Chapter 9

PROVISION OF MENTAL HEALTH SERVICES IN OPERATION IRAQI FREEDOM 05-07

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INTRODUCTION

During Operation Iraqi Freedom (OIF) 05-07, the third anniversary of combat operations in Iraq was observed. The battlefield had changed dramatically since US forces first invaded Iraq in March 2003. Open fighting along the routes into major cities had been replaced with door-to-door city fighting. The enemy had changed from a visible fighting force into a largely unseen guerilla force. As the battlefield transformed, so did the provision of mental health services. Mental health providers still supported soldiers, but this task evolved, resulting in the improvement of earlier operations, the incorporation of new missions, and an increased emphasis on data collection. Being in country for 3 years and utilizing the widespread availability of computerized technology, military mental health provision developed to a level of sophistication never before seen in a theater of operations.

This chapter will explore how duration of the conflict affected the provision of mental health services during OIF 05-07. It will look at factors that influenced the entire military that had consequences for mental health providers, such as facing a more sophisticated enemy, living on more developed bases, and implementing new Department of Defense policies. It will also look at ways in which mental health services expanded based on lessons learned from OIF-I and OIF-II. Finally, the length of the conflict and the increasing number of casualties amplified media interest in the conflict and in mental health services available to soldiers in combat. This chapter will discuss the influence of the media on the provision of mental health services during OIF 05-07.

CHANGING DYNAMICS OF THE CONFLICT

A More Sophisticated Enemy

In March 2003, the enemy was clear—the Iraqi Army commanded by Saddam Hussein. After Hussein's troops surrendered in April 2003, defining the "enemy" became more complicated. Pockets of insurgent groups coupled with sectarian violence began producing coalition casualties through various guerilla warfare tactics. During the ensuing years, these tactics became more sophisticated, using the skills of sharpshooters and explosives experts. These deadly encounters with insurgents resulted in the decision by the US military that there had to be increased preparedness for all deployed soldiers. Consequently, one of the improvements made during OIF 05-07 was that all soldiers already deployed, as well as those soon to deploy, were given protective equipment that was normally provided only to combat units. In addition to the Army combat uniform and improved Kevlar helmets, all soldiers were also issued "hemcon" (hemorrhage control) bandages, which were a vast improvement over the previous field bandage. Soldiers received deltoid and axillary protector plates, and enhanced small arms protective insert plates, aimed at providing better protection. However, these protective measures also significantly increased the weight each soldier had to carry. This extra weight, especially in the hot summer months, was an added stressor for all soldiers, including the combat operational stress control providers during travel outside the forward operating base (FOB).

Travel between FOBs was improved during OIF 05-07. During the first half of OIF-I, travel was in soft-sided vehicles for the simple reason that there were no up-armored vehicles. The dangers of ground travel (ie, improvised explosive devices, rocket-propelled grenades, suicide bombers) became more common and deadlier, necessitating the requirement that all vehicles traveling outside the FOB be up-armored. In general, although more travel now occurs via aircraft than during OIF-I (where nearly all travel was by ground convoy), most combat stress control teams continue to travel by convoy.

Another area in which there was improvement as the conflict continued was the standardization of convoy procedures. During OIF-I, depending on the location of the team and its higher headquarters, there was a wide variation in procedures. Some teams traveled by nontactical vehicle, while other teams were required to be in a convoy of at least three vehicles, with a specified number of crew-served weapons. Although the standardization of convoy procedures was developed to enhance safety, this more-involved process has created frustrations for the combat stress control teams who regularly need to leave a FOB to provide services to a supported unit.

More Developed Forward Operating Bases, More Developed Mental Health Services

The living and working conditions improved considerably by OIF 05-07. During OIF-I, soldiers (including mental health personnel) lived and worked out of tents for the most part, using burnout latrines, field-expedient showers, and meals, ready-to-eat. Conditions began to improve even before the end of the OIF-I rotation, and the improvements continued through each rotation. During OIF 05-07, the majority of personnel lived and worked in trailers or buildings

that were climate controlled and had electricity, including hygiene facilities with running water. Even the presence of beds instead of an Army cot contributed to the overall improvement in the standard of living. Obviously, these improvements affected the level of stress perceived by the supported soldiers as well as the mental health personnel providing the support.

One observation of the 30th Medical Brigade (TF30 Med) mental health personnel is that subordinate units seemed to be reporting more psychiatric patients than expected by combat operational stress control (COSC) doctrine. A rough comparison was made of the average monthly number of new psychiatric contacts to the average monthly number of new combat stress contacts from the Combat Operational Stress Control Workload Activity Reporting System (COSC-WARS) reports from OIF-I, OIF-II, OIF 04-06, and OIF 05-07. The average number of new psychiatric contacts rose disproportionately higher than the average number of new combat stress contacts from OIF-I to OIF 05-07. (Only a rough estimate is possible as data collection during the early part of the conflict was obviously not the priority.) The reasons for the increase are not clear. Among possible explanations are improved workload reporting procedures, an increase in the population at risk or the number of soldiers deploying with psychotropic medications, or providers more willing to use medication to treat combat stress and thus convert what would have traditionally been a new combat stress contact into a psychiatric contact. Providers were likely more comfortable prescribing medication because the living environment was more stable and better follow up was available; thus soldiers would not need to be sent out of the theater for treatment.

There was a very clinical feel to many of the services provided during OIF 05-07. (One benefit that comes from a longer conflict is that better working conditions develop.) During OIF-I, tents were the norm. By OIF 05-07 the tents had been replaced by buildings—working in buildings instead of working outside the same tent where one lives lends itself to a more clinical feel. Additionally, more combat stress control (CSC) units had teams collocated with a combat support hospital (CSH) compared to OIF-I.[1] These teams would frequently provide primarily mental health services. Often times, this was out of necessity, as they were the only mental health providers on the FOB, or the CSH did not have the personnel due to split-base operations. Sometimes this was the choice of the provider, the combat stress control commander, or the CSH commander.

This is not to say that COSC personnel were not providing preventive outreach services. As alluded to earlier, many of the division mental health personnel had a preventive focus, as did the mental health personnel from echelons above division beyond those in the CSC units. All teams from the CSC units did some form of outreach through classes, consultation, and education, as well as regular outreach by walking around and talking to the supported units.

By OIF 05-07, theater mental health assets had learned the basics of their jobs in a combat environment and began to expand their roles into more forensic and administrative psychiatry services, which would not normally be associated with combat psychiatry. Sanity boards and mental status evaluations are not even mentioned in the COSC field manual[2] or the two psychiatry volumes in the *Textbooks of Military Medicine* series.[3,4] It is unclear if the requests for these specialty services had any relationship to the fact that mental health services were being offered in more clinical environments, and thus providers were more able or prepared to fulfill these requests.

The fact that commanders and soldiers were requesting these services while deployed to a combat zone merits discussion. The Mental Health Advisory Team (MHAT) IV found that soldiers who had deployed to Iraq more than once were more likely to screen positive for depression, acute stress, anxiety, or other mental health problems. It also reported that soldiers who screened positive for a mental health problem were twice as likely to engage in unethical behavior as those who did not screen positive.[5] The number of moral waivers for felonies given to recruits increased from 459 in 2003 to 1,002 in fiscal year 2006.[6] Thus, whether due to a mental health problem or a history of illegal behavior, it appears that the longer this conflict continues, the greater the chances are that soldiers will be acting out while deployed, and there will be an ever-increasing need for sanity boards or command-directed mental health evaluations performed in theater.

Established mental health clinics during OIF 05-07 also managed to work out logistical problems that plagued clinics at the start of the conflict. One of the biggest improvements was the formulary, which now contains a broader spectrum of antidepressant medication and stimulants, two concerns brought up by providers during OIF-I.[7] The formulary was frequently reevaluated, as the Multi-National Force–Iraq (MNF–I) pharmacists held quarterly meetings that allowed providers to make suggestions for additions or substitutions.

Despite great interest in knowing how many psychotropic prescriptions were written in theater, several mechanisms make this data difficult to accurately report. First, most established psychiatric patients deploy with a 90-day supply of medication from their home duty station or soldier readiness processing site. The TRICARE mail-order pharmacy was also

frequently used for established psychiatric patients and those stabilized on medication in theater. Theater pharmacies ordered their own stocks of medications and kept their own records of prescriptions written for each psychotropic. Thus, centralized order tracking would only reflect shipments to theater pharmacies, not how much of those shipments were actually being prescribed.

Another advance that occurred in theater was the increased availability and usage of Composite Health Care System-Interactive Training Tool (CHCS-ITT), the deployment electronic medical record. Because CHCS-ITT is linked with the computerized medical record system utilized in garrison, provider notes written in the combat zone can be accessed at any military treatment facility in the world. This system greatly improved continuity of care between the Iraq Theater of operations and the medical facilities where soldiers were being treated and reduced the biggest risk of paper documentation—misplacement. Unfortunately, the only facilities that had reliable electricity, computer access, and CHCS-ITT trainers were the Level III CSHs and Level II battalion aid stations. Unless they were collocated in one of these facilities, the CSC teams did not have access to the CHCS-ITT system.

The debate that had occurred in garrison mental health clinics was subsequently heard in theater. This debate centered on the inclusion of mental health notes in the general medical record and the lack of privacy of the computerized mental health record. The CHCS-ITT "sensitivity feature" was nonfunctional in theater. This sensitivity feature, also known as the "break the glass" feature, keeps record of all users accessing any clinical notes labeled as "sensitive." Prior to accessing a sensitive note, medical providers are warned with a pop-up message that they are about to read sensitive data and they will be audited. For CHCS-ITT, in-theater providers could designate a note as sensitive, but there was no record created of who accessed a sensitive note and there was no warning pop-up message. To use the system while protecting patient privacy, some providers opted to keep all their records electronically unsigned, which kept the encounter in an "open" status and prevented other providers from being able to read the notes, but still allowed treating providers to write up a summary of their encounter with the patient and print it out. The disadvantage of this was that future mental health providers could not access these notes because they were never closed, and open encounters significantly downgraded the entire system so that all notes in all clinics on that particular network took longer to write.

With more established FOBs offering more services, KBR (formerly Kellogg Brown & Root, the largest civilian contractor in Iraq at the time), and the Army and Air Force Exchange Service required more civilian employees during OIF 05-07 than in OIF-I. Problems arose when these employees, who were supposed to be psychiatrically cleared prior to their deployment, showed up at military mental health clinics in need of treatment. This put military providers in an uncomfortable position for several reasons: *(a)* military malpractice did not cover the care of contractors, *(b)* contractors were not eligible for care and so prescriptions would be difficult to fill, and *(c)* if the contract agency found out that an employee was receiving mental healthcare, the employee would be sent home, so when contractors presented to mental health clinics, they asked the providers not to report them. KBR brought its own employee assistance program counselors to Iraq, which was helpful when KBR employees were involved in a casualty-producing incident, because their own counselors could offer debriefings or counseling. However, KBR had no physicians or psychiatrists on staff. Because only physicians can initiate air evacuation requests, military psychiatrists were tasked with authorizing all KBR psychiatric emergencies requiring evacuation from theater.

Developed FOBs brought with them communication systems that were vastly improved from OIF-I. This had several implications for the mental health community. First, most FOBs now had widespread Internet access and phone centers, which enabled soldiers to call home more regularly. Mental health providers in theater considered this a mixed blessing—soldiers could receive additional support or they could receive devastating news, yet they were still expected to perform the mission.

Another consequence of improved communication, especially the ability to send US mail across FOBs fairly reliably, was that the design for MHAT IV could be simplified. Rather than having a team of researchers come into theater and travel across FOBs administering the surveys, the surveys were sent by express mail to the theater. They were then mailed to the mental health assets organic to the FOBs where the participating units were stationed. The surveys were administered by each unit's mental health asset and then mailed back to the MNF–I surgeon's office, where MHAT IV was housed. This new process allowed for a reduction in the number of researchers needed to deploy to theater. The mission now focused more on data analysis rather than survey administration. Although this expanded the mission of the theater mental health provider, it gave units an opportunity to interact with their own mental health assets, rather than with a group of outsiders. It also decreased the need for travel across FOBs by MHAT personnel, a process with its own inherent risks. Ultimately, there were delays in the mail system, so MHAT personnel

did more travel than was originally planned, but this was still far less than previous MHAT teams.

Increased Multiple Deployers

Clearly, with each additional year of the conflict, the chances increase that the population of deployed soldiers will contain greater numbers of multiple deployers. The increased number of multiple deployers during OIF 05-07 was not unique to soldier patients seeking mental healthcare. Many healthcare providers were also affected. It is not unusual to have COSC providers return from a deployment only to discover the need to prepare for the next deployment. They may not have had sufficient time to recover from the first deployment. The very nature of providing COSC services in a combat theater means repeated exposure to stress and hearing the tragedies of those being supported. Twenty-one percent of OIF 05-07 behavioral health providers reported high or very high levels of burnout.[5] It is unclear how many of these providers had had multiple deployments. An area of further research might be to look at the long-term effect of multiple deployments on behavioral health providers, especially with little time between each one.

Ongoing provision of mental health service would have resulted in rotation through Army providers more quickly had it not been for the US Air Force and Navy contributing greater mental health assets than in previous OIF years. The Air Force deployed its mental health providers for 4 months at a time. They were placed in CSC teams or in the Air Force hospital in central Iraq. The Navy deployed its mental health providers in support of Marine line units, but also filled some of the rotating reservist slots of the CSC units.

New Department of Defense Policies

As after-action reports and other reported difficulties from OIF-I and OIF-II made their way through the top levels of the military, new policies made their way down in an attempt to make needed improvements. One such policy concerned treating victims of sexual assault. This policy originated as a result of an inquiry made by the Secretary of Defense (then Donald Rumsfeld) in February 2004 over concerns of sexual assault allegations made by soldiers deployed to Iraq and Kuwait.[8] A task force that was formed to investigate these allegations found inconsistency in sexual assault prevention programs across the services. The task force reported that barriers to reporting sexual assault were significant in the military environment and that without an advocate looking out for the victim, it was easy to overlook a victim's rights and needs. Among the task force's recommendations was the establishment of a Department of Defense policy addressing sexual assault prevention and response, and the creation of a task force that would oversee this policy. After receiving congressional approval, Department of Defense Directive 6495.01, the Sexual Assault Prevention and Response Program, was published in October 2005. It outlined the treatment and care for victims of sexual assault and required that provisions be made for theater operations. The Army published its policy in Army Command Policy, Army Regulation 600-20, which was first published February 1, 2006, and revised June 7, 2006.

The Sexual Assault Prevention and Response Program affected theater mental health providers because it potentially added further missions. First, behavioral health personnel were often tasked with acting as the unit's victim advocates due to their demonstrated ability to empathize. Even if they were not victim advocates, however, mental health personnel had the potential for greater contact with sexual assault victims, because the new policy required immediate availability of mental health services for all victims presenting to a medical treatment facility. Alternatively, a mental health visit could be the first contact a sexual assault victim had with the medical community. Thus providers had to know about the new reporting options, which were restricted reporting and unrestricted reporting. In restricted reporting, only the treatment community is authorized to know the victim's identity (the victim's chain of command is never told about the assault). In unrestricted reporting, the victim's chain of command is informed and an official Criminal Investigation Division inquiry is opened. Finally, sexual assault review boards were now meeting in theater and behavioral health chiefs were a required component of these boards.

The other policy that had a significant effect on the mental health mission during OIF 05-07 took effect June 1, 2006, when the Army revised its deployment drug testing procedures. The main changes involved giving more responsibilities to deployed units.[9] This included medical personnel because medical review officer (MRO) services now had to be available in the deployed environment. An MRO is a physician appointed to determine if a urinalysis positive for opiates, barbiturates, steroids, or stimulants is the result of a legitimate prescription or illegitimate use.[10] In garrison, MROs are trained through a medical command course and are certified after passing an examination.

An informal survey of division surgeons and the CSHs indicated that there were not enough certified MROs in theater to handle this new tasking. Ultimately, the decision was made to have two MROs appointed at each Level III CSH, two at the multifunctional medical battalion, and additional MROs as needed in the

divisions. The Army Forensic Drug Testing Program then distributed training CDs to theater. Commanders appointed MROs, the CDs were reviewed, and MROs took the certifying exam via e-mail. The majority of newly appointed MROs were psychiatrists, although some of the CSHs appointed family practice physicians.

In addition to the MRO mission, the new drug testing policy also affected the mental health community by identifying more substance abusers in theater. Unfortunately, the Army Substance Abuse Program did not formally exist in theater, thus treatment and rehabilitation options for those identified were extremely limited. Some of the larger FOBs had Alcoholics Anonymous meetings, but for the most part, any drug and alcohol counseling was left to chaplains and the mental health community.[11]

Improvements in Command and Control of Echelon-Above-Division Stress Control Personnel

As the theater matured, so did the ability to command and control COSC personnel in the echelon-above-division units. At the start of combat operations, there were many changes in command structure, supporting units, who would support whom, and so forth.[1] During OIF 05-07, not only was there only one medical headquarters in theater, but it was stationary. There was no longer a need to move north as the conflict progressed.

Each rotation made improvements, and by OIF 05-07 the medical headquarters had a firm foundation on which to build. The introduction of a mental health consultant at the Multi-National Corps–Iraq (MNC–I) level continued during OIF 05-07 as a dual role position with the TF30 Med mental health consultant. This permitted a single medical headquarters to coordinate plans with the divisions and other separate brigades, as well as ensure the MNC–I and MNF–I commanders and command surgeons were kept informed. The result was an enhanced ability for greater situational awareness and coordination of COSC/mental health needs and services.

This enhanced situational awareness also assisted in planning for coverage. Because of improved communication systems, a stationary headquarters, and solid foundation from previous rotations, planning was able to be more deliberate and organized, obtaining input from multiple sources. As the theater changed, so did the method of estimating COSC coverage. In OIF-I, one CSC unit provided coverage to a specific division; there was one preventive team per brigade. By OIF 05-07, area support was the norm. COSC coverage was divided more by geographic location than strictly by division.

Situational Awareness

Managing and directing the COSC medical functional area in a theater of operations requires accurate and up-to-date situational awareness. This required verification of the location of COSC personnel in theater, by clinical specialty. Fortunately, a listing that included MH personnel from the divisions, KBR, the Air Force, the Navy, and the Marine Corps Operational Stress Control and Readiness (OSCAR) teams already existed. A database was developed, adding clinical specialties at each location, and updated regularly. This listing proved to be extremely helpful and provided the situational awareness required for optimal management of COSC resources. Not only did it help to identify the proper unit to task when specific missions were requested, but it also assisted in the planning process by ensuring minimal duplication of services among the various mental health resources on an FOB.

Planning Process

Even though the theater had evolved considerably since the start of the conflict, having the right number of people in the right place was always a challenge. Because planning did not have to occur as troops were on the move, as at the beginning, it was possible to use a very thorough planning process. TF30 Med developed a process that utilized a historical review of workload and operational tempo, COSC doctrine, and a staffing model. (The staffing model that was used was based very closely on one proposed by the second MHAT.[12] It considered three primary categories of services: (1) clinical, (2) unit outreach, and (3) the restoration center. The clinical usage was calculated based on the average of the percentages that want help, need help, and use help. Some of the assumptions were corrected to reflect current processes, and items were modified to be applicable in the deployed environment.)

This was the "science" of operational planning. The "art" of operational planning was then employed by comparing the requirements from the different methods, considering input from the CSC unit commanders, and applying the technical knowledge and expertise of the staff officer. The result was a proposed realignment plan. Mental health personnel in TF30 Med were always cognizant of their role as consultants, and not the final decision makers. Therefore, this recommended plan was presented throughout the chain of command and others involved in providing COSC/mental health services. Because this process may be different from what is experienced by most mental health providers, it bears explanation. The plan was initially reviewed and approved within TF30 Med—

from clinical operations, through G3 (operations), to the commander/theater surgeon. It was then staffed through TF30 Med's direct reporting units—the commanders, the operations officers (S3s), and of course the CSC unit leadership. The units being supported were part of the divisions, so the plan was briefed to the division surgeons and medical planners as well. Additionally, the equivalent personnel from the US Navy were included in the discussion. Changes were made at each step, based on input and needs identified. The final product was published in a fragmentary order. Even then, it specified only the minimal number of personnel at each FOB—by unit—and the location of the restoration centers. The CSC unit commanders were still responsible for determining the correct specialty and personnel to place at each location.

Coordination and planning was continuous. Distribution of COSC personnel changed and adapted as situations changed or divisions made requests. This involved TF30 Med working in partnership with MNC–I mental health consultant, and coordinating closely with the senior mental health personnel of both divisions and Marine Expeditionary Forces on the placement of CSC units—fostering cooperation and minimizing duplication of services.

As previously alluded to, provision of services involved planning and anticipating needs for the future as well. During OIF 05-07, this included coordinating with the US Air Force, which was compiling a CSC for a follow-on rotation. TF30 Med invited an Air Force representative to attend the COSC conference held in theater and meet other CSC commanders, discuss the mission, and get questions answered. The commander of the CSC unit that the Air Force team would be replacing also provided vital input to smooth the transition. After the visit, the utilization of the Air Force liaison officer in country proved invaluable in fine-tuning the coordination, planning, and preparation for the incoming team.

Another manner in which command and control was improved was in the redistribution of the CSC units. After extensive mission analysis and communication with all involved, including the incoming medical headquarters, the CSC units were placed under the command and control of the newly formed provisional multifunctional medical battalion. One of the benefits to having all the CSC units under the same battalion was the enhancement of the ability to coordinate among all of these units. It was now easier to maintain situational awareness across the theater, task the most appropriate unit for any missions that arose, and simplify communication. An illustration of this was when the members of a specific brigade combat team (BCT) were told that they were going to be extended. The extension meant the BCT would need to relocate, and would involve a change in COSC team as well. Due to the ease in communication under one battalion, the efforts of each of the CSC units was well-coordinated and they were able to ensure a minimal disruption of services and affect on the soldiers in the BCT. This also included TF30 Med coordination with the BCT's organic mental health personnel.

Challenges

As with previous rotations, the OIF 05-07 rotation faced several challenges. One of these was the rotation of the divisions midway through the tour of the combat stress control unit supporting them. When the new division arrived, it would sometimes want to change the number or specialty of the mental health personnel on different FOBs. Different mental health personnel may vary on how to implement COSC/mental health services. The challenge presented itself in that the CSC team had already established trust and rapport with the supported units. Changing COSC personnel would affect continuity of care. This was not a problem for the division soldiers as they were leaving, but the supported population included soldiers from the echelon-above-division units as well. It was easier to address this challenge because of the open lines of communication between the CSC units, their battalion headquarters, and the TF30 Med.

Another challenge was in the coordination of who would provide services on a particular FOB. Because the method of team placement emphasized minimizing duplication of services, the only mental health support might be through the division team. This would often require the division mental health personnel to perform COSC and mental health activities to both echelon-above-division and division soldiers. Naturally, the reverse occurred when a CSC unit team was the only mental health asset at a location.

Standardization of Practices

The better-established theater provided the opportunity for the standardization of policies and procedures, and quality control. There are certain issues that seemed to be prevalent in providing COSC services, spanning the OIF rotations. Topics such as how to document contacts, how to measure workload, what is required to evacuate a soldier, and even interpretation of COSC doctrine were addressed. Standardization was difficult when personnel brought with them different levels of training in COSC and differing individual comfort levels with the prevention and outreach focus of COSC. COSC doctrine addressed these topics, but finding the answer was cumbersome at best. To alleviate this, TF30 Med simplified the search by addressing

these topics in the COSC annex to the operation orders for both TF30 and MNC–I. This annex established consistent policies and practices theater-wide.

Documentation

One of the main principles behind COSC is to maintain a nonclinical approach when managing soldiers with combat and operational stress reaction (COSR).[2] However, COSC personnel perform interventions and activities not only for soldiers with COSR, but also those with diagnosable psychiatric conditions. What, constitutes appropriate documentation for a soldier with COSR? Does the documentation differ from that for mental health treatment of a psychiatric disorder? Where is this documentation kept, and for how long? Based on COSC doctrine found in Field Manual 4-02.51, a policy was established based on whether or not a soldier would be placed in a COSR restoration program.

Care for a soldier participating in a restoration program for COSR was tracked from the initial contact until the soldier was released from the program. It included the COSC interventions and activities provided, soldier response, and a summary of COSC services provided. This record, or file, was kept separate from the soldier's outpatient treatment record or deployment health record, and safeguarded on premises. As outlined by the Patient Administration Systems and Biostatistics Activity, this file was kept by the CSC unit for 5 years, and destroyed in December of the fifth year.[13] Only a notation of the dates and the CSC unit providing the services was entered into the soldier's official record.

Care for soldiers with COSR, but not participating in a restoration program, was documented according to the level of intervention and severity of COSR. One level was a soldier who was experiencing normal stress reactions, and received only brief supportive "therapy," skill acquisition, or "psychoeducation" to normalize the response. These contacts did not require documentation. However, the soldier who was experiencing a more severe, yet normal, stress reaction would require a notation in the outpatient treatment record. These reactions are described in Field Manual 4-02.51 as "maladaptive stress behaviors."[2] Documentation was also required if the COSR was interfering with the soldier's ability to function. The notation included the CSC unit, a statement that there were no safety issues, and no medication was needed. At the soldier's request, the provider would document any of the above situations. Care for soldiers with psychiatric disorders was documented the same as if the care was provided in garrison. The standards outlined in Army Regulation 40-66 apply on deployment, too.[14]

Reporting Workload

Keeping accurate records is important in identifying any potential trends in healthcare use, incidence of disease, and injury rates. Current methods in force health protection and healthcare include reporting disease nonbattle injuries, surgery hours, and hospital inpatient occupancy. The types of interventions and activities performed in COSC do not fit well into these types of reporting methods. As a result, the COSC-WARS was developed. Because the OIF units were the only ones using the COSC-WARS, permission was received to revise the form. During OIF 05-07, the COSC-WARS summary report was modified twice in an effort to ensure the data collected were sufficient to answer requests from a variety of sources. The final version contained data that allowed accurate responses to requests from the Government Accountability Office, Office of The Surgeon General consultants, and the command surgeons at all levels—MNF–I, MNC–I, and TF30. This form also provided data that proved to be invaluable in the planning process. It is important to note that this process also utilized input from the users of the form—the COSC personnel. The latest version of the COSC-WARS summary report was on a Microsoft Excel worksheet that was easier for the units to complete, and with nearly zero errors. The report was also easier for TF30 staff to collect and enter error free into the summary worksheet. Automatic totals made responding to inquiries and analyzing data almost effortless. Due to the elimination of specific identifying information, units could submit the report over nonsecured means.

Completing the COSC-WARS summary report often seemed a daunting task because of the length. However, COSC personnel were provided with various methods of explanation that included a decision diagram and line-by-line explanations. The more problematic terms such as "walk-about" and "COSR contact" were also explained.

Keeping Statistics

Psychiatric casualty statistics were frequently requested from all levels of leadership, from TF30 Med through MNF–I. Prior to OIF 05-07, most casualty statistics that were reported were based on the daily figures from the Level III hospitals, which included inpatient hospitalizations and inpatient and outpatient evacuations. This resulted in underreporting the number of evacuations, as outpatient evacuations also occurred from the divisions and Level II clinics. This

realization led to the creation of a new database, the Mental Health Casualty Tracker for OIF (MHCTO) during OIF 05-07. The MHCTO utilized six sources of information: (1) the daily inpatient census report for theater, (2) the daily inpatient census report for garrison, (3) the US Transportation Command Regulating and Command and Control Evacuation System, (4) the Joint Patient Tracking Application, (5) the Command Critical Intelligence Requirements, and (6) the MNC–I casualty report. Combining these separate data sources into one database allowed for the tracking of all inpatient mental health admissions in theater, all inpatient and outpatient air evacuations, and all suicide completions and suicide attempts that resulted in hospitalization or air evacuation. Because all the notes were electronic and had to be read to fill in the data fields, this also served as a quality assurance measure for all air evacuations.

Suicide statistics were also frequently requested. In addition to tracking the raw numbers, it became apparent that there was a lot of useful information available in the Army Suicide Event Reports (ASER) that had already been completed for suicide events occurring in Iraq. The TF30 Med mental health consultant was able to analyze the raw data on all ASERs submitted for the Iraq theater of operations. As a result of this analysis, it was clear that providers had different interpretations of certain questions, which resulted in lower quality data. The TF30 Med mental health consultant made the ASER a higher priority and took a more proactive stance toward completed ASER submissions for all suicide attempts. With the help of the MHCTO, suicide attempts were now easier to track, so corresponding mental health providers were now contacted and informed of the expectation that the ASER would be submitted. Certain providers even sent ASER drafts to the mental health consultant to ensure accuracy. With more providers submitting more accurate ASERs, the accuracy of the suicide statistics for OIF 05-07 was greatly improved over previous years. Additionally, in the clinical background information gathered from the MHCTO and the ASER it was possible to read about actual incidents in which buddy aid—the basis for Army suicide prevention programs—was successfully administered and resulted in a saved life. Every month, a new vignette was chosen and disseminated at the TF30 Med Battle Update Brief.

Quality Assurance

Having standardized practices and theater-wide policies in place was the first step toward assuring that quality care was consistently being provided across theater. The next logical step was to devise a way to ensure these policies were available and understood by those to whom they applied. By OIF 05-07 the electronic communication systems had been greatly improved and allowed wide dissemination of information. It was now possible to send the policies, through command channels, all the way down to the individual provider. Additionally, the TF30 Med chief of professional services held a regular teleconference in which the deputy chiefs of clinical services from all the CSHs and the multifunctional medical brigade, in addition to the division surgeons, were invited. The mental health consultant regularly disseminated new theater-wide mental health policies through this manner, which allowed for a dynamic discussion to take place prior to the implementation of new policies.

One such policy that was initiated during OIF 05-07 was the guidelines for psychotropic prescribing in theater. The purpose of the guidelines was threefold. First, they set a standard with which most psychiatrists should already be familiar, but primary care providers may not. Secondly, they clearly stated that psychiatrists and certain psychiatric advanced nurse practitioners were the only mental health providers credentialed to prescribe psychotropic medication. (Anecdotally, medical providers had asked social workers and psychologists to write prescriptions, unaware that this was not within their scope of practice.) Finally, the guidelines offered an information paper for commanders, who frequently asked providers which of their soldiers were taking psychotropic medications. There seemed to be a misperception that starting someone on an antidepressant would lead the soldier to be nonmission capable. (Also anecdotally, many soldiers reported feeling more mission capable once their depressive or anxiety symptoms were under better control from medication.)

Another method used to support subordinate units in ensuring quality of care was the staff assistance visit (SAV). TF30 Med conducted SAVs to gain a first-hand awareness of "best practices," make recommendations where indicated, and answer questions. It provided the valuable opportunity to get to know the combat stress control teams and COSC/mental health personnel, their locations, and so forth. A checklist was developed to standardize the questions asked during the visit and to help clarify TF30 Med's priorities. The visit was not meant to be punitive, but rather to offer assistance in meeting expectations outlined in TF30 Med policies and procedures. The SAV was coordinated with the direct reporting unit commanders or deputy chiefs of clinical services, allowing a visit to each CSC unit headquarters and restoration center, mental health personnel at the CSHs, and some area support medical company mental health personnel. It also allowed

the headquarters to obtain input from subordinates. In conjunction with these visits, TF30 Med personnel acted as an advocate for COSC/mental health at higher levels. A good example of this occurred after an SAV to one of the CSHs. Based on input from the mental health personnel, the TF30 Med mental health officer could ensure that the need of CSH mental health personnel for appropriate space was heard at brigade headquarters. This included current and future facility needs.

Toward the end of its rotation, TF30 Med decided to institute more regular, formalized, quality control through the establishment of monthly mental health chart reviews. Up until this point, peer reviews were inconsistently being done and most were informally conducted, usually consisting of case discussions. The first question to be addressed was which encounters were to be reviewed: COSR, psychiatric mental disorder (PMD), or both. Because providers were presumably more familiar with the behavioral health standards of the Joint Commission, and because there was more ambiguity in the COSR charting requirements, it seemed reasonable to start with chart reviews on the PMD charts rather than the COSR charts. The next issue was determining a standard for mental health charting in theater. The MNC–I surgeon/TF30 Med commander's directive was that the standards in theater be the same as those for garrison. Even though the Joint Commission would never visit the combat zone, its standards were based on patient safety issues, which still applied in theater. A garrison mental health chart review was then e-mailed to all the CSHs and CSC commanders for feedback on which standards did not apply to the theater. After a consensus was reached, the next step was to determine how isolated clinics could perform the review. It was decided that if there was only one provider at a certain location, that provider was expected to have another medical provider conduct the chart review. This only happened on rare occasions because of the frequency of CSC commander SAVs. The results of the reviews were then e-mailed to the mental health consultant, who could verify to the TF30 Med commander that they were being done.

As a result of the mental health peer review, there was now one standard for mental health charting in the combat zone. This brought up some issues that were previously not being addressed. First, it became apparent that most reserve providers were unaware of the requirement for cosigning the notes of their mental health technicians. Not having a civilian equivalent of an outpatient mental health technician, this was understandable. Additionally, more questions were being asked about what was in a specific provider's scope of practice, such as whether or not a psychiatric nurse practitioner was able to prescribe medications. Finally, as mentioned previously, with more forensic psychiatry requests, there was an increased likelihood that psychiatric charts could be subpoenaed. Chart reviews indicated that this, along with limits of confidentiality, was not always discussed with patients.

Another quality assurance initiative developed by TF30 Med involved a review of the scope of practice of unlicensed providers, such as medics and other health technicians. Upon learning that there were unlicensed psychologists in theater who required regular supervision, the TF30 Med commander began discussions with the Office of The Surgeon General and Medical Command about this practice. Ultimately, the decision was made that no further unlicensed psychologists would deploy to the Iraq theater of operations. The mental health community was not prepared for this policy change. In the immediate aftermath of this, major changes had to be made in assignments. The result was an acute shortage of psychologists, which led to psychiatrists or psychiatric nurse practitioners being used to fill vacant deployment psychologist slots. According to the director, Behavioral Health Proponency, Office of The Surgeon General,[15] training for psychologists in the last year has been extended to 2 years to prevent unlicensed psychologists from being assigned to deployable positions.

ROLE OF THE MEDIA

The quality of information provided to the media is important and can have widespread effect on the mission. To this end, the TF30 Med COSC and mental health consultants worked closely with the task force in developing a Public Affairs Office policy as it related to COSC operations in theater. This ensured the protection of the service members being supported, and provided guidelines for the providers on releasing information. This policy also covered any articles or research requests from providers in theater. Headquarters has a broader awareness of events across the theater, is in a better position to ensure the information is consistent with the overall mission objectives of OIF, and that release of this information is compliant with operational security requirements. By having TF30 Med answer incoming questions, it allowed providers in the field to focus on their mission of providing COSC/mental health services to the force.

Although it is impossible to determine exactly how much the media influenced the daily operations of mental health providers during OIF 05-07, there were headlines that commanded the attention of soldiers and military leadership alike. These media reports ultimately translated into combat mental health prac-

tices being more carefully scrutinized and greater accountability of mental healthcare providers, neither of which is necessarily a negative result. In this section a closer look will be taken at some of the more significant headlines during OIF 05-07 and how they potentially impacted the mental health community.

Reporting Increase in Suicide Rates

In April 2006, the 2005 Army suicide rate was released and became widely quoted in the press, the media, and on the Internet. The Associated Press reported that 83 soldiers killed themselves in 2005, the greatest number of Army suicides since 1993.[16] The following month, *The Hartford Courant* ran a series entitled "Mentally Unfit, Forced to Fight." In an article in the series, titled "Potent Mixture: Zoloft and a Rifle," the authors discuss case reports of soldiers prescribed medication in a combat zone who later committed suicide. The article suggested that psychotropic medications were being prescribed too freely in theater and were related to suicides.[17]

The release of the 2005 suicide rate generated considerable interest in the topic of suicide and, specifically, how it applied to the conflict. In "Zoloft and a Rifle," the authors used the increased suicide rate to criticize the combat effort and point out flaws with military mental health. The article sent a mixed message to soldiers in theater—the authors cared about soldiers and wanted to honor those who committed suicide, yet if they were having problems, health providers in theater would only make them worse. Little attention was paid to the theater suicide prevention programs already in existence, or the power of buddy aid.

As the reporting of the increase in the suicide rate spread throughout the media, TF30 Med and MNC–I received additional inquiries related to suicide statistics. By April, the MHCTO was fully operational, which enabled the TF30 Med to support the requests for information. As mentioned previously, studying the ASERs also provided valuable information about theater suicides that was frequently requested by mental health providers and was presented at theater mental health conferences.

Although dramatic, "Zoloft and a Rifle" did bring up a valuable point regarding how nonpsychiatrists were treating mental illness. An informal survey of physician assistants in theater demonstrated that comfort levels with the use of psychotropics varied greatly. This prompted the MNC–I surgeon to commission the psychotropic prescribing guidelines, which came out as a MNC–I fragmentary order during the summer of 2006. The guidelines were meant to assist providers in better understanding psychotropic prescribing in the combat zone and included information about monitoring laboratory reports, side effects, drug interactions, standard of care for treating psychiatric disorders, and what to tell commanders requesting information about their soldiers.

Airing the *Baghdad ER* Special

Baghdad ER is a Home Box Office special that aired May 21, 2006. It is a graphic and emotional account of the realities of combat through the experiences of a CSH. Yet graphic documentaries also have other implications. They can serve as powerful reminders or "triggers" for soldiers who have been exposed to trauma. *Baghad ER* is indeed a harsh reminder of the brutal realities of combat.

Lieutenant General Kevin Kiley, then the Army Surgeon General, directed Army mental health experts to prepare for the impact of *Baghdad ER*. Said Kiley, "This film will have a strong impact on viewers and may cause anxiety for some soldiers and family members."[18] He suggested that mental health facilities should extend their treatment hours and reach out to the troops proactively. The Army recognized that it had to address the near-term implication of the program and also recognized that the families and soldiers who might be traumatized by this media event might also have on-going psychological issues.

The theater mental health consultant wrote the following talking points,which were disseminated in theater prior to the airing of the program.

1. Most soldiers returning from deployment seek to avoid images and media coverage related to the global war on terrorism. Soldiers in theater will have limited access to the HBO special. The greatest impact will likely be on soldiers' families, brought about by fears raised from direct viewing or the publicity afterwards.
2. Technology has significantly altered communications with the home front, with increased accessibility and frequency. Mental health providers have noticed spouses who are coping poorly can significantly affect the morale of their deployed soldier.
3. In the days and weeks following the program airing, commanders should:
   - Check in with their soldiers to see how their spouses are coping.
   - Consider limiting contact immediately before a mission or have mental health assets or chaplains available during popular calling periods.
   - Be aware of common warning signs of

increased stress, such as soldiers becoming isolated, becoming easily angered, or seeming distracted, and a change in work performance.
- Encourage soldiers to talk with their peers, chaplains, or mental health providers if they start to feel more stressed after talking with family members.

4. There are assets available in stay-behind elements to assist family members coping with a soldier's deployment, such as TRICARE and Military OneSource. Additionally, commanders should encourage active participation in family readiness groups, as this provides a unique opportunity for families with a common interest to support each other.[19]

Based on conversations with CSC providers, the aftereffects from *Baghdad ER* were not as intense in theater as was expected. Nevertheless, the event was a clear example of how the media influenced mental health providers in theater during OIF 05-07.

Media Coverage of Civilian Deaths in Haditha

In November 2005, Marines killed 24 Iraqi civilians in the town of Haditha, Iraq. Specifics of the story were not immediately available, but eventually it was reported that the killings were in retribution for a roadside bomb in which a Marine had been killed. *The Washington Post* wrote that "[t]wo US military boards are investigating the incident as potentially the gravest violation of the law of war by US forces in the 3-year-old conflict in Iraq."[20]

Haditha was a complex media event because it lasted for months, as each new revelation had its turn in the media frenzy that followed. Mental health experts were often interviewed to try to make sense of the killings. The psychiatrist Robert Jay Lifton explains that "atrocity is a group activity." Therefore, he writes at *Editor & Publisher* "[t]o attribute the likely massacre at Haditha to 'a few bad apples' or to 'individual failures' is poor psychology and self-serving moralism."[21] Lifton says that the Haditha incident can be understood as what he calls "an atrocity-producing situation," which he defines as "one so structured, psychologically and militarily, that ordinary people, men or women no better or worse than you or I, can commit atrocities."

Interest in combat ethics grew substantially during OIF 05-07 as a result of the killings in Haditha. All subsequent war misbehavior was often presented in comparison to that event. MHAT-IV was commissioned by the MNF–I commander with the request to investigate combat ethics. The MHAT-IV accomplished this through survey questions and focus group discussions. The final report includes information about behaviors during deployment and discusses ideas for teaching ethics. Recommendations include incorporating battlefield ethics in all behavioral health counseling and anger management classes, especially when conducted in a combat zone.[5] These recommendations could substantially increase the scope of duties of deployed mental health providers.

SUMMARY

This chapter has explored how the provision of mental health services advanced during OIF 05-07 as a result of a more mature battlefield. Without having to worry about basic necessities or establishing new clinics, mental health providers were able to take on additional missions, such as serving as MROs or on sexual assault review boards, responding to the media, and meeting standards of care that were the same as garrison mental health clinics. The provision of mental health consultation to TF30 Med, MNC–I, and MNF–I leadership was also able to advance because providers had become adept at mastering the basics. Although not mentioned specifically in this chapter, brevity, immediacy, contact, expectancy, proximity, and simplicity (BICEPS) remained as the cornerstone of mental health services in the combat zone during OIF 05-07. The fact that they did not require alterations speaks to their universality. As future battlefields will likely look as different from OIF as OIF does from World War II, it is reassuring to know that there will be at least one constant in the provision of mental health services. That constant is the BICEPS approach to combat and operational stress reactions.

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