Chapter 40

BEHAVIORAL HEALTH ISSUES AND DETAINED INDIVIDUALS

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INTRODUCTION

The US military provides appropriate healthcare services for enemy prisoners of war and other individuals detained during operations. Doctrine and international treaties require that detainees be provided "equivalent care" to prevent deterioration of their condition. The scope of detention healthcare operations is dictated variously by the magnitude of the detention activities in theater, the typical duration of an individual's detention, cultural norms and situational factors affecting the problems presented by detainees, and the availability of resources in theater.

In Operation Iraqi Freedom, behavioral health services to detainees first emerged as a critical operation in 2003, when it was discovered that local psychiatric inpatients had been released into the streets by retreating enemy forces, and that Coalition troops had captured and detained many of them in facilities at Umm Qasr. The emergent need to distinguish between distressed psychotic individuals and acting-out enemy combatants required immediate diversion of combat and operational stress control assets to the detention mission. At that time, noncombatant detainees who were seriously mentally ill were discharged to community care. In 2004, as detainee operations stabilized, nongovernmental organization surveyors expressed concern that seriously mentally ill individuals retained in detention were receiving care from providers other than licensed behavioral healthcare practitioners and that the standard of equivalence of care was not being met. At the time of this text's preparation, three separate medical task forces with augmented behavioral health teams have rotated through theater detainee healthcare operations in Iraq. This chapter provides a basic framework of operations in detainee behavioral healthcare, reflecting the lessons learned by the first two contingents, Task Force Medical (TF MED) 115 and TF MED 344. To help the units tasked with this challenging job apply these lessons, the chapter will discuss critical mission activities and common problems in the process of preparing and executing the detention behavioral healthcare mission.

TRAINING THE TEAM

Predeployment Preparation

Predeployment is a stressful time for all involved. The unit mission focus is on common training tasks; the command emphasis is on facilitating service members' transition from the home environment to the combat environment. Nevertheless, every effort should be made for personnel to receive appropriate mission-specific training prior to deployment to a detention mission. Predeployment preparation should include, at a minimum, four essential components: (1) reviewing current Department of Defense (DoD) and federal and state corrections healthcare policy and procedures, (2) establishing communication with unit personnel currently on site in theater, (3) reviewing cultural information specific to the host nation, and (4) gaining familiarization with the detention care setting.

Most DoD behavioral health providers have never worked in the corrections environment, much less the detention healthcare environment; a review of current corrections policy and procedures is a must. Detention healthcare is similar to healthcare given to patients overseen by the Federal Bureau of Prisons, an agency of the US Department of Justice. Bureau of Prisons standard operating procedures (SOPs) provide the model used to develop military protocols for detention care. These various SOPs[1,2] address essential topics including suicide prevention, medication distribution, and screening procedures, all key elements in the detainee care mission. If time permits, personnel should consider visiting a local corrections establishment to talk with the medical personnel about providing care in a corrections environment.

Perhaps the most important step in preparing to deploy is establishing communication with the personnel being replaced. This point cannot be stressed enough. The current active unit has implemented SOPs that will be suitable for most purposes, and deploying staff should obtain and review them to become familiar with current operations and capitalize on lessons learned before arriving in country. The currently deployed unit can also provide information on particulars of the environment such as billeting information, recreational facilities, supplies to bring, and available resources. Communication may be difficult because of time zone differences, but multiple channels exist: e-mail, telephone, or even videoconference, if available. Exchanging contact information benefits everyone; for the outgoing unit, the process of training the incoming unit has its own value. Most units have tremendous pride in their organization and appreciate others' interest and willingness to accept their feedback and experiences. Changes in existing protocols will undoubtedly be needed, but current SOPs provide a good place to start.

If no behavioral health unit was previously in country and the mission is to establish the first detention behavioral healthcare program in the area occupied,

it is especially important to understand the standards by which behavioral healthcare will be evaluated, as well as learning what assets will be available to support the mission. Although the program is mandated to provide detainees with equivalent care, the perception of what "equivalent" means can vary widely, so it is important to establish as soon as possible what services and level of care are intended. DoD doctrine, US Bureau of Prison standards, and community standards within the area of operations (AO) can help inform this decision.[1–5]

In most cases, detainees are from a different culture than the typical service member patient. Cultural differences can be an obstacle to establishing rapport and to patient care delivery. Misunderstandings between patient and clinician can be frustrating in an already tense environment, so it is important for providers to be familiar with common local customs and courtesies. This information can be found on the Internet, in textbooks, and in other historical sources. If possible, a briefing by someone from the particular culture will be very helpful. Prior to deployment in 2005, TF MED 344 enjoyed extensive cultural briefings from Iraqi expatriates, which made the transition into that environment much smoother than it might otherwise have been.

Additionally, briefing by a medical provider from the culture is invaluable. Names of medications and the social significance of different forms of treatment may differ. It is essential to know some of the cultural differences in the way medicine is practiced; for instance, the perception of mental illness can vary tremendously among cultures. Understanding some of the basic differences and perceptions increases the effectiveness of even basic treatments; however, it is important to assess the quality of source information. For example, TF MED 344 was repeatedly informed that rural Iraqis considered behavioral health issues to be signs of malign influence, and that the indigenous personnel were unsophisticated and wary of behavioral health issues. In fact, the population appeared to have a good knowledge of behavioral health issues and protocols. One illiterate farmer, detained during a sweep of his community, thanked providers for their interest in his mental state and acknowledged that he was depressed, but stated his preference to work with his local cleric about his feelings of loss over the death of his sons in the conflict.

Cultural issues and phenomena are limitless, and there is no way to be totally prepared for the situation in theater. For example, it is common knowledge that psychosis often presents differently in different cultures. When TF MED 344 staff encountered a detainee who reported concerns about his visions of a talking chicken, the question arose as to whether this was a psychosis or malingering. Certainly in a US population, malingering was more likely. Discussion with translators and other detainees provided no indication that chickens had any particular significance in this culture, and other psychotic individuals in camp tended to have auditory hallucinations without visual manifestations. While it was not possible to be sure, the subsequent presentation of several other patients with exactly the same hallucinations suggested to staff that the "talking chicken" phenomenon was malingering behavior. In stark contrast, the extremely high incidence of self-injurious behavior turned out to have several cultural antecedents, including both an acceptance of excoriation as a religious ritual and a history of self-mutilation among prisoners during the Saddam Hussein regime to avoid being brutalized even more by their guards.

While cultural issues are legion, it also is important to recognize the universal nature of mental illness. For example, one patient managed by TF 344 reported that God spoke directly to him and told him that all infidels would die. This presentation could certainly have reflected the social-political context of the conflict; however, other camp residents repudiated the patient's statements and were concerned for his welfare and safety. The individual was truly psychotic and responded well to antipsychotic medications. Another detainee presented with a long history of self-injurious behavior, and swallowed any sharp object he could find. His behaviors increased as attention to them increased. He was diagnosed as a self-destructive borderline personality and required extremes of behavioral management.

The context of care in a detention camp differs significantly from deployment to any other forward operating base or operations center. In a detention camp, the enemy is not only outside the perimeter, but has a large presence within the perimeter as well. This has two main effects. First, security protocols assume a significant place in day-to-day operations. Second, coalition personnel are confronted with a uniquely stressful task of interacting on a daily basis with the enemy, creating a number of behavioral health issues that can affect operations.

Security issues are always legion during deployment to a hostile AO. In detention care, security is doubly important. Access to the patient routinely requires special clearance and passes, and time must be planned to allow for multiple security checks. Patients are not seen privately. "Outpatient" interactions may be through a security barrier. Armed guards accompany hospitalized patients or those seen in a clinic. Clinical schedules must be coordinated with the guards' transportation schedules for these custodial staff. Daily operations are likely to be interrupted by

head counts, missing person checks, or crowd control operations. In the Iraq AO, detainees were assigned numbers rather than being referred to by name, making it difficult to track cases, especially because detainees were routinely shifted from camp to camp as a security precaution.

Medical and custodial staffs are patently affected by having to interact with the enemy on a daily basis. They cannot treat the enemy aggressively, and must provide compassionate care even when threatened or disparaged by the detainee. They cannot establish friendships or trusting relationships with the individuals they see most often each day. The stress of detainee care causes irritability, anger, and dissatisfaction rarely seen in other healthcare or operations centers. Management of this distress is an important part of the behavioral healthcare mission.

The Clinical Process in Detainee Care

The clinical process in detention care also differs markedly from that in other clinic-based operations. Staff may or may not need a refresher in basic clinical assessment and brief counseling techniques, but the team invariably requires training in detention operations. Training should address screening, assessment, intervention expectations, crisis response, and coordination of care.

Every new detainee is screened for behavioral health risk factors as part of their initial medical evaluation. A brief questionnaire covering previous behavioral health treatment and current behavioral health concerns is administered through an interpreter. Familiarity with the screening process and with typical detainee reactions to the behavioral health interview is a must. Intake screening is a volume business: screening must proceed at the pace of internment operations. This can range from 50 screenings a week to 150 a day, with little advance notice, depending on the pace of operations in theater. It will be tempting to assign one or two individuals to the screening process, because it is inherently different from other clinical operations and can be accomplished best by personnel who are experienced with the procedure. Even when this is done, however, every member of the team must be able to complete the screening interview both to provide surge capacity and because this is a must-do procedure that if not completed delays the movement of the detainee into the camp.

The intake screen identifies new detainees who need follow-up evaluation. Detainees may also be referred for evaluation by military police, by the medical team, by other detainees, or through self-referral. At Abu Ghraib in 2004 and 2005, after systematic improvements in the detention facility were established, it was typical for providers to see a dozen individuals for new assessment and disposition each week. Personnel must be comfortable with conducting a functional assessment leading to initial diagnosis and disposition in sparse conditions, using an interpreter for the interview portion of the assessment. Clear criteria for assessment and disposition should be established and practiced prior to deployment. Mobilization site training will most likely provide "typical" cases that are florid in their presentation, a training model that is unrealistic and not useful. Instead, training should focus on assessment of anxiety disorders in an anxiety-provoking situation, identification of malingering, and differential diagnosis of adjustment disorder and major depression. The patient cannot be expected to be a reliable informant; the information received will be distorted by translation; and the setting will create ambiguities that make a typical assessment model untenable. The behavioral health clinician must rely on behavioral signs and reports of functional impairment from collateral sources at least as much as on the patient's own report.

Ongoing review of the active caseload is more complex in detention care than in the clinic or in the corrections setting. Patients do not have regular appointments; they are scattered across a barbed wire encampment and are moved frequently for security reasons. A concerted effort must be made to develop and sustain a patient tracking system. Once continued care is established, clear outcome criteria should be established and monitored for each case. Establishing outcome criteria will probably be the part of this process most reminiscent of normal clinical practice.

One of the most frequent questions asked by providers outside of this setting is whether the military really "does therapy with those guys." Odds are that most intervention will involve medication management, behavioral intervention, and education or brief supportive counseling rather than psychotherapy per se. Among the many factors mitigating against the establishment of therapeutic trust are the likely brevity of care, as well as cultural and privacy issues preventing in-depth treatment in most cases. However, as in any setting, treatment approaches should be adjusted to meet the needs of the individual.

Detention care can be volatile, and is a 24-hour operation. The clinical team is on call at all times. Although the facility includes physical safeguards to keep aggressive and suicidal detainees secure, custodial staff values the reassurance and direction that on-call behavioral health consultants provide when detainees have problems off-shift. Clinicians must respond to every call, even if the situation is under

control. A common problem is threats of self-harm to obtain camp privileges. In Iraq, where many historical factors facilitated self-excoriation, it was not uncommon to be called to attend to a detainee who had cut himself shallowly across the chest and threatened further self-harm if his demands were not met. In the United States, this behavior would be an indication of serious underlying pathology, but in this setting the behavior was more often than not an extreme example of manipulative or coercive behavior on the part of a detained individual.

Finally, the behavioral health team will not operate in isolation. Detainees receiving behavioral health services are also under care of the medical team. Some primary healthcare providers will prefer to prescribe their own psychotropics, and some will use medicines from the behavioral health formulary for other purposes, such as pain management. Nongovernmental organizations are often involved in coordinating social services for the detainee. It is necessary to establish protocols for coordinating medication procurement as well as coordinating care with the healthcare team, including medication procurement, record keeping, and social service contact management. The behavioral health team should train on and practice these protocols before entering the operational area.

Unit Transition

Several things can be done to optimize the transition from one unit to its replacement at the detention center. The outgoing unit will probably know their replacements at least a month or two before the transition. If the incoming unit has not contacted the outgoing unit in that period, the outgoing unit should work through their leadership to contact and establish a working relationship with their replacements. In addition to preparing for a successful handoff, preparing the detainees over a period of about a month is useful in minimizing disruption. Replacements should arrive early enough that outgoing staff can demonstrate current procedures for at least a week.

This staffing overlap is commonly referred to as the "left seat/right seat ride." To set up the new unit for success, it is strongly recommended that staff with similar roles be paired with outgoing staff during duties for several days, allowing newcomers to adjust to the environment, see the day-to-day operation, and ask questions. A date should be designated for the takeover of duties by the new staff, accompanied the first time by outgoing staff. Optimally, the oncoming unit should have at least a day or two to function independently prior to the departure of the outgoing unit, although this schedule can run into problems. In both TF MED 115 and TF MED 344 some medical teams were ready to relinquish their duties the day replacements arrived. Others, feeling pride of ownership, did not feel comfortable standing by while the replacement staff took over and learned the job.

Tours are generally for 1 year and invariably rapport will be established between staff and detainees. Detainees talk among themselves and with other medical and nonmedical staff, and often have some idea when units are scheduled to depart, knowing that units usually change somewhere around the 11- or 12-month point. Detainees have an active interest in the transition and may ask detailed questions. They will understand the transition process and probably try to find out exactly when the new unit will take over. Some appreciate the care they received and will feel anxiety about the upcoming transition and termination. However, operational security should be kept in mind: detainees should not be given specific dates or any other information that may be used to threaten security. Personnel should be vague and ensure detainees that their care will continue; no information about troop movements should be divulged.

Units preparing for departure often shift focus to the task of reintegration and manage ongoing tasks with less interest and enthusiasm. Personnel should maintain operational focus: the outgoing unit has the responsibility to prepare both the detainees and the gaining unit for a successful, seamless transition. A modified termination process and a well-planned and executed left seat/right seat ride will give the outgoing unit closure, knowing that the mission they conducted and improved upon will be handed over to people they were able to train. The gaining unit will build upon and modify procedures to optimize the care they deliver over the course of their tour.

EFFECTIVE USE OF TRANSLATORS

Communication with detainees is essential to effectively assess and treat them. Most detainees will not speak English, and unless the medical staff speaks the detainee's language, the use of a translator is vital in obtaining a good history. In some settings, translators are intentionally rotated among sites and services as a security measure, making it impossible to thoroughly train a few select individuals. This may be a source of contention. Frequently, as a medical team becomes familiar with a translator, they feel confident in them and request sole access to them. This is not good practice. During TF MED 344's tenure, no fewer than three

proficient and apparently friendly translators were removed from service: two were found to have passed information to hostile elements, and one was removed for continually asking for cast-off uniforms. Incessant questions about vacation plans or other personal information, which might be normal in other settings, are not a sign of a reliable interpreter.

It is unlikely that many translators will have expertise in behavioral health or behavioral health terminology. Some cultures may have different understanding of terms such as "hallucinations" or "delusions," so questions about these symptoms may get lost in translation and render the assessment ineffective. Other concepts may be uncommon in a particular culture, and some questions might be seen as offensive or disrespectful. Translators may have their own opinions about the patient's problems, and may not make the effort to translate the questions exactly. Furthermore, personnel must be aware that hired translators may be traditional enemies of the detained population: they may come from neighboring countries in conflict with that of the detainee, or they may have opposing politics.

Personnel should take time up front to get to know the translators and ascertain their understanding of behavioral health terminology, as well as their ability to convey information to a detainee. Translators should understand the importance of asking the patient every question posed, rather than providing answers themselves. Hired translators should be used when possible, but the unavailability of hired translators should not impede the successful execution of the mission. In the absence of a hired translator, detainees who are fluent in English may be required to serve as translators. Custodial staff may be able to recommend a detainee who has proven to be effective and may have assisted them on other occasions. Although clinicians might initially be reluctant to use a detainee as a translator, having a trusted detainee assist can be both extremely effective and enlightening. Detainees may feel more comfortable opening up to a fellow detainee who they respect and admire than to a hired translator they may not trust. Establishing a rapport with the detainees is important for successful treatment, and sometimes having a working relationship with one of their peers who speaks English can facilitate an effective therapeutic relationship.

DEVELOPING A TREATMENT PLAN

It is important to bear in mind, in this setting more than most, that diagnosis is functional: the goal is not necessarily to determine the etiology and nature of the disorder but to develop effective treatment. International standards for care in this setting specify treatment of mental disorders that result in incapacity to care for oneself or in increased risk of deterioration of function or health; the emphasis on functional impairment must be highlighted. Functional impairment is a critical ingredient in deciding to provide care, especially if resources are limited. To that end, personnel must

- diagnose only to the level of the available data;
- develop treatments using rubrics that maximize functional outcome as simply and as safely as possible; and
- rely on outcome monitoring to adjust and eventually to titrate treatment.

Diagnosis and treatment in detention care is vulnerable to many problems not experienced in other settings: language and cultural barriers to establishing good communication, subtle cultural factors associated with the meaning of mental illness for the detainee, pressure in detention to acquire marketable drugs or to garner attention or respite from the compound, and group dynamics affecting the individual's behavior. The absence of good collateral information and the biases of the interpreter and custodial staff toward mental illness and toward the detainee complicate matters immeasurably. Available information includes the self-report of the detainee, third-party reports from camp mates and custodial staff, records from medical services provided during detention, observation, and functional assessment. Because the translation may be unreliable, the clinical interview should rely more heavily on behavioral observation than most clinicians are accustomed to.

Behavioral Management Considerations

Establishing a program for managing behavioral problems, or providing consultation, is an essential part of a successful detainee behavioral healthcare mission. Military police deal with behavioral challenges daily and often turn to the behavioral health team for advice and support. Some detainees test the limits of acceptable behavior, which must be handled effectively to prevent others from acting in similar fashion. Often, unacceptable behavior occurs to achieve secondary gain, and the behavioral health team can educate the corrections staff on appropriate means to address the behavior without rewarding the detainee (which reinforces the behavior and causes others to engage in the same or similar behavior). The behavioral management program can empower the corrections staff and

significantly curtail inappropriate detainee behavior.

Detainee custodial staff members have one of the most challenging jobs in the military. Staff members may have a corrections background, and these personnel can utilize their prior experience and training to effectively manage inappropriate behavior. Others have no prior corrections experience and may be operating in a detainee environment for the first time with very limited training. Faced daily with hostile and belligerent detainees, most custodial staff do an exceptional job maintaining order and discipline. When detainees engage in behavior that poses a threat to themselves or others, custodial staff will call on the behavioral health team for assistance. To facilitate teamwork, behavioral health personnel should establish a working relationship with custodial staff early in deployment. Behavioral health personnel should introduce custodial staff to the most common behaviors associated with mental illness and encourage them to get the behavioral health team involved early if they have concerns or are unsure of how to handle a particular situation. Custodial staff will appreciate knowing they can call on behavioral health professionals if they need assistance. Often, the behavior can be controlled by simply removing the detainee from the environment or by giving the detainee some time alone away from other detainees. Furthermore, the behavioral health team is responsible for training the custodial staff to recognize when a detainee may be psychotic, experiencing another Axis I disorder, or having a primary Axis II problem so they can contact the team to make an assessment. A good clinical assessment will aid in determining what the primary problem is and help in making the appropriate decision to resolve the situation.

Primary Axis II problems, common in any corrections population, can be expected in the detainee population as well. Common reasons for acting-out behavior involve secondary gain such as wanting more cigarettes, wanting to get out of the heat and into an air-conditioned building, and a host of other reasons primarily viewed by the detainee as obtaining pleasure and reducing suffering. Inappropriate behavior may include self-injurious behavior such as cutting, eating barbed wire, making suicidal statements, making suicidal gestures, and faking seizure-like activity or other medical conditions that commonly require removal from confinement and evaluation in the hospital setting. This behavior can be significantly reduced by having a medical or behavioral health team evaluate detainees in their living space and by transporting them only if medically indicated. However, contact with the behavioral health team on site can itself become a detainee's goal.

Despite some similarities to corrections setting, the detention care setting is unique, and common clinical assumptions about the etiology of acting-out behavior must be suspect. Although some detainees cut themselves or threaten suicide for reasons such as trying to leverage a move to a better tent, other acting-out behavior may have a more malign purpose: creating a distraction so that another detainee may be threatened or killed, distracting custodial staff from efforts by detainees to build a tunnel, or signaling a plan for a riot. At times there may be no apparent reason for such behavior. On one occasion in 2005, detainees were received at Abu Ghraib from an Iraqi prison. All were screened for health and behavioral health needs, and most were found to be in poor condition because of harsh conditions at the Iraqi prison. Somewhat to the surprise of providers, most expressed pleasure at being returned to Abu Ghraib, where they had initially been triaged months earlier before being turned over to the Iraqis. One such individual, who was extremely vocal in his pleasure at returning to the relative comfort of American detention, nevertheless faked a seizure within an hour of being returned to the camp.

Having a designated observation area located in the detainee compound allows medical staff to bring the care to the detainee and limits the need for transport outside of the compound. In addition to observation, basic first aid, including suturing, bandaging, checking vital signs, administering medications, and other necessary interventions that do not require transport to the hospital can be done in the detainee compound. The designated area should be near the corrections staff command post or another area where detainees can be watched constantly but within their compound and as close to their living area as possible, so even direct contact with the behavioral health team can be limited if malingering to obtain such contact is suspected. TF MED 115 dealt with the increasingly self-injurious behavior of one detainee by strictly limiting the patient's access to the hospital, a treatment plan that required constant reassurance to the emergency medical teams that were called on to dress moderately severe self-inflicted injuries in the camp's field setting. This strict restriction on access to the hospital eventually reduced the frequency of self-injurious behavior by the detainee, proving its value.

Medication Management and Distribution

Although some detainees with mental illness will not require medications, others will, and should be offered the appropriate medication to effectively treat their respective illness. Mental illnesses among detainees reflect those in the general population and include mood disorders, anxiety disorders, psychotic disorders, substance use disorders, personality disorders, and others listed in the *Diagnostic and Statistical*

Manual of Psychiatric Disorders. Many medications commonly used and available in the United States are not available throughout the world, so cultural awareness can play an important role in prescribing appropriate medications. A given detainee may have been effectively treated on a psychotropic medication prior to being detained and should remain on that medication. Additionally, if the treatment is going to be necessary and continued after the detainee is released, selection of a medication that is available in the local economy should be strongly considered to facilitate accessibility and ongoing treatment. Otherwise, the indications, contraindications, side effects, and prescribing guidelines for a particular class of medications remain the same as in other settings.

Depending on the size of the detainee population and the number of detainees on medication, distribution can be a complicated and time-consuming process. Care must be given to prevent hoarding; consideration should be given to potential lethality or medical complications; and if possible selection of medications that can be taken daily, rather than more often, will increase compliance and decrease the demand on the staff distributing each medication.

Each staff member responsible for distributing medication should be trained on the proper distribution technique. The technique is essentially the same as what is practiced in many US prisons: distributing each dose separately and watching closely to prevent deception and hoarding. A sequence of actions needs to take place to ensure that the right patient receives the medication, and actually swallows it (Exhibit 40-1).

This is required for each medication, and each detainee must be required to follow the procedure. Hoarding medications can be a serious problem, and abuse of psychotropics is endemic in this population. Medical staff, including behavioral health personnel, must be trained in this process, and leadership should make spot checks to ensure the process is being adhered to. Mental health personnel should take the lead in this process. Detainees may protest initially, but with continued practice most comply without hesitation. Furthermore, the process of interacting with detainees twice a day improves the therapeutic alliance: some detainees view the interaction as extremely supportive and benefit clinically from the interaction, although this process can be time consuming and very demanding on the medical staff member. Staff members can rotate administering medications. This also helps prevent burnout and helps the staff get to know the detainees.

Some detainees may be on other medications prescribed by different providers. It should be routine to review the medical record or to check with the pharmacy to get a list of all prescribed medications for each detainee to ensure there are no contraindications or overlaps in medication. Medical providers should discuss potential side effects for each medication with detainees and ensure each detainee has given informed consent prior to starting a medication. A medication education program is useful to prepare detainees for eventual release, when they will probably be provided a several-day supply of medication.

EXHIBIT 40-1

MEDICATION DISTRIBUTION PROCESS FOR DETAINEES

- Confirm the patient's identity by comparing the detainee's identity card or armband to the person presenting for treatment (trading armbands for favors is not unknown); do not administer the medication if identification is not positive.
- Administer each medication as a single dose; do not give a detainee requiring medication twice a day both doses in the morning.
- Ask the detainees to hold out their hand, and then place the medication in their hand.
- Ensure they have water to help with swallowing the medication.
- Watch them carefully as they put the medication into their mouth and swallow.
- After they swallow, have them open their mouth and stick out their tongue to check for "cheeking" the medication. Have them open their hands with their fingers spread apart to ensure they don't have the medication still in their hands.
- After making sure they have actually swallowed the medication, the detainees can be excused from the area.

Communicating With Other Sites

Interacting with behavioral health staff at other detention sites should be facilitated early in the deployment. Detainees often are transferred from one site to another depending on the legal issues associated with their case. Communication between detention camps allows the effective transfer of detainees with behavioral health problems and enhances the continuation of treatment without interruption. The gaining facility should prepare by reviewing pertinent medical records, obtaining appropriate medications, and discussing any concerns with the staff members who have been treating the detainee. Without a working relationship between staff, detainees will be transferred

and the gaining team can potentially be caught off guard and this may impact patient care. Communication between staff at different sites should occur on a regular basis, because moves often are sudden and unanticipated. The frequency can be determined based on patient acuity and need. Sometimes the gaining team receives information about transfers before the losing staff. Problems arise when detainees arrive at the new location and say they were taking psychiatric medications or receiving psychiatric treatment, and there is no record of the treatment. Often the detainee does not know what medications are being administered. Without the knowledge of current diagnosis and treatment, an effective treatment plan may be interrupted and the detainee will have to start the assessment and treatment process from the beginning, a frustration for both the detainee and the behavioral healthcare staff.

SPECIAL CLINICAL ISSUES

Common syndromes in detention care include situational reactions to capture and adjudication, fear of other detainees, distress related to being separated from family, and reactions to the inevitable inactivity associated with detention. Detainees often present with acute anxiety immediately after transfer to the facility or before trial. They often complain of insomnia, fatigue, or depressed mood, symptoms that on inquiry are related to poor sleep habits and inactivity. Awareness of these situational factors can reduce overdiagnosis and overuse of medication with this population.

Individuals in detention often attempt to assert control, gain special privileges, or reduce boredom in ways that bring them to the attention of the behavioral health team. Aggression toward others, unusual behavior such as bathing in sewage, and suicidal statements or parasuicidal behavior may be typical signs of mental illness, but in this context often are manipulative or testing behaviors. Hunger strikes, another behavior of significance seen in the detention population, are discussed in detail below because of their unusual political nature. Differential functional diagnosis and training of custodial staff in behavioral management are important tools in managing these potentially disruptive concerns.

Cognitive disorders present a special challenge in military detainee care. Primary disorders that may present include the entire gamut of these illnesses: developmental disorders including mental retardation; acquired traumatic brain injury, acute or chronic; metabolic, vascular, or other invasive lesions from a medical cause; or age-related dementia. All represent special circumstances affecting the detainee's ability to function and therefore trigger a special obligation on the part of the military caretaker. Unfortunately, most instruments designed to detect cognitive impairment are insensitive to cultural factors and to educational deprivation, making them unsuitable in this setting, even when effective, nonbiased translation services are available.

Privacy and confidentiality are recurring issues in behavioral health service systems. Although it is benevolent to argue that the detained individual has a right to confidentiality, in this setting even the right to refuse treatment may be arguable if detainees' behavior causes substantial risk to themselves or others. Command has a legitimate interest in the mental state of detainees with serious emotional or cognitive issues, as do custodial staff responsible for the compound. It is likely that other residents of the compound will be aware of the patient's behavioral health issues, especially if the behavior is disturbed. Interviews must be conducted in the public view, or at least with a guard present. Reasonable respect for human dignity and privacy is always indicated, but in this setting confidentiality in its strictest interpretation is unlikely and should not be promised.

Medical record management is another special clinical issue in the military detention setting. International standards require a single portable medical record that follows the patient and that can be accessed by the patient, his or her representative, or oversight agencies such as the International Red Cross. This apparently simple requirement is complicated by the typically dispersed nature of forward base detention settings: the record-keeping facility is likely to be in the hospital, not the camp, necessitating maintenance of a local working record in many instances. In the current conflict, detainees are identified by number, rather than by name, because of ambiguities in establishing identities and also to protect the individual. This makes matching the patient to the record difficult as well. Frequent movement of detainees for security or legal reasons further complicates compliance with medical record standards.

HUNGER STRIKES: A UNIQUE CLINICAL ISSUE

Behavioral health consultation to hunger strikes constitutes a special or command-directed assessment and as such requires the involvement of a doctoral-level behavioral health provider to meet the criterion of

equivalent care to detainees. The military psychologist, psychiatrist, or doctoral social worker involved must be aware of international standards for the treatment of hunger strikers and the theater policy on hunger strikes; must be cognizant of cultural factors impinging on the detainee's decision to fast; and if at all possible must consult with the facility commander, with Judge Advocate General staff, and with the detainee's primary care provider to determine relevant contextual and situational issues before engaging with the detainee or making recommendations to command.

There is strong international sentiment in favor of hunger strikers, based on a history of their use to protest repressive political regimes. The international medical community supports self-determination by the detainee and proscribes forced feeding.[6,7] Nevertheless, not all hunger strikes have the same degree of legitimacy.[8] Reactive food refusers, much more common than political hunger strikers, are much more likely to rapidly terminate their fast without adverse consequences.

A typical hunger strike protocol[9] requires the behavioral health provider to assess the competence of the fasting detainee at the outset of the hunger strike and daily thereafter. In addition to the complications created by the adversarial nature of a detention setting, the crosscultural aspects of assessment in a military context make this a challenging task. Because assessment will be ongoing throughout the hunger strike, the provider must be aware of the typical course of a hunger strike and of the impact of starvation on an individual's emotional and cognitive status.

Assessment

The detainee engaging in a hunger strike is not allowed to refuse reasonable evaluations. The situation is analogous to evaluating a reluctant person suspected of dementia: the assessment is in the patient's best interest. However, it is important to attempt to obtain informed consent for this and subsequent assessments, if only to establish a reasonable working relationship with the patient. The purpose, extent and limitations of evaluation, boundaries of the relationship with the provider, role conflicts that may develop, and issues of medical record confidentiality should be described. If the detainee refuses to be interviewed, observation and information from collateral sources become critical in establishing the person's competence. In one such instance in theater, the attending physician was given a fixed interview protocol to follow that allowed assessment of immediate, delayed, and procedural memory, and was primed with specific questions to ask. The psychologist observed the interaction on closed-circuit television to allow clinical assessment of the patient's cognitive status.

Relevant factors in determining initial competence to fast include the presence of a mental disorder affecting judgment and decision making; problems with impulse control leading to importune behavior; a cognitive disorder including mental retardation, brain injury, or dementia; coercion by or influence of others; and inaccurate situational information. Personal history, facility records, and clinical observation during the interview are essential tools in the assessment. Standard cognitive instruments are unlikely to be available, making psychometric evaluation of dementia or cognitive disorder difficult. The last two factors listed, coercion or influence by others and inaccurate situational information, are less accessible to historical review or direct assessment, but are important areas of concern. One incipient hunger strike during the TF MED 344 experience was avoided by clarifying the process of judicial review for the detainee.

The initial interview should clarify that the detainee does intend to engage in a hunger strike. Language problems and confusion on the battlefield can create inaccurate perceptions: one detainee transferred from a division internment facility to the tertiary internment facility or theater internment facility for a hunger strike protocol in early 2006 immediately denied intent to fast when interviewed in the emergency room and ate as soon as his gastrointestinal distress and nausea were treated. As part of clarifying intent, the behavioral health provider discusses with each detainee whether he plans to fast to death, or if he will accept medical advice and limit his hunger strike when his health is imperiled.

The behavioral health provider is mandated to clarify the detainee's reason for entering into a hunger strike. The provider does not, however, become engaged in negotiating with the detainee concerning demands, for a variety of reasons: maintaining a useful neutrality with the detainee separates the issue of refusal to eat from the issue that the detainee wishes to bring to public attention, an important strategy in managing the hunger strike situation. In one typical hunger strike situation, the detainee began every conversation with a request to see the combatant commander; each request was met with a response that the commander was aware of the request and the psychologist could do nothing to facilitate this matter.

Daily reassessment of the detainee's emotional and cognitive status is required. A routine should be established with the primary care provider that allows the behavioral health provider to review any medical factors that may be affecting the detainee and to interview the primary care provider about his or her

interactions with the detainee. Initial reassessments are usually not fruitful except to help establish a pattern and a relationship, as cognitive and emotional changes are unlikely in the first week of the hunger strike.

Follow-up assessments include evaluation of subtle cognitive changes caused by altered nutritional status, such as a tendency to make more risky decisions, become irritable, and be increasingly oppositional, especially in situations involving confrontation.[10] Minor memory or concentration problems that may signal the onset of delirium resulting from reduced metabolism, medications, altered nutrition, or organ dysfunction must be recognized early to avoid rapid cognitive deterioration. Hunger strikers with suicidal or morbid ideation, alteration in future orientation, or reduced interest in pleasurable activity, may be depressed—a condition for which they may allow treatment. The assessment also evaluates the detainee's confidence in his physician, his understanding of the medical information he is provided, and his intent to persist in the hunger strike.

Cognitive measures are sensitive to educational and cultural factors (few instruments have been normed for use in different cultures) and are vulnerable to practice effects; repeated administration on a daily basis will invalidate their use just as the information they can provide becomes more critical. The behavioral health provider should design an observational protocol using routine interactions in the detention setting to assess memory, concentration, verbal fluency, and motor coordination rather than relying on tests.

Documentation of findings is critical. There are three possible outcomes of a hunger strike: the detainee ends the hunger strike voluntarily, the detainee is fed forcibly, or the detainee dies from complications related to not eating. Especially in the event of forced feeding or death, the basis for medical and subsequent administrative decisions about care must be clearly documented and communicated.

Intervention

The behavioral health provider cannot collaborate with coercive or deceptive strategies, nor agree to strategies that might be perceived as maltreatment of the detainee. Although it is reasonable to withdraw privileges or hold the detainee in isolation to prevent contagion or coercion, for example, it is not reasonable to restrict access to hygiene facilities or exercise. Exposing the patient to pleasant aromas and pleasing presentations of meals may be useful; deliberate exposure to others eating, taunting with food, or excessive exposure to food may constitute abuse and is likely to be counterproductive. Threats of forced feeding are counterproductive, create an adversarial atmosphere, and are considered coercive by the international community.

Psychological management of the hunger strike should focus on limiting unwarranted attention to the detainee during the hunger strike to reduce unintended reinforcement of the unwanted behavior. Medical management and administrative negotiations should be matter-of-fact and without emotional overlay. Effort should be made to separate treatment of the hunger strike and treatment of the concerns raised by the detainee: the decision-maker for the demands should be distinct from the medical and custodial personnel who work with the detainee. These two issues should never be linked during discussions with the detainee.

Consultation

The military behavioral health provider consults to the attending physician and to command regarding various aspects of the hunger strike situation, often in ways not anticipated by the command authority. It was the senior author's experience that command expectations may exceed the role of the consultant: there may be an expectation that the behavioral health provider has greater insight into the hunger striker's motivations than is possible, or that the provider may in some way be able to intervene and somehow induce the hunger striker to end the fast. Clear delineation of roles and capabilities is essential.

Healthcare providers do have a valuable role in protecting both the patient and the military command from the adverse consequences of the hunger strike. The careful balance between consulting to the care of the hunger striker, balancing competing ethical issues often associated with this situation, acknowledging international standards of care, and advising command regarding effective actions requires a thoughtful approach to this type of situation.

The behavioral health provider discusses with the treating physician the available literature on hunger strikes, the ethics associated with managing both hunger strikers with a terminal goal and those willing to accede to medical advice, and the importance of avoiding an adversarial relationship with the patient. The physician should be encouraged to establish benchmarks for various decisions, including informing the patient of critical medical milestones and what findings to use to signal command that medical incapacity may be imminent.

Command is likely to consider forced feeding very early in the hunger strike, in part because the consequences of allowing the detainee to die in custody are extreme and in part because of limited knowledge about the likely time frame of the hunger strike. Keep-

ing the detainee alive through forced feeding, however, may simply prolong the hunger strike, carries its own medical risks, and is not likely to be necessary for health reasons in the first weeks of the strike. Good medical advice is critical to limiting the commander's reactive responses, and effective consultation on approaches to the hunger striker will give command options other than coercive methods.

SUMMARY

Providing psychiatric care in a battle zone to an enemy combatant poses unique professional and personal challenges. There is no true civilian analogue to this situation. Because the mission is unique, it is important to develop a clear understanding of the clinical mission and its inherent systemic issues before entering the area of operations. It is vital to understand the full political and humanitarian impact of the behavioral healthcare provider's role in this setting to appreciate the importance of the mission and to reconcile the accompanying complex and often contradictory emotions and reactions.

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