

Joint Mental Health Advisory Team 8 (J-MHAT 8)
Operation Enduring Freedom 2012
Afghanistan

12 August 2013

Office of The Surgeon General
United States Army Medical Command

and

Office of the Command Surgeon
Headquarters, US Army Central Command (USCENTCOM)

and

Office of the Surgeon General
US Forces Afghanistan (USFOR-A)

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1. EXECUTIVE SUMMARY

1.1 Introduction

The Joint Mental Health Advisory Team 8 (J-MHAT 8) 2012 mission to Afghanistan in support of Operation Enduring Freedom (OEF) was established at the request of senior operational leaders and supported by the leadership of US Forces Afghanistan (USFOR-A). As in previous years, the Office of The Surgeon General of the Army took the lead in mission execution; however, similar to J-MHAT 7 (2010) the mission was supported by the Offices of the Surgeons' General of the Navy and Air Force along with the Office of the Medical Officer of the Marine Corps. In addition, the J-MHAT 8 was supported by the US Joint Staff Surgeon. Finally, key support was provided by the Office of the Command Surgeon, USCENTCOM and the Office of the Surgeon General, USFOR-A. J-MHAT 8 is the second MHAT to have Joint representation and the first to have an International (British Army Psychiatric Nurse) representative.

The purpose of J-MHAT 8 was to:

1. Assess behavioral health in OEF land combat forces by surveying Service Members (SMs) in Army and Marine maneuver units
2. Examine theater-wide delivery of behavioral healthcare in OEF
3. Provide recommendations for sustainment and improvement to command

During April, May, June, and July 2012, 1,363 SMs (994 Soldiers & 369 Marines) completed the anonymous J-MHAT 8 survey. To ensure comparability across years, maneuver unit platoons were the target population for J-MHAT 8. Of the 994 Army surveys, 619 were collected from 46 Army maneuver platoons. Of the 369 Marine surveys, 212 were from 12 maneuver platoons. All non-maneuver surveys were removed from further analyses as maneuver unit SMs were the intended population for J-MHAT 8. In addition, 117 surveys were collected from Army, Navy and Air Force behavioral health (BH) personnel in the Afghanistan Theater of Operations (ATO).

From 30 May to 30 July 2012, the J-MHAT 8 (a) processed and analyzed survey data, (b) examined secondary behavioral health data sources, (c) conducted focus group and interviews with Soldiers, Marines and BH personnel, and (d) wrote the technical briefing and draft report. Thirteen Soldier, 8 Marine and 22 BH focus groups/interviews were completed. The J-MHAT 8 report assessed the key issues from J-MHAT 7 with additional examinations of anger, Army and Marine resilience/mental health training, leadership and sleep, dietary supplement use, additional "BH self-management" items (e.g. Soldiers know how to help themselves), and a greater emphasis on the theater-wide BH System Assessment.

The report contains four key sections:

1. Status of Soldiers compared to four (2010, 2009, 2007 & 2005) previous OEF samples
2. Status of Marines compared to one (2010) previous OEF sample
3. Comprehensive OEF behavioral healthcare assessment and suicide prevalence
4. Integrative recommendations

J-MHAT 8 attempted to collect Service Member survey data using a cluster sample of randomly selected maneuver unit platoons. This sampling strategy was first used in the MHAT missions conducted in 2009 (MHAT VI: OIF and MHAT VI OEF) and again during J-MHAT 7 (2010) in OEF. The strategy has several advantages. First, it randomly selects respondents at the platoon level in order to minimize the possibility of drawing a biased sample. Second, it is feasible to execute within a combat environment, and third the sampling strategy is replicable across years

helping minimize any potential that differences across years would be due to sampling (rather than substantive) reasons. Many Army and Marine units in J-MHAT 8 provided non-randomly selected maneuver units. Army sample analyses of key variables (combat experiences and mental health symptoms) comparing the sub-population that included all Army maneuver units with the sub-population that included only units in the sampling plan showed that the Soldiers in Army maneuver units did not differ significantly from those in the sampling plan. Therefore, analyses were conducted on all 619 Army maneuver unit surveys. Marine analyses on key variables such as combat experiences and mental health symptoms comparing the sub-population that included all Marine maneuver units with the sub-population that included only units in the sampling plan showed that there were significant differences. Therefore, those Marine platoons that did not meet the random cluster-based sample were removed from the data set. All Marine analyses in this report are from the 212 Marines that were in the random cluster-based analyses.

1.2 Key Findings and Recommendations: Army

All key Army findings report significant ($p < .05$) differences from J-MHAT 8 (2012) compared to 2010, 2009, 2007 and 2005 OEF samples. If a year is not mentioned, there was no significant difference from 2012.

1.2.1 *Well-Being Indices*

1. Morale: Significant decline in reports of unit morale relative to 2010, 2009 and 2005. Individual morale is unchanged compared to 2010 but significantly lower than 2009 and 2005.
2. Psychological Problems: Self-reported rates of a combined psychological problem measure (acute stress, depression, or anxiety) are significantly lower than 2010 and 2007 but significantly higher than 2005. The rate of acute stress is significantly lower in 2012 compared to 2010 but higher than 2005.
3. Suicidal Ideation: Rates of reported suicidal ideation are unchanged from 2010, 2009, and 2005 but lower than 2007.
4. Concussive Events: Soldiers continue to report high exposure to concussive events. Compared to 2010, a higher percentages of Soldiers report being evaluated by “Medical Professionals or a Medic/Corpsman” for concussions if they were knocked out but similar rates to 2010 if the Soldiers report being in a vehicle blast, within 50 meters of a blast, or having a head injury. However, the evaluation rate may be higher than estimated because Soldiers may not consider receiving a Military Acute Concussion Evaluation (MACE) from a Medic/Corpsman at the point of injury to be an “evaluation”. That is, Soldiers’ sense of an “evaluation” may entail an MRI or some type of more detailed medical examination.

Recommendation #1: Educate SMs on how they will be evaluated and treated if they have a concussion.

Recommendation #2: Continue to refine the Department of Defense Instruction (DoDI) 6490.11 evaluation criteria regarding distance from blast [within 50 meters of a blast (inside or outside)] (CONUS).

5. Sleep Problems: Soldiers report concern about lack of sleep predominantly due to poor sleep environment and nighttime duties. Sleep problems due to stress about their personal lives are reported at a similar rate to sleep problems due to stress related to combat.

Recommendation #3: Incorporate sleep hygiene and discipline into pre-deployment training. Emphasize that small unit leaders are responsible for implementing sleep discipline and mitigating factors that lead to poor sleep environments (In Theater and CONUS).

6. Medication Use. Reported medication use for a mental health or combat stress problem is significantly lower than 2010 (1.8% vs. 3.5%). This rate is significantly lower than the antidepressant use rate of 4.6% among a demographically comparable civilian sample.

1.2.2 Risk Factors

7. Combat Experiences: Overall, the level of reported combat experiences is similar to 2010 but the nature of the experiences changed significantly with a lower percentage of Soldiers reporting shooting at the enemy and being responsible for the death of an enemy combatant. However, a higher percentage of Soldiers in 2012 report that an IED exploded near them.
8. Role/Mission Expectations: During Focus Groups, Soldiers report anger about their changing roles as the mission has evolved from combat operations to working alongside the Afghan National Army (ANA) as the ANA transitions to the primary security force.
9. Deployment Concerns: A lower percentage of Soldiers report concern about long deployment length, difficulty communicating back home, lack of privacy or personal space, and boring and repetitive work. However, a higher percentage of Soldiers are concerned about uncertain redeployment date, not having the right equipment or repair parts, and continuous operations.
10. Multiple Deployments: Soldiers on their 2nd deployment (primarily NCOs) report lower individual morale.

1.2.3 Protective Factors

11. Small-Unit Leadership: Ratings of company-level officer leadership are significantly lower relative to 2010, similar to 2009 and 2007; perceived leadership issues were a common theme in Soldier focus groups; no significant change in Non-Commissioned Officer (NCO) leadership ratings emerged.

Recommendation #4: Integrate and evaluate behavioral health and changing mission focused, scenario-based training at Combat Training Centers (CTCs) to address operational stress particularly for platoon and company-level leaders.

12. Behavioral Health Stigma and Barriers to BH Care: Fewer 2012 Soldiers report that the availability of BH services would affect their decision to seek BH Care. All other BH stigma and barriers unchanged relative to 2010. Stigma is higher (sometimes double) for those who screen positive for a mental health problem.

13. Resilience Training and Training Adequacy: Most Soldiers report receiving training in managing the stress of deployment/combat but few remember if it was the mandatory Pre-Deployment Resilience Training. Training adequacy for managing stress is rated significantly lower than in 2010.

Recommendation #5: Ensure effective implementation of Comprehensive Soldier and Family Fitness (CSF2) Master Resilience Trainer (MRT) Resilience Training to help Soldiers deal with operational stress. Refine Pre-Deployment Resilience Training to focus on operational (non-combat) stress, interpersonal conflict, and relationship issues for Soldiers and junior (company-grade) leaders. Refine Post-Deployment Resilience Training to include a focus on the transition to a garrison environment with garrison leadership and discipline for active component Soldiers. Tailor training for reserve component (RC) Soldiers to include RC-specific issues such as possible job loss/unemployment.

Recommendation #6: Continue to evaluate CONUS-based and in-theater resilience training (e.g. MRT, Resilience Campus concept) programs and endorse evidence-based training.

1.3 Key Findings and Recommendations: Marines

All key Marine findings that report differences are significant ($p < .05$) differences from J-MHAT 8 (2012) compared to the 2010 OEF sample.

1.3.1 *Well-Being Indices*

1. Individual Morale: The percent of Marines reporting high or very high individual and unit morale are not significantly different from 2010.
2. Psychological Problems: The rate of Marines reporting psychological problems (acute stress symptoms, depression or anxiety) is not significantly different in 2012 compared to 2010.
3. Suicidal Ideation: Marine 2012 rates of reported suicidal ideation are unchanged from 2010.
4. Concussive Events: Marines report a high rate of exposure to concussive events. Compared to 2010, the trend was for more Marines reporting being evaluated by "Medical Professionals or Medics/Corpsmen for concussions. However, many Marines still report they were not evaluated by a medical professional or Medic/Corpsman, especially if they were within 50 meters of a blast. The evaluation rate may be higher than estimated because Marines may not consider receiving a Military Acute Concussion Evaluation (MACE) from a Medic/Corpsman at the point of injury as an evaluation. Marines may expect an MRI or some type of more detailed medical examination.

1.3.2 *Risk Factors*

5. Combat experiences: 2012 Marines report a similar overall level of combat experiences relative to 2010.

6. Sleep Problems: The percentage of Marines who report high or very high concern about not getting enough sleep is lower in 2012 than in 2010. The reasons for sleep disruption are primarily nighttime duties and poor sleep environment.

1.3.3 Protective Factors

7. Unit Climate Variables: Compared to 2010, 2012 Marines report a similar level of perceived platoon combat readiness.
8. Small-Unit Leadership: 2012 Marines report lower ratings of NCO leadership compared to 2010 but reported higher officer leadership ratings relative to 2010.
9. Behavioral Health Stigma and Barriers to Care: Higher reports of stigma are associated with receiving behavioral healthcare relative to 2010. Specifically, more 2012 Marines report that members of their unit might have less confidence in them compared to 2010 Marines.
10. Training and Training Adequacy: Adequacy of training for suicide prevention increased relative to 2010. However, a majority of Marines surveyed report that they do not know if their unit has an Operational Stress and Readiness (OSCAR) team and that the OSCAR team did not (or they were unsure) provide any services during the deployment.

Recommendation #7: Fully Implement Navy/Marine Corps Combat and Operational Stress Control (COSC) Doctrine (NTTP 1-15/MCRP 6-11C) and the Operational Stress Control and Readiness (OSCAR) Guidance (MARADMIN 597/11). Undertake an aggressive education plan to ensure awareness of the COSC and OSCAR program at all levels.

11. Positive Impact of Deployment: significantly more Marines in 2012 report pride in their accomplishments, dealing with stress better and greater confidence in their abilities as a consequence of deployment relative to 2010.

1.4 Key Findings from Behavioral Health (BH) Personnel and Recommendations for Improving Delivery of BH Care

1. Finding: Pre-existing mental health conditions. Providers report that Service Members (SMs) arrive with non-stabilized psychiatric symptoms, some on multiple psychotropic medications; these often strain resources and result in occupational problems. Providers estimate that up to 60-70% of SMs presenting to BH clinics have some pre-existing condition. It is not clear whether SMs with pre-existing conditions have been stabilized prior to deploying or whether their condition deteriorates after they arrive in theater.

Recommendation #8: Rewrite policies regarding pre-deployment BH screening for SMs with pre-existing BH conditions. Clarify criteria used to grant BH waivers. Consider conducting retrospective and prospective analysis on the percentage of SMs presenting with pre-existing conditions and unstable symptoms.

2. Operational Stress: Providers report the most common issue SMs present to BH clinics with is operational stress related to leadership issues. There are also co-morbid symptoms of suicidal and homicidal ideation (SI/HI) present. Providers reported that the number of HI cases was striking relative to garrison reports of homicidal ideation.

Recommendation #9: Conduct retrospective and prospective analysis of SMs presenting with homicidal ideation using external assets (e.g. MHATs) or organic theater assets. Evacuate SMs who consistently present with homicidal ideation.

3. BH Allocation: There are sufficient BH resources in Theater (1:723). However, patient encounter (MSAT/TMSD) data demonstrates unevenly distributed BH personnel resources by region, population at risk (PAR), and type of clinic. Restoration Centers in particular are heavily staffed but have a low patient census.

Recommendation #10: Continue a staffing ratio of between 1:700 and 1:800 to support delivery of BH care for dispersed units. Conduct a comprehensive review of BH assets in theater by location, PAR, clinics, and SM needs; develop an effective system to collect data on BH outreach services. BH should continue to coordinate with operational commanders regarding reduction/dispersion of troops so that BH resources can be allocated appropriately.

4. Command and SM lack understanding of BH: Commanders and SMs do not understand what BH can provide, where BH services are located, Command-Directed Evaluations and BH patient confidentiality. There is inconsistent naming of BH Services that causes further confusion.

Recommendation #11: Educate line commanders regarding available BH resources in theater, appropriate use and the basic tenets of BH treatment, requirements for patient confidentiality, legal requirements of command-directed mental health evaluations, and BH evacuations. Issue command (Company Commander/First Sergeant) teams graphic training aids (GTAs) with this information. Implement an aggressive education and awareness campaign for SMs regarding available BH resources in theater. Replace inconsistent BH Clinic naming conventions with standardized names which are recognized across the Services and understood by both line and BH personnel.

5. BH evacuations: There were 585 BH Evacuations in 2011 (above all other categories except Battle Injury and Nonbattle Injury). Three issues arise regarding BH evacuations: 1) patient's unit must provide 1 or 2 nonmedical attendants as escorts for the patient who is evacuated from theater, which strains line command personnel resources; 2) patients are held on medical wards until they are released for evacuation; 3) nonstandardized paperwork requirements.
6. MHATs: Although there are important outcomes, many of the findings and recommendations in J-MHAT 8 are similar to previous MHATs.

Recommendation #12: Suspend conducting annual or semi-annual MHATs. Conduct future MHATs on an as-needed basis focused on targeted issue(s) and when requested by Operational Leaders.

2. BACKGROUND

2.1 Mission and Background

The J-MHAT 8 OEF mission is to assess behavioral health and well-being among land combat forces; examine the theater-wide delivery of behavioral healthcare, and provide recommendations for sustainment and improvement to command.

J-MHAT 8 deployed to Afghanistan in support of Operation Enduring Freedom (OEF) from 30 May to 30 July, 2012. This report presents J-MHAT 8 findings from anonymous surveys; focus groups with junior enlisted Service Members and NCOs from land combat maneuver platoons, and focus groups and interviews with behavioral health personnel. The J-MHAT 8 members were assigned to US Forces Afghanistan (USFOR-A) and worked under the guidance of the USFOR-A Surgeon General.

2.2 Sampling Strategy

J-MHAT 8 recommendations are based upon multiple sources of information (survey data, records reviews, focus groups, and interviews). Much of the report however, centers on data from anonymous surveys collected from land combat Soldiers assigned to maneuver unit platoons. The J-MHAT 8 attempted to collect the maneuver unit sample by randomly selecting two platoons from two randomly selected line companies from every Army maneuver battalion in theater and three platoons from three randomly selected line companies from every Marine maneuver battalion in theater. Due to there being fewer Marines compared to Soldiers in theater, the additional Marine platoon per company is to provide adequate sample size to have enough power to detect meaningful differences across years.

There are five advantages with the random cluster-based sample. First, Soldiers in these units are war-fighters engaged in direct combat-related tasks. At a conceptual level, therefore, all platoons can be considered interchangeable providing a convenient way to generate a random sample of war-fighters. Second, maneuver unit platoons are a core component of deployed combat forces; consequently, the sampling strategy is replicable across years and contexts. Third, the sampling plan can feasibly be implemented in an operational environment using a fragmentary order (FRAGO) to identify the units, and using organic medical personnel in brigades to conduct surveying.

The fourth advantage is that sampling platoons in maneuver battalions provides a relatively close link to previous MHAT data. Comparisons between the J-MHAT 8 OEF sample and Army data from previous years are confounded by different sampling strategies; nonetheless, the focus on Army Brigade Combat Teams (BCTs) across MHATs provides a reasonable basis for comparison. The 2007 Army OEF sample had a particularly large group of non-BCT units, so for that year we focus on the 252 male BCT respondents. The relatively low number of respondents in the 2007 sample produces variability in the estimated responses for that year; therefore, the 2007 values are marked with an “*” and a footnote refers to the small sample size.

The Army contrast between J-MHAT 8 in 2012, J-MHAT 7 in 2010, and MHAT VI in 2009 provide compelling comparisons because the same type of units (maneuver unit platoons) were sampled across years; consequently, we can be more confident that observed differences reflect fundamental changes in either the nature of the force (e.g., differences in the percentage of multiple deployers across years); changes in how the maneuver units are used (e.g., different troop dispersion across years), or changes in kinetic activity (e.g., differences in combat

experience levels across years). Another way to think about the sampling is to note that the use of similar maneuver sampling across years helps ensure that observed differences are not due to (a) changes in demographic characteristics such as rank and age or due to (b) selecting units with inherently different functions.

Even with the same maneuver sampling plan across years, it is still important to statistically control for time in theater. This is because the sampling plan was not developed in a way to ensure uniformity in this variable, and time in theater has repeatedly been shown to be related to a number of outcomes in previous MHAT reports. In addition, because comparisons are being drawn across samples that did not use the platoon-based cluster sampling strategy, we also control for rank in the statistical analyses and provide sample adjusted values as though the entire sample were composed of male, E1-E4 Soldiers in theater for 7 months.

A final advantage with the use of cluster sampling is that it provides some degree of anonymity to Soldiers. As noted in the MHAT VI OEF report, the anonymity is less than that offered in MHAT I to V; however, it is substantially higher than a random sampling approach that identifies specific Soldiers based on individual demographic characteristics.

Despite these advantages, there are also limitations with this approach. First, the population of maneuver unit Soldiers represents less than half the deployed population (see McGrath, 2007). Therefore, a maneuver unit sample is not representative of the entire deployed force in the ATO. Second, by using a cluster sample of platoons, little data is collected from officers, senior NCOs or females. Third, because the sampling provides detailed information about platoon membership, care had to be taken to avoid potentially incriminating items. Specifically, to address concerns raised by the Defense Manpower Database Center (DMDC) and human use review boards, specific items related to drug use, alcohol use and potential war crime violations were omitted for MHAT VI, J-MHAT 7, and J-MHAT 8.

The J-MHAT 8 focuses on land combat units and has the capability and historic data to model changes occurring in maneuver units; however, other populations of SMs may benefit equally from assessment and monitoring. In particular, support personnel experience operational stress and could benefit from these types of assessments. All three Services conduct service-specific research and assessments that include support personnel. In addition, all Service personnel use joint BH resources once they arrive in theater. Therefore, support personnel from all Services may benefit from having a joint assessment of their deployed forces.

A random sample of maneuver units described above was requested by the J-MHAT 8. However, the original USFOR-A Fragmentary Order (FRAGO) that identified the units to participate in the J-MHAT 8 mission incorrectly requested 2 platoons per Army brigade, not 2 *maneuver* platoons per every battalion, per every brigade. Therefore, many units provided Soldiers from platoons other than those identified in the random sample. Additionally, some units provided Soldiers from non-maneuver units (support and headquarter platoons) that were not in the sampling plan. All non-maneuver unit Soldier surveys were removed from analyses. This reduced the Army sample from to 994 Soldiers to 619.

As a result, the J-MHAT 8 conducted analyses that showed that maneuver unit Soldiers are similar to Soldiers in maneuver units identified in the sampling plan (2nd Platoon, A Company and 4th Platoon B Company) on key variables such as combat experiences and psychological problems (Figure 2.2 and Figure 2.2.1). Values that are underlined are significantly different than J-MHAT 8 (2012) values. Combat experience and mental health findings will be explained later in this report. The key point of the graphs below is that the raw and adjusted values for

both combat experiences and mental health problems are very similar. Therefore, the Army section of the J-MHAT 8 report provides results from all 619 maneuver unit Soldiers.

Figure 2.2 Combat experience comparison between Soldiers in maneuver units and those in the sampling plan only

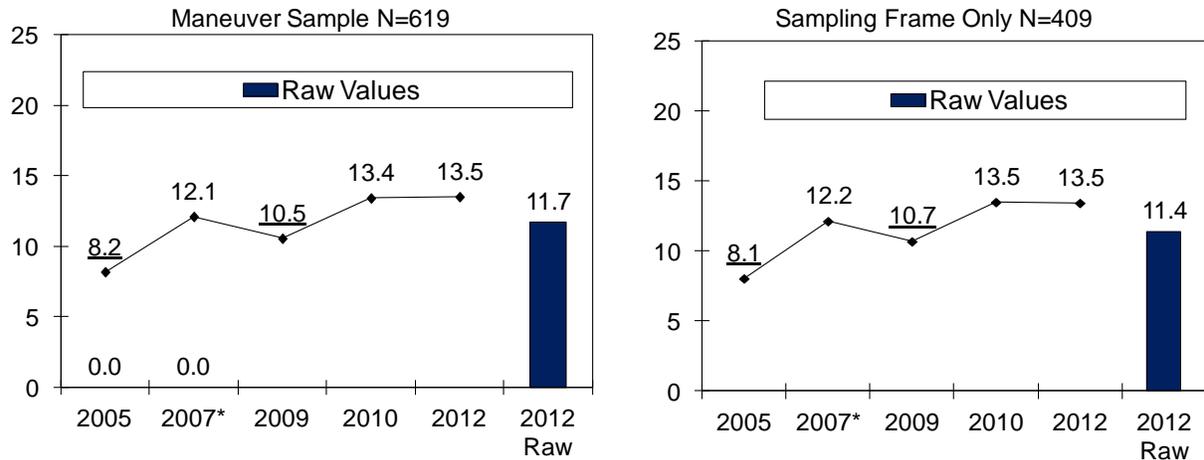
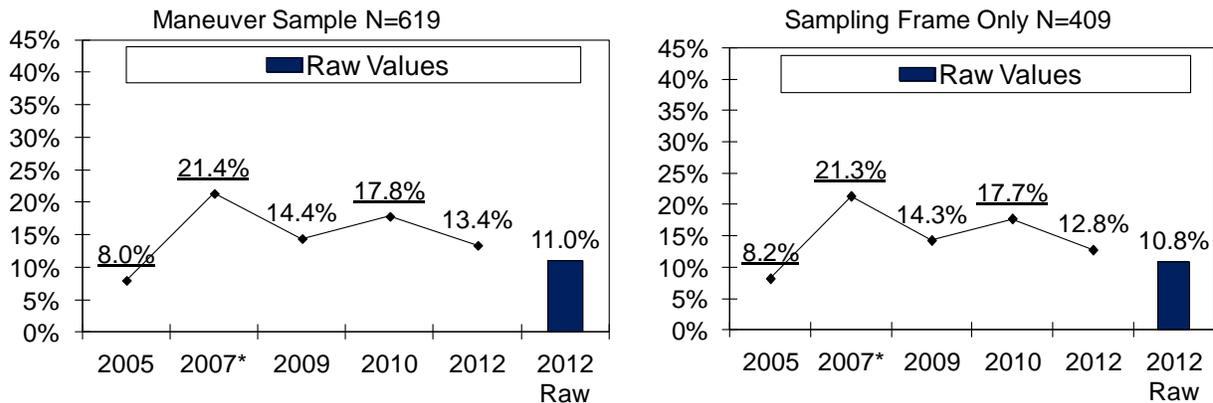


Figure 2.2.1 Mental health comparison between Soldiers in maneuver units and those in the sampling plan only



Marine units provided some platoons that met the random cluster-based sample request and others that did not. The J-MHAT 8 conducted analyses that tested whether maneuver unit Marines are similar to Marines in maneuver units identified in the sampling plan (2nd Platoon, A Company, 4th Platoon, B Company, or 1st Platoon, C Company) on key variables such as combat experiences and psychological problems. There were significant differences on key variables. Therefore, those Marine platoons that did not meet the random cluster-based sample were removed from the data set. This reduced the number of the Marine sample from 369 who completed surveys to 212 in the random sample. All Marine analyses in this report are from Marines that were in the random cluster-based analyses.

2.3 Comparison Groups

As noted in J-MHAT 7, a key advantage of repeatedly conducting Mental Health Advisory Teams is that multiple iterations contribute to extensive historical databases. These databases provide a referent basis for interpreting findings. Consequently, in the current report we separately contrast Army and Marine data collected in 2012 to Army and Marine data from

previous OEF assessments. The details of the Army comparisons are provided below. Marine comparisons will be provided later in the report.

2.3.1 Army Sample Across Time

Army J-MHAT 8 data is compared to Army OEF MHAT data collected in 2005, 2007, 2009, and 2010. The basic statistical model includes time as a categorical predictor using the 2012 J-MHAT 8 OEF Army sample as the referent. As noted, graphs present sample-adjusted values based on male respondents and adjusted for demographic sample differences in rank and months deployed. Specifically, the sample-adjusted values represent 1) male, 2) junior enlisted Soldiers deployed for 3) seven months. Seven months is selected as the referent for months deployed as this time point represents the three quarter mark in a nine month deployment. In January 2012, the Soldier tour length was changed from 12 months to nine months. NCOs are used as the referent when examining multiple deployment effects.

Note that because sample-adjusted values are based on data combined across all OEF Army MHATs, the values listed in this report may not exactly match values from previous MHAT reports. Values are adjusted based on the attributes of the combined MHAT 2005, 2007, 2009, 2010, and 2012 samples, and adding 2012 data to the total sample produces slight changes in the sample-adjusted values. In addition, data that was returned after the cut-off date for the report from the previous MHAT was added to the master database. In the case of the 2010 OEF data, an additional 35 surveys were added to the database after the cut-off date and these additional surveys may produce slight changes in the 2010 numbers reported in J-MHAT 7.

2.3.2 Marine Sample Across Time

Marine J-MHAT 8 data is compared to Marine OEF MHAT data collected in 2010. The basic statistical model includes time as a categorical predictor using the 2012 J-MHAT 8 OEF Marine sample as the referent. As noted, graphs present sample-adjusted values based on male respondents and adjusted for demographic sample differences in rank and months deployed. Specifically, the sample-adjusted values represent 1) male, 2) junior enlisted Marines deployed for 3) four and one-half months. Four and one-half months is selected as the referent for months deployed as this time point represents the three quarter mark in a standard seven month Marine Corps deployment. NCOs are used as the referent when examining multiple deployment effects.

As with the Army data, note that because sample-adjusted values are based on data combined across 2010 and 2012 Marine OEF MHATs, the values listed in this report may not exactly match values from the J-MHAT 7 report. Values are adjusted based on the attributes of the combined 2010 and 2012 samples, and adding 2012 data to the total sample produces slight changes in the sample-adjusted values.

2.4 Analytical Strategy and Verification of Results

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

2.5 Focus Groups

The J-MHAT 8 conducted 13 Army focus groups with a total of 72 Soldiers (36 junior enlisted and 36 NCO) at locations across Regional Command (RC) North, RC East, and RC South and 8 Marine focus groups with a total of 53 (25 junior enlisted and 28 NCO) Marines in RC

Southwest. Additionally, 14 focus groups representing 52 behavioral health personnel from all three Services were conducted with providers in RC North, RC East, RC South, and RC Southwest. Finally, J-MHAT 8 also conducted seven Individual BH Interviews predominantly due to position (e.g. CSC Commander) and one Consultant Interview with the Theater Behavioral Health Consultant. Themes from the Soldier focus groups are integrated into the relevant sections of the report to augment the survey-based data and are in Chapter 8 of the report. Themes from the BH focus groups are also integrated into the relevant sections of the report to augment the survey-based data and in the BH Care System Assessment (Chapter 10).

Service Member focus group questions addressed the following topics: 1) resilience/behavioral health training, 2) sleep, 3) anger, 4) leadership emphasis on resilience/behavioral health and well-being, 5) transitioning from a combat environment to a garrison environment, and 6) behavioral health care. Based on the discussion topics, four primary thematic areas related to service member health and well-being emerged. These thematic areas include: 1) deployment-related stressors and challenges, 2) coping strategies, 3) developing resilience and 4) seeking behavioral health care.

Behavioral Health focus groups concentrated on 4 broad themes, 1) services available for the SM in need of behavioral health care, 2) interaction with line commanders, 3) care for the behavioral health provider, and 4) resources in theater.

3. CONCEPTUAL OVERVIEW

The J-MHAT 8 OEF Soldier and Marine survey contains the core survey measures used in all previous MHATs. MHAT surveys are adapted from the Land Combat Study developed by the Walter Reed Army Institute of Research (WRAIR: Hoge, et al., 2004; Hoge, et al., 2007; Riviere, 2008).

Many of the J-MHAT 7 report topics are assessed in the J-MHAT 8 report. However, like previous years, the J-MHAT 8 survey includes items of emergent interest to operational and medical leadership. The current J-MHAT 8 survey includes the following substantive changes discussed in the report:

1. A separate section of questions targeting resilience/behavioral health training.
2. A series of questions addressing anger
3. Items assessing leadership and sleep disruption
4. A series of questions assessing the use of dietary supplements
5. Additional questions on reasons why SMs may not use mental health resources

3.1 Service Member Combat & Well-Being Model

The key topic areas within the J-MHAT 8 survey cover: 1) Well-Being Indices, such as behavioral health status; 2) Risk Factors, such as combat experiences; and 3) Protective Factors, such as willingness to seek care. The framework is based on a conceptual Soldier Adaptation Model adapted from Bliese and Castro (2003) and presented in MHAT V, MHAT VI, and J-MHAT 7 reports.

3.1.1 *Well-Being Indices*

These measures are based on a standard set of behavioral health status indicators to include:

1. Individual and Unit Morale
2. Acute Stress (PTSD), Depression and Anxiety
3. Suicidal Ideation
4. Use of medications
5. Sleep
6. Anger

3.1.2 *Risk Factors*

In the conceptual model, behavioral health rates are driven by risk factors. As in J-MHAT 7, risk factors are broken down into four major classes. The first class of factors is composed of combat-related events. Research has demonstrated that high levels of combat experiences (e.g., being attacked or ambushed, killing the enemy, etc.) are associated with higher levels of psychological problems, such as acute stress (Dohrenwend, et al., 2006). The second class of factors is relationship problems. The third is operational tempo (OPTEMPO)-related experiences such as deployment length and multiple deployments. The final category is comprised of deployment concerns related to non-combat stressors such as work concerns.

3.1.3 *Protective Factors*

Based on the conceptual framework, behavioral health and performance can be improved either by: (a) reducing or eliminating factors that put Service Members at risk; or (b) strengthening

protective factors, thereby providing Service Members with better coping skills when exposed to factors that place them at risk.

In a combat environment, many risk factors are unavoidable (e.g., exposure to potentially traumatic combat events) or are the direct product of National Military Strategy decisions (e.g., the size of the military requires deploying Service Members multiple times). For these reasons, many behavioral health interventions focus on developing and enhancing programs designed to help Soldiers cope with known risk factors in an attempt to improve resilience. The current J-MHAT 8 report examines:

1. Unit factors such as small-unit leadership, cohesion and perceived readiness
2. Stigma and willingness to seek BH care
3. Perceived barriers to BH care
4. Other “BH Self-Management” reasons why SMs may not seek BH care.
5. Perceived adequacy of suicide and behavioral health training
6. Resilience training provided by Master Resilience Trainers (MRTs)
7. Dietary supplements
8. Post-Deployment Growth

4. SOLDIER REPORT: SAMPLE CHARACTERISTICS

Table 4.1 provides details on selected demographic variables for the J-MHAT 7 (2010) maneuver sample compared to the J-MHAT 8 maneuver sample (2012). Although the two samples show no differences on key demographic variables such as age, rank, and number of deployments, they differ on several other variables. Specifically, the J-MHAT 8 sample (a) has more National Guard; (b) averages less time spent in theater, and (c) spends less time outside of the unit's main Forward Operating Base (FOB).

The differences related to time spent outside the FOB reflect a change in the nature of the OEF mission and the way in which Soldiers are being employed throughout theater. More Soldiers are involved in working with the Afghan National Army (ANA) as the ANA assumes the major role in providing security forces. The change related to time in theater reflects that the J-MHAT 8 team came into theater in May to July of 2012, while the J-MHAT 7 team was in theater July to September of 2010. Time in theater is controlled statistically to normalize the data.

Dwell time is only reported for active component Soldiers as policies related to dwell time are different for National Guard and Reserve Soldiers. It is interesting to note that, for unknown reasons, the 2012 sample contains a significantly higher percentage of Soldiers who did not answer the marital status question relative to 2010. Marital status was not statistically controlled for across years since a series of models controlling for both Rank and Marital status found no evidence that marital status is a consistent predictor of key outcomes such as mental health symptoms.

Table 4.1: J-MHAT 7 (2010) and J-MHAT 8 (2012) Army Sample Characteristics

| Demographic Variable | J-MHAT 7 (#) | | J-MHAT 8 | | |
|---------------------------|------------------------|---------|----------|---------|-------|
| | n | Percent | n | Percent | |
| Age | 18-24 | 580 | 61.3% | 374 | 60.4% |
| | 25-29 | 228 | 24.1% | 165 | 26.7% |
| | 30-39 | 105 | 11.1% | 71 | 11.5% |
| | 39+ | 22 | 2.3% | 7 | 1.1% |
| | Unknown | 11 | 1.2% | 2 | 0.3% |
| Rank | E1-E4 | 622 | 65.8% | 405 | 65.4% |
| | NCO | 286 | 30.2% | 190 | 30.7% |
| | Officer / WO | 34 | 3.6% | 22 | 3.6% |
| | Unknown | 4 | 0.4% | 2 | 0.3% |
| Component* | Active | 872 | 92.2% | 522 | 84.3% |
| | Reserve | 3 | 0.3% | 1 | 0.2% |
| | National Guard | 69 | 7.3% | 94 | 15.2% |
| | Unknown/Other | 2 | 0.2% | 2 | 0.3% |
| Marital Status* | Single, never married | 491 | 51.9% | 311 | 50.2% |
| | Married/Separated | 378 | 40.0% | 240 | 38.8% |
| | Divorced | 49 | 5.2% | 17 | 2.7% |
| | Unknown/Widowed | 28 | 3.0% | 51 | 8.2% |
| Deployment History | First Time | 573 | 60.6% | 357 | 57.7% |
| | Second Time | 260 | 27.5% | 176 | 28.4% |
| | Third or More | 113 | 11.9% | 86 | 13.9% |
| Dwell-Time (+) | Less than 12 Months | 32 | 3.7% | 12 | 2.3% |
| | 12 to 24 Months | 230 | 26.4% | 134 | 25.7% |
| | More than 24 Months | 83 | 9.5% | 59 | 11.3% |
| | 1st Deployment/Unknown | 527 | 60.4% | 317 | 60.7% |
| Time in Theater* | 6 Months or Less | 530 | 56.0% | 505 | 81.6% |
| | 7 to 12 Months | 393 | 41.5% | 76 | 12.3% |
| | More than 12 months | 0 | 0.0% | 10 | 1.6% |
| | Unknown | 23 | 2.4% | 28 | 4.5% |
| Days Outside FOB* | 15 or Less | 460 | 48.6% | 342 | 55.3% |
| | More than 15 | 438 | 46.3% | 213 | 34.4% |
| | Unknown | 48 | 5.1% | 64 | 10.3% |

(#) 35 additional cases were added since the J-MHAT 7 report

* Significantly Differs Across Years

(+) Values exclude National Guard and Reserve Soldiers

5. SOLDIER REPORT: WELL-BEING INDICES

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

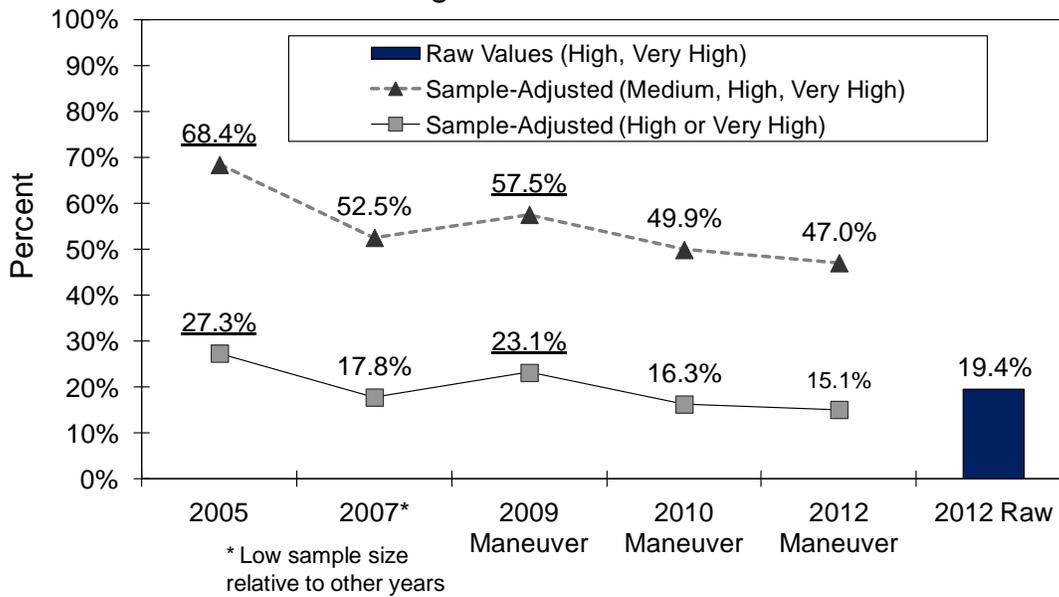
1. Across-year comparisons represent sample-adjusted maneuver unit values for each of the five OEF MHATs. Values are adjusted for rank and time in theater, and represent male E1-E4 Soldiers in theater for 7 months. Values that significantly differ from J-MHAT 8 values are underlined. All across-year comparisons are adjusted values unless specifically noted.
2. Raw 2012 values include all maneuver unit survey responses and allow one to compare the overall population with sample-adjusted maneuver unit values. A sample adjusted value lower than a raw value, for example, would generally indicate that rank has an effect, therefore including NCOs and Officers increases the raw value compared to the adjusted value.

5.1 Morale

5.1.1 Individual Morale

Figure 5.1.1 provides the sample-adjusted percent of Soldiers who report (a) high or very high individual morale (line with squares on the end), and (b) **medium**, high and very high individual morale (line with triangles on the end). Individual morale in 2012 is similar to the values reported in 2010 and 2007 but significantly lower than 2009 and 2005. The difference in individual morale relative to 2009 and 2007 mirrors the differences in combat experiences during those 2 years, in that those were the years with the lowest combat experience levels. Notice the raw value for high/very high individual morale in 2012 is higher than the 2012 sample-adjusted value because the raw value includes NCOs and Officers who report higher morale while the adjusted value “normalizes” the responses to that of a junior enlisted Soldier. Junior Enlisted Soldiers are the appropriate level to normalize J-MHAT 8 data as they make up the majority of Soldiers in maneuver units.

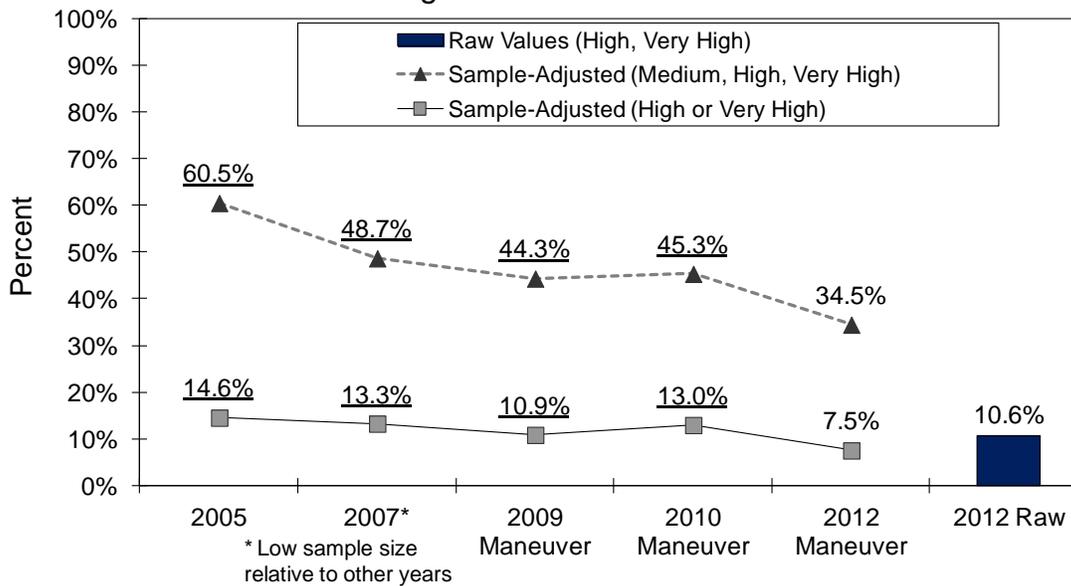
Figure 5.1.1 Individual Morale



5.1.2 Unit Morale

Figure 5.1.2 provides the sample-adjusted percent of Soldiers who report (a) high or very high unit morale, and (b) **medium**, high and very high unit morale. The values for 2012 are significantly lower than all previous years. Based on Soldier Focus Groups discussions, lower unit morale may be due to negative feelings associated with the changing nature of the mission from combat operations to working with the ANA or perceived leadership issues.

Figure 5.1.2 Unit Morale

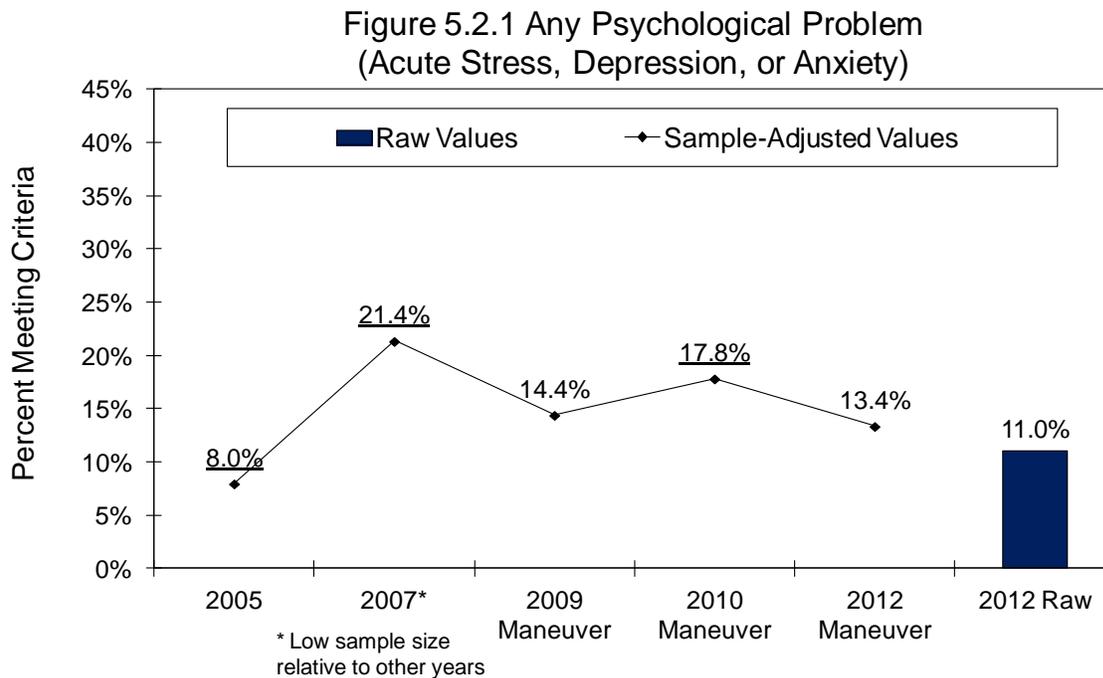


5.2 Behavioral Health: Acute Stress, Depression and Anxiety

Soldiers' ratings of depression, generalized anxiety and acute stress (i.e., symptoms of post-traumatic stress) were assessed using standardized, validated scales (Bliese, et al., 2008; Spitzer, Kroenke, & Williams, 1999; Weathers, Litz, Herman, Huska, & Keane, 1993). Details on scoring specific scales are available in previous MHAT reports. Of note, measures of depression, anxiety and acute stress are not a diagnosis. The standardized, validated scales measure whether a Soldier reports symptoms consistent with the DSM-IV-TR (Diagnostic and Statistical Manual of Mental Disorders [DSM-IV-TR]; American Psychiatric Association, 2000) criteria for each problem. Additionally, for depression and anxiety, the Soldiers must report impairment in their work or in their ability to get along with other people.

5.2.1 Behavioral Health: Any Psychological Problem

The combined rating of any psychological problem (acute stress, depression or anxiety) is presented in Figure 5.2.1. The percent of Soldiers who report psychological problems in 2012 is significantly lower than 2010 and 2007, similar to 2009, and higher than 2005.



5.2.2 Acute Stress, Depression and Anxiety

The specific values for acute stress, depression and anxiety are provided in Table 5.2.2. Acute stress rates in 2012 are significantly lower than values reported in 2010 and 2005. Depression and anxiety scores are significantly lower than values from 2007; however, the small sample size for this year makes the point-estimate less reliable.

5.3 Anger

Soldiers' ratings of anger are reflected in questions about anger directed towards others in the unit. The percentages of Soldiers who report a) shouting or yelling at others, b) kicking/smashing/slamming/punching inanimate objects, c) threatening others with violence, and d) getting into fights at least once in the past 30 days are presented in Table 5.3. Compared to 2010, rates of anger episodes and verbal expressions of anger are similar among Soldiers in the 2012 J-MHAT 8 sample and the 2010 J-MHAT 7 sample.

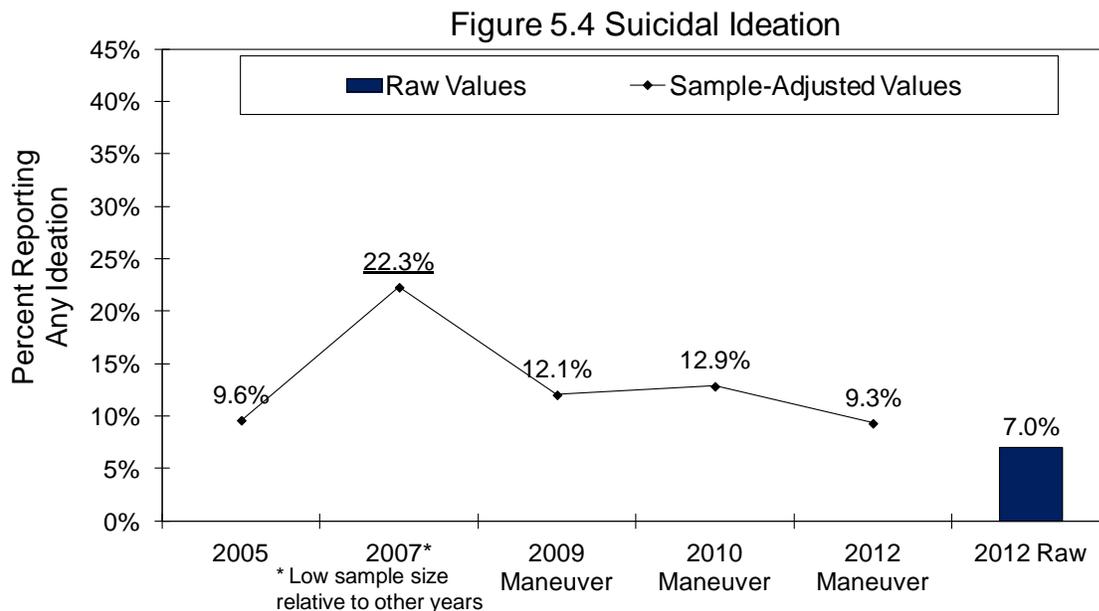
| <i>Table 5.3: Sample-Adjusted Percents for Male, E1-E4 Soldiers in Theater 7 Months</i> | | |
|--|-------------------------------------|-------------------|
| | Percent at least once in past month | |
| | J-MHAT 7 OEF 2010 | J-MHAT 8 OEF 2012 |
| Get angry at someone in your unit and yell or shout at them | 68.2% | 64.7% |
| Get angry with someone in your unit and kick or smash something, slam the door, punch the wall, etc. | 37.2% | 32.3% |
| Threaten someone in your unit with physical violence | 32.9% | 27.5% |
| Get into a fight with someone in your unit and hit the person | 8.6% | 8.4% |

J-MHAT 8 added additional anger questions focused on self-perceptions of temper, what SMs do when angry, anger control and if anger was seen as helping SMs perform their duties. Forty percent (40%) of Soldiers said they keep their anger bottled up inside when they are angry; 23.5% said they had a fiery temper. Table 5.3.1 shows that Soldiers report consistency in terms of their self assessment of their ability to control their anger and their anger behaviors. For example, approximately 93% of Soldiers who said they have poor/very poor control of their anger also reported they got angry at someone in their unit and yelled/shouted at them in the last month compared to 53% of those who said they had high/very high control. Likewise, those who reported they had very poor/poor control of their temper were more likely to report they got into a fight and hit a person compared to those who said they had high/very high control (28.6% vs. 2.5%). This may mean that the best way to determine who is likely to act on their anger is to ask Soldiers if they have control over their anger.

| | Very poor or poor control | Moderate control | High or very high control |
|--|---------------------------|------------------|---------------------------|
| Get angry at someone in your unit and yell or shout at them | 92.9% | 81.6% | 52.7% |
| Get angry with someone in your unit and kick or smash something, slam the door, punch the wall, etc. | 83.3% | 44.9% | 11.8% |
| Threaten someone in your unit with physical violence | 63.4% | 35.4% | 11.7% |
| Get into a fight with someone in your unit and hit the person | 28.6% | 6.8% | 2.5% |

5.4 Suicidal Ideation

Suicidal ideation is assessed using a single depression item on the J-MHAT 8 OEF survey. This item (item 9 of the Patient Health Questionnaire [PHQ]) asks Soldiers if they have been bothered by thoughts that they would be better off dead or of hurting themselves in some way over the last four weeks. For the purposes of the report, any response other than “Not at all” is considered a positive response. Figure 5.3 shows that the 2012 rate of Soldiers reporting any suicide ideation is different only from the 2007 value (the latter value being based on a small sample and therefore less reliable than other numbers).



5.5 Pain Medications

J-MHAT 8 was the second MHAT to assess Soldiers' use of pain medications for chronic pain. The chronic pain questions used in the J-MHAT 8 survey were developed by the Kansas Department of Health and Environment and added to the 2007 Centers for Disease Control (CDC) Kansas Behavioral Risk Factor Surveillance System. In total, 556 Soldiers provided responses to the question with 34.9% (n=194) reporting chronic pain. The vast majority of Soldiers reporting chronic pain either took no medication (52.1%; n=101); or took over-the-counter drugs (33 %; n=64). Only 8.8% (n=17) of the respondents with chronic pain reported taking prescription pain medications, with 13 of the 17 (76.5%) reporting that the medication was prescribed in theater. All of these numbers are similar to those reported in J-MHAT 7.

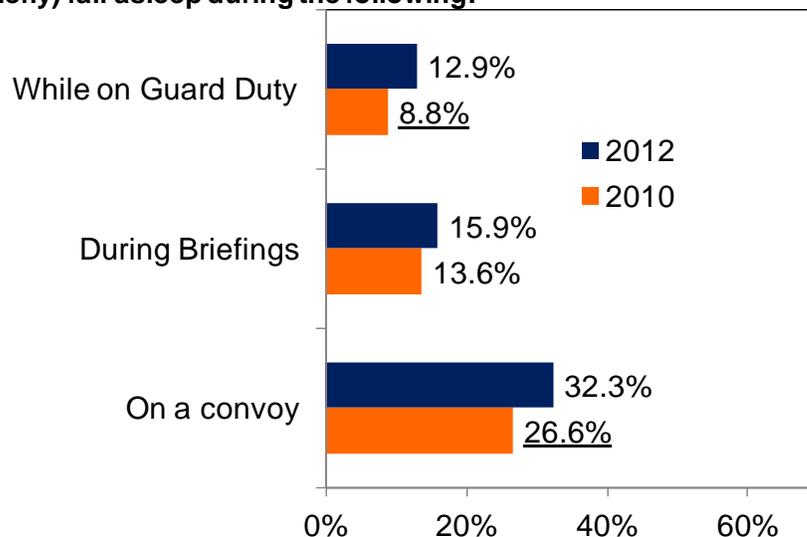
As a further point of reference, in a subsample of 180 randomly selected employed men between the ages of 18-34 with health insurance in the state of Kansas (Toblin, et al., 2012), 15.0% reported chronic pain. Of those with chronic pain, 48.1% were taking an over-the-counter drug and 14.8% reported taking a prescription medication. With this as a referent group, it is clear that reported rates of chronic pain are much higher in the military sample (35.6% versus 15%, respectively); however, rates of prescription pain medication use among those reporting chronic pain is lower in the Army than in the random sample of men from Kansas (7.4% versus 14.8%, respectively).

5.6 Sleep

Approximately one-fifth of 2012 Soldiers surveyed report having some sleep problems. Notably, 22.9% of Soldier reported that they were having problems falling asleep at night and 22.6% that they had trouble staying asleep at night. Additionally, 20.6% had problems staying asleep during the day following night operations. As can be seen in Figure 5.6, over 10% of Soldier report falling asleep during briefings and nearly a third during convoys. Finally, 26.8% of Soldiers report having high or very high concern that they are not getting enough sleep and 6.3% of Soldiers surveyed in 2012 and 4.3% in 2010 reported making a mistake or having an accident due to sleepiness. These findings suggest that there are sleep problems in theater and leads to the question of what causes these sleep disturbances.

Figure 5.6 Places Soldiers Fall Asleep

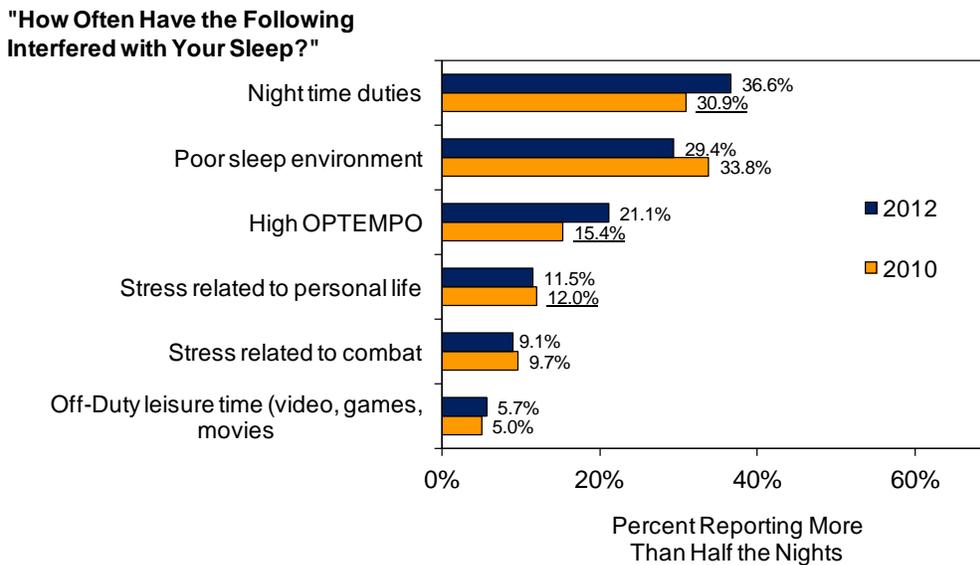
“How often during this deployment, did you (even briefly) fall asleep during the following:



5.6.1 Factors Impacting Sleep

Figure 5.5.1 shows the adjusted value percent of Soldiers who report that their sleep has been disturbed or interfered with more than half of the last 30 nights by (a) stress related to combat, (b) stress related to personal life and problems, (c) poor sleep environment (too noisy, bright, hot, cold, etc.), (d) high OPTEMPO, (e) nighttime duties, and (f) off-duty leisure activities (video games, movies, etc.). J-MHAT 8 is the second time that these questions were asked, so comparisons are only made to J-MHAT 7.

Figure 5.6.1 Army Reasons for Sleep Problems During Last Month



The highest causes of sleep disturbances were nighttime duties and poor sleep environment. Some of these issues are related to the nature of combat operations and being at remote locations. For instance, a junior enlisted Soldier in a focus group when asked what interfered with getting good sleep stated “Everything, guard duty, layout for equipment, patrols, power issues (air conditioning), (enemy) contact, home issues, random nonsense, a blast-you’re up and on edge, movies, people being inconsiderate while others are trying to sleep.”

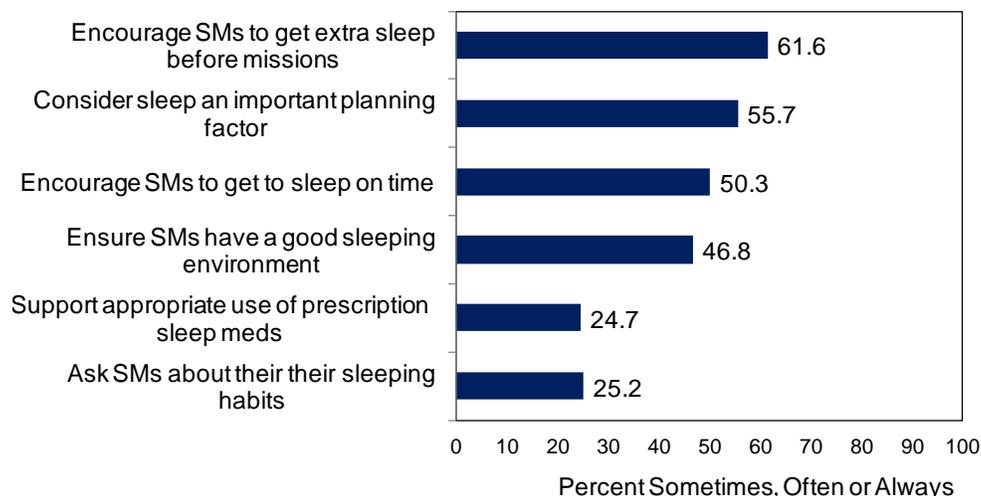
Similar to 2010, the reports of sleep problems being due to stress related to personal life is virtually the same frequency as stress related to combat. This finding continues to be salient given the continued high degree of combat experiences and the behavioral health focus group findings that operational stress (non combat-related) is the major reason Soldiers are going to behavioral health clinics (see Chapter 10). This finding indicates the degree to which concerns about family and other aspects of a Soldier’s personal life continue to impact deployed Soldiers.

5.6.2 Leadership and Sleep

Previous MHATs have shown the influence that non-commissioned officer (NCO) leadership can have on Soldier well-being. To further explore this, J-MHAT 8 asked a series of questions to assess the influence of NCO leadership on sleep hygiene. Just over 60% of Soldiers report that NCOs “sometimes, often or always” encourage SMS to get extra sleep before missions that require long hours. Approximately 25% Soldiers say that NCOs “sometimes, often or always”

support the appropriate use of prescription sleep medications (like Ambien) when SMs need help with sleeping.

Figure 5.6.2 NCO support of sleep hygiene



In addition, we assessed whether sleep leadership was related to combat readiness. Combat readiness was measured with a 3-item scale in which Soldiers were asked whether they agreed with the statements “I think my platoon would do/did an excellent job in combat”; “I think the level of training in my platoon is high”; and “I have real confidence in my platoon’s ability to perform its mission.” Results show that sleep leadership items were significantly correlated with Soldiers’ reports of how combat ready they believed their unit to be. For example, as seen in Table 5.6.2, when leaders “encouraged SMs to get extra sleep before missions” or “consider sleep an important planning factor”, Soldier’s reports of combat readiness were higher.

| NCO Sleep Behavior | Combat Readiness |
|--|-------------------------|
| Encourage SMs to get extra sleep before missions | 0.33** |
| Consider sleep an important planning factor | 0.31** |
| Encourage SMs to get adequate sleep | 0.29** |
| Encourage Service Members to nap when possible | 0.28** |
| Encourage SMs to get to sleep on time | 0.27** |
| Ensure SMs have a good sleeping environment | 0.27** |
| Ask SMs about their sleeping habits | 0.2** |
| Discourage the use of caffeine or nicotine use within several hours before trying to go to sleep | 0.14** |

** Significant p<.01

5.7 Medications for Sleep and Mental Health Problems

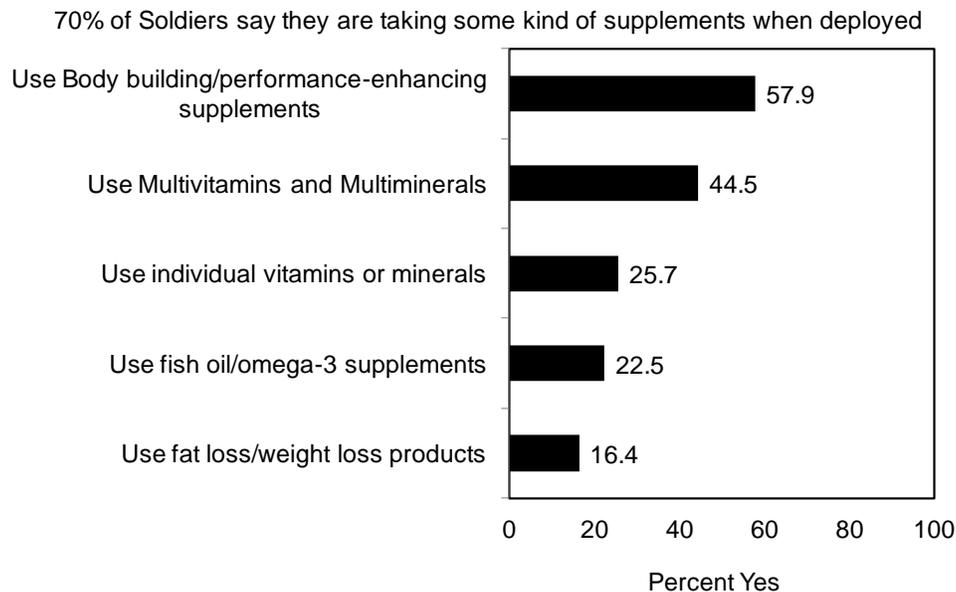
In J-MHAT 8 (2012), J-MHAT 7 in 2010 and MHAT VI in 2009, respondents were asked 1) “Have you taken any medication for a sleep problem during this deployment?” and 2) “Have you taken any medication for a mental health or combat stress problem during this deployment?”

Of the 2012 survey respondents, 6.4% of the Soldiers reported taking medications for sleep problems compared to 11.3% in J-MHAT 7. This difference is significant. In terms of mental health medications, 1.8% of the Soldiers sampled reported taking medication for a mental health or combat stress problem in 2012 compared to 3.5% in 2010 and 2.6% in 2009 (a non-significant difference). As a point of reference, in interpreting the use of medications for mental health or combat stress, Olfson and Marcus (2009) report rates of antidepressant medications use from nationally representative probability samples collected in 1996 and 2005. Based on these data, the rate of antidepressant use for (a) 21-34 year old (b) males who were (c) employed with (d) health insurance was 2.28% in 1996 and 4.59% in 2005. The values of 1.8% up to 3.5% reported on the last two J-MHATs (2012 and 2010) are well-within the National estimates for this demographic group.

5.8 Nutritional Supplements

For the first time, J-MHAT 8 asked questions about dietary supplement use in theater. Since J-MHAT 8 was the first year this set of questions was asked, we cannot make comparisons across years. Seventy percent of Soldiers report taking some kind of nutritional supplements when deployed. Almost 60% (57.9%) of Soldiers report using body building/performance-enhancing supplements; and 16.4% reported taking fat loss/weight loss products. Additionally, the majority of Soldiers (56.8%) reported that their use of dietary supplements did not change during the deployment; 9.1% reported decreased use of nutritional supplements; and 18.1% reported increased use of nutritional supplements during the deployment.

Figure 5.7 Supplements



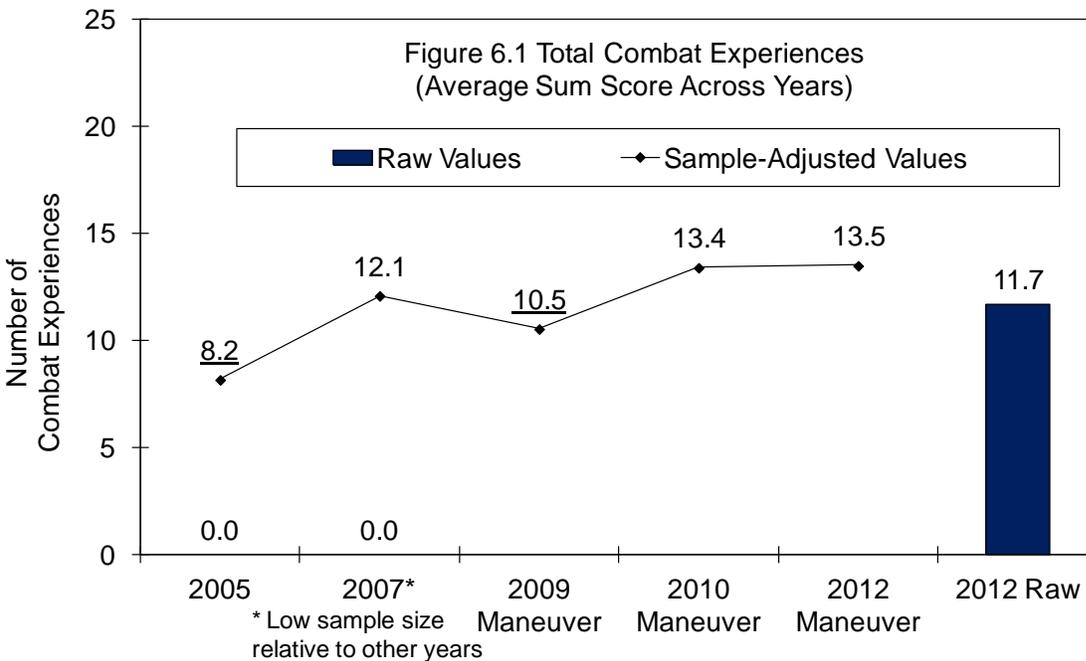
6. SOLDIER REPORT: RISK FACTORS

As noted, it is convenient to classify Soldier risk factors into four broad categories: combat-related risk factors, relationship problems, OPTEMPO-related risk factors, and deployment concerns. Changes in behavioral health indices are presumably associated with changes in these four risk factor categories.

6.1 Combat Experiences

Exposure to potentially traumatic experiences is one of the principal risk factors for behavioral health problems in combat settings (Fontana & Rosenheck, 1998). Thirty combat experience items have been consistently assessed across MHATs. A combat experience sum score indicating the sum of whether the Soldier experienced each of the 30 items at least once provides an efficient way to summarize changes in combat experiences across years.

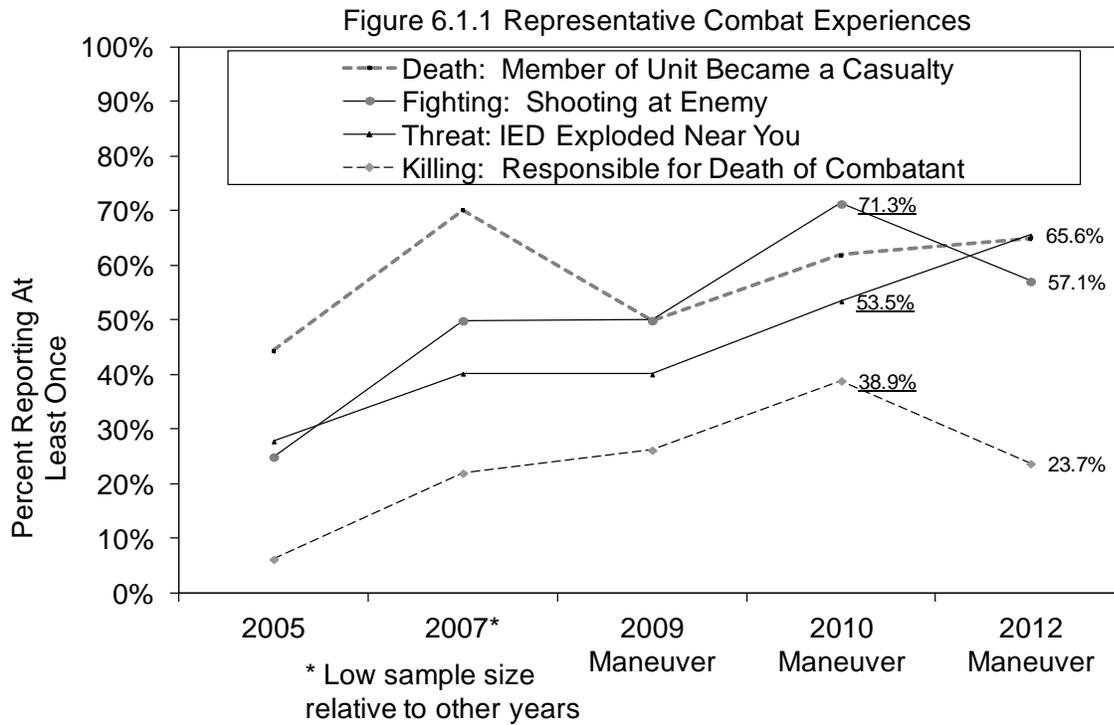
Figure 6.1 provides a comparison of the sample-adjusted mean number of combat experiences from 2005 to 2012. The overall level of combat experiences reported by Soldiers in 2012 is similar to 2010 and 2007 but significantly higher than 2009 and 2005.



Researchers such as Fontana and Rosenheck (1998) suggest that it is useful to categorize combat experiences into five dimensions: 1) Fighting, 2) Killing, 3) Threat to Oneself, 4) Death/Injury of Others, and 5) Atrocities. Wilk et al. (2010) showed that combat items such as those asked on the J-MHAT survey can be reliably categorized into the five dimensions and that these dimensions are useful in terms of predicting behavioral health outcomes.

The 30 items assessed in the J-MHAT 8 survey can be categorized into four of the five dimensions (atrocities were not assessed). Figure 6.1.1 provides a representative item from each of the four dimensions across time. For ease of comparisons, 2010 values that are not significantly different from 2012 are not shown. Analyses showed that although the overall rates

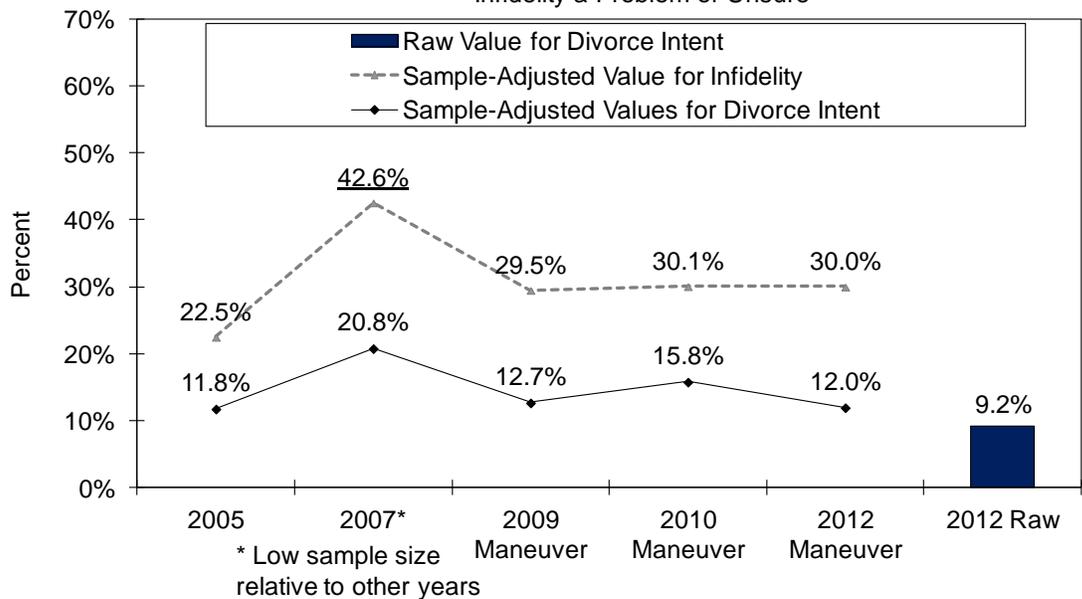
of combat experiences reported in 2012 are similar to 2010, the types of experiences have changed with the changing mission from combat to working side-by-side with the Afghan National Army (ANA). Soldiers in 2012 report significantly lower rates of shooting at the enemy and being responsible for the death of an enemy combatant compared to 2010. Consistent with the change in enemy tactics, 2012 Soldiers report higher rates of having an Improvised Explosive Device (IED) explode near them. The difference between the rates of a member of the unit becoming a casualty in 2012 vs. 2010 is not significant.



6.2 Relationship Problems

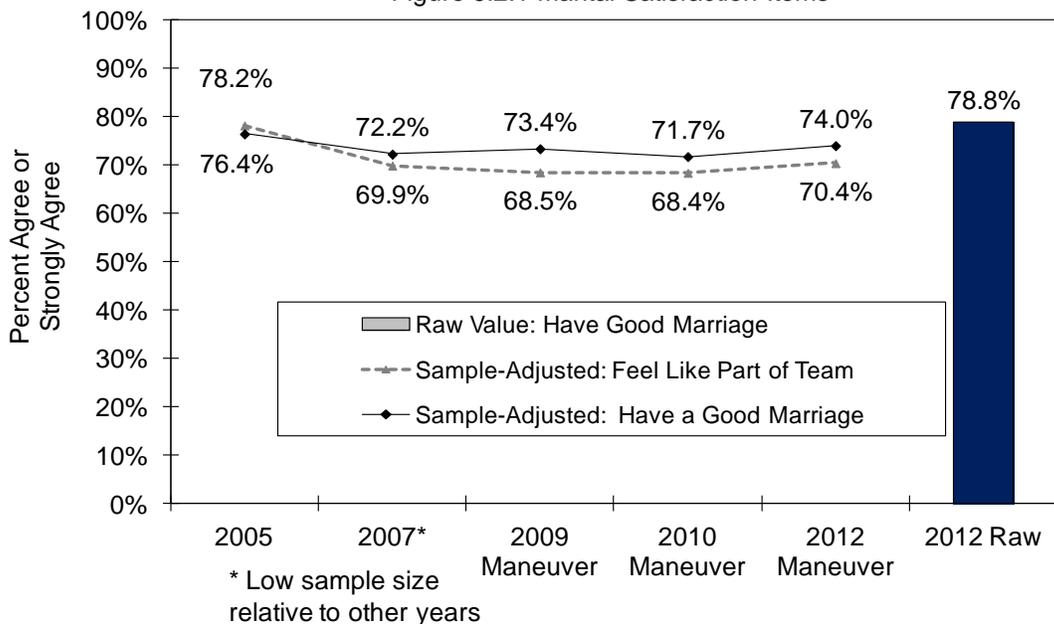
Relationship problems with spouses comprise a second major risk factor for a variety of behavioral health issues. The J-MHAT 8 reports two straight-forward indices of relationship problems: 1) the percent of married Soldiers that report they are considering a divorce or separation and 2) the percent of Soldiers that endorse “yes” or “unsure” to the question of whether infidelity is a problem in their marriage. Figure 6.2 shows that like 2010, the values in 2012 are not statistically different from other years with the exception that concerns about infidelity were significantly higher in the small sample of maneuver unit Soldiers collected in 2007.

Figure 6.2 Planning Divorce / Separation
Infidelity a Problem or Unsure



Intent to divorce or separate and concern about infidelity are more extreme instances of marital relationship problems; consequently, they may not be as sensitive to changes as would less extreme questions about marital relationships. Figure 6.2.1 provides responses to two marital satisfaction items adapted from Norton (1983): 1) I have a good marriage, and 2) I really feel like a part of a team with my spouse. The figure shows that the adjusted percentage of married Soldiers reporting positive marital satisfaction on these two items has not changed significantly since 2007.

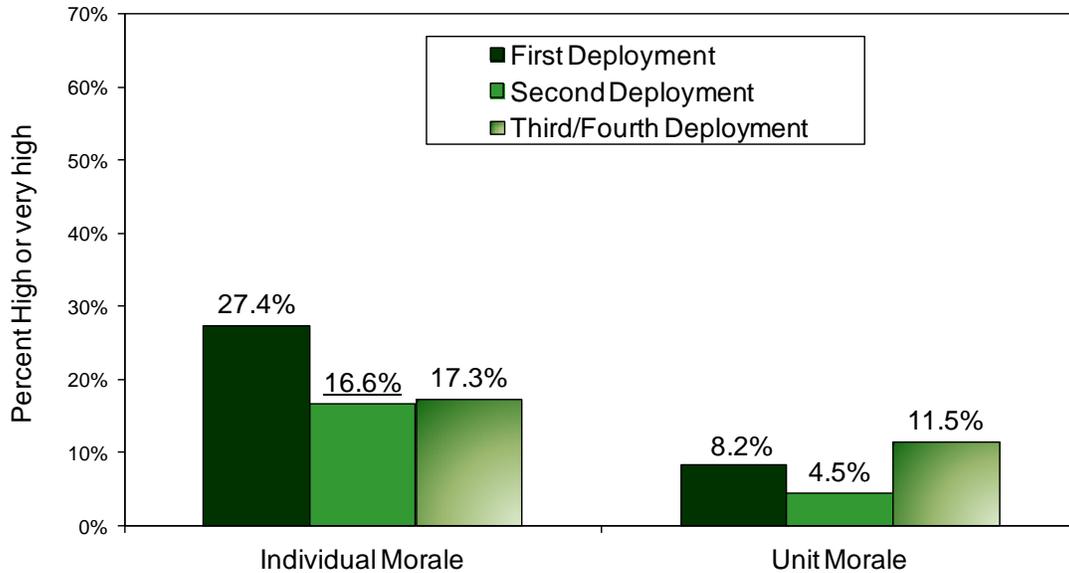
Figure 6.2.1 Marital Satisfaction Items



6.3 Multiple Deployments and Morale

Previous MHATs in Iraq and Afghanistan identified multiple deployments as a risk factor for a variety of well-being indices. Figure 6.2.2 reveals that this finding holds somewhat true for J-MHAT 8. There is a significant relationship for multiple deployments on individual morale for NCOs on their second deployment. Specifically, significantly fewer NCOs on their second deployment report high or very high morale compared to those on their first deployment.

Figure 6.3 Sample-Adjusted Values for NCOs in Theater 7 Months (referent is First Deployment)



6.4 Deployment Concerns

While combat experiences are intense events that put Soldiers at risk, other less dramatic, but more chronic concerns can also adversely impact behavioral health (Thomas, Britt, Odle-Dousseau, and Bliese, 2011). MHAT surveys assess a core set of 11 deployment concern items listed in Table 6.3. The concerns expressed during 2012 are mixed compared to 2010. A few of the concerns (e.g. concern about uncertain redeployment date) are significantly higher than 2010 while others (e.g. difficulty communicating back home) are lower. The former may be due to many units moving to the 9-month rotations, and other units having their deployments end early. The latter may be due to the theater becoming more technologically mature.

Table 6.3: Adjusted Percents for E1-E4 Soldiers in Theater 7 Months.

| Trouble or Concern Caused By | J-MHAT 7 2010 | J-MHAT 8 2012 |
|---|------------------|------------------|
| Lack of time off for personal time. | 34.4% | 38.9% |
| Uncertain redeployment date. | <u>24.5%</u> | 35.4% |
| Continuous operations. | <u>27.5%</u> | 35.1% |
| Not getting enough sleep. | 30.7% | 32.7% |
| Being separated from family. | 31.3% | 31.1% |
| Boring and repetitive work. | <u>35.8%</u> | 30.2% |
| Not having the right equipment or repair parts. | <u>24.1%</u> | 30.0% |
| Lack of privacy or personal space. | <u>37.1%</u> | 23.8% |
| Difficulties communicating back home. | <u>23.3%</u> | 17.3% |
| Illness or problems back home. | 13.8% | 14.6% |
| Long deployment length. | <u>26.6%</u> | 12.8% |

7. SOLDIER REPORT: PROTECTIVE FACTORS

Protective factors are the third broad category of variables in the conceptual model of Soldier well-being. Many of these protective factors are referred to as psychological resilience. The concept of psychological resilience can be defined as the ability to maintain psychological health (or even to experience psychological growth) when faced with challenges. As illustrated in this section, protective factors are affected, both positively and negatively, by multiple constructs to include unit climate, individual coping behaviors, the willingness and ability to seek behavioral health (BH) care, marital support, and perceptions of behavioral health/resilience training designed to help Soldiers. Additionally, J-MHAT 8 is the first MHAT to ask Army- and Marine-specific questions about their respective Resilience/Mental Health Training Programs.

7.1 Unit Factors

Unit factors such as small-unit leadership (NCO and officer), cohesion, and readiness are directly related to unit well-being, and often play a role in attenuating the link between deployment stressors and behavioral health outcomes (e.g., Bliese & Castro, 2003; Bliese, 2006). Figure 7.1 contrasts across years, the adjusted value ratings of the two central unit factors (cohesion and perceived unit readiness). For clarity in presentation, scale scores were dichotomized such that any scale score above 3.0 is considered positive and any scale score below or including 3.0 is considered negative. Scores above 3.0 equate to Soldiers agreeing or strongly agreeing with items measuring cohesion and unit readiness (e.g. platoon members stand up for each other, level of training in the platoon is high). There were no significant differences between 2012 and 2010 on cohesion or perceived unit readiness but both are significantly higher in 2012 than all other previous MHATs.

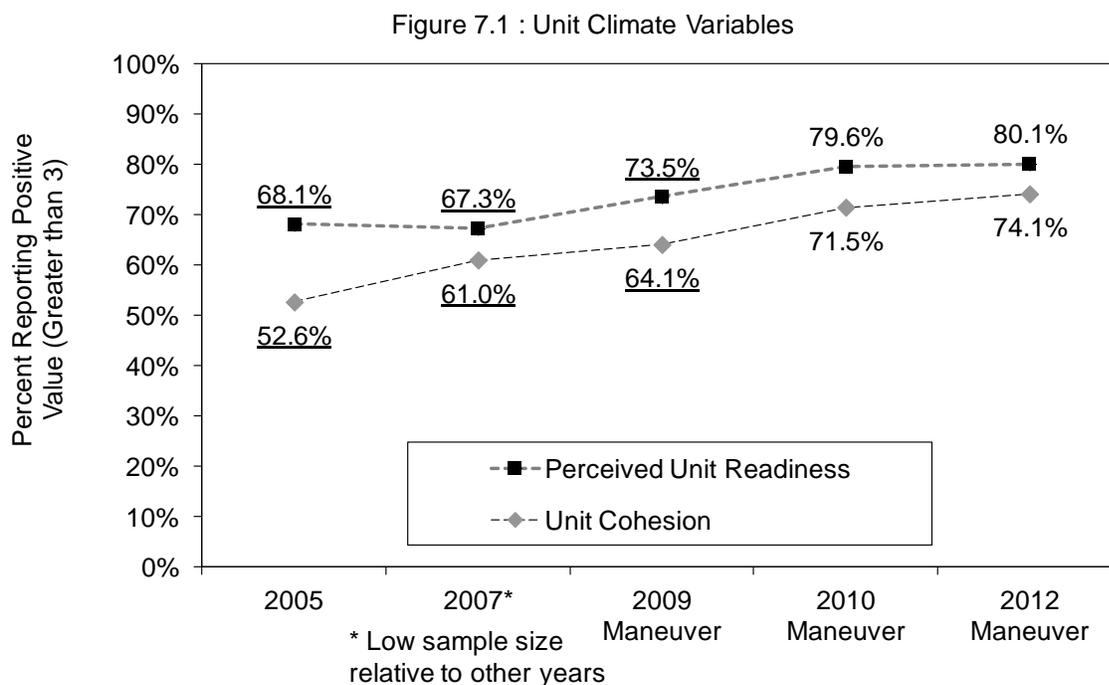
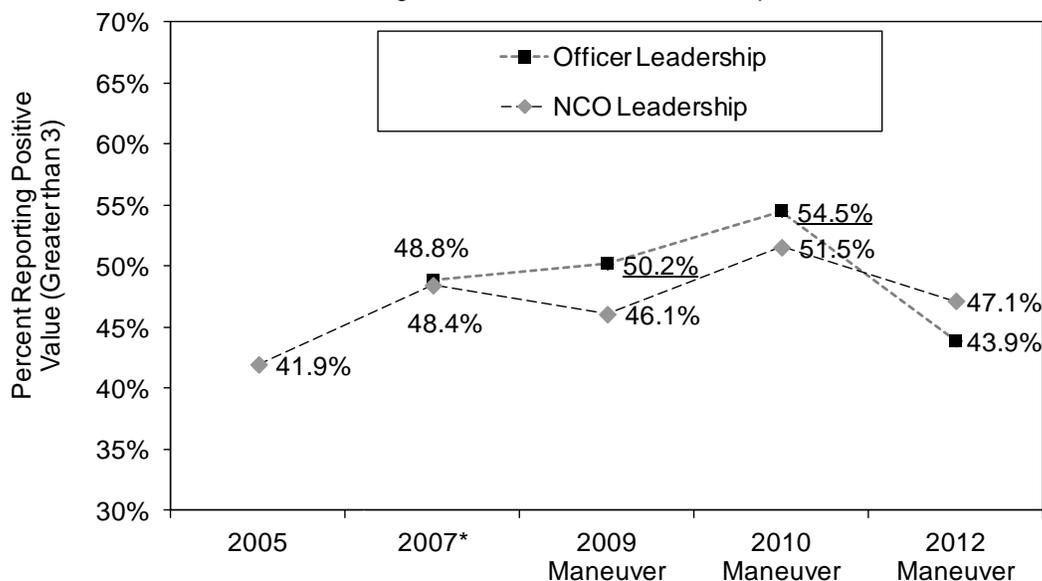


Figure 7.1.1 provides ratings for small-unit (company-level) NCO and officer leadership. Officer leadership values are not provided for 2005 because several core items were not included in the 2005 survey. Ratings of officer leadership in 2012 were significantly lower than all previous

years. As an example of poor officer leadership, one junior enlisted Soldier in a focus group said “they ask you how you are, but they’re not really interested.” Based on input from a BH Provider in theater, J-MHAT 8 added a new leadership question to the survey focused on whether Soldiers believed that officers were tactically sound. When asked, 55.8% of Soldiers said their officers never or seldom demonstrated tactical proficiency and competence. Ratings of NCO leadership, however, were no different than past years.

Figure 7.1.1 Small Unit Leadership



7.2 Stigma and Barriers to Receiving BH Care

At an organizational level, one way to enhance resilience is to encourage Soldiers to seek BH care before problems escalate. Stigma and organizational barriers to receiving BH care may prevent Soldiers from getting needed help. From this perspective, low levels of stigma could be considered a protective or resilience factor. A key contributor to seeking BH care is overcoming the stigma associated with behavioral healthcare. One of the challenges is that stigma is strongest among individuals who screen positive for psychological problems (Hoge, et al., 2004) and this finding has been seen in all previous MHATs. Therefore, when looking at changes in rates of perceived stigma, it is informative to examine those who screen positive for psychological problems (acute stress, depression or anxiety). J-MHAT 8 assessed stigma and barriers by asking Soldiers whether they agreed with items that would affect their decision to seek mental health counseling if they had a problem during the deployment.

Table 7.2 provides the sample-adjusted rates (E1-E4 Soldiers in theater 7 months) between 2010 and 2012 for (a) those that **do** screen positive for mental health problems, and (b) those that **do not** screen positive for mental health problems. Response rates to these questions have remained stable across years. Of note is that fewer 2012 Soldiers report that the availability of BH services would affect their decision to seek BH Care in 2012 compared to 2010.

Table 7.2: Sample-Adjusted Stigma and Barriers Percents for E1-E4 Soldiers in Theater 7 Months

| BH Stigma | | | | |
|--|---------------------------------|------------------------|-----------------|------------------------|
| | Percent Agree or Strongly Agree | | | |
| | J-MHAT 7 | | J-MHAT 8 | |
| | 2010 | | 2012 | |
| | Screen Positive | Do Not Screen Positive | Screen Positive | Do Not Screen Positive |
| I would be seen as weak. | 48.3% | 25.1% | 48.6% | 22.7% |
| It would harm my career. | 28.8% | 15.6% | 39.5% | 17.0% |
| My unit leadership might treat me differently. | 44.8% | 22.4% | 39.4% | 21.7% |
| Members of my unit might have less confidence in me. | 41.5% | 23.3% | 39.2% | 22.0% |
| My leaders would blame me for the problem. | 32.3% | 12.3% | 35.8% | 14.2% |
| It would be too embarrassing. | 29.6% | 13.9% | 35.6% | 16.3% |
| Barriers to Accessing BH Care | | | | |
| | Percent Agree or Strongly Agree | | | |
| | J-MHAT 7 | | J-MHAT 8 | |
| | OEF 2010 | | OEF 2012 | |
| | Screen Positive | Do Not Screen Positive | Screen Positive | Do Not Screen Positive |
| There would be difficulty getting time off work for treatment. | 45.3% | 16.9% | 46.1% | 17.1% |
| It's too difficult to get to the location where the mental health specialist is. | 29.8% | 14.2% | 35.0% | 10.8% |
| It is difficult to get an appointment. | 24.2% | 9.6% | 30.9% | 9.6% |
| My leaders discourage the use of mental health services. | 14.9% | 5.0% | 19.9% | 4.4% |
| Mental health services aren't available. | 28.7% | 11.8% | 19.0% | 6.6% |
| I don't know where to get help. | 18.1% | 5.0% | 18.5% | 8.0% |

7.3 BH Self-Management: Other Reasons for not Seeking BH Care

There may be other reasons that Soldiers do not seek BH care. In a recent publication, Kim, et al., (2011), found that Soldiers' beliefs about mental health are the main determinant of behavioral health care seeking behavior. Alternatively, Soldiers may not go to BH because they do not believe that BH can make a difference. J-MHAT 8 is the first MHAT to examine these types of reasons for Soldiers not seeking BH treatment.

Table 7.3 provides rates for both Soldiers screening positive for a mental health problem and those not screening positive. In the table, it is noteworthy that the only BH self-management value that is significantly higher for those who screen positive than those who do not screen positive is “Strong people can resolve psychological problems by themselves.” Most of the items that relate to Soldiers’ beliefs that they can handle BH problems (e.g. “I know how to help myself” and “I would prefer to manage my problems on my own”) are not significantly different for those who screen positive for a mental health problem versus those who do not. The issue of BH Self-Management is an area that warrants further research.

Table 7.3 Behavioral Health Self-Management Percents for Those who Screen Positive and Those Who Do Not Screen Positive for Mental Health Problems

| | Percent Agree or Strongly Agree | |
|--|---------------------------------|------------------------|
| | J-MHAT 8 | |
| | Screen Positive | Do Not Screen Positive |
| Factors that affect your decision to receive mental health services | | |
| I would prefer to manage my problems on my own | 41.8% | 41.3% |
| Mental health counseling can be helpful for those who need it | 41.8% | 36.6% |
| I know how to help myself | 41.1% | 39.5% |
| Strong people can resolve psychological problems by themselves | <u>40.4%</u> | 25.3% |
| I would rather get information on how to deal with the problem on my own | 35.2% | 28.3% |

J-MHAT also asked for the first time whether Soldiers believed that 1) mental health professionals understand SMs and 2) mental health care doesn’t work. There are significant differences between the responses for those who screen positive for a BH problem and those who do not. Those who screen positive for a BH problem are more likely (31.6% vs. 13.8%) to say mental health professionals do not understand SMs than those who do not screen positive. Similarly, they are more likely to say mental health care doesn’t work (19.3% vs. 5.6%).

7.4 Training

The next section on protective factors focuses on Soldiers’ reports of whether they received Resilience/Mental Health Training and Suicide Prevention Training and whether the training they received is perceived to have been effective. Table 7.4 shows that the percentages of 2012 Soldiers who report that they received 1) suicide prevention training and 2) training to manage the stress of deployment and/or combat are similar to 2010. In addition, the percentage of Soldiers who report they have assisted another SM with a mental health problem in the past year has declined from 2010 to 2012. Similarly, the percentage of Soldiers who have helped a SM who had a mental health (MH) problem get MH help has decreased from 2010 to 2012. These findings may reflect the lower percentage of maneuver unit Soldiers who screen positive for a MH problem.

Table 7.4: Sample-Adjusted Percents for Male, E1-E4 Soldiers in Theater 7 Months.

| | Percent "Yes" | |
|---|------------------|------------------|
| | J-MHAT 7 2010 | J-MHAT 8 2012 |
| Suicide and Stress Training / Use | | |
| I have received suicide prevention training in the past year. | 81.5% | 85.1% |
| I have received training in managing the stress of deployment and/or combat prior to this deployment. | 78.7% | 77.1% |
| I have assisted one or more fellow Service Members with a mental health problem in the past year. | <u>31.6%</u> | 25.7% |
| I helped a Service Member who had a Mental Health Problem get professional help. | <u>23.8%</u> | 18.2% |

Table 7.4.b shows a significant decrease in the percentage of 2012 Soldiers that agree or strongly agree that the training in managing the stress of deployment and/or combat was adequate compared to 2010.

Table 7.4.b: Sample-Adjusted Percents for Male, E1-E4 Soldiers in Theater 7

| Adequacy of Suicide and Stress Training | Percent Agree or Strongly Agree | |
|--|---------------------------------|------------------|
| | J-MHAT 7 2010 | J-MHAT 8 2012 |
| I am confident in my ability to identify Service Members at risk for suicide. | 62.9% | 63.9% |
| I am confident in my ability to help Service Members get mental health assistance. | 70.3% | 67.9% |
| The training for identifying Service Members at risk for suicide was sufficient. | 59.8% | 55.9% |
| The training in managing the stress of deployment and/or combat was adequate. | <u>56.4%</u> | 49.9% |

Taken together, these two tables indicate a mixed story relative to 2010. The percent of Soldiers who report being trained may have stayed consistent, but perceived training adequacy in managing the stress of deployment and/or combat has significantly decreased.

7.4.1 Resilience Training

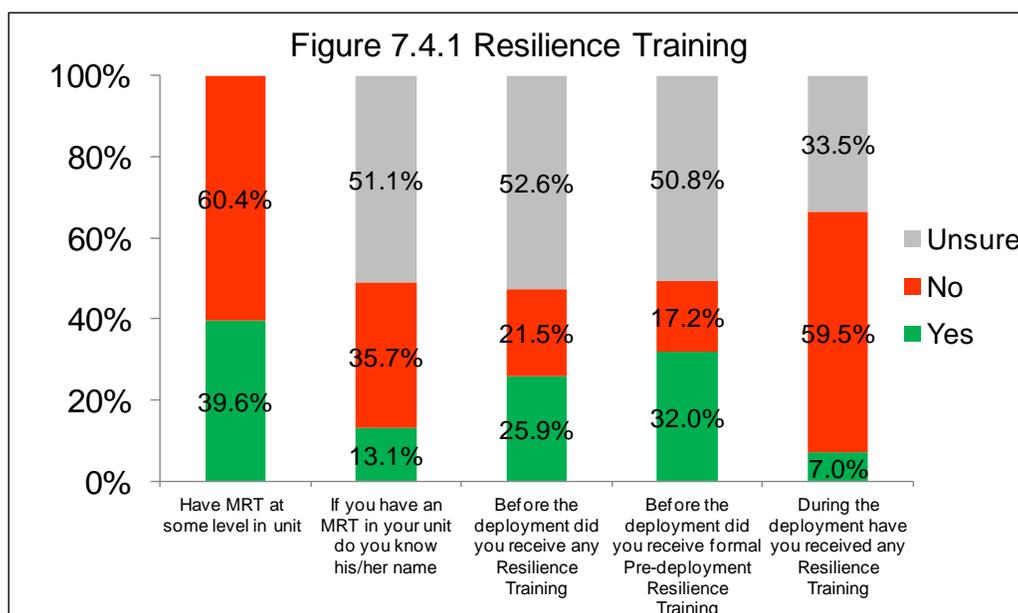
One of the new focal topics of J-MHAT 8 is resilience training. Resilience is defined as the ability to grow and thrive in the face of challenges and bounce back from adversity. The US

Army launched Comprehensive Soldier Fitness (CSF) in 2007 to increase the resilience and performance of Soldiers, Families, and Army Civilians. In late 2012, after the J-MHAT 8 mission in theater was complete, CSF was renamed Comprehensive Soldier and Family Fitness (CSF2) to put further emphasis on the Family component of resilience training. CSF2 works to increase Soldier, Family and Civilian resilience by assessing and training specific physical, emotional, social, spiritual, and Family strengths through self-development, institutional training, and operational training. One of the key pillars of CSF2 is the Master Resilience Trainer (MRT). MRTs attend a two-week course in which they are trained to provide resilience training to their units.

The J-MHAT 8 survey asked Soldiers “Do you have a Master Resilience Trainer (MRT) in your unit?” The response options assessed the unit level (company, battalion, or brigade) at which the MRT was working as well as an option for not having an MRT in the unit. Figure 7.4.1 shows that just over 39 percent (39.6%) of Soldiers report they have an MRT in their unit and the most common level (18.6%) is the battalion. Approximately one-fourth (25.9%) of all Soldiers report receiving **any** resilience training from an MRT before the deployment.

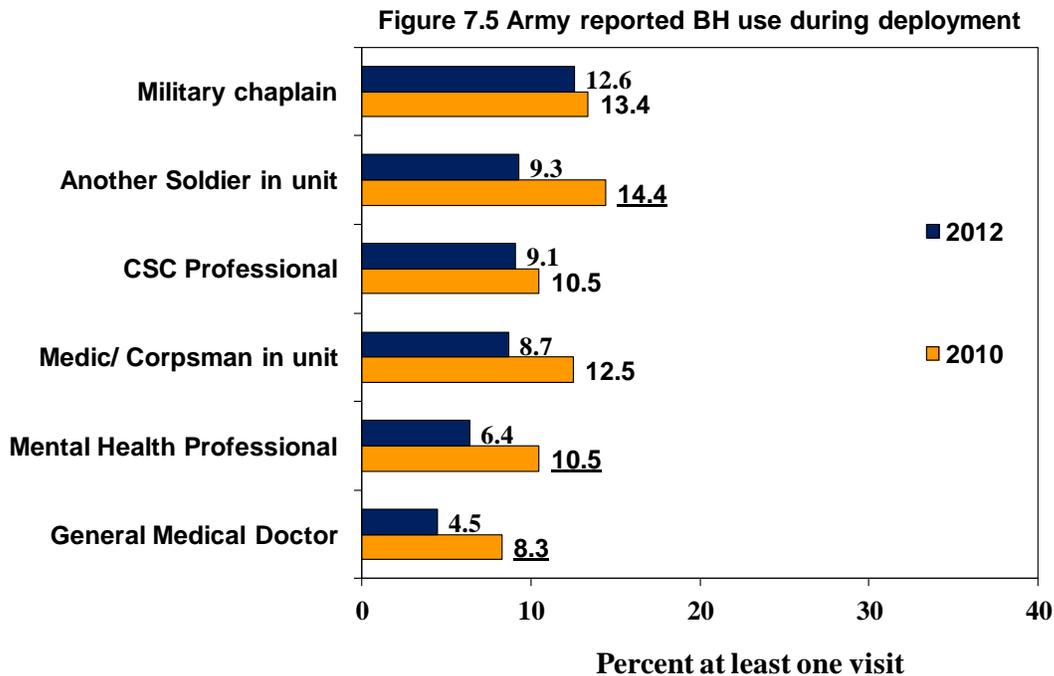
Since 2007, the Army has required that Soldiers receive Pre-Deployment BATTLEMIND mental health/resilience training. As of 30 March 2010, per the direction of CSF2, Pre-Deployment Resilience Training replaced Pre-Deployment BATTLEMIND as the required resilience training to help Soldiers prepare for combat deployments. When asked specifically about the Army-mandated **Pre-Deployment** Resilience Training for Soldiers, 32% reporting received this training while 50.8% were unsure if they received the training. Of those who received the training, 36.5% found it at least somewhat useful in helping them prepare for this deployment.

Soldiers were also asked if they received resilience training from an MRT **during the deployment**. Only 7% reported they had received MRT Resilience training during the deployment and 33.5% said they were unsure. To assist in determining the most appropriate in-theater resilience training, Soldiers were asked during Focus Groups “What resilience skills should be targeted by training modules during deployment?” The most frequently endorsed skills were 1) addressing general deployment stress, 2) addressing combat related stress, and 3) managing sleep. See Soldier Focus Group Summary, Chapter 8, section 8.2.3



7.5 Use of Behavioral Health (BH) Services

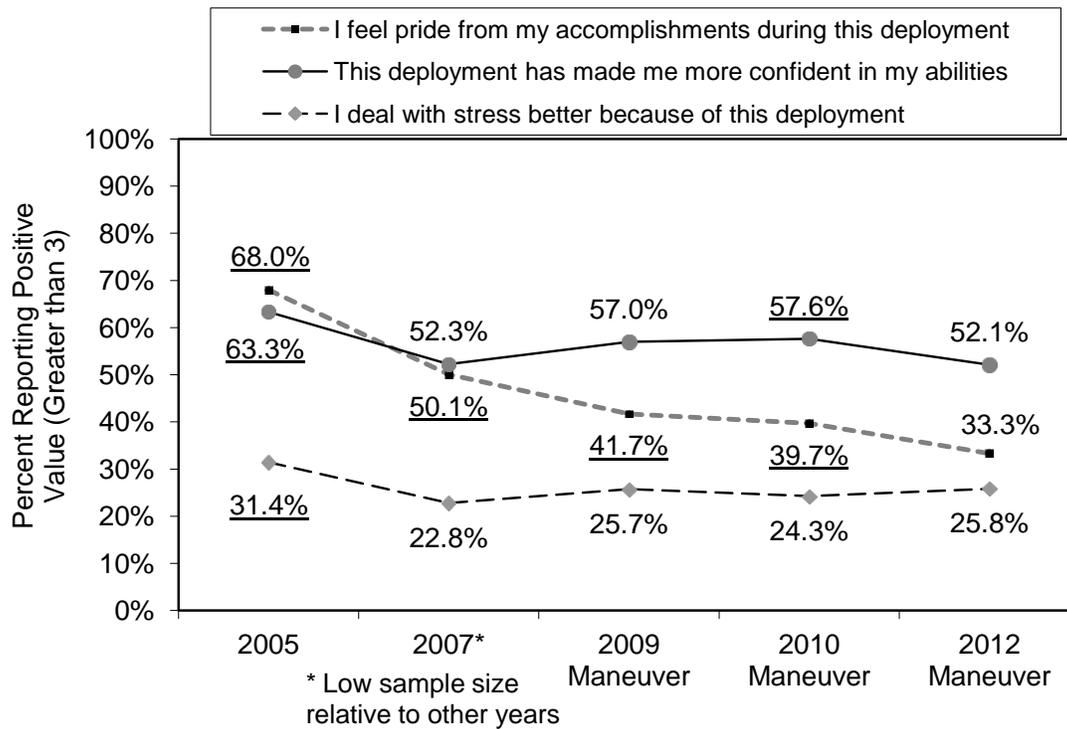
The next section on protective factors focuses on Soldiers' reports of whether they received behavioral health (BH) services during the deployment. Overall, 13.7% of all Soldiers report receiving counseling/mental health services from a Chaplain, member of their unit, combat stress control (CSC) professional, a medic/corpsman, a mental health (MH) professional, or a general medical doctor at least once during this deployment. Figure 7.5 shows the adjusted values (normalized for all 5 years of MHAT Afghanistan data) for the percent of Soldiers who report at least one visit for a mental health problem. As can be seen, Chaplains were the source most used. Soldiers in 2012 report they are talking less about behavioral health problems with their fellow Soldiers, MH professionals, and general medical doctors than in 2010. This corresponds to the reports that fewer Soldiers screen positive for a MH problem in 2012 compared to 2010.



7.6 Positive Impact of Deployment

As mentioned previously, the concept of psychological resilience includes at least two positive responses to adverse circumstances: being able to maintain baseline psychological health and/or have positive psychological growth. Several questions included on the J-MHAT 7 and J-MHAT 8 surveys probe whether the experience of deployment resulted in positive changes in Soldiers' confidence, pride, and ability to manage stressful circumstances. Figure 7.5 indicates that the percentage of Soldiers who agreed with the statement "I deal with stress better because of this deployment" has remained relatively stable since 2010. In contrast, significantly fewer Soldiers in the 2012 J-MHAT 8 sample report pride in their accomplishments and fewer report greater confidence in their abilities as a consequence of deployment relative to J-MHAT 7 (2010).

Figure 7.6 Positive Effects of Deployment



8. SOLDIER FOCUS GROUP SUMMARY

Soldier focus groups addressed the following topics: 1) resilience training, 2) sleep, 3) anger, 4) leadership emphasis on resilience and well-being, 5) transitioning from a combat environment to a garrison environment, and 6) behavioral health care. Based on the discussion topics, four primary thematic areas related to service member health and well-being emerged. These thematic areas included: 1) deployment-related stressors and challenges, 2) coping strategies, 3) developing resilience and 4) seeking behavioral health care. Sub-themes within each area will be discussed in order of those which were most consistently noted by Soldiers within the groups.

8.1 Methods

The J-MHAT 8 OEF team conducted 13 focus groups with a total of 72 Soldiers [6 focus groups with junior enlisted (E1-E4, n=36) and 7 focus groups with NCOs (E5 to E8, n=36] from within the ATO (see table 8.1). J-MHAT 8 team members met with maneuver unit Soldiers at Forward Operating Base (FOB) Salerno, FOB Joyce, FOB Finley Shields, Camp Marmal, and FOB Pasab, representing Regional Commands (RCs): RC East, RC North and RC South, respectively.

Focus group sessions were conducted separately for junior enlisted Soldiers and their NCOs. Participant identities were kept anonymous and participants were informed of the confidential nature of the focus groups. Sessions ranged in duration from 1-2 hours, with the average session taking approximately 90 minutes.

| <i>Table 8.1: Soldier Focus Group Demographics for J-MHAT 8 (2012)</i> | | | | | |
|--|----------|----------|-----------------------------------|----------------|----------|
| Variable | n | % | Variable | n | % |
| Rank | | | Component | | |
| E1-E4 | 36 | 50% | Active | 59 | 82% |
| NCO | 36 | 50% | National Guard | 13 | 18% |
| Marital Status | | | Children | | |
| Single | 32 | 44% | Yes | 35 | 49% |
| Married | 40 | 56% | No | 37 | 51% |
| Deployment History | | | | (Means) | |
| First Time | 34 | 47% | Time (Months) in Theater | 5.58 | |
| Second Time | 21 | 29% | Years in the Military | 4.99 | |
| Third or More | 17 | 24% | Months Deployed Since 9/11 | 15.94 | |

Given that the answers provided were often similar regardless of rank (junior enlisted or NCO) or regardless of duty status (active duty or National Guard); the findings will be presented as an aggregate. Survey results in related areas were compared to results of the focus groups and when applicable, comparisons will be presented in relevant sections.

8.2 Soldier Focus Group Results

8.2.1 Deployment-Related Stressors and Challenges

Stress occurred due to work and family situations as well as the daily hassles of living in a deployed setting. Commonly noted stressors included: 1) leadership concerns, 2) workload, 3) changing role expectations, 4) a garrison environment culture, 5) sleep difficulties, 6) boredom, 7) lack of privacy, and 8) maintaining relationships back home. Sleep and the transition back to garrison were addressed in-depth in the focus groups; however, they were not the primary stressors for Soldiers. Many of the other stressors noted are intricately tied to these two topics. For example, workload was a factor that contributed to lack of sleep, and a garrison environment culture and maintaining relationships also related to challenges associated with transitioning back to a garrison environment. These interdependent relationships between and among stressors demonstrates a complexity that must be considered when addressing resilience training and behavioral health needs of Soldiers.

Within deployment-related stressors and challenges, three contributing factors emerged: work factors (e.g., leadership, duties), followed by daily hassles (e.g., boredom, lack of privacy), and family factors (e.g., communication, parenting). As indicated above, sleep and the transition back to a garrison environment were also stressors but will be discussed separately as they relate to more than one theme.

8.2.1.1 Work Factors

Leadership, occupational/job expectations and workload were the primary work-related stressors addressed. Soldiers indicated that they experienced stress because they thought that they were treated poorly by leadership and that in some cases they were unable to voice their concerns without reprisal (e.g., being given additional duties or somehow making their jobs harder). They also thought that there were double-standards with regard to work ethic and appearance. For example, some Soldiers viewed leadership as not being as fit as they should be, yet they enforced fitness rules on their Soldiers. Additionally, Soldiers perceived that some leaders did not hold as high a standard regarding the appearance of their uniforms as they held for their Soldiers. At times, Soldiers viewed leaders as focusing on making themselves look good regardless of the impact on the unit. Soldiers also noted that while they came to do a specific job, in some cases they did very little of their own job responsibilities, either due to shortages in personnel or changes in mission expectations. Some Soldiers who expected to perform combat missions were placed on guard duty while Soldiers who expected to do their regular job (e.g., mechanic) were performing combat missions such as route clearance. Other stressors included the lack of a clear schedule and additional taskings. Soldiers stated that they were given short notice on the hours for their mission even when they believed that notice could have been provided earlier. This was also tied to the perception that information was being unnecessarily withheld. Additional taskings were often given at the last moment or right after missions and reduced the opportunity to sleep due to the increased workload. At one location, the lack of the proper equipment or not having enough equipment also made it difficult to perform job tasks and also increased workload. Specific equipment examples were not provided. Increased workload also occurred as a result of Soldiers' interactions with the Afghan

National Army (ANA). Soldiers indicated that they often had to perform the jobs of the Afghan Soldiers because the Afghan Soldiers were not yet prepared to perform the roles they were trained to do. They were further concerned with the impact of the rules of engagement on their ability to do the mission. Soldiers indicated that they were in harm's way but that the rules of engagement made it nearly impossible to react.

8.2.1.2 Daily Hassles

Daily hassles that emerged included boredom and a lack of privacy as well as conforming to a garrison environment culture. Soldiers who were not utilized to their full extent often became bored and found it difficult to find productive ways to occupy their time. Although they watched movies, went to the gym and spent time on the internet, the sense that they were not contributing to the mission in the manner expected made it difficult to appreciate the downtime. Close quarters was an additional hassle, given that several Soldiers lived in a single room, privacy became non-existent and the lack of time alone became stressful as they were constantly surrounded by the same Soldiers, whose habits were occasionally annoying (e.g. talking on phone or keeping the lights on while others are sleeping). Conversely, survey responses indicated that significantly fewer 2012 Soldiers expressed concern about lack of privacy or personal space compared to 2010 Soldiers (23.8% vs. 37.1%).

A garrison environment culture was also a stressor. Soldiers indicated that because of the lack of gainful employment, leadership focused on strong enforcement of uniform standards that the Soldiers felt were unwarranted in the current environment. This is not to say that they thought standards were not important, but rather the level of enforcement was out of proportion to the situation. For example, after a difficult mission, Soldiers would come back only to be reprimanded because their uniform was awry in some way.

8.2.1.3 Anger Associated with Deployment Stressors

Many of the work-related and daily hassles stressors resulted in feelings of anger and frustration, although Soldiers may have experienced other emotions, anger was the focus of the sessions. Questions centered on what situations made them angry, how they handled their own anger, how the unit reacted when Soldiers got angry as well as how the individual reacted when fellow Soldiers got angry.

Anger primarily stemmed from issues with leadership, occupational/job expectations, and conflicts with fellow Soldiers and leaders. Soldiers were angry at their leaders because they thought that they were out to get them by focusing on everything that was wrong, such as improper wear of the uniform or damaged equipment rather than on the welfare of the troops. They perceived uniform standards as being reflective of a garrison culture that should not always apply when in a deployed environment. Soldiers were also angry when they were not informed of missions in a timely manner (especially when they perceived that leadership knew ahead of time) and/or because of a lack of communication in general. They thought that leaders did not always listen to what they had to say, that they were treated poorly and/or that leaders were hypocritical. Soldiers were also angry if they thought that their leaders were lazy and set different standards for themselves as opposed to those that they lead. Occupational/job expectations were another issue. Soldiers who expected to do one mission and were involved in missions not related to their military occupational specialty (MOS) or did not have the opportunity to be involved in duties related to their MOS to the extent that they expected (i.e., lack of combat) were also frustrated. Rules of Engagement (ROEs) also fostered anger because Soldiers indicated that the ROEs were so strict that when they felt threatened by the Afghans while conducting operations, they could not protect themselves (e.g., having rocks thrown at

them). In addition to leadership issues and conflicts, Soldiers also had conflicts with fellow Soldiers due to a lack of consideration for others, particularly when other Soldiers made a lot of noise or kept the lights on when they were trying to sleep.

Despite their anger, Soldiers displayed significant restraint and indicated that they would often walk away from the situation and take a “time out” or would talk to a peer to obtain their perspective on the situation or just to vent their frustrations. This finding is consistent with the survey results in which only 7% of Soldiers indicated that they had poor or very poor control of their anger in the past month. Other Soldiers chose to go to the gym or listen to music, watch TV or talk to their family in an effort to focus on something other than whatever made them angry.

Given their own anger experiences, Soldiers understood the anger of other Soldiers and encouraged them to talk or even seek help from behavioral health if needed. However, when Soldiers observed anger displayed by leadership, Soldiers tried to ignore it. In some cases anger was not tolerated in the unit but it depended on the reason for the anger. If the anger was perceived as legitimate, then there would be a discussion about ways to handle the situation; otherwise a Soldier may be reprimanded for their anger. Generally, anger was only displayed among peers, thus if a junior enlisted Soldier was angry at their NCOs or NCOs were angry at officers, they would still maintain their professionalism.

8.2.1.4 Family Factors

Some of the married Soldiers stated that since they were not back home, they did not have a voice in how the household was run, to include parenting. Many of the married Soldiers thought that the spouse should make those decisions given that they are not physically present, but noted that it is sometimes difficult to reintegrate back due to differing role expectations upon return and the occasional need to isolate oneself from the family to have some personal space that they did not have in the combat environment. Extensive access to the internet and phones was also problematic for those Soldiers who set high expectations for communications with family members (i.e., regularly scheduled phone calls). When Soldiers were unable to call due to mission requirements, spouses occasionally were concerned that their Soldier was injured or killed or were upset that the Soldier did not call at the usual time.

8.2.1.5 Sleep

Sleep questions were related to factors associated with sleep difficulties, strategies designed to mitigate sleep disruptions, as well as education and leader emphasis on sleep hygiene. As expected, sleep difficulties were often noted; however, these difficulties were mainly attributed to four primary reasons: external, uncontrollable factors such as 1) the job itself and 2) the sleeping environment as well as internal, controllable factors such as 3) cognitions (e.g. thoughts of work) and 4) behaviors (e.g., utilizing sleep time for leisure activities). The demands of the job were the number one reason for the lack of sleep, while sleep environment, Soldier cognitions, and Soldier behaviors were less likely to be given as reasons for the lack of sleep. Although two groups of NCOs indicated that they were obtaining enough sleep, the remaining 11 groups of NCOs and junior enlisted Soldiers indicated that they were not obtaining enough sleep.

With regard to the job, long hours, rotating shifts, shifts with minimum time in between and night shifts resulted in difficulties either obtaining enough sleep and/or difficulties in falling asleep and staying asleep. Approximately 23% of Soldiers who completed the survey had difficulties falling

asleep while 23% had trouble staying asleep within the past month. In addition to working varied shifts and often working seven days a week, Soldiers indicated that they were often given additional taskings prior to their shift that prevented adequate sleep. Lack of a clear schedule for completing these taskings as well as the actual mission also contributed to sleep deprivation. Soldiers indicated that they were not informed prior to deployment that their job during the deployment may entail little sleep or downtime, or the opposite, that given the current nature of the war, they may have more opportunities to sleep and may not see as much combat as anticipated. Consistent with concerns about job demands expressed in the focus groups, 37% of the Soldiers who completed the survey indicated that nighttime duties interfered with their sleep while 21% of Soldiers indicated that a high OPTEMPO interfered with their sleep.

Environmental factors also played a role in the ability to sleep. Hot temperatures, broken air conditioners, noisy roommates, and lights resulted in less quality sleep as did the occasional indirect fire from the enemy. According to Soldiers who completed the survey, 29% indicated that the sleep environment interfered with their sleep.

Thoughts about the impending workday as well as a lack of time management also contributed to sleep problems. In some cases, rather than sleeping during the provided timeframe, some Soldiers chose to engage in leisure activities such as playing video games and making phone calls, which led to less sleep. However, less than 6% of Soldiers who completed the survey stated that these activities were responsible for their lack of sleep.

For those who had difficulty sleeping, a variety of measures were taken; however, medication was rarely used to alleviate the problem. In the instances it was mentioned, Melatonin and Ambien were the medications used. Soldiers indicated that doing their best to maintain a routine was one key measure taken to obtain quality sleep. Making sure that lights were out at a particular time, cooperating with roommates on designated quiet hours, sleeping whenever one had the opportunity and the use of breathing exercises were all strategies designed to improve sleep quality.

Although difficulty in obtaining quality sleep is a common stressor, training and leadership emphasis on sleep varied from zero emphasis to a significant emphasis with most Soldiers indicating that there was at least some emphasis on sleep hygiene. This is consistent with survey findings in which over 55% of Soldiers indicated that NCOs in their platoon encourage their Soldiers to get adequate sleep and consider sleep an important planning factor. Approximately 62% encourage Soldiers to get extra sleep before missions that require long hours. For those leaders that did emphasize sleep hygiene, they went around to ensure that Soldiers were not overburdened and that they were provided, to the greatest extent possible, adequate time to sleep. On the other hand, some Soldiers indicated that leadership focused on their own sleep needs and not the needs of the men that they lead or that leadership believed that four hours of sleep is enough. In addition to discussing leadership's emphasis on sleep, Soldiers were asked who they thought would be best qualified to address sleep hygiene (e.g., medics, officers, NCOs, medical providers). Answers were varied and sometimes more than one answer was given. Medics, NCOs, individual Soldiers, healthcare providers with expertise in sleep issues and everybody were the answers provided with medics and NCOs being the predominant choices.

8.2.1.6 Transitioning Back to a Garrison Environment

Transition questions focused on potential challenges that may arise once Soldiers are back in garrison such as potential conflict between combat veterans and Soldiers new to the Army, as well as required leadership skills in a garrison environment (as opposed to a combat

environment). Several challenges were identified with regard to the transition process but a number of Soldiers also noted that they are currently experiencing a garrison environment while in theater. Similar to the stressors, the challenges are representative of work, home and daily life. In terms of work, changes in the Army (e.g., females doing infantry work, promotions, downsizing), changes in the mission to peacekeeping/humanitarian, PCSing and ETSing (transitioning out of the Army) were all considerations discussed. Additionally, National Guard Soldiers indicated that some of them had lost jobs and would be facing unemployment upon their return as well as difficulty enrolling in schools since their return would be early in the college semester. Soldiers did not necessarily perceive all of these challenges as negative, but recognized that they and their fellow Soldiers would need to be aware of the potential ramifications of these changes and be more flexible with regard to the changing environment.

Potential challenges at home and daily life included excess alcohol consumption, which may lead to aggressive and dangerous behavior, increased spending (e.g., buying expensive cars due to additional money earned in combat), interacting with civilians who do not understand a Soldiers' deployment experience, divorce, going from no freedoms to many freedoms, difficulty in deciding how to utilize one's free time, and reintegration with and isolation from family members. Soldiers also indicated that they foresee problems between combat veterans and new Soldiers. Combat veterans will likely not have as much respect for and may even harbor some resentment towards the new Soldiers since they cannot relate to their experiences and will likely give the new Soldiers a hard time about their lack of experience. Many of the Soldiers currently serving have never been part of a garrison force and thus do not know what it is like. However, many Soldiers also indicated that they were in the same position once and while they may give the new Soldiers a difficult time, they would take the new Soldiers under their wing and limit the war stories told.

In terms of comparing leadership skills needed for a combat versus a garrison environment, some Soldiers thought that the skills are primarily the same with a few exceptions. Skills that remain the same include: focusing on the well-being of Soldiers and maintaining standards and discipline. Soldiers stated that leaders need to be prepared to enforce the standards and discipline of a garrison environment (e.g., uniform appearance, saluting) which may not be as enforced in a combat environment. With regard to different skills, Soldiers thought that effective management of how much alcohol their troops consume would be a skill needed in garrison given that Soldiers did not have the opportunity to drink for several months and will likely consume significant amounts of alcohol upon their initial return. Additionally, they indicated that leaders should be able to effectively integrate new Soldiers with combat veterans into the units. Another consideration noted was training, leaders need to be able to focus on gearing up for field missions rather than combat missions but also need to remember that historically the Army is a fighting force and thus Soldiers still need to maintain their combat skills.

8.2.2 Coping Strategies

Soldiers used several strategies to mitigate the potential negative effects of the various work, family, and life stressors they experienced. Soldiers were asked how they coped with the general demands of the deployment as well as the most difficult events of the deployment. Social support was the primary method of dealing with the general demands of deployment. Soldiers indicated that they received social support either by contacting friends and family back home, by talking to their buddies, by just hanging out with their buddies and watching TV or by engaging in sports such as basketball or other unit events. Other often-used and noted strategies included emotion-focused strategies such as reading, maintaining a sense of humor, keeping busy in general, playing games, taking college courses, and going to the gym.

Social support was also the primary strategy employed when coping with the most difficult aspects of the deployment. Soldiers communicated their thoughts and feelings with their buddies and occasionally with their families, although they did not want to unnecessarily burden their families with their concerns. Soldiers tried to build a sense of camaraderie by focusing on the value of their mission and the positive things that they accomplished in the face of dangerous situations. To a lesser extent, meditation, religion and spirituality were strategies that Soldiers used to cope with some of the most difficult aspects of deployment.

In addition to the strategies noted above, Soldiers occasionally chose strategies that were focused on directly solving the problem. For example, if a Soldier had a financial problem, leadership would help the Soldier go to the appropriate institution to help resolve the issue. Similarly, if a Soldier was experiencing stress due to their job, they would work towards planning and completing the task in the most efficient and effective manner possible in order to reduce their stress.

8.2.3 Developing Resilience

Given that Soldiers experience a multitude of stressors surrounding deployments and do not always utilize positive coping strategies, extensive efforts are being made to provide Soldiers with the resources they need to optimize their well-being and resiliency. Such resources may be applied not only to deployed environments but also to garrison environments. The most recently developed resilience training program for the Army is Comprehensive Soldier and Family Fitness, which defines resilience as “the ability to grow and thrive in the face of challenges and bounce back from adversity.” This program is designed to build the resilience and enhance the performance of every Soldier, Family member and Department of the Army Civilian and is responsible for training Master Resilience Trainers (MRTs). MRTs are Soldiers and DA civilians who are graduates of a 10 day course that teaches them how to instill resilience in other Soldiers and Family members (Reivich, Seligman, & McBride, 2011).

Resilience questions focused on training that occurred prior to and during deployment as well as how the training was delivered (i.e., in-person, electronically or a combination of methods). Additionally, Soldiers were asked how beneficial the training was and what they wish they had known that would have helped them to be more resilient. Soldiers also indicated whether or not they had a Master Resilience Trainer (MRT) in their unit and the types of services the MRT provided to the unit. Lastly, Soldiers were asked to identify if they thought developing specific resilience training modules would be beneficial and to what degree those modules would help on a scale of low, medium and high helpfulness.

8.2.3.1 Resilience Training Prior to and During Deployment

Many Soldiers indicated that they received formal resilience training prior to deployment. However, several did not recall receiving this training given that they were inundated with several briefings prior to the deployment and because several months had passed since the training occurred. Similarly, the survey results indicated that 32% of Soldiers received pre-deployment resilience training while 51% were unsure. Soldiers unanimously stated that they did not receive formal resilience training during their deployment and noted that during the deployment would not be the optimal time as it would be counterproductive given their busy schedules. Survey findings indicated that 60% of Soldiers said they did not receive training during the deployment while 33% were unsure. Occasionally, informal resilience-related discussions occurred with leadership or with peers. When receiving pre-deployment training,

they indicated that it was conducted by either military and/or civilian personnel (in some cases by an MRT) and was presented via PowerPoint as part of several days of pre-deployment training on a number of topics. Resilience training occurred through multiple sources, to include Family Readiness Groups (FRGs), at Battalion level in an auditorium, at the Company and Platoon level and through websites at the Education Center.

Of the 13 focus groups, 6 groups indicated that they had a Master Resilience Trainer (MRT) in their unit and the remaining 7 groups either did not know if they had an MRT in their unit or were unfamiliar with the concept of a MRT. Only 40% of Soldiers who completed the survey stated that they had an MRT in their unit. These findings may in part be accounted for given that the MRT program is fairly new and because pre-deployment commitments may prevent attendance at the training. When MRTs were present they were noted for their involvement in providing pre-deployment resilience training.

8.2.3.2 Benefits of Resilience Training

Soldiers thought that this training would be particularly beneficial for junior enlisted Soldiers who were experiencing their first deployment. Additionally, even if they did not find it beneficial for themselves, they still thought that it would benefit someone and thus is worthwhile. They also indicated that training would be more beneficial if it were conducted in a small group setting that allowed for discussion and tailoring the training to the needs of the unit. Soldiers indicated that they would like the training to include Soldiers who had deployment experience as well as subject matter experts, such as a clinical psychologist, with whom a relationship and sense of trust could be built. Soldiers indicated that they thought this training was helpful in terms of recognizing the signs associated with someone who was not as resilient.

Soldiers were also asked what resilience training they think would have been helpful to receive prior to deployment as well as what they wish they had known that would have aided in their ability to be resilient. They stated that knowing what resources would and would not be available would have been helpful, particularly at Combat Outposts (COPs), where fewer behavioral health resources are readily available relative to Forward Operating Bases (FOBs). Soldiers also indicated that knowing how to handle traumatic events would be helpful. They also indicated that knowing what to expect when they arrived in theater would have been helpful. Specifically, knowing the OPTEMPO (or lack thereof) would have been beneficial in developing/maintaining resilience as some Soldiers were not prepared for the lack of sleep, while others Soldiers, based on past deployments, were not prepared to be bored because they were not performing as many combat missions as in the past. As with sleep hygiene, Soldiers were asked who they thought would be best qualified to address resilience (e.g., medics, officers, NCOs, medical providers). Again, answers were varied and sometimes more than one answer was given. MRTs, Medics, NCOs, and individual Soldiers were identified as those who would be best qualified to provide guidance on this topic with MRTs and NCOs being the primary answers given.

8.2.3.3 Future Training Modules

Topics of the proposed training modules focused on several aspects addressed in the focus group sessions to include: work (e.g., work conflict, and transitioning to a garrison environment), health and well-being (e.g., sleep and anger management, adapting to physical stress, grief, and helping buddies manage stress), and family (e.g., communication, parenting and strengthening relationships) (See Table 8.2). The numbers in each column represent the number and percentage of focus groups that indicated how helpful they thought the training would be on the scale listed below (i.e., low, medium, and high). Occasionally not everyone in

the group agreed with the rating so the majority vote is included. For example, if 5 of 6 members in a given group thought the level of helpfulness was high, then the overall group rating given was high. Generally, each individual within the group was in strong agreement about the ratings given to each module. Everyone was asked to provide a rating. In the one case where a split group decision emerged for the “managing work conflict on deployment” module (4 for low and 4 for medium in one group), the answer was recorded as low since it is reflective of the majority decision across groups. Soldiers were also asked if there were other training modules needed, and if yes, what those modules should be.

Training related to managing anger, coping with grief, and parenting was consistently rated as being highly helpful, if provided in the proper context. Specifically Soldiers indicated that a small group setting in which the training is tailored to the specific needs of the Soldier, the leader and the family would be of most benefit. However, Soldiers thought that modules related to managing work conflict and helping buddies handle stress would be the least helpful while other training modules tended to be split among the three categories. Soldiers also indicated that at times, certain modules would be less helpful for them but more helpful for their spouses or their leaders. For example, Soldiers indicated that they thought their spouses could benefit more from training on modules such as communications and maintaining strong relationships back home. They also thought that in some cases leaders might benefit more from modules related to managing anger and work conflict than they themselves would.

Regarding additional training, Soldiers stated that modules in the areas of financial planning, understanding and responding to the needs of one’s spouse, officer trust of NCOs, enforcement of training standards, reducing complacency in a war zone, and understanding traumatic brain injury (TBI) would also potentially enhance resilience.

Table 8.2 Resilience Training Modules

| Topic: | Low | | Med | | High | |
|--|-----|----|-----|----|------|----|
| | # | % | # | % | # | % |
| Coping with grief | 4 | 31 | 1 | 7 | 8 | 62 |
| Parenting while deployed | 4 | 31 | 1 | 7 | 8 | 62 |
| Managing anger | 4 | 31 | 2 | 15 | 7 | 54 |
| Maintaining strong relationships back home | 3 | 23 | 4 | 31 | 6 | 46 |
| Managing sleep | 5 | 42 | 2 | 16 | 5 | 42 |
| Addressing stress resulting from transitioning from combat to non-combat | 6 | 50 | 1 | 8 | 5 | 42 |
| Addressing global deployment stress (boredom, lack of privacy, etc.) | 6 | 50 | 2 | 17 | 4 | 33 |
| Sleep management for leaders (for self and those they lead) | 5 | 38 | 4 | 31 | 4 | 31 |
| Managing the constant availability of communications back home | 7 | 54 | 2 | 15 | 4 | 31 |
| Adapting to prolonged physical stress (hyper-arousal) | 5 | 42 | 4 | 33 | 3 | 25 |
| Managing work conflict on deployment | 8 | 62 | 2 | 15 | 3 | 23 |
| Helping Buddies handle stress | 8 | 62 | 3 | 23 | 2 | 15 |

8.3.4 Behavioral Healthcare

Soldiers were asked if they would seek behavioral healthcare if they felt the need and the rationale for their decision. Stigma and leadership support were the two primary reasons given for deciding whether or not to access BH care. Additionally, Soldiers were also asked if they would seek telebehavioral health services which is a confidential, computer-based communication between a Soldier and behavioral health provider, and the rationale for their decision. (See section 16. Behavioral Health Care Assessment for an in-depth discussion of behavioral healthcare services provided to Soldiers while in theater.)

8.3.4.1 Help-Seeking Behaviors

Stigma and barriers to BH care continue to impact Soldiers' decisions to seek help from a behavioral health provider. However, even those Soldiers who stated that they themselves may not seek help were in some cases receptive to the idea, at least for other Soldiers and acknowledged that such care may be of some benefit. In some cases Soldiers who said they would not go to behavioral health stated that they may go voluntarily if they felt they absolutely needed it, but it would be a last resort. They even suggested that it be mandatory for everyone

to have to see BH so that the stigma is alleviated. This may suggest that this is the beginning of a slight cultural shift in thinking based on the Army's extensive efforts to reduce the stigma of seeking behavioral healthcare. Some Soldiers indicated that they and/or their leaders have sought such services, although not everyone felt that their needs were met by the providers. For those Soldiers who were willing to see a provider, this would not be their first option as many indicated that they would talk to their friends or family first. Some Soldiers also indicated that they had sought behavioral healthcare but did not find it to be effective and thus would not pursue again in the future. However, they indicated that they do not fear that seeking help will ruin their careers. Leadership plays a key role in reducing this stigma. If Soldiers knew that their leaders went to behavioral health and were not ostracized or if their leaders discussed the importance of seeking help and encouraged this behavior then Soldiers were more willing to consider this form of healthcare. These Soldiers recognized that behavioral health services would enable them to enhance their health and be more effective in their jobs.

Soldiers who would not seek, or would be far less likely to seek, behavioral healthcare services indicated that receiving any kind of healthcare would be considered a sign of weakness by their peers and leaders and that it would be akin to going to sick call, which is also discouraged. Some Soldiers have heard other Soldiers talk negatively about those who sought help and this further adds to the stigma. They were also concerned that if they did seek services, then they may be pulled from performing certain duties, which would be a further burden on the unit. A few Soldiers were also still concerned about their careers and believed that they would not be promoted. Another concern was that a provider would prescribe medications and that these medications would hinder their functioning and ability to do their jobs. However, this is not to say that Soldiers would not seek help from family, friends or their Chaplains, in whom they feel a greater sense of trust. Trust was a key factor in their decision as they were concerned that what they chose to discuss with a provider would be revealed to leadership.

8.3.4.2 Telebehavioral Health

Many Soldiers were not familiar with the telebehavioral health (TBH) concept; although some indicated that their units participated upon redeployment. This unfamiliarity included a lack of knowledge regarding the means of communication and whether or not the service was even available at their current location. This is consistent with the survey findings in which 66% stated that they did not know if TBH was available. Only five of the focus groups had at least one person who was familiar with the concept.

Differing opinions emerged about whether or not Soldiers would use telebehavioral health services. Soldiers who would use the service indicated that it would be convenient and that it would provide more healthcare options. They also indicated that Soldiers may be more likely to discuss their concerns with someone via this method rather than seeing a provider in-person as it would give them a greater sense of anonymity since the provider would not be someone from their unit and since their buddies would not know that they were receiving care. For those Soldiers who would not use the service, they were concerned about confidentiality and that it may not be available at sites where it is most needed. Soldiers also thought that the conversation may be recorded or leaked on the internet and that leadership may be informed. Additionally, Soldiers indicated that they would prefer to discuss their concerns with someone that they knew and trusted, rather than someone that they never met before. Another reason noted for not seeking this form of care was the impersonal aspect of interacting with someone who is not sitting in the same room and thus Soldiers felt this could not replace the traditional behavioral health format.

8.4 Summary

Results of the focus groups indicate that Soldiers experienced a multitude of stressors that were primarily related to the job itself or the daily hassles associated with everyday life in theater. Leadership concerns, workload, and occupational/job expectations were at the forefront of the stressors listed and were intricately intertwined. Daily hassles were mentioned almost as often, with issues such as living in a garrison environment while in theater, boredom and lack of privacy being hassles that were most problematic for Soldiers. Family-related stressors were mentioned far less often, although they too emerged as important to Soldier well-being. Although these stressors are not new, as noted earlier, the salience of these stressors may differ over time based upon changes in the overall mission (i.e., drawdown of forces and movement towards a supporting role). Work stressors and daily hassles were stressors that resulted in anger directed at both leadership and their fellow Soldiers; however, despite their anger, most Soldiers exercised restraint and did not act on their anger. Sleep was another stressor and issues such as long hours, rotating shifts, shifts with minimum time in between and night shifts contributed to sleep difficulties. Additionally, environmental factors such as room temperatures, and noisy roommates played a significant role in their lack of sleep. A less frequently noted reason for sleep difficulties was self-induced, whether it be from playing video games or chatting with Family back home, which is contrary to some perceptions that this may be a key reason for sleep difficulties. Transitioning back to a garrison environment posed some stress in terms of reintegrating with families and the civilian sector but was not a source of primary concern at the time of the sessions, perhaps because the Soldiers are focused on their current environment.

Efforts to mitigate the negative effects associated with the job may be targeted based on an understanding of what stressors are most likely to occur. Soldiers often indicated that they did not know what to expect or that they were unable to control their circumstances, whether it was a change in their duty description or a change in the length of their tour. Providing information to Soldiers at pre-deployment that explains that the environment will be fluid may help Soldiers to better prepare themselves cognitively to cope with their circumstances. Several coping strategies were utilized to prevent or mitigate stress, with Soldiers overwhelmingly stating that they relied on social support from their buddies to deal with their frustrations. Strategies in the form of reading, going to the gym, playing games and sports were also often cited as methods to reduce stress.

Although several Soldiers indicated that they had an MRT in their unit, several others indicated that they did not know if they had an MRT. Additionally, Soldiers did not always remember if they received training from an MRT or if they received training at all pre-deployment because they were overwhelmed with several PowerPoint briefings during a short period of time. Thus, few were able to speak to the benefits of such training but did note that even if not beneficial for them, others, particularly junior enlisted, could benefit from the program.

Soldiers indicated that they thought coping with grief, parenting while deployed and managing anger were the most important topics to address in comparison to other potential training topics. However, they also noted that some topics such as managing work conflict, maintaining relationships and communications would be important for leaders and spouses. Consideration regarding the timing (e.g., pre-deployment or earlier), composition (e.g., small groups of NCOs or junior enlisted), and method of presentation (e.g., PowerPoint or alternatives to PowerPoint) is needed to maximize the benefit of the resilience resources provided.

Behavioral healthcare providers are an additional resource that may aid in developing resiliency. Although the stigma still exists, Soldiers appeared to be more receptive to receiving such help, if

not for themselves, at least for others. Few were familiar with telebehavioral health and Soldiers had differing views on the potential benefits. Soldiers who liked the concept noted that it would be more anonymous and those who did not like the concept were concerned that their information may not be kept confidential and were concerned that it was impersonal. Leadership, specifically the ability of leaders to advocate for seeking BH care and/or share their personal stories of receiving behavioral healthcare, is a major factor in removing the stigma associated with BH treatment by a healthcare provider.

9. SOLDIER REPORT: DISCUSSION AND RECOMMENDATIONS

9.1 Overview of Findings

Results from J-MHAT 8 Soldier survey and focus groups demonstrate the changing picture of behavioral health (BH) among maneuver unit Soldiers in Afghanistan in 2012. Specifically, the results illustrate that fewer report behavioral health symptoms (acute stress, depression or anxiety) and the rate of medication for BH problems is also down. This is likely due to the changing nature of the combat experiences that Soldiers report and perhaps due to the increased emphasis on resilience in the Army as well as increased BH Provider contact at the Forward Operating Bases (FOBs) and Combat Outposts (COPs). There is also a change in the nature of the deployment (non-combat) concerns Soldiers report. However, this reported change in mission may be related to lower reports of unit morale on the survey as well as frustration expressed in the focus groups about not doing the combat mission the Soldier expected to do. In addition, Soldiers expressed further frustration from working with the Afghan National Army (ANA).

9.1.1 *Well-Being Indices*

Soldiers reported a significant decline in their perceived unit morale relative to 2010. This appears to be associated with the changing nature of the combat mission, transition to a garrison type environment while still in theater, and leadership issues as reported in the Soldier focus groups and indicated in the survey responses. Both survey results and Soldier focus groups reported some concern about lack of sleep, indicating that poor sleep environment and nighttime duties were the primary contributors to the sleep problems.

Although there was a reported decrease in perceived unit morale, maneuver unit Soldiers' mental health is better as evidenced by survey results showing lower rates of screening positive for a mental health problem. Lower acute stress rates are the driving factor for improved mental health. In addition, reported medication use for mental health or combat stress was significantly lower than 2010 (1.8% vs. 3.5%). This rate is also significantly lower than the antidepressant use rate of 4.6% among a demographically comparable civilian sample. The finding of decreased psychological problems may be associated with the changing nature of the combat experience since 2010. In addition, this finding might suggest that although many do not remember the pre-deployment resilience training they received, it may have had a positive impact on the mental health and well-being of Soldiers.

9.1.2 *Sleep Hygiene*

Over 25% of Soldiers report concern about lack of sleep, predominantly due to poor sleep environment and nighttime duties. Interestingly, sleep problems due to stress about their personal lives are reported at a similar rate to sleep problems due to stress related to combat. Also, sleep leadership items were significantly correlated with Soldiers' reports of how combat ready they believed their unit to be. Finally, we found that there were varying degrees in the Soldiers' rates of NCO behaviors related to sleep hygiene. For example, many NCOs (>60%) encouraged Soldiers to get extra sleep before missions but few (~25%) asked Soldiers about their sleeping habits. This shows that there is room for improvement in leader influence on sleep hygiene.

Army Recommendation 1: Incorporate sleep hygiene and discipline into pre-deployment training. Emphasize that small unit leaders are responsible for implementing sleep discipline and mitigating factors that lead to poor sleep environments (In Theater and CONUS).

9.1.3 *Changing Nature of Combat*

A leading risk factor for developing a mental health problem is combat activity. Survey data and focus group reports indicate that overall, the level of reported combat experiences was similar to 2010 but the nature of the experiences changed significantly, with a lower percentage of Soldiers reporting shooting at the enemy and being responsible for the death of an enemy combatant. However, a higher percentage of 2012 Soldiers report that an IED exploded near them. During focus groups, Soldiers reported anger about their changing roles as the mission has evolved from combat operations to working alongside the Afghan National Army (ANA) as the ANA transitions to the primary security force. Although this changing role may cause frustration for Soldiers, it may also be a factor in reducing combat-related mental health problems.

Other positive findings indicate that Soldiers reported less concern about long deployment length, difficulty communicating back home, lack of privacy or personal space, and boring and repetitive work. In 2012 a higher percentage of Soldiers reported concerns about uncertain redeployment date, not having the right equipment or repair parts, and continuous operations. As the drawdown of combat troops in Afghanistan continues and the nature of the combat experience changes even more, it is important to monitor further changes in Soldiers' concerns and frustrations.

Army Recommendation 2: Integrate and evaluate behavioral health based scenario-based training at Army Combat Training Centers CTCs to address operational stress particularly for platoon and company-level leaders.

9.1.4 Behavioral Health Self-Management

There are many reasons that might keep Soldiers from going to BH, even when they need it. Traditional stigma and barriers to receiving BH Care usually focus around concerns with things such as being seen as weak or not getting time off for treatment. However, we found that there may be other reasons that Soldiers do not seek BH services. These may be related to what we are calling Behavioral Health Self-Management. That is, Soldiers endorsed these types of beliefs on the survey by agreeing to statements such as "I know how to help myself" and "strong people can resolve psychological problems by themselves." We believe that this possible line of reasoning of why Soldiers don't get BH help is worth exploring as it may help guide how we train Soldiers and how we offer them BH help.

Army Recommendation 3: Conduct research to explore behavioral health self-management-the belief that SMs may be able to handle mental health problems on their own.

9.1.5 Protective Factors: Unit Climate, Leadership and Resilience Training

Strong leadership and cohesive small-units are a protective factor against low morale.

Soldiers in 2012 rate platoon-level officers significantly lower than Soldiers in 2010, and although there was no significant change in Non-Commissioned Officer (NCO) leadership survey ratings, focus groups reported dissatisfaction with both NCO and officer leadership.

Indices for BH stigma were unchanged relative to 2010. However, for those individuals who reported mental health symptoms, BH stigma was higher (sometimes double) than for those who reported no mental health symptoms. This is an important finding in that those who may need help the most are those who might be most reluctant to seek it. Additional survey findings indicate that Soldiers report believing that 1) they can resolve psychological problems by themselves and 2) strong people can resolve psychological problems by themselves. However, this is a new survey question and there is no referent group to compare response rates.

Regarding resilience training, most Soldiers report receiving training in managing the stress of deployment/combat but few remember if it was the mandatory Pre-Deployment Resilience Training. Although Soldiers report fewer psychological symptoms and reduced medication for BH problems, they rated training adequacy for managing stress significantly lower than in 2010. This finding may indicate that the training does not address the issues the Soldiers are currently facing or that Soldiers are already managing stress effectively and find the training less than useful. Another possibility is that Soldiers were so inundated with pre-deployment training that they were overwhelmed with PowerPoint briefings to the extent that they were unhappy with pre-deployment training in general.

Army Recommendation 4: Increase effective implementation of Comprehensive Soldier and Family Fitness (CSF2) Master Resilience Trainer (MRT) Resilience Training to help Soldiers deal with operational stress.

Army Recommendation 5: Refine Pre-Deployment Resilience Training to focus on operational (non-combat) stress, interpersonal conflict, and relationship issues for Soldiers and junior (company-grade) leaders.

Army Recommendation 6: Refine Post-Deployment Resilience Training to include a focus on the transition to a garrison environment with garrison leadership and discipline for active component Soldiers. Tailor training for reserve component (RC) Soldiers to target RC-specific issues such as possible job loss or unemployment.

Army Recommendation 7: Continue to evaluate CONUS-based and in-theater resilience training (e.g. MRT, Resilience Campus concept) programs and endorse evidence-based training.

10. MARINE REPORT: SAMPLE CHARACTERISTICS

To ensure comparability across years, only J-MHAT 7 (2010) and J-MHAT 8 (2012) samples of OEF Marines directly engaged in combat activities in Afghanistan were selected for analyses. Table 10.1 provides details on selected demographic variables for the J-MHAT 7 (2010) and J-MHAT 8 (2012) Marine maneuver unit random cluster-based samples. The two samples differ on several key demographic variables. Specifically, the J-MHAT 8 Marine sample has fewer junior enlisted Marines but more NCOs than the J-MHAT 7 sample. The J-MHAT 8 sample also has more first time deployers, but they report less dwell time than members of the J-MHAT 7 sample. Finally, Marines in the J-MHAT 8 sample report fewer days outside the Forward Operating Base (FOB). Differences in time spent in theater and rank are controlled statistically in subsequent analyses to normalize the data.

Table 10.1: J-MHAT 7 (2010) to J-MHAT 8 (2012) Marine Sample Characteristics

| Demographic Variable | | J-MHAT 7 (2010) | | J-MHAT 8 (2012) | |
|--|------------------------|-----------------|---------|-----------------|---------|
| | | n | Percent | n | Percent |
| Age | 18-24 | 272 | 81.2% | 166 | 78.3% |
| | 25-29 | 55 | 16.4% | 41 | 19.3% |
| | 30-39 | 7 | 2.1% | 4 | 1.9% |
| | 39+ | 0 | 0.0% | 0 | 0.0% |
| | Unknown | 1 | 0.3% | 1 | 0.5% |
| Rank** | E1-E3 | 234 | 69.9% | 127 | 59.9% |
| | NCO | 93 | 27.8% | 77 | 36.3% |
| | Officer / WO | 7 | 2.1% | 4 | 1.9% |
| | Unknown | 1 | 0.3% | 4 | 1.9% |
| *E1-E3 are junior enlisted, E4-E9 are NCOs for Marines | | | | | |
| Component | Active | 332 | 99.1% | 212 | 100.0% |
| | Reserve | 1 | 0.3% | 0 | 0.0% |
| | Unknown/Other | 2 | 0.6% | 0 | 0.0% |
| Marital Status | Single | 209 | 62.4% | 134 | 63.2% |
| | Married | 86 | 25.7% | 65 | 30.7% |
| | Divorced | 5 | 1.5% | 2 | 0.9% |
| | Unknown/Widowed | 35 | 10.4% | 11 | 5.2% |
| Deployment History* | First Time | 197 | 58.8% | 164 | 77.4% |
| | Second Time | 99 | 29.6% | 32 | 15.1% |
| | Third or More | 39 | 11.6% | 16 | 7.5% |
| Dwell-Time* | Less than 12 Months | 8 | 2.4% | 47 | 22.2% |
| | 12 to 24 Months | 120 | 36.1% | 55 | 25.9% |
| | More than 24 Months | 17 | 5.1% | 11 | 5.2% |
| | 1st Deployment/Unknown | 187 | 56.3% | 99 | 46.7% |
| Time in Theater | 6 Months or Less | 323 | 96.4% | 205 | 96.7% |
| | 7 to 12 Months | 0 | 0.0% | 0 | 0.0% |
| | More than 12 Months | 1 | 0.3% | 0 | 0.0% |
| | Unknown | 11 | 3.3% | 7 | 3.3% |
| Days Outside FOB* | 15 or less | 68 | 20.3% | 134 | 63.2% |
| | More than 15 | 253 | 75.5% | 59 | 27.8% |
| | Unknown | 14 | 4.2% | 19 | 9.0% |

* Significantly Differed Across Years

11. MARINE REPORT: WELL-BEING INDICES

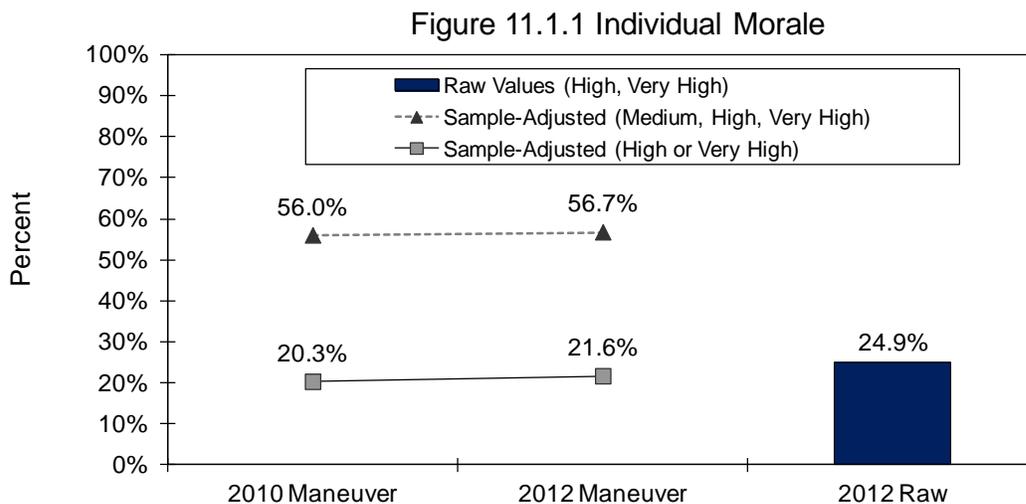
Behavioral health indices provide an overview of the well-being of the deployed force. This section reviews a variety of measures assessed with Marines during J-MHAT 8 OEF (2012) and compares them to the previous Marine J-MHAT 7 OEF 2010 data. The standard graph used in this section provides:

1. Across-year comparisons represent sample-adjusted maneuver unit values for J-MHAT 7 and J-MHAT 8. Values are adjusted for rank and time in theater, and describe male, E1-E3 (junior enlisted) Marines in theater for 4.5 months. Values that significantly differ from J-MHAT 8 values are underlined.
2. Raw 2012 values include responses from all maneuver unit survey participants, including NCOs and Officers. Thus, raw 2012 values sometimes differ from sample-adjusted maneuver unit values, which reflect only responses from male, E1-E3 Marines, as described above.

11.1 Morale

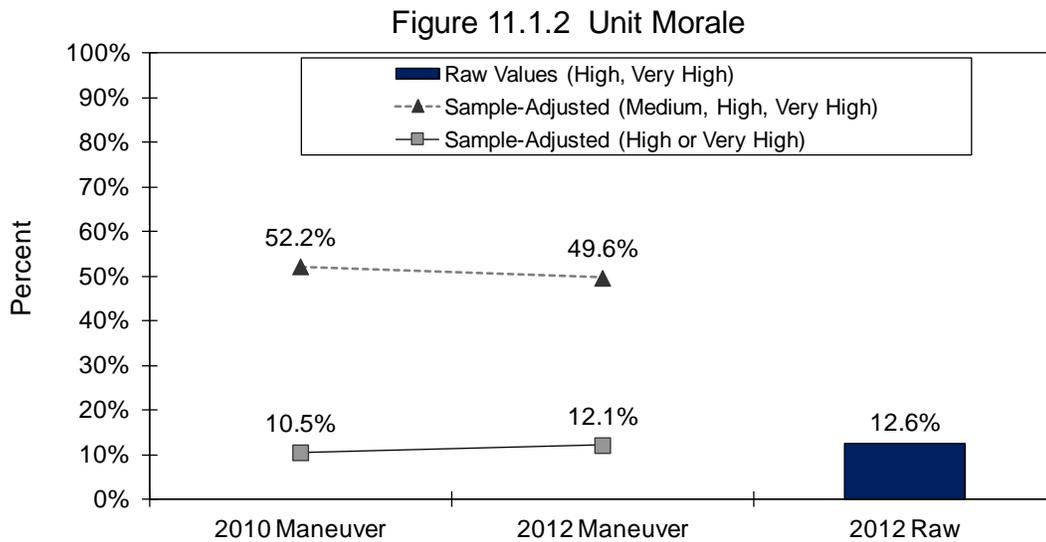
11.1.1 Individual Morale

Figure 11.1.1 provides the sample-adjusted percent of E1-E3 Marines in theater for 4.5 months who reported high or very high individual morale (line with squares on the end) and the percent who reported **medium**, high or very high morale (line with triangles on the end). The percent of 2012 Marines reporting high or very high morale and those reporting **medium**, high or very high is not significantly different from 2010. In the figure, notice that the raw value (24.9%) for high or very high individual morale in 2012 is slightly higher than the 2012 sample-adjusted value (21.6%). This occurs because the raw value also includes NCOs and Officers who typically report higher morale than junior enlisted personnel.



11.1.2 Unit Morale

The sample-adjusted percent of Marines who rate unit morale high or very high (squares on the end) and percent reporting **medium**, high, or very high unit morale in 2012 compared to 2010 (triangles on the end) are presented in Figure 11.1.2. The values for Marine unit morale in 2012 are similar to 2010.



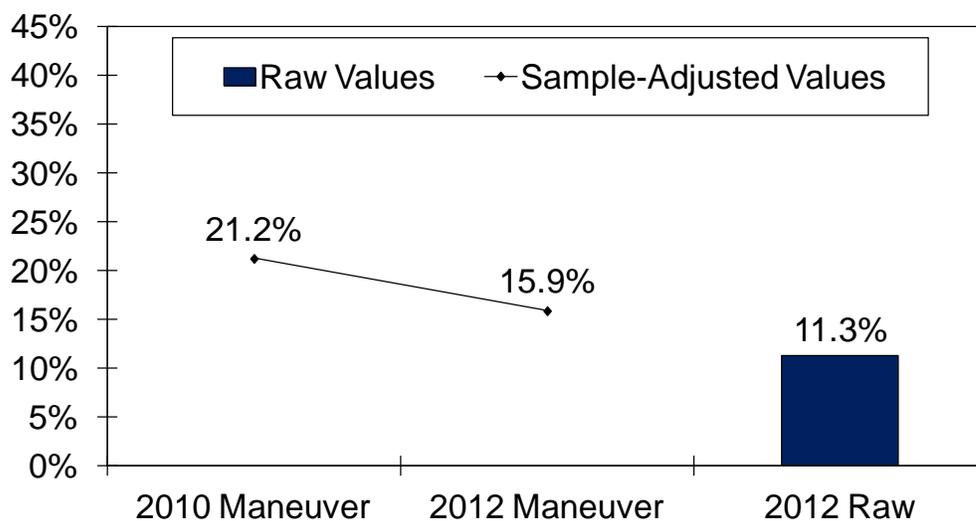
11.2 Behavioral Health: Acute Stress, Depression and Anxiety

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

11.2.1 Behavioral Health: Any Psychological Problem

The combined rating of any psychological problem (acute stress, depression or anxiety) is presented in Figure 11.2.1. The percent of Marines reporting one or more psychological problems in 2012 is trending toward fewer reported problems, but it is not significantly different than in 2010.

Figure 11.2.1 Any Psychological Problem
(Acute Stress, Depression, Anxiety)



11.2.2 Acute Stress, Depression and Anxiety

The specific values for acute stress, depression, and generalized anxiety are provided in Table 11.2.2. All J-MHAT 8 (2012) Marine rates (acute stress, depression, and generalized anxiety) are also trending toward not significantly different than J-MHAT 7 (2010).

| Mental Health Indicator | Sample Adjusted Values | | Raw Value |
|---------------------------|------------------------|------------------|------------------|
| | J-MHAT 7 2010 | J-MHAT 8 2012 | J-MHAT 8 2012 |
| Any Mental Health Problem | 21.2% | 15.9% | 11.3% |
| Acute Stress | 18.8% | 15.1% | 10.9% |
| Depression | 4.4% | 3.9% | 2.4% |
| Anxiety | 5.2% | 3.0% | 1.9% |

11.3 Anger

Marines' ratings of anger are reflected in several questions about anger directed towards others in the unit. The percent of Marines who report (a) shouting or yelling at others, (b) breaking inanimate objects, (c) threatening others with violence, and (d) getting into physical altercations at least once over the past 30 days is presented in Table 11.3.1. Compared to 2010, a greater percentage of Marines in the 2012 J-MHAT 8 sample report threatening someone in their unit. All other measures of anger, whether verbal, or reports of actual violence directed toward objects (e.g. door, wall) or other unit members are not significantly different.

Table 11.3.1: Raw Values and Sample-Adjusted Percents for Male, E1-E3 Marines in Theater 4.5 Months

| Survey Item | J-MHAT 7 | | Raw Value |
|--|--------------|----------|-----------|
| | OEF 2010 | OEF 2012 | OEF 2012 |
| Get angry at someone in your unit and yell or shout at them | 80.4% | 77.1% | 77.6% |
| Get angry with someone in your unit and kick or smash something, slam the door, punch the wall, etc. | 47.5% | 45.3% | 42.9% |
| Threaten someone in your unit with physical violence | <u>40.1%</u> | 50.6% | 47.6% |
| Get into a fight with someone in your unit and hit the person | 17.4% | 19.4% | 17.6% |

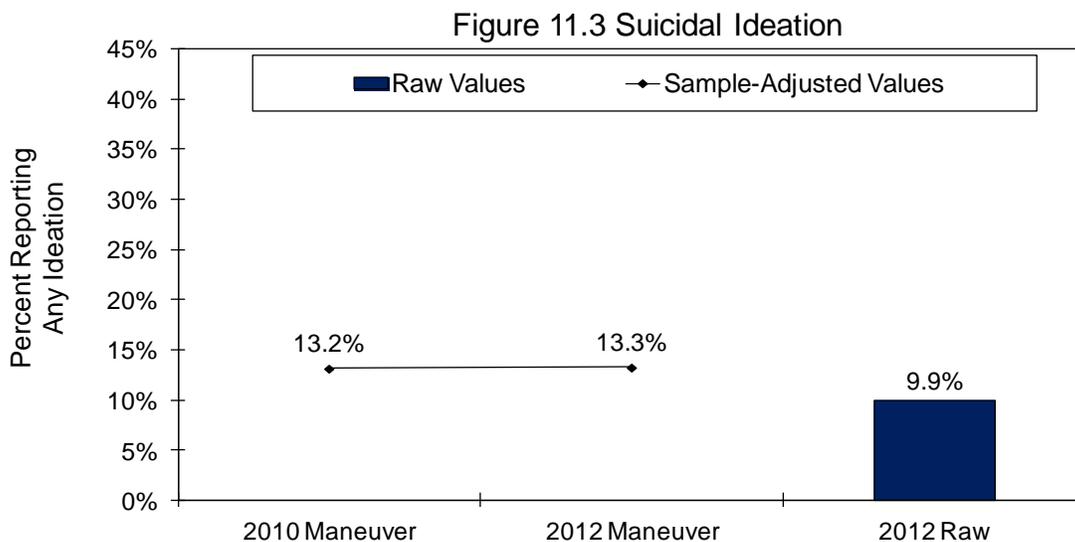
The J-MHAT 8 added additional anger questions focused on self-perceptions of temper, what SMs do when angry, anger control and if anger was seen as helping SMs perform their duties. Forty percent (40%) of Marines said they keep their anger bottled up inside when they are angry; 23.5% said they had a fiery temper. Table 11.4.2 shows that Marines report consistently in terms of their self assessment of their ability to control their anger and their anger behaviors. For example, approximately 100% of Soldiers who said they have poor/very poor control of their anger reported they got angry at someone in their unit and yelled/shouted at them in the last month compared to 57.7% of those who said they had high/very high control. Likewise, those who reported they had very poor/poor control of their temper were more likely to report they got into a fight and hit a person compared to those who said they had high/very high control (28.6% vs. 1.4%). This may mean that the best way to determine who is likely to act on their anger is to ask Marines if they have control over their anger.

Table 11.3.2 Raw Percentages for J-MHAT 8 Anger Items by Anger Control

| Survey Item | Very poor or poor control | Moderate control | High or very high control |
|--|---------------------------|------------------|---------------------------|
| Get angry at someone in your unit and yell or shout at them | 100.0% | 77.1% | 57.7% |
| Get angry with someone in your unit and kick or smash something, slam the door, punch the wall, etc. | 85.7% | 51.4% | 16.9% |
| Threaten someone in your unit with physical violence | 71.4% | 60.0% | 16.9% |
| Get into a fight with someone in your unit and hit the person | 28.6% | 28.6% | 1.4% |

11.4 Suicidal Ideation

Suicidal ideation is assessed using a single depression item on the J-MHAT 8 survey. This item (item 9 of the PHQ-D) asks Marines if they have been bothered by thoughts that they would be better off dead, or of hurting themselves in some way over the last four weeks. For the purposes of this report, any response other than “Not at all” was considered a positive response. Figure 11.3 shows that rates of suicidal ideation remain fairly constant across J-MHAT 7 and J-MHAT 8 Marine samples.



11.5 Pain Medications

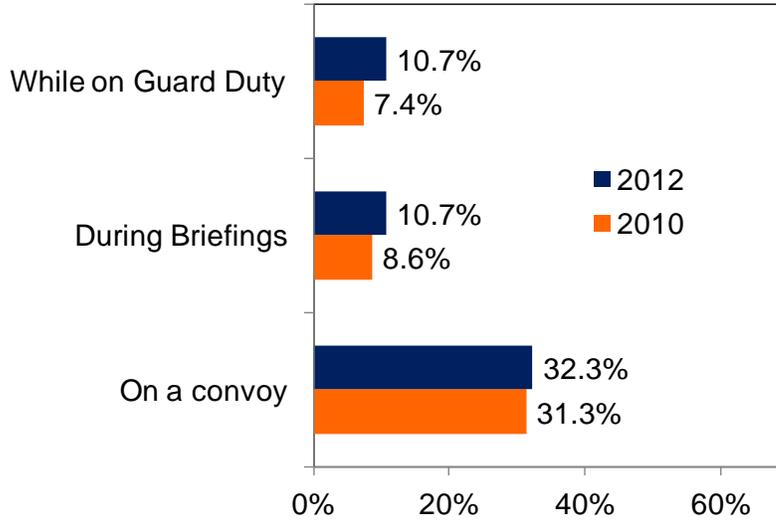
The J-MHAT 8 assessed Marines' use of pain medications using a chronic pain module developed by the Centers for Disease Control (CDC) that was added to the 2007 Kansas Behavioral Risk Factor Surveillance System. In total, 194 Marines provided responses to the question with 25.8% (n=50) reporting chronic pain. This is significantly less than the 36% of Marines in 2010 who reported having chronic pain. The vast majority of 2012 Marines who reported chronic pain either took no medications (62%) or took over-the-counter drugs (28%). However, only 6% (n=3) of the respondents in chronic pain reported taking prescription pain medication, with 2 of the 3 reporting that the medication was prescribed in theater.

As a point of reference, in a subsample of 180 randomly selected employed men between the ages of 18-34 with health insurance in the state of Kansas (Toblin, et al., 2012), 15.0% reported chronic pain. Of those with chronic pain, 48.1% were taking an over-the-counter or prescription medication, and 14.8% reported taking a prescription medication. With this as a referent group, it is clear that the reported rates of chronic pain are higher in the Marine Corps sample (25.8% versus 15%, respectively); however, rates of prescription pain medication use among those taking medications for chronic pain is lower in the Marine Corps than in the random sample of men from Kansas (6% versus 14.8%, respectively).

11.6 Sleep

Overall, a lower rate (28.8%) of 2012 Marines surveyed report having sleep problems compared to 2010 (38.5%). Consistent with this finding, significantly more 2012 Marines (24.6%) report getting more than 7 hours of sleep per day compared to Marines in 2010 (14.7%) even though a similar percentage (2012 - 48.7% vs. 2010 - 42.7%) report needing 7 or more hours sleep per day to feel well-rested. Of those 2012 Marines who do report sleep concerns, 27.2% reported that they were having problems falling asleep at night and 22.6% that they had trouble staying asleep at night more than half of the past month. Additionally, 24.9% had problems staying asleep during the day following night operations more than half of the past month. Finally, 26.3% of Soldiers report having high or very high concern that they are not getting enough sleep. As can be seen in Figure 11.6, approximately 10% of 2012 Marines report falling asleep during briefings and nearly a third during convoys. Finally, 4.3% of Marines surveyed in 2012 and 6.3% in 2010 reported making a mistake or having an accident due to sleepiness. These findings suggest that there are sleep problems in theater and leads to the question of what causes these sleep disturbances.

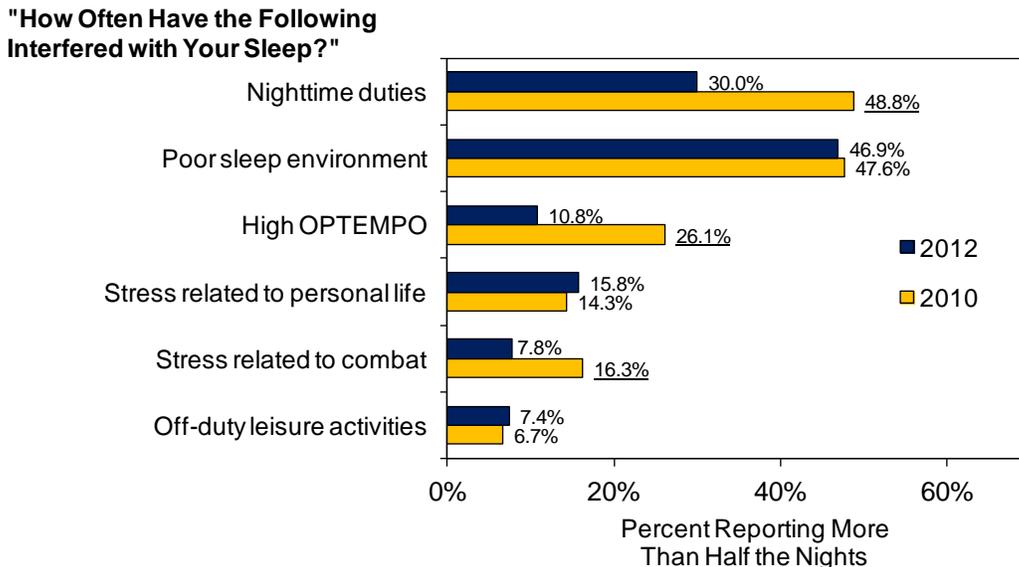
Figure 11.6 Places Marines Fall Asleep
 “How often during this deployment, did you (even briefly) fall asleep during the following:



11.6.1 Factors Impacting Sleep

Figure 11.6.1 presents the adjusted value percent of Marines who reported that their sleep has been disturbed or interfered more than half of the last 30 nights by (a) stress related to combat, (b) stress related to personal life and problems, (c) a poor sleep environment (too noisy, bright, hot, cold), (d) high OPTEMPO, (e) nighttime duties and (f) off-duty leisure activities (video games, movies, etc.). Notice the high percent of Marines who report that their sleep is disturbed by the poor sleep environment and nighttime duties. J-MHAT 8 is the second time that questions about sleep disturbance were asked. Of note, 2010 Marines’ reports of not getting enough sleep due to night time duties and High OPTEMPO are significantly lower than in 2010.

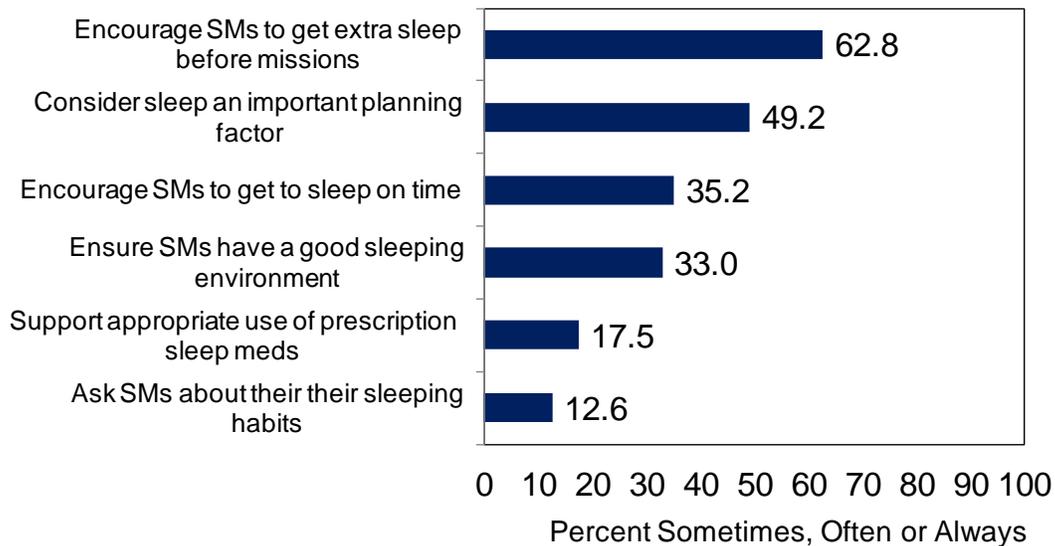
Figure 11.6.1 Reasons for Sleep Problems During Last Month



11.6.2 Leadership and Sleep

Previous MHATs have shown the influence that non-commissioned officer (NCO) leadership can have on Service Member well-being. To further explore this, J-MHAT 8 asked a series of questions to assess the influence of NCO leadership on sleep hygiene. Just over 60% of Marines report that NCOs “sometimes, often or always” encourage SMs to get extra sleep before missions that require long hours. Approximately 18% Soldiers say that NCOs “sometimes, often or always” support the appropriate use of prescription sleep medications (like Ambien) when SMs need help with sleeping.

Figure 11.6.2.NCO support of sleep hygiene



In addition, we assessed whether sleep leadership was related to combat readiness. Combat readiness was measured with a 3-item scale in which Soldiers were asked whether they agreed with the statements “I think my platoon would do/did an excellent job in combat”, “I think the level of training in my platoon is high”, and “I have real confidence in my platoon’s ability to perform its mission.” Results show that sleep leadership items were significantly correlated with Marines’ reports of how combat ready they believed their unit to be. For example, as seen in Table 11.6.2., when leaders “encouraged SMs to get extra sleep before missions” or “consider sleep an important planning factor”, Marines’ reports of combat readiness were higher.

| NCO Sleep Behavior | Combat Readiness |
|--|------------------|
| Encourage SMs to get extra sleep before missions | 0.32** |
| Consider sleep an important planning factor | 0.28** |
| Ensure SMs have a good sleeping environment | 0.26** |
| Encourage SMs to get adequate sleep | 0.24** |
| Encourage Service Members to nap when possible | 0.21** |
| Encourage SMs to get to sleep on time | 0.16** |
| Discourage the use of caffeine or nicotine use within several hours before trying to go to sleep | 0.15* |

* Significant $p < .05$, ** $p < .01$

11.7 Medications for Sleep and Mental Health Problems

In J-MHAT 8 (2010), respondents were asked (1) “Have you taken any medication for a sleep problem during this deployment?” and (2) “Have you taken any medication for a mental health or combat stress problem during this deployment?” In all, 11.2% of Marines in the 2012 sample and 7.1% of the 2010 sample reported taking medications for sleep problems. Only 1.5% of the Marines in the 2012 sample, compared to 1.6% in 2010, reported taking medication for a mental health or combat stress problem.

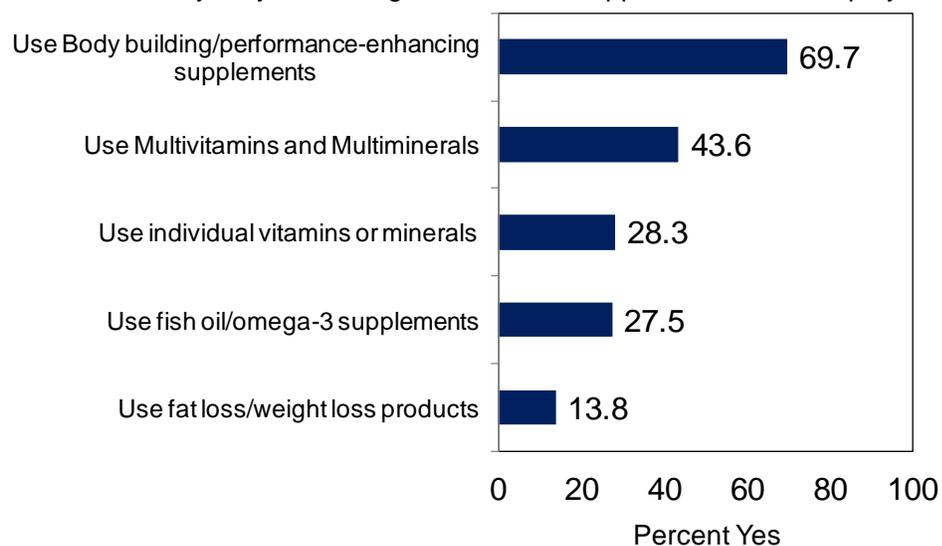
As a point of reference, in interpreting the use of medications for mental health or combat stress, Olfson and Marcus (2009) report rates of antidepressant medication use from nationally representative probability samples collected in 1996 and 2005. Based on these data, the rate of antidepressant use for (a) 21-34 year old (b) males who were (c) employed with (d) health insurance was 2.28% in 1996 and 4.59% in 2005. Clearly the rate of 1.5% reported by Marines in 2012 is below the national estimates for this demographic group.

11.8 Nutritional Supplements

For the first time, J-MHAT 8 asked questions about dietary supplement use in theater. Since J-MHAT 8 was the first year this set of questions was asked, we cannot make comparisons across years. Seventy-nine percent of Marines report taking some kind of nutritional supplements when deployed. Almost 60% (57.9%) of Marines report using body building/performance-enhancing supplements; and 16.4% reported taking fat loss/weight loss products. Additionally, the majority of Marines (56.8%) reported that their use of dietary supplements did not change during the deployment; 9.1% reported decreased use of nutritional supplements; and 18.1% reported increased use of nutritional supplements during the deployment.

Figure 11.8 Nutritional Supplements

79% of Marines say they are taking some kind of supplements when deployed



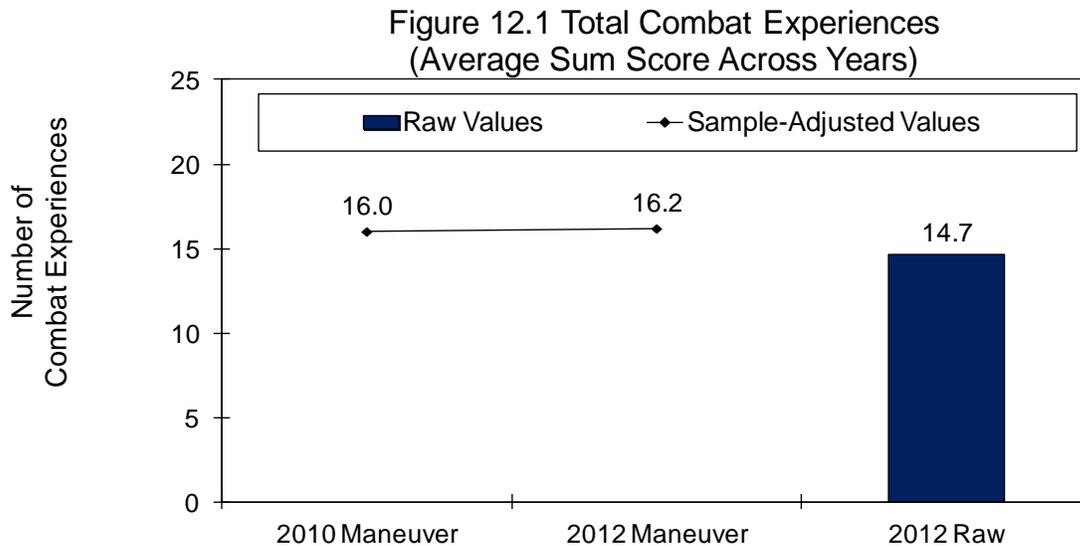
12. MARINE REPORT: RISK FACTORS

As noted in the conceptual model (section 3), service member risk factors may be placed into four broad categories: combat-related risk factors, relationship problems, OPTEMPO-related risk factors, and deployment concerns. Changes in behavioral health indices are presumably associated with changes in these four categories of risk factors.

12.1 Combat Experiences

Exposure to potentially traumatic experiences is one of the principal risk factors for behavioral health problems in combat settings (Fontana & Rosenheck, 1998). Thirty combat experience items have been consistently assessed across MHATs. A combat experience score indicating whether the Marine experienced the item at least once provides an efficient way to summarize changes in combat experiences across years.

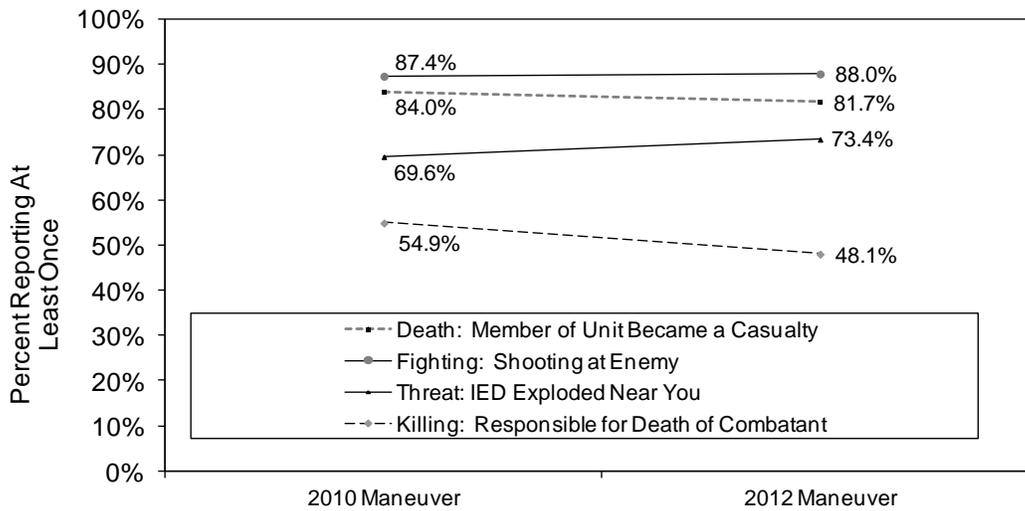
Figure 12.1 provides a comparison of the sample-adjusted mean number of combat experiences from 2010 and 2012. The levels of combat experiences reported by Marines in 2012 are similar to those reported in 2010.



Researchers such as Fontana and Rosenheck (1998) suggest that it is useful to categorize combat experiences into demand-related dimensions: Fighting, Killing, Threat to Oneself, Death/Injury of Others, and Atrocities. Wilk et al. (2010) show that combat items such as those asked in the MHAT survey can be reliably categorized into the five dimensions and that these dimensions are useful in terms of predicting behavioral health outcomes.

The 30 items assessed in the J-MHAT 8 survey can be categorized into four of the five demand-related dimensions (Atrocities are not assessed). Figure 12.1.1 provides a representative item from each of the four dimensions across time. Analyses showed that the rates reported in 2012 are not significantly different than the rates reported in 2010.

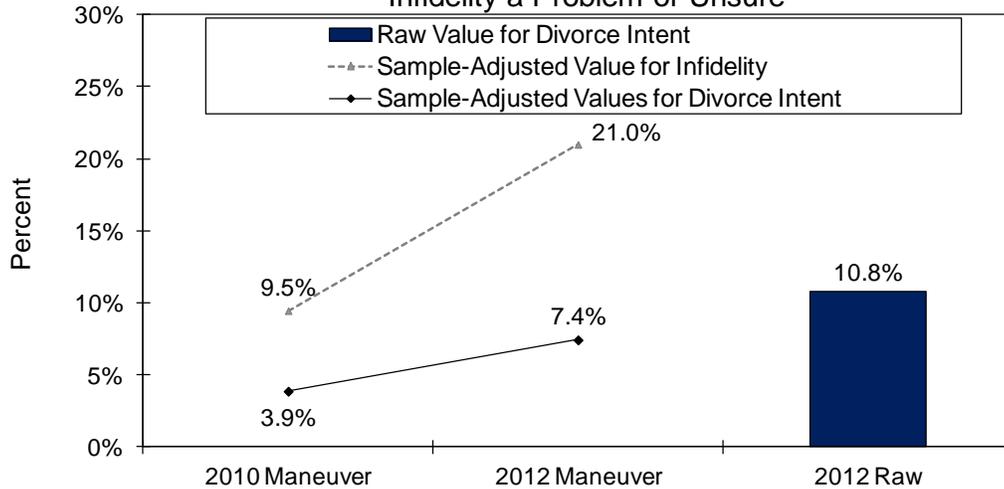
Figure 12.1.1 Representative Combat Experiences



12.2 Relationship Problems

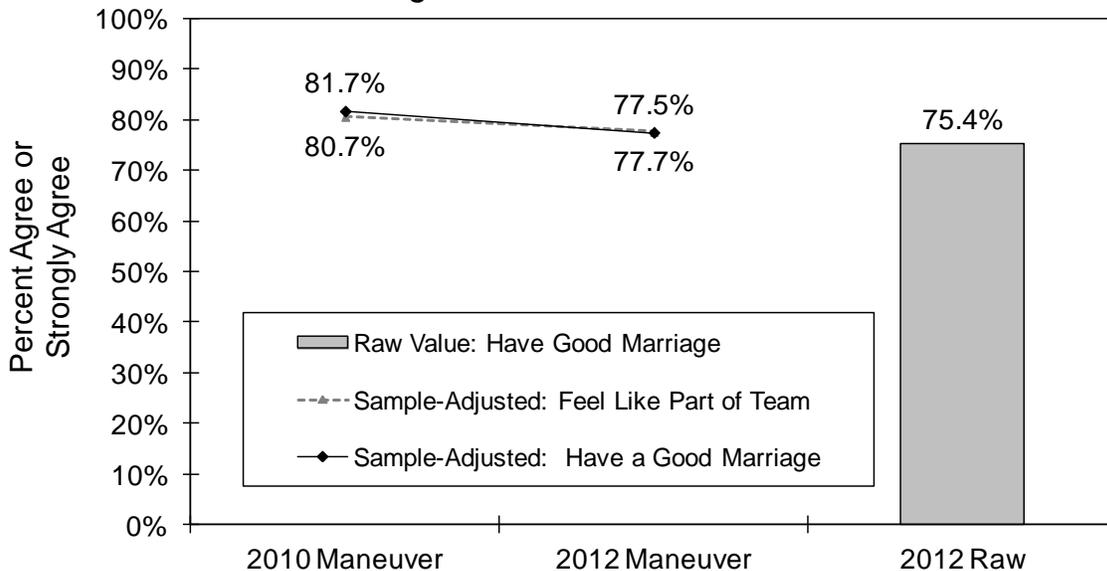
Relationship problems with spouses comprise a second major risk factor for a variety of behavioral health issues. Two straight-forward indices of relationship problems are (a) the percent of married Marines that are considering a divorce or separation and (b) the percent of Marines that endorse “yes” or “unsure” to the question of whether infidelity is a problem in their marriage. Figure 12.2 shows that the number of Marines planning divorce or separation in 2012 is higher, but due to the small number (n=65) of married Marines in the sample, the difference is not significantly different than in 2010 (n=86). Likewise, concerns about infidelity are not significantly different in Marines in the J-MHAT 8 sample than Marines surveyed in J-MHAT 7. Note that the small sample sizes of married Marines makes these estimates less stable than estimates based on larger sample sizes, so the values may fluctuate considerably across years.

Figure 12.2 Planning Divorce / Separation
Infidelity a Problem or Unsure



Intent to divorce or separate and concern about infidelity are more extreme instances of marital relationship problems; consequently, they may not be as sensitive to changes as would less extreme questions about marital relationships. Figure 12.2.1 provides responses to two marital satisfaction questions adapted from Norton (1983): (1) I have a good marriage, and (2) I really feel like a part of a team with my spouse. The figure shows that the percentage of E1-E3 Marines reporting positive marital satisfaction on these two items has not significantly changed from 2010.

Figure 12.2.1 Marital Satisfaction Items



12.3 Deployment Concerns

While combat experiences are intense events that put Marines at risk, other less dramatic, but more chronic concerns can impact behavioral health. MHAT surveys assess a core set of 11 deployment concern items listed in Table 12.3. Notice in the table that five concerns among 2012 Marines are significantly lower than for Marines in 2010. Specifically, in 2012 Marines report significant decreases in difficulties communicating back home, lack of time off for personal time, not getting enough sleep, continuous operations, and long deployment length. These findings are consistent with a maturing theater, the shift in mission focus and deployments being cut short as the number of Marines in theater was being drawn down during the time the J-MHAT 8 was in theater.

Table 12.3: Adjusted Percents for E1-E3 Marines in Theater 4.5 Months.

| Trouble or Concern Caused By | Percent rating High or Very High Trouble or Concern | |
|---|---|-------------------|
| | J-MHAT 7 OEF 2010 | J-MHAT 8 OEF 2012 |
| Being separated from family. | 17.4% | 18.8% |
| Illness or problems back home. | 12.6% | 11.6% |
| Boring and repetitive work. | 31.2% | 37.2% |
| Difficulties communicating back home. | <u>35.6%</u> | 9.4% |
| Uncertain redeployment date. | 16.6% | 12.5% |
| Lack of privacy or personal space. | 29.5% | 33.0% |
| Lack of time off, for personal time. | <u>34.4%</u> | 23.7% |
| Not having the right equipment or repair parts. | 25.2% | 25.6% |
| Not getting enough sleep. | <u>39.8%</u> | 26.3% |
| Continuous operations. | <u>37.2%</u> | 27.9% |
| Long deployment length. | <u>22.0%</u> | 10.8% |

13. MARINE REPORT: RESILIENCE FACTORS

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

13.1 Unit Factors

Unit factors such as small-unit leadership (NCO and Officer), cohesion, and readiness are directly related to unit well-being, and often play a role in attenuating the link between deployment stressors and behavioral health outcomes (e.g., Bliese & Castro, 2003; Bliese, 2006). In other words, under demanding circumstances such as high levels of combat, effective leadership can serve as a protective or buffering influence that reduces the amount of acute stress Soldiers report (MHAT VI, OIF Report). Attenuating or buffering effects have been detected in MHAT reports with sample sizes well over 1,000 (MHAT V and MHAT VI from OIF), but are difficult to detect in smaller sample sizes (<1000) because effect sizes associated with interactions tend to be small. Given this background, it is not surprising that no interactive effects were observed between unit factors and risk factors such as combat experiences in the 2012 survey with Marines. Even without these interactive effects, however, it is valuable to examine if ratings of these core unit factors vary across years.

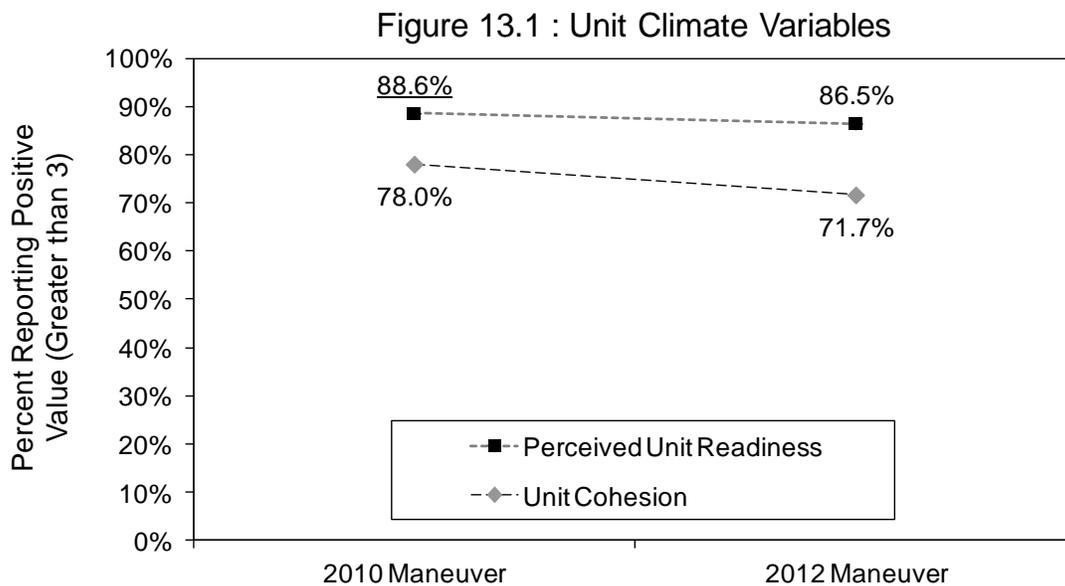
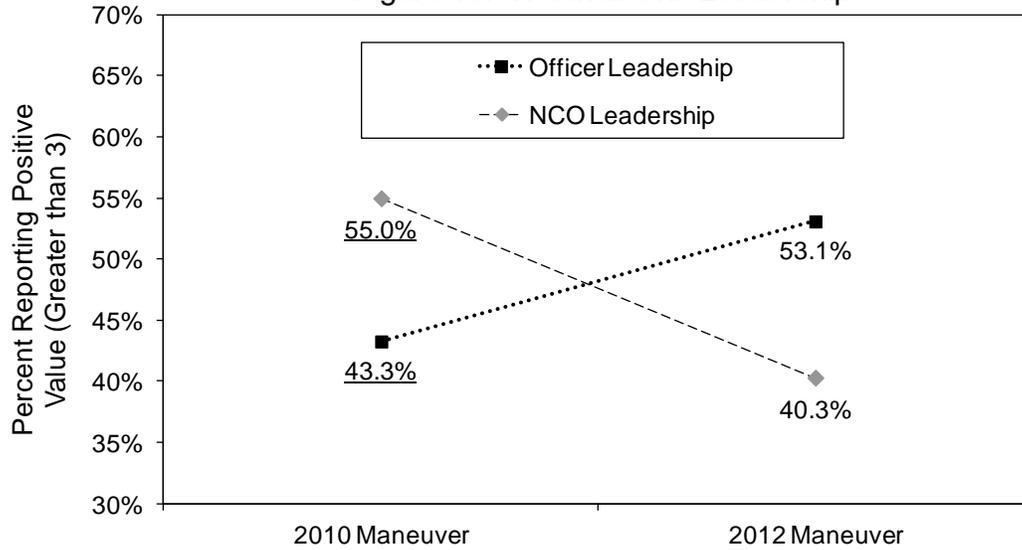


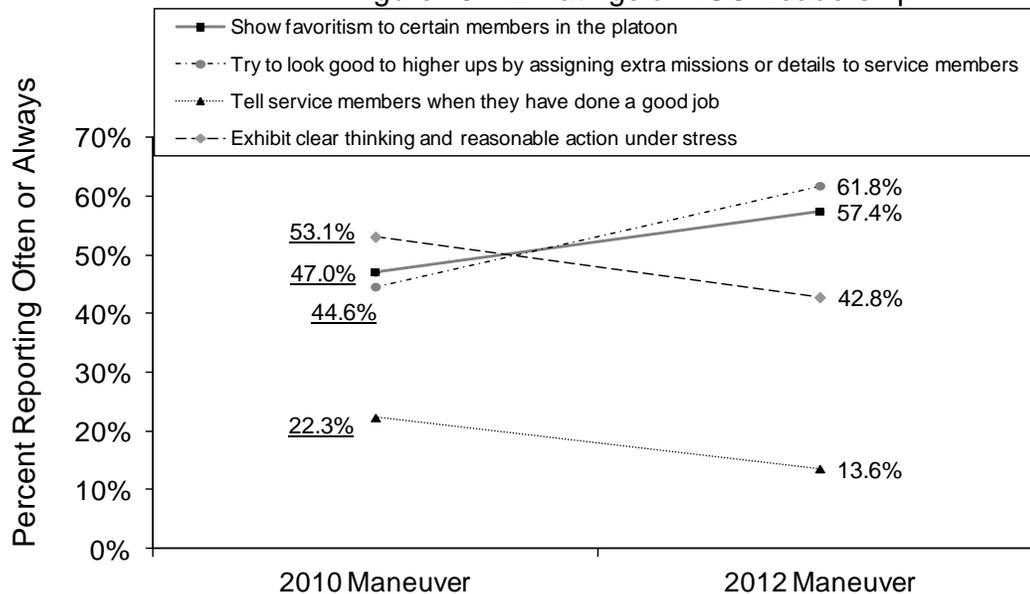
Figure 13.1 shows that Marines' 2012 adjusted value ratings of Perceived Unit Readiness and Unit Cohesion are similar to those of Marines in 2010.

Figure 13.1.1 Small Unit Leadership



Marines' 2012 ratings of Officer Leadership are significantly higher than ratings obtained in 2010. However, ratings in 2012 for all dimensions of NCO leadership are lower than 2010. Figure 13.1.2 shows the adjusted value individual items that make up the NCO leadership scale. As can be seen, the junior enlisted Marines ratings of the two positive NCO leadership behaviors (telling SMs when they have done a good job and exhibiting clear thinking and reasonable action under stress) are significantly lower in 2012 compared to 2010. Conversely, the two negative NCO leadership behaviors (showing favoritism to certain members in the platoon and trying to look good to higher ups by assigning extra missions or details) are significantly higher in 2012 compared to 2010.

Figure 13.1.2 Ratings of NCO Leadership



13.2 Stigma and Barriers to Receiving BH Care

At an organizational level, one way to enhance resilience is to encourage Soldiers to seek BH care before problems escalate. Stigma and organizational barriers to receiving BH care may prevent Soldiers from getting needed help. From this perspective, low levels of stigma could be considered a protective or resilience factor. A key contributor to seeking BH care is overcoming the stigma associated with behavioral healthcare. Importantly, one of the challenges is that stigma is strongest among individuals who screen positive for psychological problems (Hoge, et al., 2004). For example, nearly 55% of J-MHAT 8 Marines who screened positive said that it would be too embarrassing compared to almost 14% of J-MHAT 8 Marines who did not screen positive. Therefore, when looking at changes in rates of perceived stigma, it is informative to examine those who screen positive for psychological problems.

Table 13.2 provides across-year adjusted rates for both Marines meeting and Marines not meeting the criteria for a psychological problem across the six stigma related questions. J-MHAT 8 values that have one underlined value indicate a significant interaction while those with two J-MHAT 8 values underlined indicate a main effect. For example, one interaction is a significantly higher percent (52.4%) of J-MHAT 8 Marines who screened positive for a BH problem reported that they were concerned their unit leadership might treat them differently compared to J-MHAT 7 Marines who screened positive (28.3%). An example of a main effect is that significantly higher percent of J-MHAT 8 Marines who screened positive **AND** J-MHAT 8 Marines who did not screen positive reported that they had concerns that members of their unit might have less confidence in them compared to J-MHAT 7 Marines who screened positive **AND** J-MHAT 8 Marines who did not screen positive (53.9% vs. 29.8% and 27.1% vs. 20.3% respectively). Specifically, the items “It would be too embarrassing” and “My unit leadership might treat me differently were both higher for J-MHAT 8 Marines only if they screened positive. Conversely, the rates of stigma related to “members might have less confidence in me” and “I would be seen as weak” were higher for J-MHAT 8 Marines compared to J-MHAT 7 Marines whether they screened positive or not.

J-MHAT 8 (2012) stigma to receiving BH care in the across-year maneuver sample showed an increase relative to J-MHAT 7 (2010). All stigma items were higher in 2012 compared to 2010, for Marines who screened positive for a BH problem and there was a main effect for two items “There would be difficulty getting time off work for treatment” and “I would be seen as weak” in that 2012 rates were higher for both those who screened positive as well as those who did not compared to 2010 rates. Sample-adjusted rates for Marines both meeting and not meeting the criteria for a psychological problem are presented in Table 13.2. For BH stigma, the only significant difference between 2012 and 2010 Marines was for those who screen positive; a higher percent reported that “there would be difficulty getting time off work for treatment.”

Table 13.2: Sample-Adjusted Percents for Male, E1-E3 Marines in Theater 4.5 Months who Screen Positive and Who Do Not Screen Positive for Any Mental Health Problems

BH Stigma

| Factors that affect your decision to receive mental health services | J-MHAT 7 OEF 2010 | | J-MHAT 8 OEF 2012 | |
|---|----------------------|------------------------|----------------------|------------------------|
| | Screen Positive | Do Not Screen Positive | Screen Positive | Do Not Screen Positive |
| It would be too embarrassing. | 22.0% | 12.3% | <u>54.8%</u> | 13.9% |
| It would harm my career. | 22.9% | 10.3% | 37.0% | 14.7% |
| Members of my unit might have less confidence in me. | 29.8% | 20.3% | <u>53.9%</u> | <u>27.1%</u> |
| My unit leadership might treat me differently. | 28.3% | 20.9% | <u>52.4%</u> | 17.9% |
| My leaders would blame me for the problem. | 16.0% | 11.5% | 17.7% | 13.0% |
| I would be seen as weak. | 26.7% | 21.9% | <u>60.6%</u> | <u>27.7%</u> |

One underline = significant interaction
Two underlines = significant main effect

Barriers to Accessing BH Care

| Factors that affect your decision to receive mental health services | J-MHAT 7 OEF 2010 | | J-MHAT 8 OEF 2012 | |
|--|----------------------|------------------------|----------------------|------------------------|
| | Screen Positive | Do Not Screen Positive | Screen Positive | Do Not Screen Positive |
| Mental health services aren't available. | 7.4% | 6.4% | 9.2% | 3.8% |
| I don't know where to get help. | 5.7% | 7.5% | 20.4% | 7.9% |
| It is difficult to get an appointment. | 8.7% | 5.4% | 21.8% | 3.3% |
| There would be difficulty getting time off work for treatment. | 20.8% | 16.2% | <u>54.9%</u> | 12.1% |
| It's too difficult to get to the location where the mental health specialist is. | 12.4% | 10.4% | 21.4% | 5.8% |
| My leaders discourage the use of mental health services. | 7.9% | 4.7% | 8.9% | 1.3% |

One underline = significant interaction

13.3 BH Self-Management: Other Reasons for not Seeking BH Care

There may be other reasons that Marines do not seek BH care. In a recent publication, Kim et al. (2011) showed that Soldiers' beliefs about mental health are the main determinant of behavioral health care seeking behavior. This same belief system may be present in Marines as well. Alternatively, Marines may not go to BH because they do not believe that BH can make a difference. J-MHAT 8 is the first MHAT to examine these kinds of reasons for Marines not seeking BH treatment.

Table 13.3 provides rates for both Marines screening positive for a mental health problem and those not screening positive. In the table none of the items are significantly different for those who screen positive for a mental health problem versus those who do not. This may be due to the small sample size. We believe that the issue of BH Self-Management is an area that warrants further research.

Table 13.3: Percents for Male, E1-E3 Marines in Theater 4.5 Months who Screen Positive and Who Do Not Screen Positive for Any Mental Health Problems

| BH Self Management | J-MHAT 8 OEF 2012 | |
|--|----------------------|------------------------|
| | Screen Positive | Do Not Screen Positive |
| Factors that affect your decision to receive mental health services | | |
| I know how to help myself | 38.1% | 42.7% |
| Strong people can resolve psychological problems by themselves | 47.6% | 32.3% |
| I would prefer to manage my problems on my own | 61.9% | 46.5% |
| I would rather get information on how to deal with the problem on my own | 47.6% | 31.0% |
| Mental health counseling can be helpful for those who need it | 57.1% | 39.7% |

J-MHAT 8 also asked for the first time whether Soldiers believed that 1) mental health professionals understand SMs and 2) mental health care doesn't work. There are significant differences between the responses for those who screen positive for a BH problem and those who do not when it comes to the first item. Those who screen positive for a BH problem are more likely (38.1% vs. 12.1%) to say mental health professionals don't understand SMs than those who don't screen positive. However, they are no more likely to say mental health care doesn't work (14.3 vs. 5.8).

13.4 Training

This section on protective factors focuses on Marines' reports of whether or not they have received suicide prevention and stress management training and whether those training modules were perceived to have been effective.

13.4.1 *Training Adequacy for Deployment Stress and Suicide*

Table 13.4.1 compares Marines' responses across years to whether or not they had received suicide prevention training and training in managing deployment stressors. In addition, Marines were asked if they had helped a fellow SM with a mental health (MH) problem and if they helped a SM with a MH get professional help. There were no differences in Marines in 2012 compared to 2010.

Table 13.4.1: Sample-Adjusted Percents for E1-E3 Marines in Theater 4.5 Months.

| Suicide and Stress Training / Use | J-MHAT 7 OEF 2010 | J-MHAT 8 OEF 2012 |
|---|----------------------|----------------------|
| I have received suicide prevention training in the past year. | 88.8% | 93.3% |
| I have received training in managing the stress of deployment and/or combat prior to this deployment. | 87.1% | 89.9% |
| I have assisted one or more fellow Service Members with a mental health problem in the past year. | 34.5% | 32.0% |
| I helped a Service Member who had a Mental Health Problem get professional help. | 21.4% | 22.0% |

Table 13.4.2 compares Marines' confidence in identifying SMs at risk for suicide and in helping SMs get MH assistance. In addition, Marines were asked to rate the adequacy of the training they received in suicide prevention and the training in managing deployment stressors and/or combat. Compared to 2010, significantly more Marines in 2012 (67.5%) agreed or strongly agreed that the training they received in identifying SMs at risk for suicide was sufficient compared to Marines in 2010 (58.1%).

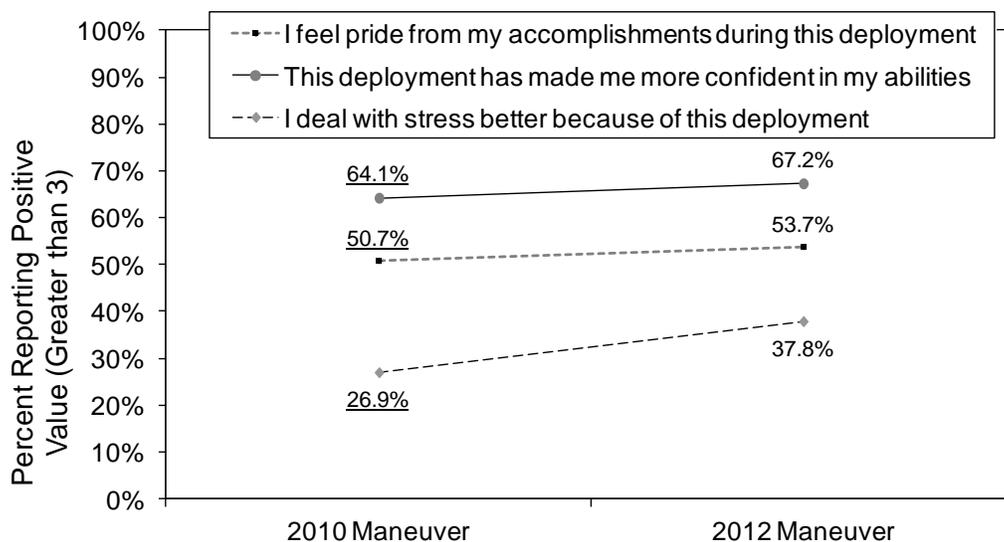
Table 13.4.2: Sample-Adjusted Percents for E1-E4 Marines in Theater 4.5 Months.

| Adequacy of Suicide and Stress Training | J-MHAT 7 OEF 2010 | J-MHAT 8 OEF 2012 |
|--|----------------------|----------------------|
| I am confident in my ability to identify Service Members at risk for suicide. | 60.7% | 62.1% |
| I am confident in my ability to help Service Members get mental health assistance. | 64.6% | 69.4% |
| The training for identifying Service Members at risk for suicide was sufficient. | <u>58.1%</u> | 67.5% |
| The training in managing the stress of deployment and/or combat was adequate. | 58.7% | 60.7% |

13.5 Positive Impact of Deployment

As mentioned previously, the concept of psychological resilience includes at least two positive responses to adverse circumstances: maintenance of baseline psychological health and/or positive psychological growth. Several questions included on the J-MHAT 7 and J-MHAT 8 surveys probe whether the experience of deployment resulted in positive changes in Marines' confidence, pride, and ability to manage stressful circumstances. Figure 13.5 indicates that significantly more Marines in the 2012 J-MHAT sample reported pride in their accomplishments, dealing with stress better and greater confidence in their abilities as a consequence of deployment relative to J-MHAT 7.

Figure 13.5 Positive Effects of Deployment



13.6 Mental Health Training

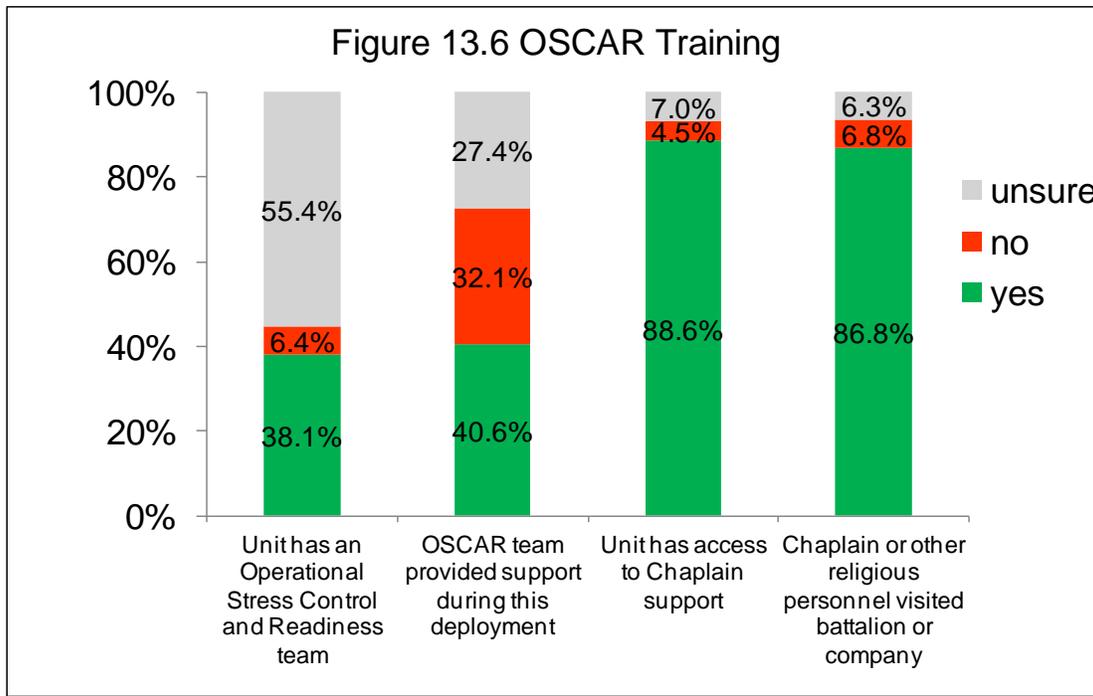
One of the new focal topics of J-MHAT 8 is mental health training, specifically the Operational Stress Control and Readiness (OSCAR) program. The term OSCAR refers to Marine-led training that builds teams of Marine leaders and medical and religious ministry personnel within each Battalion-sized unit. This training assists Commanders in maintaining their warfighting capabilities by identifying, managing, and preventing combat and operational stress issues in a timely manner. The Mission of the OSCAR program is to conserve the fighting strength of the Marine Corps through a proactive community mental health approach, preventing Marines from becoming “patients” through the appropriate application of the PIES (proximity, immediacy, expectancy and simplicity) principles. PIES guides the delivery of BH care recommending it be physically close to where the Marines are located (proximity), as near to the time of the event (immediacy) as possible, with the expectation that the Marine will fully recover and be able to return to duty (expectancy) and finally in as uncomplicated manner (simplicity) as is possible.

The goal of the OSCAR Team members is to provide leadership by example and mentor and help reduce stigma associated with seeking behavioral health assistance. When OSCAR Mentors encounter Marines with stress issues beyond their ability to assist, they refer Marines to the next level of support, usually the Team’s OSCAR extenders. OSCAR extenders are Medical Officers and Corpsmen, Chaplains and Religious Program Specialists who “extend” the capabilities of OSCAR Mental Health Professionals by bridging the gap between Marine OSCAR mentors and OSCAR Mental Health Professionals.

OSCAR Team Certification is conducted by an OSCAR Trainer and requires six hours and covers basic OSCAR knowledge, skills, and attitudes required to function as effective mentors extenders and mental health professionals on the Battalion-level Team.

The J-MHAT survey asked Marines a series of questions about the OSCAR program and the support they provided. Figure 13.6 shows that 38.1% of Marines reported that their unit had an

OSCAR team, with 40.6% reporting that the OSCAR team provided support during the deployment. Additionally, 20% of the J-MHAT 8 Marines reported that the training provided by the OSCAR team was useful. Finally, Marines reported more interaction with the Chaplain than the OSCAR team members.



14. MARINE FOCUS GROUP SUMMARY

The overarching goals of the focus groups in J-MHAT 8 are to examine resilience of the Marines and how the pre-deployment training in Operational Stress Control and Readiness (OSCAR) Training assisted them. According to the Marine Administrative Message (MARADMIN) 597/11, dated November 2011, the Marines should have received OSCAR training and have an OSCAR certified team mentor in their unit.

The main topics within the focus groups were Sleep concerns, Anger issues, Leadership's support of Marine's well-being, Transition from Combat to Peacekeeping Missions and Behavioral Health Care to include Tele-behavioral Health Care.

Methods

The J-MHAT 8 OEF team conducted 8 focus groups with a total of 53 Marines: 4 focus groups with junior enlisted (E1-E3, n=25) and 4 focus groups with NCOs (E4 to E6, n=28) from within the ATO (see table 14.1). The J-MHAT 8 team members traveled to meet with Marines in RC-South West (e.g. Camp Leatherneck, Camp Dwyer, FOB Sabit Qadam, and FOB Shir Ghazay).

| Table 14.1 Marine Focus Group Demographics for J-MHAT 8 (2012) | | | | | |
|--|----|-------|---------------------------------|-------|--------|
| Variable | n | % | Variable | n | % |
| Rank | | | Component | | |
| E1-E3 | 25 | 47.2% | Active | 53 | 100.0% |
| NCO | 28 | 52.8% | | | |
| Marital Status | | | Children | | |
| Single | 34 | 64.2% | Yes | 10 | 18.9% |
| Married | 19 | 35.8% | No | 43 | 81.1% |
| Deployment History | | | (Means) | | |
| First Time | 29 | 54.7% | Time (Months) in Theater | 5.83 | |
| Second Time | 13 | 24.5% | Years in the Military | 3.99 | |
| Third or More | 11 | 20.8% | Months Deployed Since | 12.08 | |

The group sessions were conducted separately for junior enlisted and their NCOs. The participants were informed that everything they contributed to the discussion would be kept confidential and that their names would not be associated with the notes taken during the session. Session duration ranged from approximately 1-2 hours, with the average session taking about 80 minutes. Sessions with NCOs typically lasted longer than those with junior enlisted Soldiers.

14.1 Themes Emerging from Marine Focus Groups

It is instructive to examine comments that were made during the focus groups. Sample comments from Junior Enlisted Marines and Marine NCOs will be presented below in the following categories: Resilience/Mental Health Training, Sleep, Anger, Leadership's support of service member's well being, transitional issues from combat to non-combat situations, and behavioral health care.

Resilience /Mental Health Training: In the Marine Corps, resilience/mental health training is based on the OSCAR model. The training of resilience is to be completed for the Marines by their own OSCAR team. The responses were mixed in their appreciation of the Resiliency/OSCAR training as they remembered it. The majority of the participants did not remember much about the OSCAR training or remembered only one or two sections of it but not that it was specifically "OSCAR" training. Of those that remembered the training, some responses were on the negative side and stated it was a "Big waste of time," "completely ineffective, almost insulting." Others gave more broad responses such as "[it was] Don't beat your wife, same old thing"; "decompression classes, annual training, transition to family, don't drink too much yada, yada."

Those who found it useful and stated, "It helped me to talk," "It taught me to look out for my buddies" and "made us aware of what to expect"; "Can recognize stress in your guys, handouts helped more than PowerPoint."

One group of NCOs were "all certified," as OSCAR Mentors yet they were not sure what OSCAR training they received besides the certification training. In a different NCO focus group, an OSCAR-trained NCO explained the program as "how to talk and listen to Marines and give

advice.” Another OSCAR-trained NCO in the same group added that the training included “more relaxation techniques, breathing, listening.”

When questioned about the format of the training, most Marines in the focus groups stated they had some suicide prevention training and stress training and that it was in the form of talk, role playing, videos and PowerPoint presentations done by civilians, officers, NCOs and Chaplains. The majority of the focus group members agreed that training is always best when it is in a smaller group and if the trainer “is experienced” both as a Marine and mentor. A good example of this thought is when one Marine said “Best if given by Marines who just left the same place. Previously deployed Marines.”

However, who actually conducted the training was unit dependent with some receiving OSCAR training from unit leadership (e.g. the Battalion XO) while others received it from the Chaplain. One Marine NCO expressed a common sentiment when he said “Doesn’t matter [who presents the training]. Material presented is what is important. Anyone with intestinal fortitude can give it. Chaplain would be good if the Marines need someone to talk to.”

When asked about having someone medical present the training, most responses were positive for having the Corpsman conduct mental health training. One caveat was that it should be a mature corpsman. For example, one Marine NCO said “It would have to be a senior corpsman, not a 19-20 year old; Some corpsmen are timid, they are an outsider being in the Navy.”

There was a consistent lack of familiarity with OSCAR personnel in the units. Most Marines simply did not know if they had OSCAR personnel in their units. For those who did know if there were OSCAR personnel, there was little concrete knowledge. One junior enlisted Marine said “Platoon SGT and Corpsman (CP) know about it (OSCAR). I know one or two squad leaders are. I think they were mentioned in the suicide lectures.”

The training’s appeal and impact appeared to be dependent on the trainer. A common, but not universal theme of the focus groups was the respect for the Chaplain. One Marine reported “the Chaplain was great.” When conducting OSCAR training, the groups seemed to appreciate a smaller group learning environment for more meaningful learning. They stated, “Small groups led by the most experienced or senior man” was how they preferred to receive training. This was consistent throughout the focus groups.

Marine NCOs who were OSCAR-certified said that the certification training was somewhat helpful. For example, one, when asked if the training was helpful, said “I think so, talked to a few people and they’re doing good now. “ However, another NCO commented that “leaders should know it already. [Training] Should be for lower NCOs like Lance Corporals. Should be able to do this as a Marine.”

Universally, Marines reported that they did not receive any OSCAR training during the deployment. When asked what mental health information would be helpful during the deployment, many felt that during the deployment was not the time to do the training. For those who felt training would be helpful during deployment, the most frequent response was training dealing with the Afghan National Army (ANA).

Another area identified during deployment training was family communication. A few of the Marines expressed the following: “Don’t have much to talk about with spouse and she doesn’t understand so I don’t say much. She asks how things are going and I can’t tell her what we’re doing since she won’t understand the terminology. It would be nice to have a family conversation smart card. Things to say that will generate conversation.”

Sleep: The majority of the Marine focus group participants admitted to not getting enough sleep. Of the Marines who responded to the survey question about what is keeping them from getting sleep, 32% reported a poor sleep environment and another 30% responded that night time duty is keeping them from getting enough sleep more than half the nights. This is consistent with the focus group responses where most stated work related and environmental issues are keeping them from getting enough sleep and not due to doing things to avoid sleep like playing video games. The reported main causes of the environmental issues included a lack of air conditioning due to power issues, and loud and inconsiderate roommates. They also reported poor sleep due to work schedules and manning shortfalls. A few Marines expressed issues related to being deployed. For example, one junior enlisted Marine said “lie for hours with things going round and around in your head”; referring to this as “Restless Syndrome.”

The Marines stated the things that help them get to sleep included movies and music but stated they did not receive training on sleep hygiene. When asked who should provide sleep training, responses were split between the Corpsman and NCOs (squad leaders).

The issue of sleep medications was discussed during some of the focus groups. Most Marines who commented on this topic did not want to use medication to go to sleep. One junior enlisted Marine said “No sleep meds; when here [at a major forward operating base] you can, but not on mission.” Another junior enlisted Marine added to this with “Thought about it, but don’t want to become dependent; I can wait till I get back to the States.” A few of the fifty three Marines discussed taking medications like Lunesta for sleep. The results were mixed with some Marines saying it was not helpful for him while other said “I took some and it helped in the short term.”

The majority of the NCOs in the focus groups stated they did not feel they had to micromanage their troops on sleep hygiene and the junior enlisted did not feel they needed to be taught sleep hygiene. The junior enlisted stated they felt that their NCO’s were setting a good example for sleep stating, “they sleep every chance they get.” This was corroborated in the survey results which asked if the Marines felt their NCOs encouraged/supported good sleep for their personnel, and of the respondents, 40% agreed that their NCOs encouraged sleep at least sometimes or more often. One good example of sleep leadership was offered when one junior enlisted Marine said “If there is a planned op there is mandatory rest time.”

Anger: A large proportion of the Marines reported becoming angry over different issues. One issue that seemed to dominate the anger discussion was the Rules of Engagement (ROE) and the feeling that the ROE was not helpful for the Marines. One Marine quoted, “Rules of engagement, not being able to shoot until fired upon but the Afghanistan National Army or ANA, can do what they want. ROE helping kill Marines. We are asking people to get hurt. Being PC. It’s about people back home and not what we need to do.” A second area that dominated the anger discussion in two of the Marine focus groups were the ANA behaviors. Specifically when asked what sorts of things make them angry the Marines stated, “the ANA threaten us, steal (our) stuff, invade (our) personal space to ask for (our) stuff and masturbating while on post.”

Other reasons that caused the Marines anger were issues with leaders being hypocritical (“holding us accountable for our hands in our pocket then they walk around like that.”), micromanagement, lack of explanation for maneuvers, garrison rules like boot blousing and haircuts and people being promoted, “above their ability and experience.” When asked about dealing with anger the majority stated they talked to peers, listened to music, went to the gym, slept or just dealt with it. The general consensus was that the Marines were good at helping one another deal with their anger in the group, “by giving each other (a hard time)” and that leaders seemed to handle their anger well. None believed that they needed more education on how to

deal with their anger. Most Marines agreed that their anger would get in the way of being able to focus and that they would need to “set it aside,” in order to perform well on a mission.

Leadership: The majority of the Marines stated that their leadership seemed to be interested in their psychological resilience and well-being and set a good example for taking care of their own well-being. One Marine stated, “They are there to help us through it.” This statement is congruent with the survey results on leadership. Of the Marines who responded on the survey, 71% of the respondents agreed that the NCOs in their platoon are concerned about their safety often or always. A minority of focus group participants mentioned training from or assistance with resilience during this deployment either by the Chaplain or their squad leader.

Transition from Combat to Peacekeeping Mission: The majority of the Marines interviewed stated there would be issues in both themselves and in their leaders going from a combat setting to a non-combat setting due to many NCO’s not being in a garrison type environment for most of their career. One Marine stated, “Yes, we will have to be more patient because many NCO’s made rank quickly without the leadership training.” Most Marines stated there would be many Marines who would leave the Marine Corps due to the garrison rules. They also stated that “hazing is going to go up” due to those Marines who have had combat experience and those that have not. This information was corroborated in the survey with the question “which best describes your current career intentions?” The Marines that responded agreed with the statements of “probably” or “definitely leave upon completion of my current obligation” 80% of the time. “We will lose many good Marines.”

Behavioral Health Care: Stigma is still prevalent in the Marine Corps according to the focus group members. 50% of respondents agreed that the “military attitudes create barriers to seeking help for stress problems.” When asked if they would be willing to talk to someone about their issues, one Marine stated “Probably not. I don’t want to share that. I don’t feel it is their business.” This was corroborated in the survey with Marine respondents agreeing 24% of the time that receiving mental health care “would be too embarrassing” and 27% agreed that they would be seen as “weak” if they sought care. Another Marine stated, “I don’t want to talk to someone that hasn’t been there, done that.” Regarding their junior enlisted going to talk to someone, one Marine NCO stated he, “Would be ok with the Marines having mental health issues if there was a specific reason like relationship issues or losing someone, but would trust (the member) less if they didn’t explain why they were being seen by MH.”

One of the goals of the OSCAR teams being embedded within the Marines is that the teams will decrease stigma. The survey results showed that 78% of respondents disagree that the OSCAR teams are reducing stigma amongst the unit. The OSCAR teams have not been with the Marines for a year yet. The results from J-MHAT 7, when compared to the surveys from the current J-MHAT, shows that there has been no change in the level of stigma so far. If there is a J-MHAT 9 in the future, this area of concern would be worth exploring.

Other areas that the majority of Marines stated would keep them from seeking mental health included concern about the lack of privacy and confidentiality if they did go see a behavioral health care provider. Another concern they mentioned was that they believed their record would be “red flagged” if they talked with mental health and that their career would be affected (25% agreed or strongly agreed). Most stated in the focus groups that they would not seek out counseling which was also reiterated in the survey results where only 17% stated they would seek help from an OSCAR team mentor and only 12% from a BH provider in their unit.

When asked about the likelihood that they would talk with someone via a computer program or “telebehavioral health (TBH),” they overwhelmingly stated they would not be willing to use TBH for therapy. They stated their reasons were that, “I need face to face,” “more personable is

better” and “it would be like talking to a robot.” They would also be concerned about privacy on the computer and that “they (the provider) could be texting while talking.”

Most of the Marines depended on their peers or the Chaplain to assist them when they needed to talk to someone. This is consistent with the survey results where over 97% of all survey respondents stated that their unit had a visit by the Battalion Chaplain and 95% stated they had access to Chaplain support.

Resilience Training Modules: Marines were asked about further resilience/mental health training that they would like to have had in order to help them either before or during deployment. A list of potential topics was generated by subject matter experts based on past studies conducted at the Walter Reed Army Institute of Research (WRAIR). The resulting table is the training that Marines stated would be helpful either before or during deployment. The top rated training they wanted to see in the future was “coping with grief”. In addition, more than half the Marines reported that helping buddies handle stress, addressing stress resulting from transitioning from combat to non-combat, and maintaining strong relationships back home were topics that would be beneficial before or during deployment.

Resilience Training Modules

| Topic: | Low | | Med | | High | |
|--|-----|-----|-----|-----|------|-----|
| | # | % | # | % | # | % |
| Coping with grief | 9 | 17% | 6 | 11% | 38 | 72% |
| Helping Buddies handle stress | 16 | 30% | 7 | 13% | 30 | 57% |
| Addressing stress resulting from transitioning from combat to non-combat | 6 | 11% | 18 | 34% | 29 | 55% |
| Maintaining strong relationships back home | 13 | 25% | 13 | 25% | 27 | 51% |
| Parenting while deployed | 9 | 17% | 21 | 40% | 23 | 43% |
| Managing the constant availability of communications back home | 23 | 43% | 12 | 23% | 18 | 34% |
| Managing anger | 24 | 45% | 13 | 25% | 16 | 30% |
| Adapting to prolonged physical stress (hyper-arousal) | 14 | 26% | 26 | 49% | 13 | 25% |
| Sleep management for leaders (for self and those they lead) | 32 | 60% | 9 | 17% | 12 | 23% |
| Managing work conflict on deployment | 34 | 64% | 13 | 25% | 6 | 11% |
| Managing sleep | 36 | 68% | 11 | 21% | 6 | 11% |
| Addressing global deployment stress (boredom, lack of privacy, etc.) | 35 | 69% | 12 | 24% | 4 | 8% |

The Marines stated they would like the psychological resilience training to be done by personnel who “generally cared and in an informal setting.” This again speaks to the smaller group setting being a more meaningful way to learn for these Marines. They stated the OSCAR training could be done by the “doc” or Corpsmen, NCO, squad leader, Chaplain or a peer.

The last question asked to Marines was “*Are there any other topics you think it would be good for Marines to know about?*” Most groups had very little to say. However, one Marine NCO expressed the frustration of a fair number of Marines when he said “Tell Marines that there’s nothing you can do help this place; nothing for [Afghan National Army] (ANA). Taliban will be still be here. You get in a gunfight, then you go your way, they go their way and fight again tomorrow. There’s no cause here. [We] Came in with good intentions that get stripped away.

Can't trust Afghan National Security Forces (ANSF) Forces; they'll lead you to an ambush. Need to put a cause behind it. Working with the ANA is bullshit cause."

Summary:

The fifty-three Marines that participated in the focus groups were articulate, proud to be doing what they are doing and warmed up to talking with the J-MHAT 8 team members very quickly. They appreciated that we were listening to them and when asked about talking to BH one Marine stated "Yesterday, I would have said no but after today I would say yes."

Within the focus groups there was a clear lack of understanding of the goals and objectives of the OSCAR teams and the MARADMIN 597/11. Due to the OSCAR being a newer program for the Marines (signed in November 2011) it is understandable that there is not great familiarity with the concept yet. However, the Marines did state the training they received helped them to "talk with others (about their issues)" and helped them "look out for their Marines."

The Marines in the focus groups mentioned different issues that caused them stress and anger. One issue that they mentioned was their frustration with the behavior of the ANA and the cultural differences, the ROE and lack of clear guidance as well as their frustration toward their leadership being hypocritical, micromanaging them, or behaving as if back in garrison with garrison standards like "blousing our boots (correctly)." The Marines were able to verbalize many ways of dealing with their anger as individuals and as a unit. But, the focus group participants stated that many Marines would get out of the Marine Corps at the end of their obligated service due to garrison rules.

The focus group participants spoke of their difficulties in obtaining enough sleep due to environmental issues like broken air conditioners or noise as well as work schedules and manning shortfalls. They reported that they were not participating in activities to avoid sleeping. The Marines stated that they are receiving training in different areas both pre-deployment and during deployment.

One area of further training that the Marines would like to see is in the area of maintaining relationships back home and the communication management of these relationships. It was stated at many junctures within the focus groups that smaller group training would carry greater weight especially if it was taught by someone who cares and has had some of the same experiences they have received.

It is evident that there is further need to educate the Marines at all levels on stress and anger management, sleep hygiene and the benefits of and what to expect when seeking mental health care. There is a great need to continue emphasizing and training on the new MARADMIN 597/11. This training and emphasis should include the composition of the OSCAR teams, what the OSCAR team is supposed to provide as well as what happens when members seek mental health, and when they should seek mental health care for themselves or for their peers. More education at all levels within the Navy and Marines is vital to achieve the goals of decreasing stigma and an ensuring an overall healthier Marine Corps.

15. MARINE REPORT: DISCUSSION AND RECOMMENDATIONS

15.1 Overview of Findings

Results from J-MHAT 8 mission show that there is a mixed story of the overall behavioral health of Marines in maneuver units in Afghanistan during 2012. Specifically, results illustrate that morale and behavioral health (BH) has stayed consistent from 2010. However, Marines' ratings of poor NCO leadership and BH stigma are higher in 2012 than 2010. In addition, although the survey results showed no significant change in combat experiences, many Marines expressed anger over the changing nature of their mission in Afghanistan. In particular, there were concerns about working with Afghan National Army (ANA). Additionally, it is noteworthy that fewer 2012 Marines report sleep disturbances compared to 2010 Marines. Finally, the review of the Combat and Operational Stress Control (COSC) and Operational Stress Control and Readiness (OSCAR) mental health program showed that both the knowledge of the program and full implementation in theater have room for improvement.

15.1.1 *Sleep and sleep leadership*

Over 20% of Marines report concern about lack of sleep, predominantly due to poor sleep environment and nighttime duties. Sleep leadership items were significantly correlated with Soldiers' reports of how combat ready they believed their unit to be. Additionally, there were variations and inconsistencies in NCO behaviors related to sleep hygiene. For example, many NCOs (>60%) encouraged Soldiers to get extra sleep before missions but few (~13%) asked Soldiers about their sleeping habits. This shows that there is room for improvement in leader influence on sleep hygiene.

Marine Recommendation 1: Incorporate sleep hygiene and discipline into pre-deployment training. Emphasize that small unit leaders are responsible for implementing sleep discipline and mitigating factors that lead to poor sleep environments (In Theater and CONUS).

15.1.2 *Non-commissioned officer (NCO) leadership*

Ratings of NCO leadership among junior enlisted Marines in 2012 were significantly lower than ratings in 2010. As previously shown in Figure 13.1.2, the junior enlisted Marines ratings of the two positive NCO leadership behaviors (telling SMs when they have done a good job and exhibiting clear thinking and reasonable action under stress) are significantly lower in 2012 compared to 2010. Conversely, the two negative NCO leadership behaviors (showing favoritism to certain members in the platoon and trying to look good to higher ups by assigning extra missions or details) are significantly higher in 2012 compared to 2010. The theme of negative leadership was echoed in focus groups when Marines talked about their NCOs inspecting their utilities (uniforms) after the Marines returned from missions, and the NCO giving the Marines a hard time if their uniform was not up to garrison standards.

Marine Recommendation 2: Consider integrating and evaluating behavioral health-based scenario-based training at the Marine Corps Air Ground Combat Center (MCAGCC) to address operational stress, particularly for platoon and company-level NCO leaders.

15.1.3 *C OSC and OSCAR*

Prevention, Identification and Treatment are the main goals of the Combat Operational Stress Control (COSC) and Operational Stress Control (OSC) doctrine. The main objectives of which are “force preservation and readiness and long term health and well-being.” The mission of the OSCAR program is to conserve the fighting strength of the Corps through a proactive community mental health approach, preventing Marines from becoming “patients” through the appropriate application of the PIES (Proximity, Immediacy, Expectancy and Simplicity) principles.

As previously noted, over half of the Marines surveyed in 2012 did not know if their unit had an OSCAR team and almost 60% were either unsure or said the OSCAR team did not provide support during the deployment. Finally, only 20% of Marines felt that the training provided by the OSCAR team was useful. The J-MHAT 8 spoke with an OSCAR provider during the deployment and he reported that the program was actively working with Marines in theater. As evidenced by the survey results and reports of a lack of understanding of the OSCAR program during Marine focus groups, there may be confusion about who is an OSCAR team member and what their role is.

Marine Recommendation 3: Fully Implement Navy/Marine Corps Combat and Operational Stress Control (COSC) Doctrine (NTTP 1-15/MCRP 6-11C) and the Operational Stress Control and Readiness (OSCAR) Guidance (MARADMIN 597/11). Undertake an aggressive education plan to ensure awareness of the COSC and OSCAR program at all levels.

Marine Recommendation 4: Continue to evaluate CONUS-based and in-theater resilience training and mental health (e.g. OSCAR) programs and endorse evidence-based training.

15.1.4 *Stigma and Barriers to receiving BH Care*

Stigma related to seeking BH care was significantly higher for 2012 Marines compared to 2010 Marines. In 2012, significantly more Marines who screened positive for a BH problem reported concern about being embarrassed and getting time off work for treatment. In addition, there was more stigma about members having less confidence in the Marine, and concern about being seen as weak in Marines who screened positive for a BH problem and for those who did not screen positive.

Marine Recommendation 5: Enhance NCO Marine Professional Education training on the NCO’s role in reducing Marine stigma through counseling & mentorship training.

16. BEHAVIORAL HEALTHCARE SYSTEM ASSESSMENT

16.1 Afghanistan Theater of Operations (ATO) Behavioral Health (BH) Overview

“We do important work here and we do a good job with it. These people (here) came ready to do their job.” (Commander, Kandahar Air Field Combat Stress Clinic)

There is a robust system of behavioral health care resources available in the Afghanistan Theater of Operations. The range of behavioral health services provided cover emergency psychiatric care and evacuation, intensive psychotherapy, brief psychotherapy (to include treatment of combat stress), medication management, outreach, education and awareness training, traumatic event management (TEM), command directed evaluations, and special duty assignment evaluations. However, the ample resources available are unevenly distributed across the theater and result in a small number of clinics providing the bulk of services. With the continuing transition of the mission and the resultant down-sizing of the Force over the next two years, it is increasingly important to review BH care delivery, including asset allocation and to make appropriate adjustments.

From April 2011 through May 2012 outpatient behavioral health visits accounted for 23% of the top 50 outpatient medical visits in theater. These encounters do not include the outreach and education, command consultation, and traumatic event management that BH personnel also provide in theater. These theater data are consistent with a recent Armed Forces Health Surveillance Center (AFHSC) Report (MSMR, Apr 2012) which demonstrates a marked increase in the number of outpatient behavioral health visits from 2007 to 2011 (2007=946K; 2011=1.9M). Although maneuver unit Soldiers in the J-MHAT 8 sample reported lower BH utilization rates than previous MHATs, service members (SMs) in general are seeking mental health treatment at increasing rates. This may be indicative of the progress that has been made to reduce stigma and make access to BH care easier for any SM in need of behavioral health care. Although there is room for improvement, there has been a visible shift in the behavior of some SMs when it comes to seeking BH care for mental health issues.

16.2 Behavioral Health (BH) Staffing and Distribution

Within the ATO, personnel numbers for both BH staff and overall military personnel remain fluid due to a combination of deployment rotations, operational requirements, and SM needs. For these reasons, it is important to recognize that the data presented below represent a snapshot of BH staffing and distribution as of June 2012.

Table 16.2 provides a breakdown of the BH personnel by occupational specialty and branch of service for OEF 2005, OEF 2007, OEF 2009, OEF 2010, and OEF 2012. In reviewing the history of BH staffing patterns since 2005, there was a steady increase in the number of BH personnel supporting the ATO from 2005 through 2010. Consistent with the draw down, in 2012, the number of BH personnel has decreased slightly. In 2007, the Air Force provided the majority of BH assets to the ATO (62.1%) with the Army providing 34.5% of the BH assets in-theater and the Navy providing 3.4%. In 2010, there was a substantial increase and shift in BH staffing, with the Army providing the majority of the BH assets, followed by the Air Force, and Navy. This trend continues in 2012 with the Army providing 67% of the BH assets, the Navy 17% and the Air Force 16%.

Table 16.2. Distribution and Ratio of MH Specialties by Service

| ARMY | | | | | |
|---|-----------------|----------------|----------------|------------------|------------------|
| SPECIALTY | MHAT 3b 2005 | MHAT 5 2007 | MHAT 6 2009 | J-MHAT 7 2010 | J-MHAT 8 2012 |
| Psychiatrist | 2 | 0 | 1 | 8 | 5 |
| Psychologist | 1 | 1 | 2 | 13 | 12 |
| Social Worker | 1 | 2 | 4 | 4 | 15 |
| Psychiatric Nurse Practitioner | 0 | 0 | 0 | 2 | 1 |
| Psychiatric Nurse* | 0 | 0 | 0 | 1 | 3 |
| Mental Health Specialist | 5 | 7 | 7 | 48 | 43 |
| Occupational Therapist | 0 | 0 | 1 | 5 | 3 |
| Occupational Therapist Technician | 0 | 0 | 1 | 7 | 8 |
| TOTAL | 9 | 10 | 16 | 88 | 90 |
| NAVY | | | | | |
| Psychiatrist | 0 | 0 | 2 | 8 | 3 |
| Psychologist | 0 | 0 | 0 | 4 | 8 |
| Social Worker | 0 | 0 | 0 | 1 | 0 |
| Psychiatric Nurse Practitioner | 0 | 0 | 0 | 1 | 0 |
| Psychiatric Nurse* | 0 | 1 | 0 | 0 | 1 |
| Mental Health Specialist | 0 | 0 | 0 | 14 | 10 |
| Occupational Therapist | 0 | 0 | 0 | 0 | 1 |
| Occupational Therapist Technician | 0 | 0 | 0 | 0 | 0 |
| TOTAL | 0 | 1 | 2 | 28 | 23 |
| AIR FORCE | | | | | |
| Psychiatrist | 0 | 3 | 3 | 3 | 3 |
| Psychologist | 0 | 4 | 4 | 5 | 4 |
| Social Worker | 0 | 3 | 3 | 5 | 2 |
| Psychiatric Nurse Practitioner | 0 | 0 | 2 | 0 | 1 |
| Psychiatric Nurse* | 0 | 1 | 0 | 1 | 0 |
| Mental Health Specialist | 0 | 7 | 13 | 14 | 11 |
| Occupational Therapist | 0 | 0 | 0 | 2 | 1 |
| Occupational Therapist Technician | 0 | 0 | 0 | 1 | 0 |
| TOTAL | 0 | 18 | 25 | 31 | 22 |
| JOINT SERVICE THEATER FORCES STAFFING RATIO | | | | | |
| Total | 9 | 29 | 43 | 147 | 135 |
| Overall Staffing Ratio | 1756 | 651 | 1123 | 646 | 723 |
| Independent Practitioner Ratio ** | 3951 | 1452 | 2194 | 1508 | 1654 |

*Psychiatric Nurse Practitioners and Psychiatric Nurses were not differentiated until 2009 MHAT

**Independent Practitioners include Psychiatrists, Psychologists, Psychiatric Nurse Practitioners, Social Workers and Occupational Therapists

Note: Data collected with assistance of ATO Behavioral Health Consultant. Rates do not include Coalition personnel. In addition, rates do not include the OEF Behavioral Health Consultant, his Executive Officer, and the NCOIC. These individuals are in full-time staff positions and do not engage in patient care.

Beginning in 2007, a push was made to redistribute individual BH personnel throughout the ATO in order to provide improved support to SMs at forward operating bases (FOBs) and combat outposts (COPs). This redistribution of assets to outlying, forward deployed locations continues to be the model of care within the ATO. Indeed Battlefield Circulation by BH assets (organic and area-support personnel) is the most preferred method by which BH providers and specialists reach SMs for individual contact, education and awareness, and command consultation. This contact is supplemented by telebehavioral health when the BH provider is unable to reach a SM in a timely manner.

The bottom of Table 16.2 provides the overall staffing ratio of BH personnel to SMs. The overall staffing ratio compares the total number of BH personnel available in theater – mental health professionals, mental health technicians, occupational therapists (OT) and OT technicians – to the overall size of the U.S. military force in Afghanistan (referred to as the population at risk (PAR)).

An estimate of the ratio of independent practitioners to the total population in theater is also provided at the bottom of Table 16.2. Independent practitioners are defined as psychiatrists, psychologists, psychiatric nurse practitioners, social workers and occupational therapists¹.

A recommendation was made in the 2009 MHAT VI report to increase the overall BH personnel to SM ratio to reach a 1:700 to 1:800 staffing ratio. Data from J-MHAT 7 OEF indicate that the 2010 overall staffing ratio was 1:646 and the ratio of independent practitioners to SMs improved as well in 2010 (1:1508). In 2012, the staffing ratio increased slightly with an overall staffing ratio of 1:723 and the independent practitioner ratio of 1:1654. As stated previously, the staffing ratios are considered fluid estimates given the ongoing drawdown in troop strength and 2012 estimates are believed to be well within the recommended BH personnel staffing levels. Monitoring of BH staff ratios and dispersion across the ATO should be continuous and coordinated with operational forces as they drawdown and relocate across the theater.

16.3 Methodology

Data were collected via distributed surveys, BH personnel focus groups, and by reviewing BH patient encounter data obtained through the Medical Situational Awareness in Theater (MSAT) tool and the Theater Medical Data System (TMDS) (1 May through 31 May 2012; 1 Apr 2011 through 30 April 2012) and patient evacuation data (2011). Note that the population of patients seen by BH providers appears to be different than the maneuver unit population described earlier in this report along many lines, including their mental health status and their branch of service. As noted in the earlier Soldier and Marine sections, the findings presented there were from Soldiers and Marines in maneuver units while the upcoming sections refer to BH personnel and any SMs who entered a BH clinic, whether Army, Navy, Air Force or Marines and whether in maneuver or support units.

16.3.1 Behavioral Health Survey Respondents

A census survey of theater BH personnel was conducted in May-June 2012. In total, 205 surveys were distributed to cover the approximately 175 (135 + 40 that were rotating out) identified providers, 117 were returned (67% survey return rate). The goal was to assess BH

¹ Although OTs are referred to as independent practitioner, they are not qualified to assess, diagnose or treat psychiatric disorders.

personnel perceptions of: standards of care; resources; combat and operational stress control (COSC) concepts and skill; stigma and barriers to care; and BH personnel well-being. The number of surveys collected in 2012 was an unprecedented 86.7% (n=117) of all available providers in the ATO (n=135). To aid in comparison with past MHAT samples, the 2012 BH survey followed a similar format to previous MHAT years. MHAT V OEF (2007), MHAT VI OEF (2009), and J-MHAT 7 OEF (2010) response percentages to all survey questions are included in Appendix C.

16.3.2 Behavioral Health Survey Demographics

Demographics for BH personnel responding to the survey are presented in Table 16.3.1. In general, the J-MHAT 8 OEF respondents included more reserve personnel than in all other MHATs. Consistent with J-MHAT 7, there were more male respondents. A lower percentage of officers (40% in 2012 vs. 57% in 2010) and therefore a lower percentage of independent practitioners responded to the survey than in previous surveys. Army personnel were slightly overrepresented comprising 78% of the sample. (Army personnel account for 67% of all BH personnel.) The average number of months deployed since 9/11 rose from 8.92 months in 2010 to 11.26 months in 2012, indicative of the large Army presence in the sample and in theater (until January 2012, Army rotations were normally 12 months long; AF & Navy deployments have ranged from 4-7 months). The increase in total months deployed may also reflect the fact that 38.5% of survey respondents had previously deployed. The 2012 respondents also reported that the average number of SMs their teams supported was roughly equivalent to 2010. However, the 2012 respondents reported spending considerably more time outside of their FOBS/home bases compared to respondents in 2010, consistent with the reported increase in battlefield circulation (as per providers in the focus groups).

Table 16.3.1. Demographics of Surveyed BH Personnel

| | MHAT 5 2007 | MHAT 6 2009 | J-MHAT 7 2010 | J-MHAT 8 2012 |
|---|----------------|----------------|------------------|------------------|
| Sample Size | n = 23 | n = 31 | n = 85 | n = 117 |
| Age Range in Years (Mode) | 30-39 | 30-39 | 30-39 | 40+ |
| Gender | 55% Male | 52% Male | 67% Male | 65% |
| Rank | | | | |
| Jr. Enlisted (E1-E4) | 22% | 23% | 20% | 26% |
| NCO (E5-E9) | 17% | 27% | 23% | 33% |
| Officers / Warrant Officers | 61% | 50% | 57% | 40% |
| Branch of Service * | 61% AF | 70% AF | 55% Army | 78% Army |
| Component (Mode) | 87% Active | 97% Active | 70% Active | 60% Active |
| Avg Months Deployed since 9/11 | 8.17 | 4.43 | 8.92 | 11.26 |
| Avg Number of Service Members team supports | 5,597 | 5,123 | 4,786 | 4,638 |
| Avg Hours spent per Week Outside FOB | 21.91 | 21.13 | 13.20 | 17.42 |
| Avg Days per Month Living Outside FOB | 4.91 | 3.96 | 3.70 | 4.42 |
| Average Number of Locations BH/COSC Team Supports | 30.17 | 8.08 | 13.52 | 14.28 |

* Percent reported for Service providing most members

16.3.3 Behavioral Health Focus Groups

BH personnel focus group and interviews were conducted to provide qualitative assessments of deployment experiences and delivery of care. Twenty-one focus groups/interviews were conducted in a semi-structured format in which open and closed ended questions were asked. Sixty BH personnel ranging from 1 to 6 personnel per group participated (36 BH providers: 61% of BH providers in theater and 24 BH technicians: 37.5% of BH technicians in theater). Focus groups with BH personnel were conducted across all of the Regional Commands (RC): RC

North, RC South, RC East, and RC Southwest. Table 16.3.3 presents the total breakdown of BH personnel by specialty

| Table 16.3.3: BH Personnel Focus Group Participants by Specialty | |
|---|-----------|
| Specialty | N |
| Psychiatrist | 9 |
| Clinical Psychologist | 13 |
| LCSW | 8 |
| Psychiatric Nurse Practitioner | 3 |
| Registered Nurse | 1 |
| Occupational Therapist | 2 |
| Behavioral Health Specialist/Technician | 24 |
| Total | 60 |

Following completion of each focus group/interview, the information obtained was transcribed and focus group themes and issues therein were identified. Behavioral health interview themes are used in combination with survey results, patient encounter data, and evacuation data to present an overall picture of the issues of concern to currently deployed OEF BH staff.

16.4 Behavioral Health System Assessment

Behavioral Health focus groups concentrated on 4 broad themes to include 1) Services Available for the SM in need of Behavioral Health care; 2) Interaction with the Line Command; 3) Care for the Behavioral Health Provider; and 4) Resources in Theater. Section 16.4 presents an overall description of each theme, whereas Section 16.5 presents the issues which emerged during the focus groups and the recommendations made by the J-MHAT 8 in collaboration with providers who participated in the focus groups/interviews.

16.4.1 Services Available for the SM in need of Behavioral Health Care

BH Services are delivered through three separate but integrated venues: Combat Stress and Behavioral Health Clinics, Restoration Clinics, and Organic BH Services. BH personnel may belong to one unit but may work in a different location from their colleagues alongside BH personnel from other units or clinics. Providers reported that to the SM this integration is seamless.

Combat Stress Clinics and Behavioral Health Clinics.

The majority of services are provided at the Role 3 Combat Stress Clinics and Behavioral Health Clinics. These clinics serve as outpatient behavioral health clinics. Essentially, providers in these clinics see anyone who walks through the door; they turn no one away. They provide emergency psychiatric care and evacuation, intensive psychotherapy, brief psychotherapy (to include treatment of combat stress), medication management, command-directed evaluations, and special duty assignment evaluations. These providers also conduct command consultation, some do outreach and education and provide traumatic event management (TEM) upon request. Licensed providers pull both day and night call providing nonstop 24/7/365 services. The patient load is heavy (KAF Role 3 providers saw on average 97 patients each in May 2012), with providers indicating the majority of SMs are being seen for pre-existing mental health conditions, personal or occupational/operational (non-combat) stressors.

Restoration Clinics.

Restoration Clinics are residential treatment facilities designed to maximize restoration and return-to-duty (RTD) for SMs. Common reasons for referral include occupational stress, relationship issues, sleep problems, and difficulties dealing with anger, grief, and loss. Restoration Programs include structured 3, 5, or 7 day skills-based training which includes resiliency building, individualized support, and recovery. These clinics are referral based; they do not take walk-ins and do not see SMs who are actively suicidal or homicidal or are unstable in any way. Direct referrals are made by licensed Behavioral Health (BH) providers (i.e. psychiatrists, psychologists, social workers, and psychiatric nurse practitioners). Other licensed medical providers (i.e. physicians, physician assistants, etc.) can consult with a BH provider in their area of operation, including using Tele-Behavioral Health, to make a referral into the program. Providers at these clinics also do outreach and education, command consultation and provide traumatic event management (TEM) upon request.

Organic Behavioral Health Assets.

Organic Behavioral Health Assets are Army behavioral health assets that are assigned to a Brigade or Division. Recently the Army Modified Table of Organization and Equipment (mTOE) has been amended so that each Brigade has two behavioral health officers and two behavioral health specialists. This change will be implemented in the Brigade Combat Teams (BCTs) from 2012 through 2014. Navy/Marine Operational Stress Control and Readiness (OSCAR) Teams are also embedded within the unit and include Navy organic behavioral health providers as well as Marines trained as OSCAR mentors and extenders. These behavioral health assets provide an array of services to include outreach and education (e.g., stress/anger management classes, tobacco cessation), TEM, consultation with commanders, “walk abouts” (providers going on unstructured walks in their area of operations and meeting and greeting commanders and SMs to explain the BH services available, etc.), and traditional outpatient therapy. They also consult with other theater MH/BH care providers.

16.4.2 Interaction with Line Command

BH providers report that their relationships with commanders vary across commands and clinics from mutually respectful and supportive to strained. BH providers also report that command attitude towards BH also varies according to command’s relationship with the SM involved in the interaction. If the commander has a positive attitude toward the SM and has a high regard for that SM, the commander is most likely supportive of BH care. However, if the SM is not well liked or respected by the commander, BH care is often seen as another weakness and a way for the SM to get out of work. BH providers report that this attitude causes friction amongst the commander, SM, and BH personnel.

In general, smaller Behavioral Health Clinics (to include organic assets) serving FOBs report better relationships with company and battalion commanders. These relationships usually consist of a smaller number of providers working with a smaller number of commanders. The providers have a smaller case load and are able to do “walk abouts”. Larger Behavioral Health Clinics consult with a larger number of commanders and for varied reasons report good relations with some commanders and poor relations with others. (e.g., BH providers have significantly higher patient loads and often first meet a commander when they are dealing with one of his troubled SMs.)

Experienced providers noted that it is incumbent upon providers to understand and educate themselves on how to communicate with command in a role as consultant and advocate for the command/mission in addition to their traditional role as patient advocate.

16.4.3 Care for Behavioral Health Providers

Invariably during the focus groups, providers reported their theater experiences in a positive light. Many said it was the highlight of their career; all felt privileged to serve those who put themselves in harm's way. That said, BH providers' morale varied across the theater with higher strain reported by providers at clinics with high utilization rates relative to providers at smaller clinics and those with low utilization rates. Morale is reported to be generally high where there are good personal relationships between medical and line commanders and between providers and technicians. There are a number of clinics that report those relationships are strained creating undue stress and contributing to burnout and low morale amongst BH personnel. On a positive note, 84% of BH respondents indicated they use some form of stress management to deal with their own personal stressors and 90% indicated they engage in physical fitness training.

A preponderance of providers felt very well prepared to complete their mission and treat patients in the deployed environment for any number of mental health conditions to include combat stress. (94% of BH survey respondents felt confident in helping SMs adapt to the stressors of combat or deployment.) A significant percentage of providers reported receiving some sort of pre-deployment Combat and Operational Stress Control (COSC) training (one week COSC course in San Antonio); this is consistent with survey results indicating 68.4% received formal COSC training. Navy providers indicated they received COSC training in their formal graduate or residency training programs. Regarding specific COSC pre-deployment training, more experienced providers reported that the clinical training was not very useful; however, meeting people who had deployed already as well as meeting people with whom they would work in theater was invaluable. Less experienced providers generally found the clinical training helpful in addition to the added benefit of learning from those who had previously deployed. Although only 55% of survey respondents reported receiving adequate pre-deployment training to prepare for their COSC duties, 93% agreed that they were prepared to evaluate and treat combat operational stress reactions and 85.5% felt prepared to evaluate and treat acute stress disorder/PTSD. This seemingly discrepant finding may be related to how respondents rated the specific COSC courses or how respondents defined "their COSC duties" vs. the tasks of evaluating and managing specific mental health conditions.

Providers report that they tend to lean on each other for emotional support and social outlets. They engage in social activities and professional development to keep morale high. The ability to keep in touch with family members and professional relationships at home is helpful as well as working out, reading, movies, and cooking. Regarding their own personal safety, providers reported feeling as safe as they can in the clinics. Procedures are followed for SMs to secure their weapons prior to sessions and many of the larger clinics have duress alarms. In addition providers report no significant safety concerns other than what would be expected when traveling around the theater. For detailed responses to the survey questions on personal safety, see Appendix C.

16.4.4 Theater Resources

Providers in general report having the necessary resources to do their jobs and complete the mission. Everyone has access to the stand alone IT system (AHLTA-Theater) which allows them to input clinical notes into the electronic medical record (EMR). Almost all are able to

connect to a server and download AHLTA-Theater notes into Theater Medical Data Store (TMDS); however, accessing the IT system which allows them to view garrison notes (AHLTA-Warrior) is not reliable at times. Office space is at a premium and the number of patients that can be seen at one time is often limited to the space available. Computers and equipment need to be refreshed. Travel in theater is sometimes difficult, particularly when traveling from large hubs to smaller ones. Traveling from FOBs to other FOBs or COPs is much easier. For providers who FOB hop and do battlefield circulation, it would be beneficial if they were granted high priority mission status (a recommendation that was also made in J-MHAT 7). In general there were few serious complaints regarding lack of resources in theater.

16.5 Issues and Recommendations

Issue 1: Pre-existing Mental Health Conditions.

As found in previous MHATs, a consistent issue cited by BH providers across the ATO was concern about SMs arriving in theater with pre-existing mental health conditions and non-stabilized psychiatric symptoms. Criteria for evaluations and waivers for SMs with pre-existing MH conditions are delineated in 3 policy documents: DODI 6490.07, Feb 5, 2010: Deployment-Limiting Medical Conditions for Service Members and DoD Civilian Employees; Health Affairs Policy Memo: "Policy Guidance for Deployment-Limiting Psychiatric Conditions and Medications", Nov 7, 2006; USCENTCOM DEC 11 Mod Eleven to USCENTCOM Individual Protection and Individual-Unit Deployment Policy.

Providers reported that waivers for pre-existing MH conditions appear easy to obtain and noted that a significant percentage of new cases have a pre-existing condition (up to 60-70%). Given the prevalence of mental health problems within the military (e.g. Hoge et al., 2004; Thomas et al., 2010), it is perhaps not surprising that those seeking care are likely to have had pre-existing conditions; however, it is not clear whether SMs with pre-existing conditions have not been stabilized prior to deploying or whether their condition deteriorates after they arrive in theater.

Although there are anecdotes about SMs arriving in Afghanistan with significant psychiatric symptoms who were told that they could get treatment once they arrived in theater, there has been no systematic analysis of this issue. Overall, providers agree that it is unlikely an unstable SM in need of MH treatment will improve upon arrival in theater.

Occasionally, SMs arrive in theater with multiple psychotropic prescriptions and needing medication adjustments present at FOBs or COPs where there is no prescribing provider. This situation poses a significant medical risk to the SM and can negatively impact the mission. Prescribing providers do not feel comfortable using telebehavioral health with such complicated cases. In addition, if there is not a prescribing provider on the SM end, it is very difficult to adjust medications as needed and ensure the SM is compliant with the treatment regimen. SMs arriving in theater with active psychiatric symptoms puts an enormous burden on line commands and mental health resources, degrading both missions.

Behavioral Health Recommendation 1: Rewrite policies regarding pre-deployment BH screening for SMs with pre-existing BH conditions. Clarify criteria used to grant BH waivers. Consider conducting retrospective and prospective analysis on the percentage of SMs presenting with pre-existing conditions and unstable symptoms.

Issue 2: Operational Stress and Suicidal/Homicidal Ideation (SI/HI).

Given the importance of small-unit leadership as a factor related to the well-being of SMs, it is perhaps not surprising that providers reported that the most common issue SMs present with is

operational stress related to leadership issues. For example, at the Bagram Combat Stress Clinic, a project improvement effort reviewed 542 case files, of those 40% (215) revealed unit/leadership issues as the presenting problem. Comorbid symptoms associated with leadership issues can be suicidal and homicidal ideation (SI/HI). Although suicidal ideation is not uncommon, it is most often transient. Providers are trained to deal with the suicidal patient and have sound processes in place to treat or evacuate patients who need a higher level of care. Providers report that the number/percentage of patients with SI is similar to that seen in garrison. (87% of BH survey respondents felt confident in their ability to evaluate and manage suicidal patients.)

In contrast to SI, providers reported that the number of HI cases was striking relative to garrison reports of HI. It is not clear whether the perceived increase in HI rates are (a) a natural by-product of SMs being exposed to stressful conditions without the “breaks” from unit members routinely experienced in garrison or (b) whether the increase reflects a fundamental difference about relationships with leaders in J-MHAT 8 versus previous deployments. Without a systematic analysis of this problem, it is difficult to interpret the providers’ concerns within the proper context.

Providers also indicated that Homicidal ideation is also most often transient and is often tied to SM’s sense that supervisors do not care about them [SMs], impose stringent and garrison-like command policies, treat them poorly/unfairly and bully them. Perhaps not surprisingly, Afghan National Army (ANA) personnel were also objects of homicidal thoughts most likely due to recent “Green on Blue” incidents (ANA personnel wounding or killing US or Allied personnel). The frustration over the changing mission and training ANA personnel was also frequently reported by SM patients. While these perceptions were based on the small percent of the deployed population that was seeking care, some of these sentiments were consistent with what was said in the Soldier focus groups.

Behavioral Health Recommendation 2: Consider conducting retrospective and prospective analysis on SMs presenting for HI; track and report HI using external assets (e.g. MHATs) or organic personnel. Address the issue of operational stress and leadership by reviewing command policies in theater and leadership training for NCOs and junior officers, particularly as it relates to interpersonal relationships and working with the ANA. Address the changing nature of the mission with SMs. Consider giving SMs personal downtime (e.g., a day off) in keeping with reduced mission demands. Remove from theater any SM who consistently presents with hostile thoughts and intentions towards anyone.

Issue 3: Asset Allocation and the Absence of Effective Outreach Data Collection.

Concerns about effective BH asset allocation throughout the theater have been consistent themes across the MHATs, and a variety of solutions have been proposed and implemented (to include designating a Theater BH Consultant). Despite these attempts, providers still continued to raise issues about allocation. It is apparent from talking to providers across the Regional Commands that some clinics and providers are feeling overwhelmed with the number of patients seen and treated while others struggle to keep themselves busy in order to feel productive. Providers at the Bagram Combat Stress Clinic (outpatient mental health clinic) reported being stressed with the case load but felt they were managing it effectively. On the other hand, RC-North providers indicated the case load was “underwhelming” and they struggled to keep busy. Following completion of the focus groups, patient encounter data collected through MSAT/TMDS for the month of May 2012 was reviewed.

The impression of uneven asset distribution was corroborated indicating that the majority of outpatient care is provided at a small number of clinics. Table 10.5 provides a snapshot of patient load for the month of May 2012. In RC East (+ the Capital Region) there were approximately 1.8 providers per 10,000 SM population, whereas in RC South, SW & West combined there were 6.2 providers per 10,000 SM population. The same was true for RC North, 6.2 providers per 10,000 SM population. Documented patient encounter data demonstrates the impact of the uneven distribution: In RC East (+ Capital Region) there were 509 patient encounters with an average of 51 patient encounters per provider. In RC South, SW, and West combined there were 399 documented encounters with an average of 11 patient encounters per provider; in RC North there were 79 encounters with an average of 20 encounters per provider. Documented encounters per clinic demonstrate the stark difference in work load not only across regions but by type of clinic as well. Of the 14 clinics across Task Force Med A, the average number of patient encounters per provider for May 2012 was 24. At Bagram Air Field Combat Stress Clinic (CSC) (RC-East, Role 3), providers averaged 97 patient encounters each for the month of May 2012. The average of the 13 clinics – Bagram not included - was 12.4 patient encounters per provider.

| Regional Command | 10,000 population | Patient encounters | Patients per BH provider |
|------------------------------------|--------------------------|---------------------------|---------------------------------|
| RC East (+Capital) | 1.8 | 509 | 51 |
| RC South, South West & West | 6.2 | 399 | 11 |
| RC North | 6.2 | 79 | 20 |
| Clinics | | | |
| 13 TF MED-A Clinics (minus Bagram) | | | 12.4 |
| Bagram | | | 97 |

Another reason for the uneven distribution of workload may be associated with the creation and stringent admissions criteria of the Restoration Centers. Potential patients must present with no SI/HI and their symptoms must be stabilized. Restoration Centers ideally provide care for those SMs most expected to return to duty. Moderate to severe cases are treated at the Role 3 facilities. Restoration Centers are heavily staffed (11 personnel onsite at BAF: 1 clinical psychologist, 5 BH specialists, 1 Occupational Therapist, 2 Occupational Technicians, 1 Chaplain, 1 Chaplain’s Assistant; and 13 personnel onsite at KAF: 1 psychiatrist, 1 psychologist, 1 LCSW, 1 psychiatric nurse practitioner, 1 psychiatric nurse, 1 OT, 2 OT assistants, 5 BH specialists)². The capacity of the centers is limited, thus limiting the number of SMs that can be seen at any one given time to a 12 person limit per week at both KAF and BAF. This equates to a maximum of approximately 48 patients per month at each clinic.

From the data available³, it appears as if the census for the Restoration Centers is extremely low, e.g., from March to May 2012 the BAF restoration center averaged 5.6 patients completing their 3 day program per month. The KAF restoration center averaged 10 patients per month completing their 4+ day program (from March to May 2012). In addition to the stringent admission requirements, BH providers report that commanders are reluctant to lose a relatively

² Restoration Center staffing data was obtained from the May 2012 COSC-WAR reports.

³ Restoration Center patient census data was obtained from the May 2012 COSC-WAR reports.

stable SM for the extended amount of time required to complete the program. In addition to the 3 or 5 days in the program, there are two days of travel tacked on to both sides of the program. A commander can lose a SM for up to 7 days for a 3 day program and up to 9 days for a 5 day program. Based on the nature/severity of presenting problems and the Restoration Center curriculum, it appears that SMs who participate in the residential programs at the Restoration Centers could be treated on an outpatient basis. The resources, including BH personnel and space, spent treating such a small number of relatively stable SMs, might be able to be put to more efficient use elsewhere in theater.

Additionally, BH personnel in Restoration Centers, Combat Stress Clinics (CSCs) and Behavioral Health Clinics (BHC) (Role 3s), and small BH Clinics across the ATO all conduct outreach and education activities, TEMs, and psychoeducational classes. It is difficult to determine the amount of time spent and prevention gained from these outreach activities. Currently there is no effective method to quantify and record this outreach work. Currently, Combat and Operational Stress Control Workload Activity Reports (COSC-WAR) is the system being used to capture outreach activity. However, the J-MHAT team was informed that the numbers in COSC-WAR were not reliable and could not be used with any degree of certainty in determining the level of outreach activities conducted by BH personnel.

Even with the sufficient number of BH personnel available in theater, only 41% of BH respondents felt there were sufficient BH assets in theater to cover the mission across the AO. It does not appear the BH personnel are being used as effectively as they might be. One possible contributing factor may be that there is no one in theater that owns all of the behavioral health assets with the exception of the USFOR-A Surgeon General and that position does not have a Behavioral Health Consultant on staff to provide BH advice. Currently the OEF Behavioral Health Consultant is a staff member for Task Force Med Afghanistan (TF MED-A) which only owns a portion of the BH assets in theater. Those assets are significant, including Army and Navy organic behavioral health assets, the NATO Role 3 BH clinic assets, Leatherneck assets or the Role 3 clinic assets at Bastion.

Behavioral Health Recommendation 3: Conduct a complete review of BH assets in theater by region and clinic according to the PAR and patient utilization rates; develop an effective system to collect data on BH outreach services provided to SMs and commands. Continue to engage with operational commanders regarding reduction and dispersion of troops so that BH resources can be allocated appropriately.

Behavioral Health Recommendation 4: Review admission criteria for Restoration Centers. Consider restructuring the 3,5,7 day programs to include standard outpatient visits and stand-alone psychoeducational classes. Consider reallocating these personnel and space resources.

Behavioral Health Recommendation 5: Create a joint billet for the USFOR-A Behavioral Health Consultant; have the USFOR-A BH Consultant serve as a member of the USFOR-A Surgeon General's staff.

Issue 4: Inconsistent Naming Conventions for BH Services.

As previously mentioned, there appears to be ample BH services in theater, however, there is confusion regarding the different nature of the various clinics in which SMs can receive behavioral health care. Providers report line commanders and SMs are confused regarding availability of BH services and by the terms Combat Stress Clinic (CSC) and Combat

Operational Stress Control (COSC) Unit. SMs have indicated to providers that they did not seek care at the CSC because their issues were not related to combat stress. They did not know where to go to see someone for problems related to relationships or work or other common behavioral health issues. Air Force MH providers, upon being assigned to the “Combat Stress Clinic” at Bagram thought they were deploying to treat soldiers with combat stress, only to find out (over time) that the Combat Stress Clinic is an Outpatient Mental Health Clinic that treats all kinds of mental health problems.

In addition, another item that is reported which adds to the confusion is the acronym WRC stands for “Warrior Recovery Center” “Warrior Resiliency Center” and “Warrior Restoration Center”; each having a separate mission and serving different populations. Sometimes a restoration center will be housed inside a recovery center. If these services are housed within one building, the providers sort out where the SM is best suited to start treatment. However, if the services are housed in different buildings or are separate entities on the installation, it is very confusing for a SM or commander to determine what services are provided where, who should go where and what they can expect of the member when he returns to duty.

Although this issue may appear trivial at first, it is a serious issue. BH providers report that behavioral health issues peak soon after SM arrival in theater when adjustment to deployment is essential. This time is also when pre-existing BH issues first come to light. Commanders and SMs alike may struggle those first few weeks/months with finding the appropriate resources for the problems they encounter. Having to wade through the myriad of options regarding behavioral health, combat stress control units/clinics, restoration centers, etc., is both confusing and frustrating and adds to the cumulative stress of the deployment.

Behavioral Health Recommendation 6: Review naming conventions for Combat Stress Control Clinics, Behavioral Health Clinics Combat Operational Stress Control Units, Warrior Restoration Centers (WRC), Warrior Resiliency Centers (WRC) and Warrior Recovery Centers (WRC). Behavioral Health Leaders and providers at all levels recommend standardizing the naming conventions and using traditional Mental/Behavioral Health Clinics as the nomenclature of choice. Clearly separate the name Warrior Resilience Centers as they are designed to build resilience among all SMs, not treat patients.

Issue 5: Line Command Education.

Providers indicate that commanders have little understanding of the behavioral health assets in theater, what services are provided at what clinics and what happens with their SMs once they seek behavioral health care. Sometimes commanders attempt to use the Restoration Centers as an inpatient psychiatric ward, an aero-medical stopping point, or a transition SM holding area. Some view the restoration centers as R & R (Rest and Relaxation) and resent SMs who attend these programs.

Most significantly, commanders appear to be confused over confidentiality requirements for SMs who self-refer for mental health care. In addition, commanders lack an understanding of the process and legal requirements for Command-Directed Mental Health Evaluations. (74% of BH survey respondents did not agree with the statement that commanders are satisfied with the amount of information they could provide; however 83% of respondents felt that the standards of how much patient information they could share with the commander is clear.)

Behavioral Health Recommendation 7: Implement an effective education and awareness campaign for line commanders regarding available BH resources in theater to include their appropriate use and the basics tenets of behavioral health treatment.

Behavioral Health Recommendation 8: Educate commanders on the legal requirements for patient confidentiality and Command-Directed Mental Health Evaluations. Develop and issue command teams graphic training aids (GTAs) with this information.

Issue 6: Medical Evacuation of the Emergency Behavioral Health Patient.

There were 585 BH emergency evacuations for SMs in 2011, above all other categories except Battle Injury and Nonbattle Injury. Providers at both the Bagram Role 3 and the Kandahar Role 3 report significant issues in the ability to evacuate emergency BH SMs in a timely fashion. Since there are no inpatient psychiatric wards available in theater, when a SM is in need of emergent BH evacuation, the SM is admitted to a medical inpatient ward. This requires the BH SM to have one or two 24/7 nonmedical attendant(s) at the SM's side. As there are no medical assets to perform this task, the nonmedical attendant(s) is provided by the SM's unit. The nonmedical attendant(s) accompany the SM on the evacuation trip to Landstuhl Regional Medical Center and then to CONUS. The loss of one or two SMs to the role of non-medical attendant(s) may negatively impact a line commander's ability to meet mission demands.

There are three issues that frequently delay the process of evacuating a SM for emergent BH care: 1) BH providers report that battalion commanders sometimes hold paperwork because they do not have enough personnel to send two individuals as nonmedical attendants to accompany the SM who is being evacuated. Providing nonmedical attendants to accompany SMs being evacuated can put a significant strain on the personnel resources for commanders and may have a negative impact on mission accomplishment. 2) BH providers report that battalion commanders do not always agree with the BH provider's assessment. As a result, the SM sits with his nonmedical attendant until the commander signs the paperwork to allow the SM to evacuate or until the commander takes responsibility for returning the SM to duty against medical advice. Only 39% of BH survey respondents indicate that commanders support their recommendations for MEDEVAC out of theater. 3) BH providers are required to complete two different processes and sets of paperwork; one for CENTCOM and one for USFORA. CENTCOM's process and paperwork are reportedly straight forward and consistent. USFORA's process is reported to be convoluted and confusing and the required paperwork often changes from one patient to the next (BH providers report they are often unaware the requirements have changed). When the paperwork is not ready, the BH evacuation is delayed.

The USFOR-A Surgeon General reported that he is coordinating with Landstuhl Regional Medical Command to explore the possibility that Landstuhl can send attendees to the ATO to escort BH evacuees to Landstuhl.

Behavioral Health Recommendation 9: 1) Create identified positions to serve as nonmedical attendant escorts for emergency BH evacuees. Thoroughly evaluate the USFOR-A Surgeon General's plan to have Landstuhl Regional Medical Center provide attendees to escort BH evacuees to Landstuhl. 2) Limit the amount of time a commander can refuse to sign paperwork to evacuate a patient. 3) Standardize USFOR-A paperwork required for BH evacuation; consider using only CENTCOM required paperwork.

Issue 7: Scope of Care and Provider/Technician Roles.

BH providers report that in-theater BH technicians (specialists) may have an expanded role and may perform more clinical tasks than in garrison, however, they must still operate under the license of an independent clinical provider. There is little in the way of formal guidance regarding the types of clinical activity that technicians and specialists can engage in and this can cause significant friction between providers and technicians. In addition, the Restoration Clinics employ Occupational Therapists to conduct some mental health functions (e.g. treating sexual assault victims) that they are most likely not trained or credentialed to do. Independent clinical providers report significant concern regarding technicians and Occupational Therapists operating outside of their scope of care. This concern is particularly relevant at FOBs and COPs where there is little oversight and documentation is sometimes poor or nonexistent.

Behavioral Health Recommendation 10: Review and clarify scope of care for BH specialists/technicians and Occupational Therapists in theater and their responsibility in support of independent BH clinicians.

Issue 8: Isolated Providers at Forward Operating Bases (FOBs).

The BH providers stationed at more remote FOBs are predominantly organic assets assigned to Brigade Combat Teams (BCTs). These BH providers are usually young (Captain, 0-3) and have recently completed their graduate training. However, they operate as independent practitioners. There is currently no theater-wide peer review program for these providers. Although senior MH leaders are working to assess and address this situation, the standard of BH care provided by these clinicians is uncertain. Much of what they do goes undocumented and when they do document, the notes in AHLTA are inconsistent and often lacking in detail (as per both the providers and the OEF BH consultant).

Behavioral Health Recommendation 11: Develop a comprehensive peer review program and oversight function for isolated providers and those organic BH assets that do not report through Task Force Med A and are scattered throughout the theater. Standards of care and clinical documentation need to be clarified and continuously taught and reviewed upon provider rotation.

Issue 9: Multiple Software Systems/Visibility of BH notes.

Although every provider has access to AHLTA-Theater and the ability to download notes to TMDS, not everyone has visibility on patient notes that have been input by other MH providers in theater or notes that were entered at garrison clinics. For example, the providers at the KAF restoration center have difficulty viewing the notes from the KAF Role 3 BHC which is about a block away (approximately 200 meters). The systems are cumbersome in that in order to see notes from garrison, providers have to log onto another system (AHLTA-Warrior) while at the same time be logged onto either AHLTA-Theater or TMDS. Sometimes the systems aren't always up and notes are just not visible. Most of the time, this is just an added frustration in that the cumbersomeness of the software systems eats up time and energy. However, when treating a complex case where the SM has had extensive garrison MH treatment (as in cases with pre-existing conditions) it is critical that the provider be able to view garrison mental health notes.

Behavioral Health Recommendation 11: Review available IT systems; consider overhaul of system so that only two systems are necessary: AHLTA-Theater, so that providers can enter their notes in a stand-alone system when traveling; and one system which would allow providers to download notes entered in AHLTA-Theater and also view notes that have been entered in garrison and by other providers in theater.

Issue 10: Telebehavioral Health (TBH) (BH Services delivered through secure chat or webcam).

Many providers have experience with TBH and have used it in garrison. Telebehavioral Health is currently being used in theater (82% of survey respondents report TBH is available at their location.), and a 24/7 TBH pilot program is underway for the month of July 2012. Most providers believe that TBH has a role to play in providing timely care to SMs; however, providers strongly indicate that TBH is not a panacea and is inappropriate in many cases. Providers feel that 24/7 TBH does not add much to the mental/behavioral health services already provided in theater and trying to replace face to face patient contact with TBH would create more problems than it would solve. Battlefield circulation is still the preferred method of BH care delivery to SMs. (78.5% of survey respondents report they prefer counseling using face to face contact with SMs, while 16.5% percent report they would prefer using a mix of TBH and face to face contact. 0% report they would like to use only TBH.)

Providers concur that TBH is not appropriate for: complex psychotropic medication management, particularly if there is not an appropriate prescriber on the SM end, initial comprehensive intake interviews/assessments, Command Directed Evaluations, or emergency referrals for SI/HI. Many BH providers reported that they believe the resources put into TBH could be better served elsewhere.

Providers concur that TBH is most appropriate for: consultation amongst MH providers across the theater; simple medication management after the initial assessment has been completed; follow up care for nonemergent, non-SI/HI patients; and as a way to touch base with a SM letting the SM know that the provider is on the way to his location and will see him soon. TBH is already being used to serve these ends.

A number of providers have had significant negative experiences with TBH due to technological problems and as a result remain skeptical of its utility. Indeed the technological issues are a real cause for concern. Once a provider/patient have had a difficult time with TBH (having it cut out in the middle of a session or not being able to start a session after multiple attempts) neither are likely to want to use the technology again.

| |
|--|
| <p>Behavioral Health Recommendation 12: Continue TBH in theater as it is currently being used; assess the outcome of the July TBH pilot program and discontinue 24/7 manning of TBH assets if it does not add significant value to the BH treatment of SMs.</p> |
|--|

Issue 11: Substance/Alcohol Use Assessment, Diagnosis, and Treatment.

Providers reported seeing few SMs with significant substance abuse (SA) issues. However, they report being confused regarding the SA policy in theater. Currently there are no treatment provisions for SA issues. Since there are no clinics designated specifically to conduct these evaluations, many providers feel that they either cannot do the assessments or can only do the assessments if the evaluation is treated as a command directed evaluation. Given that substance/alcohol abuse evaluations are often associated with administrative action as well as recommendations for education and treatment, it is important to have clear guidance on who can perform the evaluations and under what conditions (only 61% of survey respondents felt confident in their ability to evaluate and treat SMs with Substance Abuse and Dependence).

During focus groups, providers were unanimous that SMs who have been diagnosed with alcohol or substance abuse or dependence should not be treated in theater nor should they be deployed if they have not completed treatment prior to deployment.

Behavioral Health Recommendation 13: Determine where Substance Abuse evaluations can be conducted and by whom.

Issue 12: Special Duty Assignment Evaluations.

Although not a significant behavioral health issue, BH providers strive to provide the same level of services available to SMs in garrison to include special duty assignment evaluations such as Military Training Instructor (MTI) or recruiter duty. Providers feel SMs should not be denied competing for these assignments just because they are deployed. These evaluations are extremely time consuming (reportedly up to 17 hrs per evaluation) with a need for considerable reach back to CONUS. In addition, the requirement for psychological testing utilizes scarce testing resources that could be used for patient care. The providers and clinics that perform these assessments are most often the ones that already have the greatest patient load. Providers suggest that the requirement for the face to face psychological evaluation should be waived until the SM returns to CONUS. Providers would like to see one joint policy for both Air Force and Army.

Behavioral Health Recommendation 14: Where possible shift Special Duty Evaluations to clinics and personnel who have low case loads. If this is not feasible, develop a joint policy waiving the requirements for the face-to-face BH evaluation for special duty assignments until the SM returns to CONUS.

17. Theater Suicide Review

17.1 Demographics

Overall suicide rates in the Army and the Marine Corps have increased in 2012. Since 2005 there has been an increasing number of Soldier suicides in the Afghanistan Theater of Operations (ATO) with a particularly marked increase from 2008 to the present (see Table 17.1; this does not take into account the troop surge⁴). In 2008, the Army OEF suicide count more than doubled compared to any previous calendar year. In 2011 the Army had 14 confirmed suicides. By mid-June 2012, the Army suicide count is on pace to be higher than any previous year with 8 suicides committed to date (data obtained from US Armed Forces Medical Examiner).

| | Year | | | | | | | | | | | |
|--------------------|------|------|------|------|------|------|------|------|------|------|------|-------|
| | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012* |
| US Army | 1 | 2 | 1 | 1 | 3 | 3 | 3 | 7 | 4 | 12 | 14 | 8 |
| US Marine Corps | | | | | | | | | | 4 | 2 | 1 |
| *As of 3 June 2012 | | | | | | | | | | | | |

Firearms are the most frequently used method of suicide in the ATO as well as CONUS (Shenassa, Catlin, Buka, 2003). Soldiers and Marines carry firearms and ammunition on their person and thus have easy access. Since 2007, gun-shot-wound (GSW) is the leading cause of suicide related death for both Army and Marine SMs. All suicidal deaths in the Army in 2012 (as of 3 June 2012) and since 2010 in the Marines were by self-inflicted GSW.

| | Year | | | | |
|--------------------|------|------|------|------|-------|
| | 2007 | 2008 | 2010 | 2011 | 2012* |
| Firearms | 91% | 94% | 92% | 93% | 100% |
| Male | 100% | 91% | 100% | 93% | 100% |
| Age ≤ 30 | 83% | 84% | 83% | 79% | 75% |
| E1 - E4 | 61% | 75% | 50% | 64% | 63% |
| Non-white | 18% | 28% | 17% | 29% | 0% |
| *As of 3 June 2012 | | | | | |

⁴ Per the Army G-1 Suicide Prevention Program Manager, suicide population rates per 100,000 are not calculated for OEF due to the low number of cases.

| <i>Table 17.1.2: Demographic Characteristics of Confirmed Marine Suicides in ATO</i> | | | |
|--|------|------|-------|
| | Year | | |
| | 2010 | 2011 | 2012* |
| Firearms | 100% | 100% | 100% |
| Male | 100% | 100% | 100% |
| Age ≤ 30 | 100% | 100% | 100% |
| E1 - E4 | 100% | 100% | 100% |
| Non-white | 25% | 50% | 0% |

*As of 3 June 2012

Junior enlisted males (E-1 to E-4), younger than 30 and most often Caucasian, commit suicide at a higher rate than any other demographic group in the Army and Marine Corps. To date in 2012, the 8 Army suicides were committed by Caucasian males with the use of firearms. Six of the 8 were committed by men who were younger than 31 and 5 of the 8 were committed by E-4 and below. The other 3 Army suicides were committed by an E-5, an E-6 and an O-3, all male, indicating midlevel grade Soldiers are not immune from the stress related to suicide. The demographics of Marines who commit suicide in the ATO are consistent across years with all being young and male and the majority being Caucasian.

18. STATUS OF J-MHAT 7 RECOMMENDATIONS

| <i>Table 12: Status of J-MHAT 7 Recommendations</i> | | |
|---|--------|---|
| J-MHAT 7 Recommendation | Status | Comments |
| Ensure the theater Behavioral Health Consultant regularly advises medical and operational command about optimal mental health resource allocation in line with Service specific delivery models; consider making position a Joint billet (In Theater). | Amber | There are adequate resources (1:723 ratio of Behavioral Health (BH) personnel to Service Member (SM)). However, resources are unevenly distributed by region, type of clinic and SM needs. The current BH Consultant is not in a Joint Billet. He is assigned to the the Medical Brigade. |
| Consider ways to prioritize travel for Behavioral Health personnel such as priority Space-A and routine access to bandage flights (in Theater). | Green | There were no reported problems for BH personnel traveling around theater. However, BH personnel do not have priority status for travel. |
| Emphasize the importance of having Medics and Corpsmen document post-concussive evaluations in Electronic Medical Records (EMR) regardless of outcome, and work to ensure compliance with directive to document evaluations (DTM 09-033) (In Theater). | Amber | There was a slight increase in the number SMs being evaluated for concussion and a significant increase in evaluation for those SMs who were knocked out. Better education is needed for SMs in what a concussion evaluation entails (likely a Medic/Corpsman giving the Military Acute Concussion Evaluation (MACE), not an MRI or any advanced medical procedures). |
| Encourage program evaluation of clinical practice tools (e.g., ANAM, ImPACT) in treatment of Service Members with mild traumatic brain injury (mTBI) /concussions (In Theater). | Amber | According to the Theater Neurology Consultant, the Military Acute Concussion Evaluation (MACE) has been validated. More Service Members report being evaluated by “Medical Professionals or medics/corpsmen.” However there is room for improvement in terms of educating SMs about concussion evaluations. |
| Continue to refine the DTM 09-033 evaluation criteria regarding distance from blast [within 50 meters of a blast (inside or outside)] as this standard may be overly conservative (CONUS). | Red | No studies have been conducted to evaluate the 50 meter criteria. See upcoming Concussion Care Information Paper for further details. |
| Incorporate sleep hygiene and discipline into pre-deployment training. Emphasize that small unit leaders are responsible for implementing sleep discipline and mitigating factors that lead to poor sleep environments commensurate with unit location and circumstances (Reference COSC FM 6-22.5) (In Theater and CONUS). | Amber | Sleep discipline is addressed in Resilience Training for Mid-Grade leaders (Senior Leader Course) as well as in Pre-Deployment Resilience Training for Soldiers. However, Soldiers report that not all of their NCOs stress sleep hygiene and discipline. For example, 56% of Soldiers and 40% of Marines reported that their NCOs encourage SMs to get adequate sleep; 47% of Soldiers and 38% report their NCOs work to ensure SMs have a good sleep environment. |
| Conduct further evaluation of the use of Tele-Mental Health as an adjunct to MH service provision in the ATO by systematically addressing Service Members’ access to and acceptance of Tele-Mental Health (In Theater and CONUS). | Amber | Most providers believe that TBH has a role to play in providing timely care to SMs; however, providers strongly indicate that TBH is not a panacea and is inappropriate in many cases. However, 66% of Soldiers and 68% of Marines report that do not know if there is TBH at their location.TF MED-A has initiated a TBH evaluation of 24-hour TBH availability. |

APPENDIX A: REFERENCES

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APPENDIX B: CONCUSSION EVALUATION

Attachment 2 of Directive-Type Memorandum 09-033 (DTM 09-033) dated June 21, 2010 detailed four concussive-related events requiring mandatory evaluations and reporting of exposure:

- a. Any Service Member in a vehicle associated with a blast event, collision, or rollover
- b. Any Service Member within 50 meters of a blast (inside or outside)
- c. A direct blow to the head **or** witnessed loss of consciousness
- d. Command-directed, especially in the case with exposure to multiple blast events

The events requiring medical evaluations can be approximated by the following items:

| | |
|--|---|
| <p>26. How many times during this deployment were you inside a vehicle damaged in a blast?</p> <p style="text-align: right;"> <input type="radio"/> 0 blast01 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 or more </p> | <p>27. How many times during this deployment were you within 50 meters of a blast explosion while dismounted?</p> <p style="text-align: right;"> <input type="radio"/> 0 blast02 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 or more </p> |
| <p>28a. Did any injury during this deployment involve a blow or jolt to your head?</p> <p style="text-align: right;"> <input type="radio"/> No, skip to question 29 <input type="radio"/> Yes headinj1 </p> | <p>23a. Did any injury you received during this deployment involve the following: Losing consciousness (knocked out)</p> <p style="text-align: right;"> <input type="radio"/> dpinjny10 No <input type="radio"/> Yes </p> |

In addition to the four items above assessing prevalence rates, the survey asked Soldiers and Marines whether they had been “evaluated by a medical professional for a TBI or concussion” using a Yes/No response option. The J-MHAT 7 report raised the issue that Soldiers and Marines may have been evaluated by a medic or Corpsman but not consider the medic or Corpsman as a medical professional. The J-MHAT 8 survey addressed this issue by asking Soldiers whether they had been “evaluated by a **Medic or Corpsman** for a TBI or concussion.”

| | |
|---|---|
| <p>30. During this deployment, were you evaluated by a medical professional for a TBI or concussion?</p> <p style="text-align: right;"> <input type="radio"/> No tbi01 <input type="radio"/> Yes </p> | <p>31. During this deployment, were you evaluated by a Medic or Corpsman for a TBI or concussion?</p> <p style="text-align: right;"> <input type="radio"/> No tbi05 <input type="radio"/> Yes </p> |
|---|---|

Figures B.1 through B.6 provides the prevalence rates of each of the four events plus the prevalence rate of whether the Soldier and Marines are required to receive a screen (Screen Required) based on the Directive. Specifically, Figures B1-B3 are for Soldiers and they show the prevalence rates for 2010 when evaluated by a Medical Professional, 2012 when evaluated by a Medical Professional and 2012 when evaluated by a Medical Professional or Medic /

Corpsman. Figures B4-B6 are parallel figures for the Marines. The total prevalence rate is divided into two subsamples – those that reported being evaluated and those that reported not being evaluated by a medical professional. The table on the bottom of the graph provides the percent within each category that reported not being evaluated by a medical professional.

Figure B.1 Army Concussive Events and Medical Screening (J-MHAT 7)

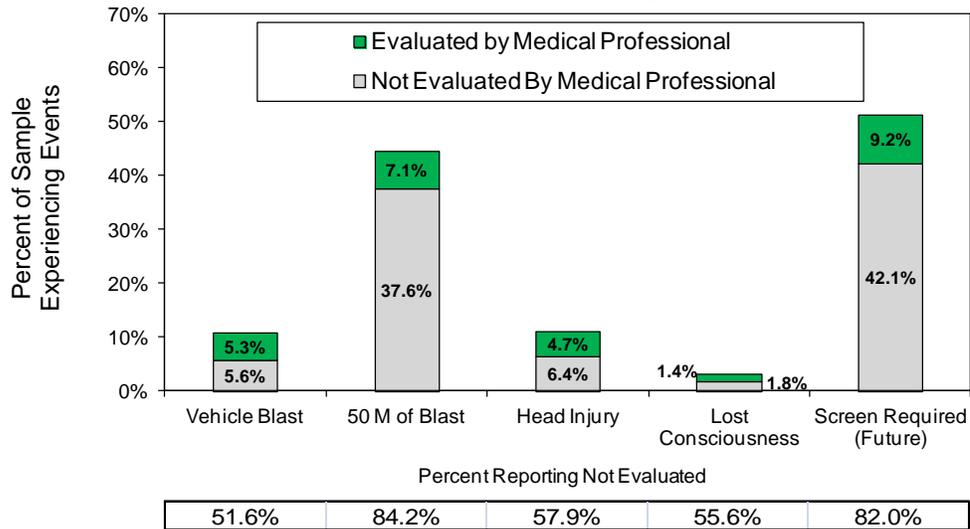


Figure B.2 Army Concussive Events and Medical Screening by a Medical Professional (J-MHAT 8)

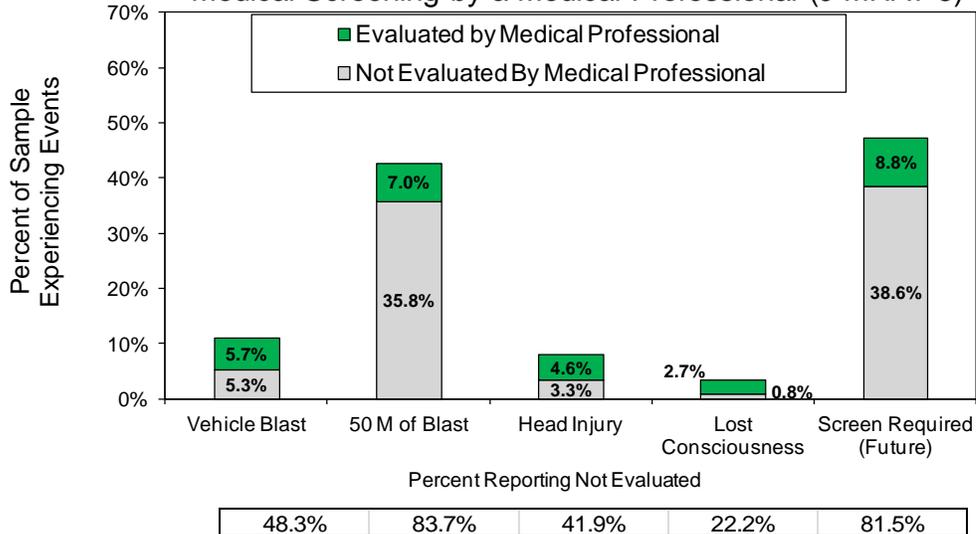
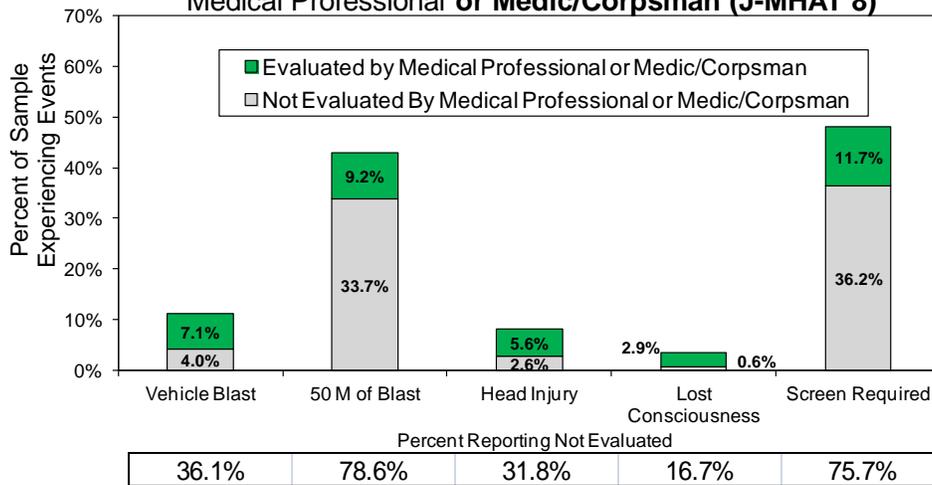


Figure B.3 Army Concussive Events and Medical Screening by a Medical Professional or Medic/Corpsman (J-MHAT 8)



The 2012 Army cumulative exposure rates in Figure B.2 are 11.0% (In vehicle damaged by blast); 42.8% (within 50M of blast); 7.9% (head injury); 3.5% (lost consciousness), and 47.4% (a future screen required based on DTM 09-033). The percent who report being evaluated by a medical professional for a concussion after being knocked out is higher in 2012 compared to 2010 (83.3% vs. 44.4%). The tables at the bottom of the figures clearly show, however, that there continues to be that a low percentage of Soldiers who report receiving evaluations. This is largely due to those who were within 50 meters of a blast not being evaluated (83.7%).

When corrected to include evaluations conducted by a Medic or Corpsman, the rates increase but still many Soldiers report not being evaluated and the largest percentage is from those within 50 meters of a blast.

Figure B.4 Marine Concussive Events and Medical Screening (J-MHAT 7)

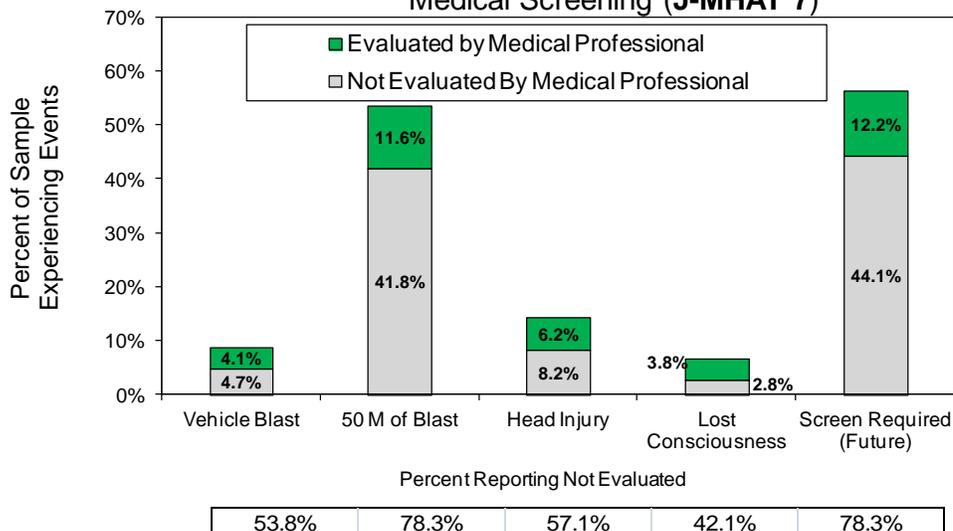
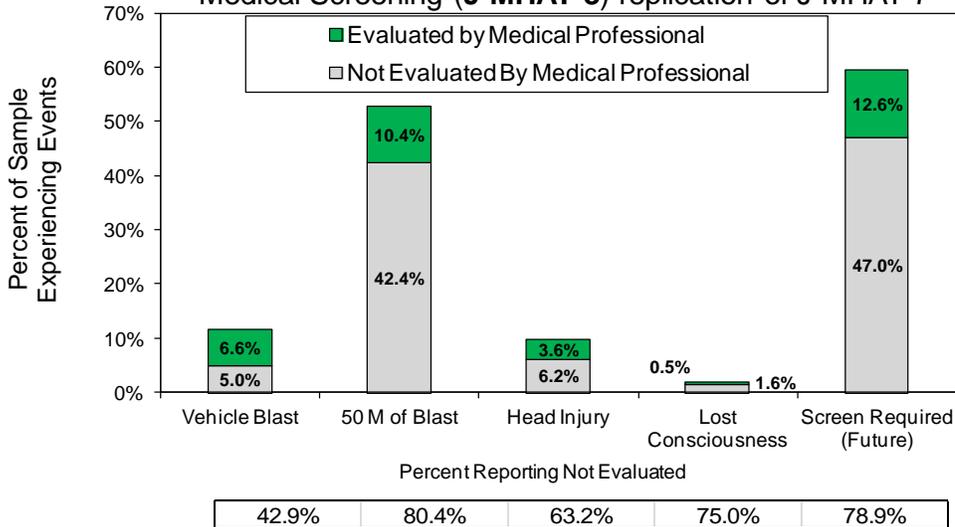
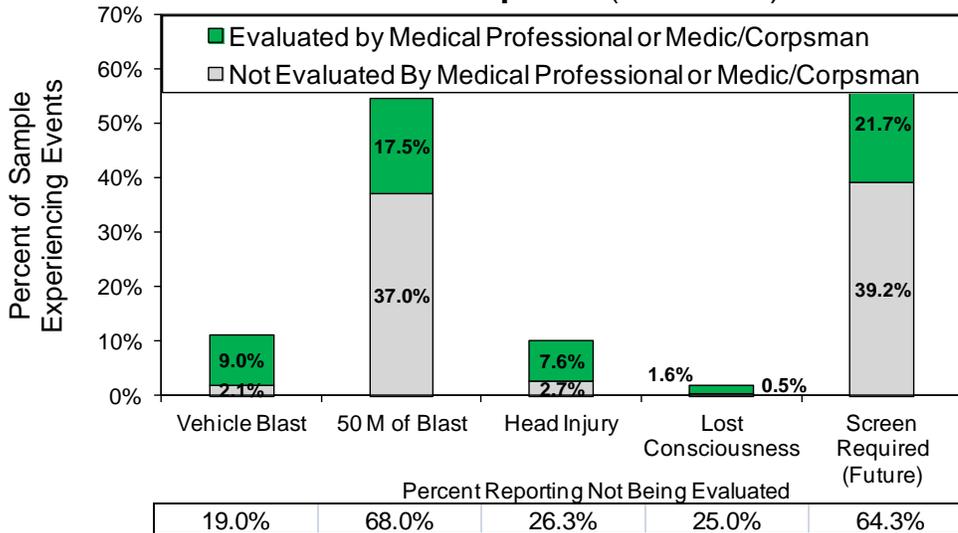


Figure B.5 Marine Concussive Events and Medical Screening (J-MHAT 8) replication of J-MHAT 7



| | | | | |
|-------|-------|-------|-------|-------|
| 42.9% | 80.4% | 63.2% | 75.0% | 78.9% |
|-------|-------|-------|-------|-------|

Figure B.6 Marine Concussive Events and Medical Screening by Medical Professional or Medic/Corpsman(J-MHAT 8)



| | | | | |
|-------|-------|-------|-------|-------|
| 19.0% | 68.0% | 26.3% | 25.0% | 64.3% |
|-------|-------|-------|-------|-------|

The 2012 Marine cumulative exposure rates in Figure B.5 are 11.6% (In vehicle damaged by blast); 52.8% (within 50M of blast); 9.8% (head injury); 2.1% (lost consciousness), and 59.6% (a future screen required based on DTM 09-033). The percent who report being evaluated by a medical professional for a concussion after being knocked is trending but not significantly higher in 2012 compared to 2010 (75.% vs. 58%). The tables at the bottom of the figures clearly show, however, that there continues to be that a low percentage of Soldiers who report receiving evaluations. This is largely due to those who were within 50 meters of a blast not being evaluated (68%). It is important to be careful with interpreting Marine results as the absolute number of Marines who met screening requirements for a concussion in the J-MHAT 8 sample was low (n=115) and only 4 of those lost consciousness.

When corrected to include evaluations conducted by a Medic or Corpsman, the rates increase but still many Soldiers report not being evaluated and the largest percentage is from those within 50 meters of a blast.

In interpreting the figures, it is important to realize that it is possible that Soldiers and Marines who experienced the potentially concussive events may not understand what it means to receive a concussion evaluation. DTM 09-033 and USFOR-A policy both state that an evaluation starts with a medic/corpsman giving a Service Member a Military Acute Concussion Evaluation (MACE). If no red flags (exposure and symptoms) are present, the medic/corpsman takes a MACE history and if there is no history of concussion, the SM will be placed on mandatory 24 hours rest and will be reevaluated after 24 hours. If no symptoms at that time, no further action. However, all MACEs must be documented in the SM's EMR. SMs may assume that an evaluation consists of seeing a medical doctor or being evaluated with a diagnostic tool such as an MRI.

J-MHAT 8 updated the J-MHAT 7 recommendation for concussion evaluation and assessed concussion evaluations during 2012. However, between 2010 and 2012, resources for concussion care have greatly increased. There are additional concussion care assets in theater as well as research being conducted in CONUS. The DTM 09-033 was transformed into a Department of Defense Instruction (DoDI) 6490.11 published in September 2012. In addition, those responsible for concussion care are in theater are not in the mental health field. Finally, concussion care centers in theater are separate from mental/behavioral health clinics. Therefore, we are recommending that concussion evaluation and care be separated from future Joint Mental Health Advisory Team missions.

Concussion Care Evaluations. Educate SMs on how they will be evaluated and treated if they have a concussion.

Continue to refine J-MHAT wording on questions addressing concussion evaluation to ensure that SMs understanding of concussion evaluation is assessed.

APPENDIX C: BEHAVIORAL HEALTH SURVEY RESULTS

| | MHAT 5 2007 | MHAT 6 2009 | J-MHAT 7 2010 | J-MHAT 8 2012 |
|---|----------------|----------------|------------------|------------------|
| DEMOGRAPHICS (% response) | | | | |
| How were you assigned to your current unit | | | | |
| PROFIS | | | | 23.9% |
| Organic | | | | 46.0% |
| Other | | | | 30.1% |
| What type of work environment did you practice in? | | | | |
| COSC | 50.0% | 56.7% | 53.0% | 71.7% |
| Division Mental Health | 20.0% | 6.7% | 9.1% | 5.3% |
| Level II | 10.0% | 10.0% | 7.6% | 7.1% |
| Level III | 0.0% | 3.3% | 18.2% | 5.3% |
| Other | 20.0% | 23.3% | 12.1% | 10.6% |
| Occupational Specialty | | | | |
| Independent BH Practitioner | 60.9% | 46.7% | 50.7% | 33.6% |
| Occupational Therapist or Technician | 0.0% | 6.7% | 9.9% | 12.9% |
| BH Specialist | 39.1% | 26.7% | 25.4% | 47.4% |
| Other | 0.0% | 20.0% | 14.1% | 6.0% |
| STANDARDS OF CLINICAL CARE (% AGREE) | | | | |
| The standard of BH care in this theater or Area of Operations are clear | 60.8% | 76.7% | 76.2% | 76.7% |
| The standards of COSC services in this theater or Area of Operations are clear | 56.5% | 76.3% | 66.7% | 67.5% |
| The standards for clinical documentation in this theater or Area of Operations are clear | 30.4% | 46.6% | 65.5% | 69.0% |
| The standards for records management in this theater or Area of Operations are clear | 26.1% | 36.7% | 52.4% | 59.8% |
| The standards for transfer of clinical BH information between levels of care in this theater or Area of Operations are clear | 30.4% | 73.4% | 39.7% | 62.1% |
| Commanders are satisfied with the amount of information I can provide | 17.4% | 13.3% | 28.5% | 25.6% |
| I encountered situations involving medical ethics in this AO to which I did not know how to respond | 60.8% | 72.4% | 80.0% | 74.8% |
| The standards of how much patient information I can share with commanders is clear | 73.9% | 73.4% | 82.1% | 82.9% |
| RESOURCES FROM COMMAND/COORDINATION (% AGREE) | | | | |
| My higher headquarters provides us with the resources required to conduct our BH or COSC mission | 52.2% | 50.0% | 44.7% | 62.4% |
| My higher headquarters encourages us to provide feedback/comments to theater/Area of Operations BH or COSC policies | 60.9% | 66.7% | 41.1% | 59.8% |
| We coordinate or integrate our BH or COSC activities with the Unit Ministry Teams in our Area of Operations | 65.2% | 66.6% | 70.6% | 67.5% |
| We coordinate or integrate our BH or COSC activities with primary care medical personnel in the battalion aid stations or medical companies | 91.3% | 86.7% | 83.5% | 83.6% |
| COMBAT AND OPERATIONAL STRESS CONSULTING (% AGREE) | | | | |
| <i>During this deployment how frequently did you:</i> | | | | |
| provide COSC outreach services (weekly) | 30.4% | 63.3% | 54.9% | 51.3% |
| conduct educational classes (weekly) | 17.3% | 33.3% | 43.4% | 51.3% |
| consult with unit leaders (weekly) | 56.5% | 67.8% | 67.5% | 58.3% |
| conduct WRAIR/Battlemind psychological debriefings (monthly) | 17.3% | 30.1% | 22.8% | 27.2% |
| conduct psychological debriefings (CED/CISD; monthly) | 39.0% | 17.2% | 25.0% | 24.1% |
| conduct Unit Behavioral Health Needs Assessments (UBHNA; every 2-3 months) | 34.7% | 23.3% | 16.7% | 27.4% |
| conduct Suicide Prevention Training (monthly) | | | | 29.8% |
| provide one-to-one BH counseling with Service Members at their worksite (weekly) | 13.0% | 30.0% | 22.9% | 25.2% |
| provide one-to-one COSC services with Service Members at their worksite (weekly) | 31.8% | 13.3% | 30.1% | 31.9% |
| provide one-to-one BH counseling with Service Members at the BH/COSC unit location (weekly) | 26.0% | 23.3% | 32.1% | 32.5% |
| provide one-to-one COSC services with Service Members at the BH/COSC unit location (weekly) | 91.3% | 80.0% | 61.9% | 70.9% |
| provide one-to-one COSC services with Service Members at BH/COSC unit location (weekly) | 65.2% | 83.4% | 65.0% | 63.8% |
| provide Resilience Training as part of CSF (every 2-3 months) | | | | 40.9% |
| provide Leader Led After Action Debriefs (LLAAD; monthly) | | | | 9.6% |
| TELEBEHAVIORAL HEALTH | | | | |
| TBH is available in my location (% yes) | | | | 82.1% |
| TBH is available in locations I support (other than your primary location) (% yes) [for those who support other locations] | | | | 76.1% |
| The bandwidth is not sufficient to support TBH in your location (% yes) | | | | 12.2% |
| The bandwidth is not sufficient to support TBH in location I support (other than your primary location) (% yes) [for those who support other locations] | | | | 12.4% |
| Have you ever used TBH (% yes) | | | | 45.3% |
| I felt there was enough privacy during my TBH encounter (% Agree) | | | | 71.7% |
| Using TBH technology is an efficient method for delivering health care (% Agree) | | | | 65.0% |
| I felt comfortable discussing Service Member's issues over TBH technology (% Agree) | | | | 70.0% |
| In a deployed environment, I prefer providing counseling/BH services to be: | | | | |
| Face-to-face | | | | 78.5% |
| Using TBH | | | | 0.0% |
| Mix of face-to-face and TBH | | | | 16.5% |
| No preference | | | | 5.1% |

| | MHAT 5 2007 | MHAT 6 2009 | J-MHAT 7 2010 | J-MHAT 8 2012 |
|--|----------------|----------------|------------------|------------------|
| CONFIDENCE IN SKILLS AND TRAINING (% AGREE) | | | | |
| <i>I feel confident in my ability to:</i> | | | | |
| use the COSC Workload and Activity Reporting System (COSC-WARS) | 13.0% | 66.6% | 39.0% | 74.1% |
| help Service Members adapt to the stressors of combat or deployment | 100.0% | 93.3% | 95.2% | 94.0% |
| evaluate and manage Service Members with suicidal thoughts or behaviors | 100.0% | 96.6% | 91.6% | 87.9% |
| evaluate and treat Service Members with substance Abuse or Dependence | 60.9% | 63.4% | 69.1% | 60.7% |
| evaluate and treat Combat and Operational Stress Reaction | 100.0% | 93.4% | 91.7% | 93.2% |
| evaluate and treat acute Stress Disorder or PTSD | 91.3% | 93.3% | 88.1% | 85.5% |
| evaluate and treat victims of sexual assault | 82.6% | 62.0% | 70.3% | 66.1% |
| perform clinical evaluation and treatment of Afghan civilians | 26.1% | 3.3% | 22.5% | 18.8% |
| perform clinical evaluation and treatment of detainees | 26.0% | 10.0% | 26.2% | 22.4% |
| perform clinical evaluation and treatment of Host Nation Security Force personnel | 21.7% | 16.7% | 35.2% | 31.9% |
| COMBAT AND OPERATIONAL STRESS COURSE TRAINING | | | | |
| I attended pre-deployment COSC Training Course (e.g. AMEDD) (% yes) | 56.5% | 16.7% | 67.5% | 68.4% |
| I attended the Master Resilience Trainer (MRT) Course (% yes) | | | | 6.9% |
| I received adequate training pre-deployment to prepare me for my COSC duties (% AGREE) | 45.0% | 50.0% | 59.1% | 55.6% |
| CLINICAL SERVICES FOR HOST NATION CIVILIANS, DETAINEES, AND SECURITY FORCES | | | | |
| Hours per week providing clinical care to Host Nation Civilians, detainees, and Security Forces (mean) | 2.95 | 11.07 | 6.37 | 0.80 |
| STIGMA AND BARRIERS TO CARE (% AGREE) | | | | |
| The medical leadership does not support BH/COSC outreach | 13.0% | 0.0% | 15.6% | 13.7% |
| The supported unit's leadership does not support BH or COSC outreach | 8.6% | 3.3% | 16.7% | 16.5% |
| There is inadequate transportation to conduct outreach activities | 39.1% | 23.3% | 44.1% | 32.5% |
| There is inadequate communication between BH or COSC and supported units | 17.3% | 23.4% | 21.0% | 17.9% |
| Service Members feel uncomfortable talking to BH or COSC personnel about their problems | 21.7% | 16.7% | 25.0% | 23.9% |
| BH or COSC personnel are unfamiliar with supported unit leadership and Service Members | 26.1% | 13.3% | 7.2% | 12.8% |
| Traveling to supported units is too dangerous | 26.0% | 6.7% | 11.9% | 12.8% |
| Arranging travel to supported units is too difficult | 39.1% | 30.0% | 28.6% | 29.1% |
| The inability to arrange travel has led to mission cancellations | 52.2% | 40.0% | 26.5% | 31.6% |
| BH or COSC personnel do not like to perform outreach services | 21.7% | 6.7% | 11.9% | 8.5% |
| BH or COSC personnel are not trained to conduct outreach services | 30.4% | 3.3% | 18.1% | 6.8% |
| BH or COSC personnel are not available due to performing non-BH or COSC missions | 17.3% | 6.7% | 10.8% | 5.1% |
| BH or COSC personnel do not think preventive outreach activities are effective | 21.7% | 3.3% | 4.8% | 4.3% |
| Commanders support BH provider recommendations for medevac out of theatre | 56.5% | 50.0% | 53.5% | 38.8% |
| Commanders respect patient confidentiality when it comes to mental health issues | 50.0% | 53.3% | 57.2% | 49.6% |
| There are sufficient BH assets in theatre to cover the mission across the AO | 47.8% | 16.7% | 28.6% | 41.0% |
| SERVICE MEMBERS NEEDS (% AGREE) | | | | |
| <i>How often do you:</i> | | | | |
| talk informally to the Service Members | 82.6% | 63.3% | 86.9% | 87.2% |
| conduct focus groups with Service Members | 8.7% | 17.2% | 15.6% | 24.8% |
| talk with the chaplains | 69.5% | 73.4% | 70.3% | 71.8% |
| talk with the unit's commander | 73.9% | 73.4% | 69.0% | 68.4% |
| talk with the unit's medical personnel | 86.9% | 63.3% | 80.8% | 77.8% |
| use validated surveys or instruments | 34.8% | 10.0% | 30.9% | 34.2% |
| use Unit Behavioral Health Needs Assessment (UBHNA) | | | | 16.4% |
| use locally developed surveys or instruments | 17.4% | 16.7% | 21.7% | 17.2% |
| develop a BH or COSC unit prevention and early intervention plan | 36.4% | 23.4% | 36.9% | 44.3% |
| conduct Command Consultation | 60.9% | 60.0% | 56.0% | 59.5% |

| | MHAT 5 2007 | MHAT 6 2009 | J-MHAT 7 2010 | J-MHAT 8 2012 |
|---|----------------|----------------|------------------|------------------|
| PERSONAL WELL-BEING (% AGREE) | | | | |
| Overall, in the PAST MONTH, how would you rate your health (% good, very good or excellent) | | | | 93.0% |
| How often in the PAST MONTH have you gone to sick call or visited a doctor or other medical professional for a physical condition (% three or more times) | | | | 1.7% |
| How often do you talk to other providers about your cases. | | | | 67.0% |
| How often do you use stress management techniques to deal with your own stressors | | | | 84.2% |
| How often do you do physical fitness training (PT) | | | | 89.5% |
| My ability to do my behavioral health job is impaired by the stressors of deployment or combat | 4.3% | 3.3% | 9.5% | 9.5% |
| My mental well-being has been adversely affected by the events I have witnessed on this deployment | 13.0% | 6.6% | 13.1% | 9.5% |
| My mental well being has been adversely affected by the cumulative effects of multiple deployments | | | | 12.1% |
| My spiritual well being has been adversely affected by the events I have witnessed on this deployment | 4.3% | 6.6% | 9.6% | 4.3% |
| Since this deployment, I have become less sensitive to the needs of the Service Members I serve or support | 4.3% | 6.6% | 14.3% | 14.7% |
| My ability to do my job is impaired by listening to the combat experiences of Service Members I have talked with while performing my BH or COSC mission | 4.3% | 3.3% | 4.8% | 4.3% |
| I have enough time to use stress management techniques | | | | 66.4% |
| I have the necessary resources to use stress management techniques | | | | 79.1% |
| I have enough time for physical fitness training | | | | 77.6% |
| I have the necessary resources for physical fitness training | | | | 84.5% |
| Rate your personal morale (percent high or very high) | 65.2% | 63.4% | 53.5% | 47.4% |
| Rate your energy level (percent high or very high) | 43.5% | 60.0% | 52.3% | 35.9% |
| Rate your level of burnout (percent high or very high) | 52.2% | 56.6% | 45.2% | 18.8% |
| Rate your motivation (percent high or very high) | 73.9% | 67.7% | 60.2% | 47.9% |
| Rate your BH/COSC team morale (percent high or very high) | | | | 50.9% |
| On average, how many hours of sleep do you get per day (% less than 7) | | | | 52.1% |
| How many hours of sleep do you need per day in order to feel well-rested (% less than 7) | | | | 29.9% |
| <i>How often have the following disrupted or interfered with your sleep over the past 30 nights (% more than half the nights)</i> | | | | |
| Stress related to combat | | | | 6.0% |
| Stress related to personal life and problems | | | | 11.1% |
| Poor sleep environment (too noisy, bright, hot, cold, etc.) | | | | 22.2% |
| High OPTEMPO | | | | 8.6% |
| Nighttime duties | | | | 2.6% |
| Off-duty leisure activities (video games, movies, etc.) | | | | 3.4% |
| Illness | | | | 0.9% |
| Other (please specify): | | | | 18.2% |
| <i>How often in the PAST MONTH did you experience the following (% more than half the days)</i> | | | | |
| Trouble falling asleep at night | | | | 17.1% |
| Trouble staying asleep at night | | | | 23.1% |
| Trouble waking up | | | | 7.7% |
| Problems waking too early | | | | 14.7% |
| CAREER INTENTIONS | | | | |
| <i>Which best describes your CURRENT career intentions (% probably or definitely leave upon completion of their current obligation)</i> | | | | |
| | | | | 22.4% |
| PSYCHIATRIC MEDICATIONS (% AGREE) | | | | |
| The procedures for ordering or replenishing psychiatric medications in this theater or Area of Operations are clear | 64.3% | 10.0% | 30.0% | 50.0% |
| In general, there has been adequate availability of appropriate psychiatric medications in the area of operations (% Yes) | 61.5% | 28.6% | 86.2% | 84.0% |
| There has been adequate availability of appropriate psychiatric medication at Level I (Battalion Aid Station) | 53.8% | 28.6% | 56.5% | 63.6% |
| There has been adequate availability of appropriate psychiatric medication at Level II (Forward Support Medical Company) | 54.5% | 28.6% | 71.4% | 83.7% |
| There has been adequate availability of appropriate psychiatric medication at Level III (Combat Support Hospital) | 84.6% | 14.3% | 100.0% | 97.9% |
| PSYCHIATRIC MEDICATIONS (% Frequently or very frequently) | | | | |
| I most frequently prescribed medications for | | | | |
| sleep problems (% chosen) | | 100.0% | 47.1% | |
| anxiety symptoms (% chosen) | | 0.0% | 11.8% | |
| depressive symptoms (% chosen) | | 0.0% | 23.5% | |
| other (% chosen) | | 0.0% | 17.6% | |
| Prescribe medications for sleep problems | | | | 43.2% |
| Prescribe medications for PTSD problems | | | | 43.2% |
| Prescribe medications for Anxiety symptoms | | | | 45.5% |
| Prescribe medications for Depressive symptoms | | | | 43.2% |
| Prescribe medications for other | | | | 27.3% |