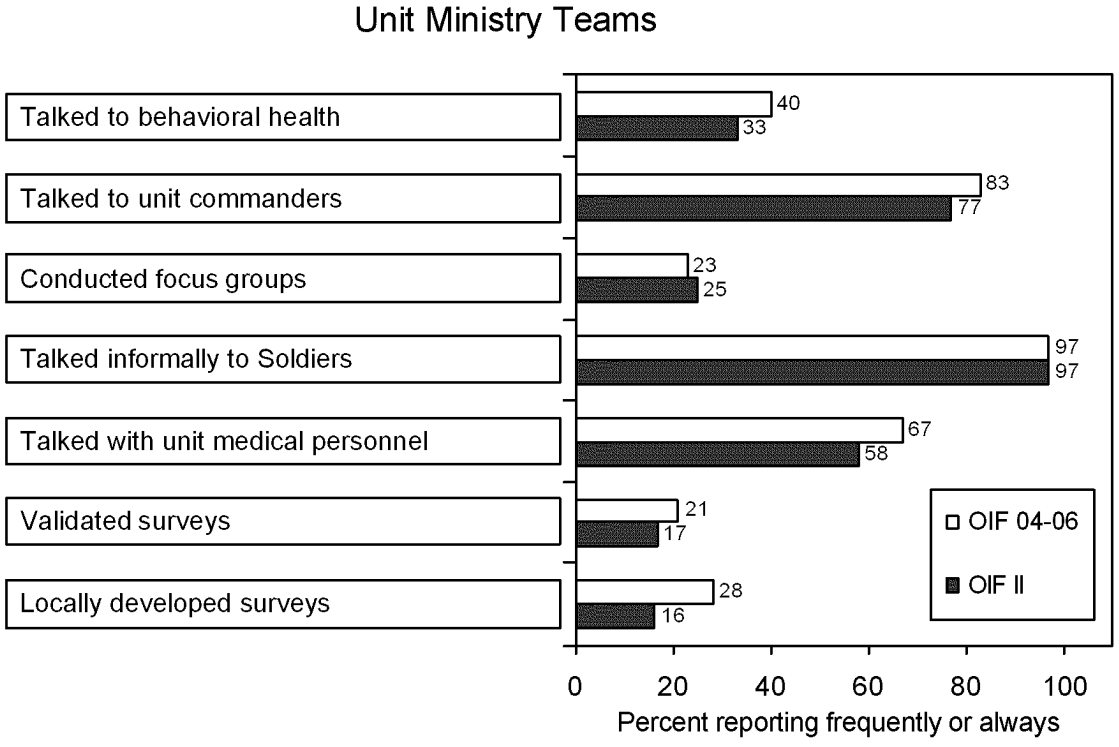
8. Systematic Unit Needs Assessment

BH providers reported using a variety of methods for assessing the BH needs of Soldiers. The figure below presents a number of methods BH providers used in assessing needs of Soldiers and units. There were significant differences between OIF 04-06 and OIF II in the use of locally-developed surveys (Chi-square = 4.74, $p < .05$).

In addition, 55% of BH providers reported conducting systematic unit needs assessment at least once every 2-3 months compared to 53% in OIF II (not shown in figure), and 32% of BH providers stated they never had performed a systematic unit needs assessment compared to 36% in OIF II. Neither of these differences were significant.



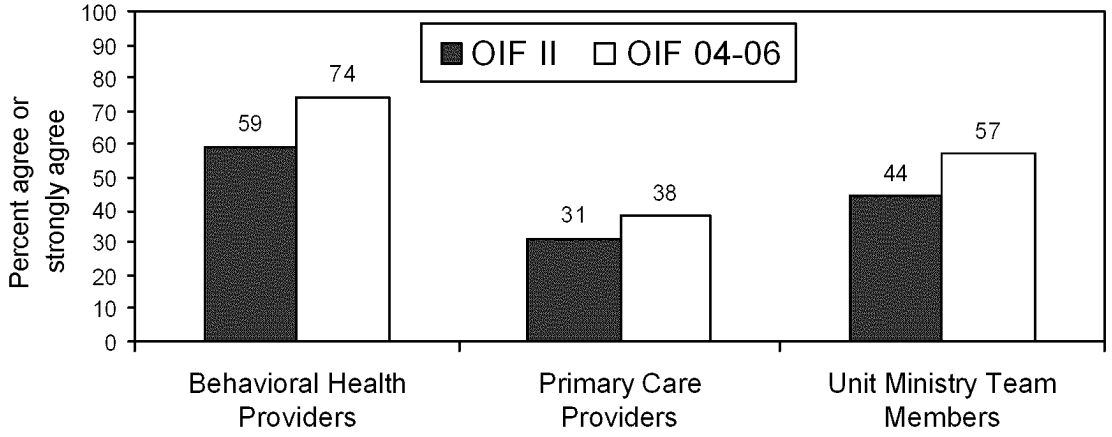
The figure below presents the methods UMT members used in assessing Soldier needs. There were significant differences between OIF 04-06 and OIF II in the use of locally-developed surveys (Chi-square = 5.31, $p < .05$).



Sixty-one percent (61%) of UMT members reported conducting systematic religious needs assessment at least once every 2-3 months compared to 49% in OIF II (Chi-square = 3.20, $p < .10$).

9. Provider Perception of Barriers to and Stigma concerning BH Care

Provider survey results reported a decrease in the perception of stigma and potential barriers to care. The figure below shows provider perceptions of the degree to which commanders welcome back Soldiers who receive behavioral healthcare. The difference between 59% reported by OIF II providers and 74% reported by OIF 04-06 BH providers was statistically significant (Chi-square = 5.44, $p< .05$). The difference between 44% and 57% reported by UMT members was not statistically significant using the conservative p-value of .05, but was significant with a less conservative p-value of .10 (Chi-square = 3.67, $p<.10$).



Commanders welcome back Soldiers who have received mental health services from my team

V. FOCUS GROUPS

A. Focus Group Methods

1. Soldier Focus Groups

Focus groups were conducted by at least two MHAT III team members with thirteen groups of first-time deployers and seventeen groups of multiple deployers. Groups consisted of 3-10 Soldiers. The structured interview questions are at Appendix C. Confidentiality and anonymity for the content of the group discussions were provided and the interviews lasted approximately 30 minutes to an hour. The findings described below were reported by at least three focus groups.

2. Behavioral Health and Provider Focus Groups

Six groups of behavioral healthcare (BH) providers and three groups of primary care (PC) providers participated in focus groups/interviews led by at least two MHAT III team members. Interviews were with one to ten providers. The structured interview questions are at found in Appendix C. The interviews were anonymous and confidential lasting approximately 30 minutes to an hour. The findings described were reported by members of at least three interview groups.

B. Focus Group Results

1. Soldier Focus Groups

Questions and responses from these focus groups are reported below.

First-Time Deployers. The first-time deployers were asked "What were the positive aspects of the deployment?"

Appreciated the "comforts of home"- ready access to Internet and phones
Job satisfaction was high
Money
Availability of mental health services was appreciated

"What were the negative aspects of the deployment?"

Enemy is more lethal- frequent use of IEDs
Army tour lengths much too long, other DoD tours are shorter
Family separation
Months without a day off, not enough down time
Feelings of helplessness about death
Working with Iraqi Army (IA) Soldiers
RC and NG Soldiers concerned about civilian jobs

Multiple Deployers. Of the multiple deployer focus groups, participants had been on at least two deployments to OIF and the deployment was for an average of 9-12 months. They were asked to compare this deployment with a previous OIF deployment in terms of what was better and what was worse on the current deployment.

"How was this deployment better?"

Better train up
Knew what to expect

"How was this deployment worse?"

Increased stress on families; not enough time with families between deployments
Worried that more deployments lead to more divorces
ROE unclear/difficult to follow; Soldiers uncomfortable with being in a defensive vs. offensive posture
More danger, more IEDs, more casualties

"When was the most difficult time during the deployment?"

The last 3 months of tour (complacency increases mortality)
Immediately after rest and relaxation (R&R)
Event-related (casualties, major operations, elections)

2. Behavioral Health Provider Focus Groups

Major themes that emerged in the behavioral health focus groups are listed below:

- Satisfied with BH provider survey questions
- Most common challenge: communication
  - Most common communication issue- needed a Corps or Forces Behavioral Health Consultant for oversight of standards of care, suicide prevention programs, management of suicide event reports, and evacuations.
  - Initial problems with phone communication were resolved
- Problems with not enough human resources to do their mission,
  - Unsure if human resources were well allocated which may explain why only 37% of BH respondents surveyed were satisfied with support from higher HQ
  - Example: a relatively underutilized fitness team on a FOB due to co-location with a BDE sized unit with organic mental health assets was moved to another FOB where it would be better utilized.
- Desired Applied Suicide Intervention Skills Training (ASIST)
- Most had formal COSC doctrine training
- Travel among FOBS was a barrier to outreach services
  - Not enough up-armored vehicles to travel
  - Waiting for higher HQ to approve travel requests caused unnecessary delay to mission

3. Primary Care Provider Focus Groups

Major themes that emerged in the primary care focus groups are listed below:

- Good relationship with their Division Mental Health team
- Rare problems with transferring a Soldier to a higher level of care, but some comments that when a Soldier was referred for therapy that no feedback was given back to the provider who sent the Soldier
- Initial problems with medication management
  - Certain psychotropics unavailable early in deployment
  - This was resolved by mid-to late deployment
- Few or no problems with evacuation out of theater
- Major problems with communication about a Soldier once Soldier left theater
  - Frustration with calling LRMC or WRAMC and being prevented from getting information due to HIPAA
  - Providers needed RTD information from the losing unit
- Seldom treated acute stress symptoms, implying that Soldiers had been triaged to a BH team
- Providers participated in as much or as little CME as desired

No evidence of a Provider Health Program
All PC groups emphasized that 6 months is an ideal deployment length

VI. SUICIDE PREVENTION PROGRAM REVIEW

MHAT III reviewed the status of the MNF-I suicide prevention program. The program included prevention and intervention activities in addition to surveillance and analysis of suicidal events. The support and participation of leadership, individual units, unit ministry teams, and behavioral health plays a vital role in the overall success of the program. Suicide prevention was an area of interest during MHAT I due to suicides that occurred in Summer 2003. The topic was also addressed in MHAT II by looking at the state of the community-based Army Suicide Prevention Program, assessing the surveillance system of completed suicides, and reviewing the suicide rate for 2004. MHAT III adopted the same methodology as MHAT II.

A. Recommendations from MHAT-II

The MHAT II report listed the following recommendations concerning suicide prevention and surveillance:

1) Designate a proponent to manage MNF-I Suicide Prevention Program.
2) Maintain vigilance by leaders and Soldier-peers to ensure Soldiers at risk for suicide receive appropriate support.
3) Implement surveillance of completed suicides and serious suicide attempts with standardized suicide reporting by BH personnel.

This section will review the current status of the overall suicide prevention and monitoring program to include prevention, intervention, and surveillance activities. The MNF-I Suicide Prevention Program consists of prevention and intervention activities. The proponent is the MNF-I Chaplain. Surveillance and analysis of suicidal behavior using the Army Suicide Event Report (ASER) is the responsibility of the U.S. Army Medical Command in cooperation with the MNF-I Surgeon.

B. Prevention

Suicide prevention training is conducted prior to Soldiers deploying to OIF, before they go on rest and recuperation leave, and in preparation for redeployment. The majority of these briefings are conducted by unit ministry teams with assistance from behavioral health assets. Results of provider and Soldier surveys indicated that training is being conducted. Unit Ministry Team surveys noted that over half of the respondents conducted suicide prevention at least monthly with ninety-seven percent (97%) noting confidence in providing such training. Thirty-five percent (35%) of behavioral health providers conducted suicide prevention training at least monthly. Eighty-two percent (82%) of Soldiers received suicide prevention training in the past year. There was a decrease from 51% in OIF II to 48% in OIF 04-06 in the number of Soldiers who reported that the training was adequate. Sixty percent (60%) of Soldiers in OIF II and

55% in OIF 04-06 reported confidence in their ability to identify Soldiers at risk for suicide.

C. Intervention

During 2005, seventeen Applied Suicide Intervention Skills Training (ASIST) sessions were conducted by Unit Ministry Teams throughout the OIF area of operations. A total of 524 Soldiers were trained, to include 85 Unit Ministry Team personnel. Unit identification for these Soldiers was not available. Ninety-eight percent (98%) of Unit Ministry Team members surveyed noted feeling confident in helping Soldiers with suicidal thoughts, and ninety-three percent (93%) of behavioral healthcare providers were confident in evaluating and managing Soldiers with suicidal thoughts and behaviors.

D. Surveillance

The Army Suicide Event Report (ASER) is the reporting and tracking mechanism for completed suicides and non-lethal events that result in hospitalization and/or evacuation of Soldiers. Sixty-two ASER reports from OIF 04-06 were submitted to the MEDCOM ASER Program Manager, nineteen of which were for completed suicides.

E. Suicide Statistics

The Armed Forces Medical Examiner (AFME) confirmed 22 suicides in the OIF area of operations during calendar year 2005. The rate is 19.9 per 100,000 in calendar year 2005, 11.0 per 100,000 in calendar year 2004, and 18.8 per 100,000 in 2003. The majority of the deaths involved junior enlisted, white, unmarried males under the age of thirty, with the cause of death listed as a gunshot wound.

Summary of Demographics on OIF 2003, OIF 2004, OIF 2005 and Army 2005 Suicides as of 18 Jan 2006				
	2005 Army Suicides	**2005 Army OIF Suicides**	**2004 Army OIF Suicides**	**2003 Army OIF Suicides**
Suicide by firearm/gunshot	77%	95%	100%	96%
Male	96%	91%	100%	92%
Age 30 or younger	69%	77%	89%	79%
E-4 or below	61%	68%	78%	71%
Married	47%	32%*	11%	38%
Minority (non-white)	21%	23%	22%	42%

*Four of the six married SM were legally separated.

F. Suicide Prevention Program Discussion

Soldiers received suicide prevention training at mandated times during the deployment cycle as verified by command and chaplain leadership. The vast majority of Soldiers surveyed noted having received such training. Unit ministry team members were active

in providing suicide prevention training with assistance from behavioral health assets when needed. Interviews with chaplain leadership noted that units were very involved in ensuring that Soldiers received suicide prevention training. The fact that fewer Soldiers reported that the training was sufficient indicates a need for review of this preventive education. Suicide prevention training in a deployed environment may require modifications of the training package used for Soldiers who are not deployed.

ASERs were submitted for nineteen of the twenty two suicides (86%) reported by the AFME. An additional fifty-one ASERs were completed for cases resulting in hospitalization and/or evacuation. Behavioral health providers generally were aware of the requirement to submit reports for completed suicides, but there was not consistent awareness of the need to perform and submit ASERs for non-lethal events. Review of hospitalization databases for medication overdose indicated a high probability that more than fifty-one ASERs might have been required for non-lethal events resulting in admission. Comparison of the ratio of ASERs submitted for completed suicides to non-lethal events (1:2.7) was significantly lower than the overall Army ratio minus the OIF submissions (1:12.0). ASERs were generally of good quality with pertinent information included, but providers were not aware of how the information was utilized. ASER submissions are currently monitored for cases of completed suicides.

The calendar year 2005 suicide rate reported by the AFME for the OIF area of operations was 19.9 per 100,000 which is comparable to the 18.8 per 100,000 during OIF I and higher than the OIF II rate of 8.5 per 100,000. The rate for the Army was 11.0 per 100,000 for calendar year 2004 and 13.1 per 100,000 for calendar year 2005. Eaton, Messer, Wilson, and Hoge (2006) analyzed military suicide rates over an 11 year period and concluded that military rates were 20% lower than a comparable civilian population and that variance of suicide rates as much as 20% to 40% per year could be attributed to random error. The demographics of completed suicides for calendar year 2005 when compared to calendar year 2004 showed an older and higher ranking population with a greater percentage married. Four were separated. Review of available ASERs revealed that most frequent risk factors were relationship issues both at home and within theater followed by Uniformed Code of Military Justice (UCMJ) actions, problems with fellow Soldiers and command, and dissatisfaction with duties.

G. Status of MHAT II Suicide Prevention Program Recommendations

1) Designate proponent to manage MNF-I Suicide Prevention Program.

Status. The MNF-I Chaplain is the designated proponent of the MNF-I Suicide Prevention Program.

2) Maintain vigilance by leaders and Soldier-peers to ensure Soldiers at risk for suicide receive appropriate support.

Status. Each unit surveyed had a proponent for suicide prevention training and commanders supported training in suicide prevention and crisis intervention. Soldier

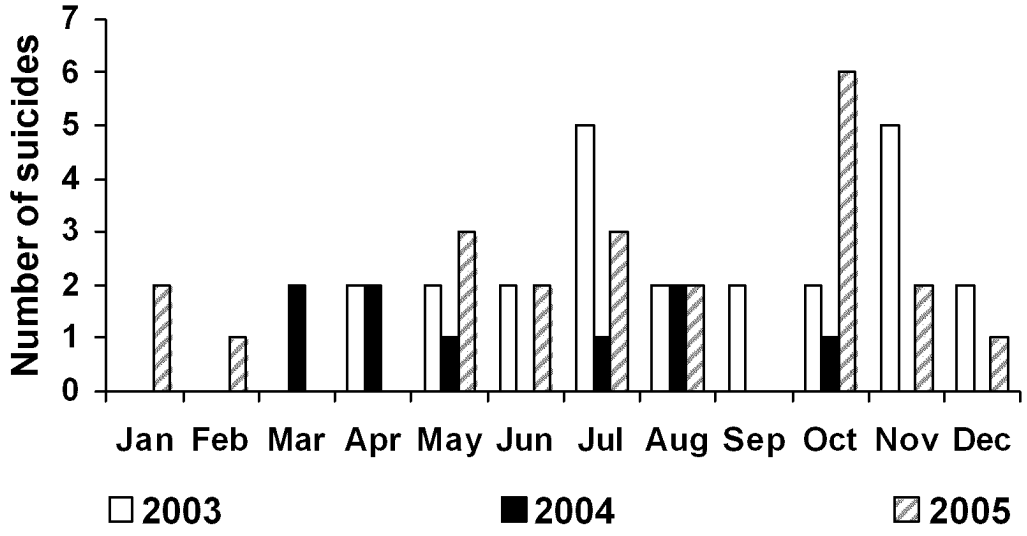
survey data indicated that fewer OIF 04-06 Soldiers rated the training as adequate. The MNF-I Suicide Program proponent should address this finding in consultation with the Army Suicide Program manager and suicide prevention training subject matter experts.

3) Implement surveillance of completed suicides and serious suicide attempts.

Status. Behavioral health personnel are submitting ASERs on completed Soldier suicides. Completion of ASERs for events resulting in hospitalization and/or evacuation can improve. BH personnel appear motivated to complete ASERs and would like feedback concerning the quality of their work and any conclusions derived from the reports. The proposed MNF-I Behavioral Health Consultant in conjunction with the MNC-I consultant should continue to monitor ASER submissions for completed suicides and non-lethal events. The MNF-I BH Consultant should conduct quality improvement assessments and training if required to ensure that providers are able to complete these reports.

The tables below present additional suicide information about the Army.

Table 1: Monthly OIF Suicides for 2003- 2005



TAB A: U.S. Army Suicide Rates: 1995-2005

Calendar Year	Rate per 100,000
1995	14.8
1996	12.4
1997	10.6
1998	12.0
1999	13.1
2000	12.1
2001	9.1
2002	11.1
2003	12.8
2004	11.0
2005	13.1
Average 1995-2005	**12.0**

TAB B: OIF Suicides: 2003-2005

SUICIDE UPDATE	2003	2004	2005
OIF Confirmed	25	12	22
OIF Pending	0	0	0
OIF Confirmed Rate	18.8	10.5	19.9

TAB C: Profile of Confirmed OIF 2005 Suicides (As of January 2006)

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

VII. BEHAVIORAL HEALTH PERSONNEL IN OIF 04-06

A. Personnel Distribution

The distribution, numbers and types of behavioral health personnel and ratio of BH personnel to Soldiers found during OIF 04-06 remained very similar to that found during OIF II.

Behavioral health personnel continue to be distributed by regions in OIF 04-06 based on the population of Soldiers in these areas. The OIF 04-06 ratios of BH personnel to Soldiers varied from 1/188 to 1/1300. OIF II ratios varied from 1/160 to 1/457, while the OIF I ratio of BH personnel to Soldiers varied from zero (no BH personnel) to 1/1214 by region. For simplicity, "FOB" includes base camps, logistical support areas, ranges, etc. In general, as the size of the FOB population decreased, the number of BH personnel to Soldiers also decreased, and the variance in the distribution of BH personnel within each size category increased.

OIF I, OIF II (Iraq only) and OIF 04-06 Distribution of Behavioral Health Personnel and Ratio to Soldiers

	OIF I Sep 2003			OIF II Sep 2004			OIF 04-06 Oct 2005		
REGION	BH	SOLDIERS	RATIO	BH	SOLDIERS	RATIO	BH	SOLDIERS	RATIO
(b)(2)-2									
IRAQ TOTAL	140	116000	1:830	215	83200	1:387	230	103100	1:448

Note: Number of Soldiers from DoD reports and is rounded.

OIF II and OIF 04-06 Behavioral Health Personnel by Specialty

Specialty	OIF II	OIF 04-06
Psychiatrist	15	17
OT	8	9
Psych Nurse	12	21
Soc Work	27	30
Psychologist	17	21
Medic	5	0
OT Tech	8	12
MH Specialist	123	120
TOTAL	**215**	**230**

OIF 04-06 Behavioral Health Personnel by Unit and Unit Type

Unit	Unit Total	?iatry	OT	? Nurse	Soc Wk	?ology	OT Tech	MH Spec
Behavioral Health Staff Officers								
(b)(2)-2								
Total	**230**	**17**	**9**	**21**	**30**	**21**	**12**	**120**

B. Conclusions

The staffing model developed by MHAT II (see MHAT II Report, Annex B, pages B-58 to B-68) described a method to determine optimal staffing based on a variety of factors and needs. The use of this model is supported by MHAT III. The MHAT II report noted that the overall provider-to-Soldier ratio (including Kuwait) had increased from 1:846 during OIF I to 1:407 during OIF II and noted that this ratio provided sufficient coverage (MHAT II Report, page G-12). However, the MHAT II report also noted that based on differing conditions and assumptions the staffing ratios could reach as high as 1:770 (MHAT II Report, page B-63). The determination of optimal staffing is a dynamic process in which any staffing ratio is subject to change based on the number and size of

the FOB's, the accessibility of BH personnel to units, and other factors which must be considered in order to determine the staffing requirements.

The number of BH providers deployed to OIF 04-06 increased by 15. The wide range of provider-to-Soldier ratios suggested that distribution of these assets may continue to be an issue as was noted by MHAT II. In order to determine the optimal number of BH assets, the MNF-I BH Consultant, respective commanders and medical planners should address distribution of these assets and apply the staffing model recommended by MHAT II.

VIII. STATUS OF MHAT II ISSUES

A. Introduction

The status of issues reported in the MHAT II report were assessed. In October and November 2005, the MHAT III team collected data through surveys, observations and communication with proponents of the issues. The tables below indicate the current status based on the GREEN, AMBER, or RED classification used in the MHAT II report. GREEN indicates substantial progress or completion achieved in addressing this issue based on data provided to MHAT III. AMBER indicates that some progress has been achieved in addressing this issue. However, the issue requires additional action. RED indicates an issue which continues to require attention. In some cases issues classified as Red may not be able to arrive at a resolution within the time period since the MHAT II identified the issue.

B. Summary

Eight of fourteen issues identified by MHAT II are green. Five are amber and one (BH quarterly training) has gone from amber to red. Soldiers reported receiving training on managing deployment stressors and the proponent for managing suicide prevention training was the MNF-I Chaplain. OIF 04-06 Soldiers reported less confidence in their ability to identify a Soldier at risk for suicide than did OIF II Soldiers The number of behavioral health assets remained essentially the same as noted during OIF II. Reports from providers indicated that distribution of resources may be an issue. BH personnel reported receiving Combat and Operational Stress Control (COSC) training prior to deployment. Soldiers reported easier access to BH personnel in the last 12 months.

Item 1 D referred to the development and fielding of a standardized method of assessing the behavioral health status of a unit. Unit needs assessment is one of the eight core COSC functional areas, yet it is arguably the least understood (FM 4-02.51 Draft). A standardized Unit Behavioral Health Needs Assessment (UBHNA) was fielded by MHAT III by training the (b)(3)-1 CSC in its use. The UNBHNAS uses methods developed by Walter Reed Army Institute of Research to assess the psychological well-being of Soldiers. A comprehensive training plan for the remainder of the behavioral health assets in theater needs to be developed.

Ten recommendations required action by MEDCOM or subordinate commands and were not specific to MNF-I. Three of these are Green, six are Amber and one is Red. Two recommendations related to the COSC are being addressed by the AMEDD Center and School (AMEDD C&S) with projected completion in Fall 2006. Additional COSC training has been incorporated into MOS training for BH MOSs. A COSC track has been added to the annual Force Health Protection Conference (FHP). Recommendations for COSC Workload and Activity Reporting (COSC-WAR) and evacuation databases will be addressed by U.S. Army Medical Command.

C. Findings

OIF II MHAT ISSUES	STATUS	OIF 04-06 MHAT FINDING
1. A. Appoint a Theater/Area of Operation BH consultant to advise the Surgeon on BH issues.	GREEN	Per the MNF-I Surgeon, a Corps-level behavioral health consultant has been appointed.
1. B. Execute an aggressive BH outreach program. Ensure that BH personnel have a regular, far-forward consultation program at the small-unit level.	GREEN	There are 219 Behavior Health assets in theater. Only 5% reported problems getting to where BH assets are located. Seventy-three percent (73%) of BH professionals report conducting MH outreach services once each week or more. CSC commanders report some difficulty getting from FOB to FOB because of transportation challenges.
1. C. Area of responsibility (AOR) BH consultants need to distribute BH assets appropriately.	AMBER	Some FOBs had no organic BH services other than UMTs but are provided services by BH professionals from other FOBs. Corps or regional level BH consultant could assist commanders in improving the distribution of resources.
1. D. Field a simple, standardized needs assessment tool for Soldiers and units.	AMBER	A Unit Needs Assessment tool was developed by WRAIR. MHAT III personnel trained the (b)(3)-1 CSC in the standardized Unit Needs Assessment Instrument. A training mechanism for theater BH personnel will need to be implemented and monitored through the MNF-I BH Consultant.
1. E. Train Soldiers in meeting the demands of deployment/combat-related stressors.	GREEN	The OIF-III Soldier Survey data indicate 78% of Soldiers reported receiving training on managing deployment stressors in the past year. Of note, WRAIR has developed and is implementing Battle Mind Training (endorsed by the Army G1) to units pre-deployment.
1. F. Improve the ability to hold Soldiers in theater closer to their own units. Create a BH Reconditioning Program.	GREEN	OIF 04-06 CSC units continue to hold Soldiers in theater and provide restoration services at a level consistent with that noted by MHAT II.
1. G. Improve the quality of behavioral healthcare services for Soldiers during evacuation.	GREEN	This issue was Green for MHAT II and remains unchanged.

OIF II MHAT ISSUES	STATUS	OIF 04-06 MHAT FINDING
2. Area of responsibility BH consultants should establish quarterly BH training meetings.	RED	BH professionals expressed strong interest in restarting quarterly BH conferences. Offering this in conjunction with the MNC-I Surgeon's Conference would be beneficial for the BH community.
3. Plan for the upcoming battle-handover.	GREEN	(b)(3)-1 CSC had a strong turnover with the (b)(3)-1 CSC in October/November 2005. (b)(3)-1 fell in on the same footprint as the (b)(3)-1 CSC. Handover at several FOBs is reported to have been seamless.
4. A. Designate proponents to manage the Coalition Forces Land Component Command (CFLCC) and Coalition Joint Task Force-7 (CJTF-7) Suicide Prevention Programs.	GREEN	The MNF-I Chaplain has proponency for suicide prevention. Unit Ministry Teams are the lead on suicide training and prevention. Over 500 personnel were trained in theater using the ASIST program. Policy is that all Soldiers receive training prior to deployment, before R&R leave and at re-deployment.
4. B. Maintain vigilance by leaders and Soldier-peers to ensure Soldiers at risk for suicide receive appropriate support.	AMBER	OIF 04-06 Soldiers reported less confidence in their ability to identify a Soldier at risk for suicide than did OIF II Soldiers (55% vs. 60% in MHAT II, $z = -2.43$, $p < .01$). Similarly, OIF 04-06 Soldiers reported less confidence in their ability to help Soldiers get mental health assistance than did OIF II Soldiers (65% vs. 75% in MHAT II, $z = -5.58$, $p < .001$).
4. C. Conduct training that provides crisis intervention skills to designated Soldiers with a goal of one trained Soldier per company.	AMBER	Battle Mind Training is available on Army Deployment Cycle Support website. Predeployment and spouse/family training is needed and is being developed.
4. D. Implement surveillance of completed suicides and serious suicide attempts with standardized suicide event reporting by BH personnel.	AMBER	Behavioral health personnel are submitting ASERs on completed Soldier suicides. Completion of ASERs for Soldier suicidal events resulting in hospitalization and/or evacuation indicate only partial compliance.
4. E. Establish a command climate that encourages appropriate help-seeking behavior by distressed Soldiers. Behavioral healthcare should be delivered as far forward as possible to maximize the likelihood of successfully returning Soldiers to duty.	GREEN	The OIF-III Soldier Survey found that the percent of Soldiers who screened positive for MH problems and also accessed professional services increased from 44% in OIF-II to 52% in OIF-III. Only 5% reported problems getting to where BH assets are located.

OIF II MHAT ISSUES	STATUS	OIF 04-06 MHAT FINDING
The following issues presented by MHAT II require actions by U.S. Army Medical Command and subordinate units.		
Future Implementation 1.A. Direct The Surgeon General (TSG) BH consultants to develop and implement a multidisciplinary COSC course to teach COSC doctrine, tactics, and procedures to all BH/COSC personnel.	AMBER	A multidisciplinary committee has been meeting at the AMEDDC&S since January 06 to revise the, "Management of COSC Casualties Course," making the curriculum relevant for training all BH/COSC personnel. The course is projected to begin in Fall 2006
1.B. Direct TSG behavioral health consultants to charter multidisciplinary PATs to develop the key elements for inclusion in the course.	AMBER	A needs assessment survey was distributed in Mar 06 to all BH personnel. Feedback from field and lessons learned will be utilized to develop the curriculum for the new course. Members of the committee will write a white paper describing the new course content for the BH Consultants.
1.C. Direct TSG behavioral health consultants to reorient the AMEDD officer and enlisted military education systems to integrate collective blocks of instruction in COSC, disaster BH, and battlefield professional practice.	AMBER	This is ongoing through the consultants. An example is the Behavioral Health Specialist Course which has modified its curriculum to include more COSC and deployment related training in the classroom as well as in the FTX portion of the course.
1.D. Direct CHPPM and TSG behavioral health consultants to ensure that a COSC/BH track is incorporated into the annual Force Health Protection (FHP) Conference.	GREEN	A BH track was incorporated in the annual FHP Conference beginning in 2003.
2. A. Medical Command should review the COSC Workload and Activity Reporting System (COSC-WARS) for sufficiency and then automate it.	AMBER	COSC-WARS continues review and analysis by the AMEDD Center and School

OIF II MHAT ISSUES	STATUS	OIF 04-06 MHAT FINDING
2. B. Medical Command should integrate COSC prevention efforts into existing and emerging theater medical databases.	AMBER	COSC-WARS continues review and analysis by the AMEDD Center and School
3. Medical Command should establish a joint process action committee to work on an evacuation database system capable of clinical, tracking, and analytical functions. It must be readily available, secure, and tailored to the needs of line commanders, medical personnel, medical regulating planners, and medical planners.	RED	MEDCOM Directorate of Behavioral Health is responsible for review of this recommendation.
4. A. Develop a peer-mentoring program using mid-grade Soldiers to facilitate the early identification and intervention for psychosocial problems at the company level.	AMBER	WRAIR has developed and fielded post-deployment Battle Mind Training which is incorporated into the Deployment Cycle Support Program. Pre-deployment training is being developed.
4. B. Improve BH support for rear-detachment commanders and Family Readiness Groups (FRGs). One possible solution would be to have social workers fulfill this mission.	GREEN	The Army Deployment Cycle Support Program managers (DCSPER-G-1 staff) are presently implementing a program to staff and resource the rear detachment and family readiness groups to ensure high quality support for Soldiers and family members.
5. Implement monitoring of serious suicide attempts within Army medical surveillance systems. Task CHPPM and the BH consultants to develop capability for monitoring serious suicide attempts at the installation, operational, and Army-wide levels. The pilot version of the ASER is a promising tool for reporting suicide attempts.	AMBER	Significant improvements have been made since MHAT II. The Army Suicide Event Report (ASER2005) was implemented as a secure WebForm completed at https://aser.amedd.army.mil. The Suicide Risk Management and Surveillance Office (SRMSO) was instituted and proceeded to identify ASER and Command POC's for the program at each MTF, initiated monthly compliance reporting, and provided quarterly and annual comprehensive reporting of results. Reporting of ASER data for completed suicides is above 90%. Challenges persist with compliance for reporting suicide-related behaviors that result in hospitalization and evacuation. Alternatives are currently under consideration to support these submissions and improve compliance. This program has been submitted for the 2008 POM to establish reliable resourcing and support critical AMEDD and Army needs.

IX. DISCUSSION

MHAT III was chartered to determine the status of the behavioral health of Soldiers, to assess the status of the behavioral healthcare system and to identify future requirements. In order to address these issues, comparisons were made with the results of previous MHAT reports. These comparisons across deployments provided a way to empirically document consistencies and changes in Soldier behavioral health status and the behavioral healthcare system. The following discussion addresses the findings of the MHAT III concerning the behavioral health status of Soldiers, the behavioral healthcare system, and provides suggestions to improve this care.

OIF II and OIF 04-06 share many similarities, particularly when contrasted to OIF I. Long deployment length was the top non-combat stressor in OIF 04-06. It was also the top non-combat stressor for Soldiers in OIF II in contrast to the uncertain redeployment date in OIF I. The nature of the operations in Iraq continues to create challenges for Soldiers and families to adapt to the dangers of combat. Deployment length, coupled with short and unpredictable periods between deployments, places increasing demands on Soldiers and families.

Ratings of personal morale between OIF II and OIF 04-06 were very similar and significantly higher than ratings of personal morale in OIF I. Each Soldier's subjective interpretation of morale makes it difficult to interpret this finding. However, factors contributing to positive morale repeatedly cited by Soldiers were the belief that their actions were having a beneficial effect, and the fact that they reported an enhanced sense of professional competence during their deployment. It was observed that Soldiers who value their contributions and described enhanced professionalism also reported positive morale.

Despite the similarities between OIF II and OIF 04-06, there are a number of subtle, incremental changes of importance. Five of these changes which are particularly noteworthy are stigma concerning behavioral healthcare, behavioral healthcare access, the nature of warfare, training for deployment stressors, and Active versus Reserve Component behavioral health status.

First, stigma associated with receiving behavioral health services declined from OIF I to OIF II to OIF 04-06. These differences were gradual and were only detected in terms of statistical significance when contrasting OIF 04-06 and OIF I. Thirty-five percent (35%) of the Soldiers in OIF I agreed that the fear of being seen as weak would affect their decision to receive mental health counseling. In OIF II, this number was 31% and in OIF 04-06 it was 28%. This decline of three to four percent each year may reflect a gradual large-scale cultural change in how Soldiers perceived those who seek behavioral health services. If these events reflect large scale cultural changes (see Bliese, 2006), they are almost certainly driven by proactive commanders who have helped normalize and emphasize the acceptability of help-seeking behaviors among their Soldiers. These changes may also be driven by the medical communities' efforts to

integrate primary care and behavioral health assets and by the Department of Defense Policy to implement the Post-Deployment Health Reassessment.

Continued command emphasis on reducing stigma is warranted by the fact that a significantly higher percentage of Soldiers who reported mental health issues also reported higher levels of concern about stigma (Hoge et. al., 2004). This suggests that those most in need of behavioral health services may be most concerned about negative consequences from receiving this care.

A second incremental change reflected in the comparisons across each OIF is that behavioral healthcare delivery continues to improve. Soldiers' reports of access to behavioral healthcare services showed gradual improvement from OIF I to OIF II to OIF 04-06, although OIF 04-06 was not statistically different from OIF II. For instance, in OIF 04-06 only 5% of the Soldiers reported it was too difficult to get to mental health specialists. During OIF I and OIF II these rates were 15% and 7%, respectively. The big change occurred between OIF I and OIF II; nonetheless, Soldiers' perceptions of access in OIF 04-06 remained excellent. Other pieces of evidence also speak to improved mental healthcare delivery. Utilization of behavioral health services reinforced the improved access finding with an increase in the number of Soldiers who reported receiving care from 23% during OIF II to 30% during OIF 04-06. In addition, primary care providers reported that they were more comfortable in OIF 04-06 than in OIF II in addressing behavioral health concerns. Seventy-four percent (74%) of the primary care providers in OIF 04-06 reported confidence in their ability to treat or assist Soldiers with combat stress reactions. In OIF II, this number was 57%. Primary care providers who feel confident to address behavioral health concerns greatly expand the capacity of the behavioral healthcare delivery system.

A third incremental change reflects the changing nature of warfare. In comparisons of combat experiences, OIF I stands out as different from either OIF II or OIF 04-06. The change between OIF II and OIF 04-06, however, is more subtle. Soldiers in OIF 04-06 reported significantly more exposure to IEDs and significantly more exposure to knowing someone injured or killed than those in OIF II. OIF 04-06 Soldiers also reported that they were in threatening situations where they were unable to respond because of the rules of engagement more often than Soldiers in OIF II. These differences in exposure to death and dealing with uncertainty reflect the evolving nature of warfare in OIF. The nature of combat experiences may partially explain the increase in the combined measure of psychological problems from 13% to 17% and that 14% of the Soldiers surveyed reported receiving a prescription for psychotropic medication. The latter finding could also reflect increased accessibility and willingness to seek mental healthcare due to lowered stigma. These increases from OIF II should be monitored.

A fourth incremental change was the degree to which Soldiers reported being prepared for suicide prevention and managing the stress of deployment. Comparisons between OIF II and OIF 04-06 found that fewer Soldiers agreed that they were adequately prepared to identify Soldiers at risk for suicide. Soldiers' responses may reflect less training in OIF 04-06 compared to OIF II. Alternatively, Soldiers in OIF 04-06 may have

received the same training as those in OIF II, but their responses may reflect the different combat environment in OIF 04-06. The change, while subtle, emphasizes the need to develop and continually update standardized training modules such as Battle Mind developed by the Walter Reed Army Institute of Research and integrate this training into the Post-Deployment Health Reassessment Program. The results also emphasize the importance of continuing to provide training in areas such as suicide prevention in theater.

A fifth incremental change reflects the rates of mental health problems between Reserve Component and Active Component units. A key finding of the MHAT II report was that non-combat Reserve Component units had significantly higher rates of acute stress symptoms. In contrast, OIF 04-06 Reserve Component Soldiers had significantly lower rates of acute stress similar to those reported by Active Component Soldiers. OIF 04-06 reserve Soldiers reported significantly lower rates of depression and anxiety than did Active Component Soldiers. Analyses of combat versus non-combat units revealed that Soldiers in non-combat Reserve Component units consistently reported lower levels of psychological problems than Soldiers in any other category. Only 9.5% of non-combat Reserve Component Soldiers were positive on the combined measure of acute stress, depression or anxiety while the comparable numbers were 17.5% for combat Reserve; 19.3% for non-combat Active and 17.0% for combat Active Component. These differences are statistically significant (z-value = 2.20, $p<.05$) and emphasize that component differences are not consistent across OIF missions. One implication of these findings is that when planning and resource allocation decisions occur, the assumption that reserve component Soldiers may have a higher rate of problems is not valid.

MHAT III provided the unique opportunity to conduct a detailed analysis of Soldiers who had previously deployed one or more times to OIF. On many dimensions of the data, multiple deployers were not significantly different than first-time deployers. However, on the dimension of acute stress symptoms, multiple deployers were different (18.4% versus 12.5%). The most likely explanation for these differences is that a number of Soldiers returned to the OIF 04-06 theater with acute stress/combat stress symptoms. This explanation is based in part on the exploratory analyses of how multiple deployers responded to combat events. Higher exposure to combat events such as knowing someone seriously injured or killed is associated with higher levels of stress. Importantly, however, the association was the same for multiple deployers as it is for first-time deployers. That is, multiple deployers do not appear to react differently when exposed to combat events. Another piece of evidence suggesting that Soldiers are returning to OIF with unresolved acute stress problems is research showing high rates of stress symptoms at 12 months post-deployment (Castro & Hoge, 2005). The assumption that Soldiers are not returning to their baseline level of functioning is important when considering the amount of time between deployments. Soldiers may return with issues related to their previous deployment. The implications of this research are that identification and treatment of combat stress symptoms when Soldiers return to home is important. The Department of Defense Post-Deployment Health

Reassessment policy to implement wide-scale post-deployment mental health screening will be beneficial in addressing this issue.

In addition to acute stress, multiple deployers reported significantly more concern about the deployment length and about the nature of the work as boring and repetitive. They also reported significantly lower perceptions of unit morale. These differences take on added significance due to the fact that multiple deployers are higher rank and more likely to be in small group leadership positions where they influence the perceptions and motivation of subordinates.

The MHAT III analyses of provider surveys yielded insights into the status of healthcare providers and their perceptions of the behavioral healthcare delivery system. Standards for the transfer of information between levels of care emerged as a key theme. In the behavioral health survey, 21% of the respondents reported that the standards for the transfer of clinical behavioral health information were clear. In contrast, in OIF II 35% of the respondents positively endorsed this item. In both OIF II and OIF 04-06, the number of providers who agreed or strongly agreed that the standards were clear for record management and clinical documentation were below expected levels. This finding coupled with the decline concerning standards for the transfer of information indicates a need for oversight.

Related to these findings were the comments recorded during BH provider focus groups to include the absence of theater level policies for a BH performance improvement program and the disposition of behavioral health records. BH providers noted conducting some performance improvement activities based upon experience at their local units, but they were not aware of any program policy within the OIF theater. BH providers noted the challenge of maintaining relevant clinical information when units left and the Soldiers under treatment remained.

Compliance with suicide event reporting for completed suicides was consistently noted, but reporting of non-lethal events will require additional effort. Monitoring and analysis of both lethal and non-lethal events using existing services' reports will permit timely assessment and feedback of potential risk indicators.

Some level of burnout was reported by all provider groups, particularly among PC providers. This finding may be due to the long period of deployment and the fact that at the time they were surveyed most were coming to the end of their deployment. PC focus groups noted providers were experiencing burnout, but did not perceive a decrement in the quality of patient care and were aware of how to recognize and address provider impairment. A certain level of provider burnout is to be expected after almost a one year deployment, but the providers surveyed and interviewed noted that they were very dedicated to their mission and high quality healthcare was being provided.

The absence of standardized unit needs assessment for BH care has been reported and was addressed by MHAT III with the introduction of a standardized instrument. The

Unit Behavioral Health Needs Assessment Survey (UNBHAS) will provide CSC units with a mechanism to provide feedback to command concerning the psychological readiness of their Soldiers. In so doing it will allow commanders access to much of the same information provided by each MHAT.

The MNF-I area of operations has an active suicide prevention program ensuring Soldiers received suicide prevention training at specified times during the deployment cycle and key individuals obtained suicide intervention training. Soldier survey results noted that there was a decrease in the percentage of Soldiers who believed that they received sufficient training in identifying Soldiers at risk for suicide. This is an area to review when updating the MNF-I Suicide Prevention Program.

MHAT III findings demonstrated continued progress in improving the behavioral health of Soldiers. The implementation of theater-specific recommendations from the previous two MHATs was evident. There is an organized approach to ensuring BH personnel are trained and prepared prior to arrival. Better access to BH personnel in the last 12 months was noted. Soldiers reported receiving training to handle deployment stressors in higher percentages.

High quality behavioral healthcare was delivered by dedicated providers who readily responded to the needs of Soldiers. Monitoring and policy development could standardize and enhance BH care delivery and could improve providers' understanding of standards of care and documentation requirements. Consistent with the strategic healthcare planning mission of the MNF-I Surgeon, a MNF-I BH Consultant in coordination with regional BH Consultants can meet this enhanced care delivery goal. Areas of interest to address include the distribution of resources, quality improvement, workload analysis and tracking, continuity of care, behavioral health staffing, and the suicide prevention program.

Planning for continuing support by behavioral health for deployed Soldiers must be linked to the realities of the combat stress environment. Sufficient behavioral health assets consistent with the level noted in MHAT II were present. The fact that Soldiers reported deployment frequency and the relatively brief amount of time between deployments as important issues makes a compelling reason to ensure that there is the proper distribution and placement of BH providers. Providing proactive BH consultation, assessment, intervention, and treatment will decrease overall Soldier morbidity, enhance combat readiness, and aid in dealing with the stressors of redeployment. The incorrect distribution or allocation of behavioral health assets may create problems throughout the military healthcare system. Adjustment of the numbers, types and locations of these assets will require oversight at a strategic level with a system that is responsive to a rapidly changing operational tempo (OPTEMPO). The right assets at the right place at the right time will be a force multiplier. Implementing a theater level BH care delivery system encompassing primary, secondary, and tertiary prevention directed by a BH Consultant will greatly enhance meeting such a goal.

X. RECOMMENDATIONS

1. Implement a MNF-I level BH policy as outlined in Appendix D

Discussion. The MNF-I Surgeon requested that MHAT III provide a force level behavioral health policy addressing the needs of the MNF-I Area of Operations. Appendix D of this report outlines a series of behavioral health issues, structure, and recommendations to meet the needs of coalition forces.

2. Designate a MNF-I BH consultant to serve in conjunction with duties as the MNC-I consultant and designate officers to serve as regional BH consultants.

Discussion. A force level behavioral health consultant serving as the principal staff officer to the MNF-I Surgeon can be the primary point of contact for behavioral health-related issues within theater. Through Regional Behavioral Health Consultants, the MNF-I Consultant can provide input to the MNF-I Surgeon regarding both operational and strategic BH issues.

3. Continue to emphasize the reduction of stigma and barriers to behavioral healthcare for Soldiers and reemphasize suicide and deployment stress training

Discussion. Stigma and barriers to behavioral healthcare remain obstacles that deserve attention at all levels. Soldiers needing assistance will seek out fellow Soldiers, chaplains, primary care providers and their chain of command before they seek behavioral healthcare. Consequently, it is important for Soldiers to feel confident in their ability to identify Soldiers at risk for suicide and confident to help them get assistance. In OIF 04-06, Soldiers show less confidence in these areas. A continuing effort to educate Soldiers on behavioral healthcare will help ensure that those in need of BH services overcome obstacles to care. Command emphasis at all levels aimed at training Soldiers for suicide prevention, stresses of combat, and reducing the stigma and barriers to BH care can ensure the behavioral health and well-being of the force.

4. Train and utilize the Unit Behavioral Health Needs Assessment Survey (UBHNAS)

Discussion. MHAT-III provided orientation and training to the (b)(3)-1 CSC. The UBHNAS can enhance unit readiness through the commander's ability to assess unit needs. Planning can be initiated to train all incoming CSC units under the guidance of the MNF-I BH Consultant. Use of the UBHNA will provide commanders with the same information at a unit level that was provided by the MHAT III Soldier Survey.

5. Continue to integrate behavioral health staff with primary care providers to help to reduce stigma and barriers to care

Discussion. Stigma and barriers to BH care remain a concern. BH care co-located with primary care reduces the stigma associated with BH, provides a readily available resource, and helps form a partnership that leads to improved access and reduced stigma for Soldiers needing BH care.

6. Continue research targeted at enhancing Soldier well-being with a focus on Soldiers who have deployed multiple times

Discussion. Learning from applied research on Soldier and family experience is a key to improving outcomes and readiness. Research concerning the effects of the war and terrorism on Soldiers and families is ongoing. In all three MHATs, researchers provided expertise in the collection and analysis of data addressing Soldier well-being. Future studies focused on Soldiers who have deployed multiple times to OIF can assist in improving the readiness of Soldiers for war and the support of their family members.

7. Provide theater-wide suicide surveillance through service-specific suicide event reports to include the Army Suicide Event Report (ASER) for Soldiers.

Discussion. Army BH providers submitted the Army Suicide Event Report (ASER). The compliance rate for ASER submissions for non-lethal events resulting in hospitalization and/or evacuation cannot be determined as such events were not identified in a systematic way. A MNF-I Suicide Prevention Program requires a method of surveillance for suicide-related events which complies with individual services' policies as well as tracking such events involving coalition partners.

8. Establish policy for the transfer of behavioral health information between providers.

Discussion. Both BH and PC providers noted a significant challenge in transferring BH information to different types and levels of healthcare. Reasons included lack of a BH documentation standard; reluctance of providers to disclose pertinent information due to perceived confidentiality issues; and uncertainty over the level of disclosure that could be made to the Soldier's command. The MNF-I BH Consultant can establish policy for minimum documentation and notification standards when transferring or referring a patient with a BH-related issue; establish a mechanism for the timely and comprehensive response to the BH consultation; and set parameters for disclosure of pertinent patient-related information to both fellow medical personnel and commanders.

9. Ensure distribution of behavioral health resources consistent with unit requirements.

Discussion. MHAT II presented a comprehensive BH staffing model (see MHAT II Report, Annex B, pgs B-58 to 68). This model can assist planners in addressing staffing needs. MHAT III noted that distribution of the number and type of behavioral health personnel as well as the ratio of BH personnel to Soldiers was similar to OIF II. Behavioral health personnel continue to be distributed by regions in OIF 04-06 with placement dictated by the footprint left from previous BH units. Some BH providers noted that due to the shifting intensity of combat, some FOBs did not have enough providers while others had more than required.

10. Establish a theater-wide behavioral health performance improvement program.

Discussion. BH provider focus groups noted the absence of a structured performance improvement program. Performance improvement activities being done were not elevated for review at higher levels; measures of performance such as chart reviews were not being accomplished; risk management reviews were not utilized for provider education and training; and there was no structured provider health program. Through the MNF-I BH Consultant, a theater-level BH performance improvement program can be established to include service-specific regulations.

11. Recommend that the proponent for Army Suicide Prevention Program training assess the requirements for a Suicide Prevention Program with elements specific to the OIF area of operations.

Discussion. Data from the OIF 04-06 survey indicated a small but significant decrease in the perception that suicide prevention training was adequate. All units surveyed reported having a proponent for training and there was sufficient command support. The proponent for Army Suicide Prevention Training should determine additional requirements for deployed Soldiers to be trained to address this issue.

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