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Mental Health Advisory Team VI

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Soldiers in Iraq and Afghanistan continue to face stress from multiple deployments into combat, but report being more adequately prepared for the stresses of deployments. Those were among findings of two teams of behavioral-health experts who surveyed and interviewed troops in the theater as part of the sixth Mental Health Advisory Team (MHAT).

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Another notable conclusion is that "dwell time" at home between deployments is important to Soldier mental health.

HEALTH TIPS

"The dwell time effect is pretty strong. It turned out to be more important than some of the other variables," commented Lt. Col. Paul D. Bliese, director of the division of psychiatry and neuroscience at Walter Reed Army Institute of Research (WRAIR). Bliese led the team in Iraq.

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"Cumulative time deployed was less important than immediate dwell time. In other words, someone who had a total of 20 months deployed over several years and 12 months dwell time was better off than someone with 12 months of total deployment, but only eight months dwell time," Bliese added. The team in Iraq found that behavioral-health problems in maneuver units return to near garrison rates (about 10 percent with problems) after 24 months of dwell time, and completely returned after 30 to 36 months of dwell time.

REPORTS

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The teams, working in Iraq from February to March and in Afghanistan from April to June, formed the sixth Mental Health Advisory Team (MHAT VI) since the start of the wars, evaluating the psychological health of troops and the behavioral-health care resources in theater. The teams included research psychologists, a social worker, a psychiatric nurse and enlisted behavioral-health specialists. This year sergeants major from WRAIR and U.S. Army Medical Research and Materiel Command also participated.

In Iraq, trends that have been tracked through all six MHATs since 2003 show a greater percentage of Soldiers reporting high or very high morale, more Soldiers reporting they plan to stay in the military after their current obligation and decreasing levels of exposure to combat.

The analyses also detected more worrisome trends such as more Soldiers reporting they are planning a divorce or separation and fewer Soldiers reporting they have good marriages.

A change in sampling methods compared to previous MHATs resulted in more feedback from "hard-to-reach" Soldiers who spend much of their time outside the forward operating bases.

In Iraq the team surveyed 1,260 Soldiers from 51 maneuver platoons and 1,182 Soldiers from 47 support or sustainment platoons. In Afghanistan surveys were completed by 638 Soldiers from 27 maneuver platoons and 744 Soldiers from 25 support or sustainment platoons. In addition, the teams conducted focus groups, interviewed and surveyed behavioral-health care providers, and examined previously-collected data.

About 12 percent of the surveyed Soldiers in Iraq had psychological problems, the lowest number since 2004. Combat exposure also was lowest since 2004. Marital problems, measured by stated intent to divorce or separate, have increased each year and now are over 16 percent.

In Iraq, Soldiers in maneuver units reported more barriers to care and higher stigma associated with behavioral-health care, compared to the last assessment in 2007. Soldiers in support or sustainment units reported lower barriers to care and lower stigma.

The Afghanistan team, led by Lt. Col. Sharon McBride, found Soldiers with more combat exposure and lower unit morale, compared to previous years. About 14 percent of the Soldiers surveyed met screening criteria for psychological problems, which is similar to the findings of the 2007 assessment in Afghanistan. Soldiers with three or more deployments had higher rates of psychological problems and marital problems. The team also found barriers to behavioral-health care were higher than in previous years, which is probably partially related to the change in the survey sample.

Behavioral-health providers who MHAT V found clustered at Bagram have been moved to more forward positions. However, MHAT VI found the ratio of behavioral-health providers to troops in Afghanistan was lower than called for by policy.

"This ratio is being actively addressed by the highest levels of leadership. They are getting more providers into the theater," Bliese said.

Several coping skills were identified as helping Soldiers be resilient during the deployment, including accepting things that cannot be changed and avoiding being overly self-critical.

Physical training during off time was associated with a reduction in psychological problems. Other off-duty activities such as surfing the Internet or playing video games was associated with a reduction in problems as long as these activities did not take up more than three or four hours a day.

"We identified resilient platoons, those that had relatively low reports of behavioral-health problems. What factor seemed most related to identifying these platoons? We looked at several variables—cohesion, perception of readiness, NCO leadership and officer leadership," Bliese said. "In this sample, the perception of officer leadership was most strongly associated with resilient platoons. Other studies have also identified the importance of NCO leadership."

Recommendations of the team for Afghanistan include increasing the number of behavioral-health personnel in the theater and

maintaining a low ratio as troop numbers surge, and appointing a senior theater-wide behavioral-health consultant and noncommissioned officer.

Recommendations for both theaters involve using personnel from combat operational stress control teams to augment the behavioral science officer of a brigade combat team, so each BCT is supported by two behavioral-health professionals.

"A dual-provider model in a BCT allows one provider to travel to remote units while the other provider covers the forward operating base," Bliese said. "Historically, each BCT has had only one provider and the dual-provider system would help provide coverage when BCTs are widely dispersed. The idea is to rearrange the assets that we have, so every BCT has access to two behavioral-health professionals."

Bliese also praised the Multinational Corps-Iraq's suicide prevention action plan, which included suicide-prevention programs throughout the pre-deployment and deployment processes, and quarterly meetings chaired by the corps' deputy commander to review trends and lessons learned.

"The emphasis on suicide prevention looked comprehensive and clearly is a priority in theater," he said.

"Deployments have changed over the years, and new issues continue to emerge," Bliese concluded. "It is critical to monitor behavioral-health status of the troops and evaluate our behavioral-health delivery system as part of a continuous-improvement process."

Text of the reports will be available on the Army Medicine Website (<http://www.armymedicine.army.mil/reports/reports.html>) and the Army Behavioral Health Website (<http://www.behavioralhealth.army.mil/research/index.html>).

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