

Executive Summary — USMI Roundtable Discussion



Promoting Mental Health In The Operational And Treatment Settings

Washington, D.C. January 19, 2007

Providing mental health services for military personnel serving in Iraq and Afghanistan, and to their families, is a complex continuum for the Defense Department, raising such issues as how to educate troops and their commanders in reactions that can be expected in combat — and how to deal with them — how to provide mental health care in-theater, and how to help troops and their families readjust once redeployment occurs.

A basic question underlying these issues is the definition of mental illness in combat — do the special circumstances of anticipated trauma make the criteria different than in civilian life? For example, being hyper-vigilant is desired in a hostile area while considered an “outlier” in regular mental health assessments. How can such differences be defined and taken into account? Are military mental health providers biased toward under-diagnosis, to help maintain the fighting force? Or, is awareness that PTSD is associated with combat a factor in attributing pathology to reactions that are normal in a hostile environment? “If you are trained for it and expect it, is it a trauma?”

To consider the various facets of these issues, the nonprofit **U.S. Medicine Institute for Health Studies**, in partnership with the Defense Department’s Health Affairs Office, convened a roundtable discussion involving federal agency, congressional and professional association participants. While the operations in Iraq and Afghanistan are being monitored more intricately than previous conflicts for their potential effects on mental health, determining the meaning of these data remains difficult, the group agreed.

Other enigmatic issues that arose in the discussion: What is emotional resiliency in the combat setting? How can the stigma too often associated with seeking help be lessened? Is there a way to return those with such pathology to the combat setting? If they are not fit to remain in military service, where in society do they go?

Summary of Discussion

Congress has exhibited its concern for the mental health of deployed troops by mandating creation of a mental health task force (its report is due in May) and monitoring pre- and post-deployment assessment of those serving in Iraq and Afghanistan. In fact, the current deployed force widely has been described as the most carefully assessed — ever. While these assessment data provide a snapshot of troops’ physical and mental health, roundtable participants said, their meaning over the longer term remains uncertain: “The bottom line is how to define and measure mental health.”

All returning troops from Iraq and Afghanistan are eligible for care in the VA system for two years after they return home and leave the military. VA offers evaluation and care to these individuals and to those who may become eligible for ongoing VA care, including annually for five years, and then every five years thereafter. Most VA evaluations are performed by primary care providers.

Another issue addressed by roundtable participants was the effect of assessment itself. Does periodic assessment create an expectation of mental problems? Or, does it help by reassuring troops that their health is being monitored? Again, the answer remains uncertain.

Participants expressed concern about a potential shortage of mental health providers in the military. Both recruitment and retention have fallen, and action is needed to reverse this trend. It was suggested that civilian organizations could serve a mentoring role by advising students of career and loan-repayment opportunities in the military.

Additional issues addressed during the roundtable discussion:

- Training for military personnel and their commanders in recognizing the warning signs of mental health problems often is not consistent and varies from base to base. It is essential that the line be part of this training effort; line awareness can help reduce the stigma associated with seeking help for a mental problem.
- Individuals differ in their ability to tolerate stress, and thus there is no simple answer as to what constitutes a condition that requires clinical intervention. “Most suffer no long-term problems, but how do we identify the subset that will?”
- There are a variety of populations in-theater to which management approaches should be tailored. For example, Navy individual augmentees now serve with some Army and Marine Corps units on the ground in Iraq — a new role with new stressors for them. “We need dozens of solutions,” one participant noted.
- Much of the health care delivered in combat areas comes from primary care providers. In terms of mental health care, this often translates into prescription of some form of medication such as SSRIs, which can be helpful. If medication is provided by primary care providers, and if by today’s medical standards psychiatrists are used primarily to treat more acute unresponsive patients, is there a need for psychiatrists in theater to keep acute patients there instead of medically evacuating them? Should psychiatrists be replaced by other psychological care providers? Should chaplains be trained to provide some preventive mental health services?
- Reserve and National Guard personnel present a specific challenge, in that they may return to areas where military and VA medical facilities may not be available to help detect and deal with mental health concerns that may arise post-deployment. How can these individuals be followed?

An innovative program in Minnesota requires returning Reserve and Guard personnel to drill at 30 and 60 days post-deployment. This allows them to stay in touch with their combat buddies and to have their family members meet those with whom they served — all of which reduces the isolation of returning after deployment in theater. This does not happen without cost, however, in the form of increased drill pay. Other model programs exist in other states as they define ways to implement a safety net for their Guard and Reserve members.

- Is the focus on pathology at the individual level diverting attention and resources from potential solutions at the organizational level? For example, perhaps it is possible to shorten deployment times — a step which would have positive benefits in the mental outlook of troops. Providing “predictability” by not unexpectedly extending unit deployments could have a similar effect. If all time and resources are focused on individual pathology, will more global prevention strategies receive any attention?
- Family members of those deployed need to have mental health services available, and family members of those killed in combat need special attention. Not to be forgotten are medical care professionals, many of whom live with the trauma of war every day they are deployed.

The purpose of the roundtable was to present diverse opinions about complex issues. While not all participants shared the same views, they were in agreement that the complexities of the issues do not lend themselves to easy solutions. Generating the right questions can help to define a set of answers. More frequent interaction among DoD, VA, other federal agencies, professional groups, and non-government organizations may help to build a community-based response.

Participants in this roundtable: Joyce Adkins of DoD; Rick Campise of the Air Force; Robert Ireland of DoD; Douglas Jacobs of Screening for Mental Health, Inc.; Bradley Karlin of VA; Michael Kilpatrick of DoD; Robert Koffman of the Navy; Gerald Koocher of the American Psychological Association; Gary Leeling of the Senate Armed Services Committee; Carolyn Robinowitz of the American Psychiatric Association; David Riggs of the Uniformed Services University of the Health Sciences; Elspeth Ritchie of the Army; William Schlenger of Abt Associates; Diana Tabler of the Senate Armed Services Committee; and Patricia Watson of the VA National

Center for PTSD. The roundtable was moderated by Ed Wyatt of EWyatt Consulting. USMI Managing Director is Nancy Tomich [www.usminstitute.org].