War Psychiatry Today

From the Battle Front
to
The Home Front

Executive Summary

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Center for the Study of Traumatic Stress
Department of Psychiatry
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Health care for our military forces is critical to sustaining our national security both in times of peace and war. Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) have highlighted the challenge of sustaining health for our soldiers, sailors, airmen, and marines across the deployment cycle – in combat and on return home. The mission of the Uniformed Services University School of Medicine (USU) is to provide education and train health care providers for our uniformed services as part of the national security mission. In doing so, USU provides state-of-the-art educational programs, maintains a critical part of the organizational memory of lessons learned and develops new knowledge to better care for those in harms way.

As part of the national security related health care mission, behavioral and mental health care – including care for and management of stress symptoms, behavioral responses to extreme environments, and mental illness that can effect mission capability and individual function – is a central focus for military medicine. In order to address the new and emerging educational needs for behavioral health care of our military forces, the Center for the Study of Traumatic Stress of the Department of Psychiatry of USU, supported by the Dean of the School of Medicine, held a two-day conference in order to: 1) Identify critical behavioral health care needs emerging from OEF and OIF and 2) Develop recommendations for necessary training and education to meet the mental and behavioral health care needs of our present military forces. The conference was informed by recent studies from the Mental Health Assessment Team I report (MHAT) (Department of the Army, 2003), recent studies by Walter Reed Army Institute of Research (Hoge et al., 2004), the Mental Health and Mass Violence intervention consensus conference (National Institute of Mental Health, 2002), and recent treatment guidelines for trauma exposed victims by the Department of Defense and the Department of Veterans’ Affairs (Department of Veterans’ Affairs 2004) and the American Psychiatric Association (American Psychiatric Association, 2004). Treatment needs, as well as barriers to providing mental health care in the theater of operations, and after soldiers return from combat, were important targets of this international consensus workshop of national and international experts and health care providers.
Experts, including mental health providers who served in OEF/OIF, met over two days to discuss topics such as providing mental health support in the combat zone, sustaining soldier performance and capability, pre-deployment behavioral and mental health preparation of line soldiers and their families, family deployment cycle needs, care of wounded and amputees, enemy prisoners of war and detainees, and post deployment reintegration. The issues discussed in this workshop have implications for education as well as for behavioral and mental health care, delivery, consultation services, medical operational doctrine and research.
The War Psychiatry Today workshop highlighted the important issue that many concepts that have served well in the past require reexamination in the context of the present war on terrorism and national security needs for homeland defense and security. For example, the cornerstone of U.S. combat psychiatry for decades has been the concepts of Proximity, Immediacy, Expectancy, and Simplicity (PIES). These principles remain useful under many conditions. Unfortunately, the validity of these concepts has never been demonstrated in clinical trials. In addition, the concepts are often cited from secondary sources that fail to include the principle of respite, which is the critical overriding principle from which the others are derived.

There have been major changes, both within the field of mental health, and in the manner in which military operations and national security are sustained (including low intensity conflict, humanitarian operations and homeland security and homeland defense). These changes create a need to review all time-honored clinically based principles and approaches that often have not been validated by traditional scientific methods but represent the best evidenced informed approaches available at a specific time. Such evidence informed principles of treatment (in contrast to evidenced based which implies a stronger level of scientific proof) are subject to more often needing to be reviewed, modified and subject to consideration in the context of newly emerged health care knowledge. In this way, the most effective health care approaches are available for the national security needs of the Department of Defense. The mental health and psychiatric programs and interventions in the combat theater as well as pre- and post- deployment must be established in accord with the most current medical knowledge and professional standards.

Education of health care professionals requires continual updating and interaction with new knowledge and new operational requirement. The discussions at this international consensus workshop provide important directions for health care professional education and training to meet the behavioral and mental health care needs for the nation’s security in the Twentieth First Century.
RECOMMENDATIONS

1. **Respite is the primary principle of acute combat related behavioral and mental health in theater.** Health care providers require education in both the factual and historical basis that underlies the concepts of behavioral and mental health care in order to provide informed, evidence based interventions and planning for behavioral and mental health care needs of new and rapidly changing demands and circumstances. The application of the concepts of proximity, immediacy, expectancy and simplicity (PIES) in modern warfare was discussed extensively at the workshop. However useful these concepts are, it is clear that they are not grounded and justified by clinical controlled studies. Respite — the principle that brings focus to the needs of the human organism for recovery, refueling, and return to base line after extreme expenditures of physical, cognitive and emotional energy — serves as the evidence informed principle that can guide other interventions and guidelines for action. The appropriate use of any guidelines is an operational issue, but clinicians need an evidenced based approach guided by high quality evidence of scientific study and where not available, best clinical practices based on evidence informed consensus. In recent times, the tendency has been to teach PIES as established fact rather than as principles that require further proof.

2. **Educate clinicians in the combat zone and the evacuation chain in evidenced based behavioral and mental health treatment and interventions for traumatic stress related disorders and behaviors as well as for stress management related to exposure to traumatic injuries, body mutilation, and violent death that is part of unit life in combat and part of hospital care in times of war.** Current training for providers emphasizes basic health care measures such as sleep hygiene, exercise, etc. However, this basic self-care may not be enough given the often overwhelming stresses of the current war. Unit cohesion, historically, has been a protective factor. More education needs to be given to the health care provider on how to promote unit cohesion within the medical environment. In addition evidenced based treatments are now available for a number of traumatic stress related disorders (including Posttraumatic Stress Disorder, Acute Stress Disorder, Depression as well as substance abuse and other behavior problems). Family readjustment and potential distress is a known part of return home and health care providers are a key link in the process of educating for return to family, and spouse/parent roles.

3. **Education and training in functional assessment (and wellness assessment) in contrast to symptom, illness and disability assessment is needed for behavioral and mental health care providers.** An inherent feature of military medicine is that providers must think about the patient’s capacity to function on the job, in addition to treating the patient’s symptoms, illness and disease. Diagnostic categories are symptom-based (e.g., in DSM-IV), but the military, even more than other occupational settings, requires evaluation of function in order to assist the patient to the maximum ability to sustain function and meet what can be mission needs and job
requirements in extreme environments. The emphasis needs to be on promoting full functioning, or when that is not possible, on understanding functional limitations and how these may influence the patient’s future. Providers must also be knowledgeable of how to teach and foster the patients’ sense of self-efficacy (i.e. confidence and skills) so that they can move from the helplessness of the injured/sick role to effective and functional.

4. **Expanded advanced training programs in disaster mental health, disaster psychiatry to include treatment of trauma related disorders, sexual assault, alcohol dependence and the management of mass casualties are needed.** War is one type of human made disaster. National security health care needs require broad based training that addresses other disaster health care needs including terrorism and natural disasters. The war on terrorism, the role of reserve and guard health care forces in state health care protection in times of national emergency and the potential of chemical, biological, radiological and/or nuclear terrorism that will bring federal and state health care resources together indicate the need to develop integrated training and education opportunities. Such education must span across federal resources to ensure familiarity with all disaster and terrorism medical responses and with state and local care planning and resources. Providers in theater reported gaps in knowledge of these topics. These subjects are part of the curriculum in military training programs, but not all providers have attended these programs. In addition, advanced education and training in these areas is needed for those behavioral and mental health care providers who will become senior consultants. USUHS currently has a disaster psychiatry fellowship that meets this need. The Army presently has authorized billets for this program. More such training opportunities are needed.

5. **Educate health care providers in emerging information technologies to estimate and track population mental health.** In a combat zone, the ability to get and input information is critical for health care providers, since their standard sources may not be readily available. This is true for general medical information, preventive information, and local epidemiologic issues. Information technology is a tool for both continuous learning and finding solutions to current problems.

   Much of the mission of combat theater mental health is providing education. Providers should bring to theater relevant teaching materials that can be adapted for an austere learning environment. Much can be downloaded via the Internet, however access to the Internet is unreliable. There is a need to consider more creative use of memory devices (e.g. thumb memory sticks) to provide data support to deployed practitioners and to move clinically helpful data sets with evacuated patients.

6. **Education programs are needed to better prepare mental health providers about the ecology of the combat zone.** Health care providers in general, and behavioral and mental health providers in particular, need to understand the environment in which they serve and view it from a systems perspective. Both ongoing and just in time training and education in this area requires development in a systematic and technology enhanced manner. The provision of just in time training—should include web based, CD-ROM, telebroadcast, rapidly deployed education teams and available “reach back” advisory expert consultation in real time both to technology
based information and also and most critically “real people” who will always provide the most current and specific rapid information database.

This includes learning both official and unofficial leadership structures, communication strategies for briefing and informing commanders and troops, and general operational knowledge. Health professionals need to understand the institutional cultures of the organizations in which they serve, and also need to know how to influence and create needed behavioral changes in these organizations and cultures. Integrating roles as members of a unit and as care providers as well as methodologies for consultation to leadership structures, both formal and informal, increases the need for ongoing real time onsite and reach back capabilities. This is ever more important with rapidly changing units, and environments. Command consultation is an essential skill. Military medical Research and Development scientists are also needed to increase the reliable and valid information available to support this educational effort.

7. **Educate behavioral and mental health providers about the stressors and health enhancing elements of family, including attending to the needs of spouses and children of wounded and deceased soldiers.** Children need to be prepared to face a parent with an amputation or facial injuries. Spouses and children need help both in restoring their own feelings of self-efficacy and in assisting the patient in developing renewed self-efficacy. Research to improve the evidence base for appropriate interventions is needed.

8. **Health care providers must understand the stages and process of soldier sailor, airman and marine deployment related separation from and reintegration with the home environment.** Separation and homecoming and reintegration are a challenge for all service members, including the providers themselves. Providers often must deal with their own separation and reintegration issues while providing guidance for their units. Principles of social support are particularly important in the reintegration process. Fortunately, much has been learned from prior deployments on this topic. Useful resources for both clinicians and families may be found at [www.usuhs.mil/csts](http://www.usuhs.mil/csts) (from The Center for the Study of Traumatic Stress) and [www.ncptsd.org](http://www.ncptsd.org) (from the National Center for Post-Traumatic Stress Disorder).

9. **Behavioral and mental health care leaders require specific training to integrate the efforts of diverse professional groups including psychiatrists, clinical psychologists, social workers, occupational therapists, chaplains, nurses, and specially trained enlisted technicians.** In austere and dangerous environments, integration may be especially challenging. The ability to operate in a joint-service environment is another essential skill. While these topics are addressed in current military training programs, experience from OEF and OIF shows that they need even more emphasis. It is critical that our mental health professional be educated so that they may seamlessly integrate their efforts to provide mental health support to the soldiers at the tip of the spear. This includes preparing them to manage any non-productive professional conflicts.
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10. **Educate behavioral and mental health care providers on the barriers to care -- individual, unit, family and organizational -- and techniques for overcoming them.** There are many barriers to seeking mental health care, which are exacerbated in a combat environment. Barriers include access to care, lack of knowledge of where care is available, difficulty of getting time off from the job, relative lack of confidentiality, and personal and organizational misperceptions of the need for and value of care. In OIF especially, the dangers of transportation are a major obstacle.

Mental health professionals must learn the nature and extent of barriers to care and potential ways to reduce them. Increased integration of behavioral and mental health care with primary care is one way to de-stigmatize mental health care and make early assessment and initial intervention more widely available for wounded in patient care and outpatient clinic care. In addition the outreach to families through primary care and other community-based institutions can increase family and spouse roles in sustaining health care of active duty, reserve and guard members. Particular attention is needed to the behavioral and mental health care needs of reserve, guard and the outreach to their families over time. Barriers to mental health care are not a uniquely military problem, and indeed affects all care for the mentally ill in our society. Research will be needed to support this effort, since to date no one has developed model solutions in either the military or civilian sector.

11. **Increased education and training of primary care physicians and physician extenders in the assessment, diagnosis and treatment of mental disorders, as well as indications for consultation and referral to behavioral and mental health specialty care is needed.** There are different strategies to integrate mental health care and primary care. Mental health providers can be integrated into primary care clinics. However, primary care providers should not have to rely on rapid access to a mental health provider. Primary care providers need to understand diagnosis and treatment of mental disorders. Specific focus of training should be on commonly used psychiatric medications, such as SSRIs and sleeping medications, and basic psychotherapy.

12. **The mental health equivalent of the Basic Life Support (BLS) course -- often called Psychological First Aid and presently a part of the focus of national attention of the Red Cross, Department of Health and Human Services, Department of Veterans Affairs and the CSTS of the USU Department of Defense -- should be developed.** Such evidence informed interventions can be the basis for organized buddy care, immediate individual care and supervisor support. In a combat zone where access to mental/behavioral health might be limited, the availability of people with such training could greatly expand access to care. However, for such a course to be truly effective, we would need to have evidence-based methods of psychological first aid. Increased research on the effective components of psychological first aid is also needed.
13. **Knowledge and education of at the continuum of medical care (from the front line, through the evacuation chain, to the home base and potentially back to the war or to the transition to civilian life and VA health care for those who are too severely injured to remain in the military) is needed.**

Health care personnel must understand the health care as a process of care and locations, each with its tasks, missions and primary goals, all of which need to relate in a seamless manner across time. The entire evacuation chain is an opportunity to provide support, treatment, and revaluation. For example, a focus on in-theater treatment can be at odds with decreased capacity to hold patients in theater. This strategy may ignore various “pause nodes” in the evacuation chain as possible sites for patient re-evaluation and treatment. Further, although the evacuation chain as it exists is a given from the point of view of the provider in the field, providers need to examine it critically in order to find opportunities to improve the system. Medical Evaluation Boards and Physical Evaluation Boards are part of this continuum and require education for providers on how they influence care for active duty and separated veterans.

Care is provided in a great range of treatment settings. To more fully educate providers about the continuum of care, educational programs between the VA and DoD need to be expanded, and providers need to be exposed to a variety of sites in the continuum, e.g., mobilization/demobilization centers, hospitals that receive wounded, hand home stations of soldiers. Education is also needed for civilian providers outside the military and VA systems, since many veterans will eventually get care from non-Federal sources.

14. **Education in the ethics of providing military healthcare including providing care and treatment to enemy prisoners and detainees.** Ethical and humanitarian care of prisoners of war and detainees is the tradition and training of military health care providers. OEF and OIF have shown that this may pose many challenges. Lessons to promote sensitive and culturally appropriate treatment have been learned from refugees, who share common characteristics with this population, including multiple traumas and often torture. The standards required in correctional facilities and for prisoners of war must also be learned. Health care providers need training in the Geneva Conventions, the law of war, the appropriate participation of providers in interrogation, and how to report abuse. They will be required to manage conflicting values, and require skills in identifying those conflicts and deciding on ethical courses of action. This area of knowledge, skills, and attitudes requires development by concerned military physicians, nurses and other health care providers with ethicists and social scientists. Teaching must separate ethical concerns of health care providers from the often different issues of importance to lawyers and others whose sole concern is representing immediate U.S. Government interests. Education in this area lends itself to a simulation and requires “reach-back” real time capability, in order that individuals in the theater can have resources outside the combat zone that they can contact for advice on ethical issues.
15. **Behavioral and mental health care providers must learn 1) concepts and first principles in order to be effective in environments in which standard skills and practices may not apply; and 2) how to document observations, assessments and interventions in order to establish a record of the rationale of their work and allow for evaluation of its effectiveness.** In a combat zone, providers typically will not be able to use all the tools and techniques they might favor in a peacetime environment. Limited or unfamiliar medical supplies, equipment, and pharmaceuticals may deprive them of favored therapeutic approaches. In addition, the tactical situation may rule out certain forms of treatment, as such weekly therapy sessions for soldiers who would have to travel for appointments. Thus, providers need to know how to adapt and improvise, but do so as systematically as possible.

16. **Educational programs and training must a) prepare military mental health professionals to develop information databases that can provide evidence on critical health care needs b) train providers in how to access such evidence databases and c) how to evaluate claims of clinical effectiveness in terms of rigorous evidence-based standards.** Our educational programs must be particularly attuned to and access to the ever new and evolving health care information knowledge base, in order to avoid reifying practices, and must always be subject to scientific research and testing. Concept-based education of health care providers across the professional life cycle must go hand in hand with operational technique based training to ensure adaptability to changing needs. Conceptual education includes why the concepts were developed, how they have worked in the past, and what their limitations are. In this way, for example, health care providers can better judge when PIES is the best model to use.

The complexity of this task, educating providers to be continuous learners of new evidence, practicing by evidence and accumulating new evidence through practice is substantial. The importance of this clinical care and learning frame for operational care needs cannot be overstated. For the military care provider this learning approach must include knowledge of combat doctrines, organization of the combat forces, changes in the organization and structure of medical support of combat operations, rapid developments in telecommunications, fundamental changes in logistic structure, as well as changes in diagnostic, behavioral and pharmacological technologies available to military psychiatrists and other mental health providers.

17. **Teach behavioral and mental health care providers how to teach.** Several of the above recommendations place the health care provider in the role of educator. Their teaching will occur in a variety of settings, each requiring different skills, e.g. formal presentations such as briefings or classroom lectures, demonstrations, clinical teaching, and teaching patients self-efficacy skills. Some military programs to train teaching skills already exist, mostly for training in formal presentation. Mental health providers need to take advantage of these programs, and new programs need to be developed to cover the range of teacher and educator skills needed.
CONCLUSION

Gathering and disseminating the lessons learned from a combat zone is an essential follow-on task after any war, and one that involves both immediate identification of issues and long-term study and analysis. The assimilation of the experiences of OEF and OIF will continue for years to come. The recommendations included here are not an all-inclusive or final list. Rather, they represent considerations based on what we know today. Some of the recommendations are already in place but are of newly increased importance. Others require new programs and efforts. The discussions included in the conference proceedings provide a broad conceptual framework from which to gather additional perspective on educational needs of behavioral and mental health care providers as well as other health care providers who must have the knowledge, skills and attitudes necessary for behavioral and mental health interventions.

As one participant said during the workshop, “The best preparation is the best intervention.” We need to teach people what to expect, what to do, when to do it, how to understand it, and how to learn from it. Often, this involves going beyond traditional medical curricula by integrating concepts from fields such as anthropology, sociology, organizational psychology, and social psychology. Military educators will need to remain engaged in the process of developing lessons learned from OEF and OIF and other elements of the war on terrorism in order to ensure that education programs prepare students to deal with the realities of modern warfare.
REFERENCES


