# Chapter 12

# PSYCHIATRIC CONSULTATION TO COMMAND

CHRISTOPHER H. WARNER, MD*; GEORGE N. APPENZELLER, MD†; JILL E. BREITBACH, PsyD‡; JENNIFER T. LANGE, MD§; ANGELA MOBBS, PsyD¥; AND ELSPETH CAMERON RITCHIE, MD, MPH¶



*Major, Medical Corps, US Army; Chief, Department of Behavioral Medicine, Winn Army Community Hospital, Building 9242, Room 20, 1083 Worcester Drive, Fort Stewart, Georgia 31324; formerly, Division Psychiatrist, 3rd Infantry Division, Fort Stewart, Georgia

†Lieutenant Colonel, Medical Corps, US Army; Commander, US Army Medical Activity, Alaska, 1060 Gaffney Road #7400, Fort Wainwright, Alaska 99703-7400; formerly, Deputy Commander for Clinical Services, Command Group, Winn Army Community Hospital, Fort Stewart, Georgia 31314

‡Major, Medical Service Corps, US Army; Neuropsychologist, Department of Psychology, Evans Army Community Hospital, USAMEDDAC, 1650 Cochrane Circle, Fort Carson, Colorado 80913; formerly, Group Psychologist, 1st Special Warfare Training Group, Fort Bragg, North Carolina

§Lieutenant Colonel, Medical Corps, US Army; Medical Director, Behavioral Health Clinic, Department of Psychiatry, Walter Reed Army Medical Center, 6900 Georgia Avenue NW, Washington, DC 20307-5001

¥Captain, Medical Service Corps, US Army; Special Forces Assignment and Selection Psychologist, Special Warfare Center and School, Rowe Training Facility, Building T-5167, 1500 Camp Mackall Place, Marston, North Carolina 28363; formerly, Brigade Psychologist, 3rd Brigade Combat Team, 3rd Infantry Division, Fort Benning, Georgia

¶Colonel, US Army (Retired); formerly, Psychiatry Consultant to the Army Surgeon General, and Director, Behavioral Health Proponency, Office of The Surgeon General, Falls Church, Virginia; currently, Chief Clinical Officer, District of Columbia Department of Mental Health, 64 New York Avenue, NE, 4th Floor, Washington, DC 20002

## INTRODUCTION

The psychological effects of warfare have been well documented throughout history. Since World War I, the US Army has been deploying behavioral health assets to the front line for treatment of combat operational stress and to advise unit commanders about combat stress and its effects on soldiers. Currently, commanders of combat units are being encouraged to attend to the overall health of their soldiers, including consulting with behavioral health professionals about the psychiatric well-being of their soldiers. One of the many challenges that behavioral health professionals are confronted with is the need to educate commanders about the role of psychiatric command consultation. This chapter outlines the many responsibilities of this role.

## ORIGIN AND HISTORY OF PSYCHIATRIC COMMAND CONSULTATION

Whereas mental health evaluations are typically thought of in terms of an encounter between a provider and a patient, a psychiatric command consultation occurs when a military commander desires to know mental health information or factors about an individual, unit, or command, and how to improve overall behavioral health. Historically, psychiatric command consultation has occurred in two different capacities: (1) attempts to screen for vulnerability and determine fitness for duty, and (2) preventive psychiatry. Previous overviews have described the history related to these components in depth. It is important to know how these roles have developed when outlining the future of psychiatric command consultation.[1] Additionally, although "psychiatric consultation" will often be performed by psychiatrists, other behavioral health professionals will also perform these consultations, thus, the term "behavioral health professionals" is used in discussion of consultations. For guidance regarding the specific roles of psychiatrists, psychologists, social workers, and technicians, the reader is encouraged to explore their individual discipline regulations.

### Screening for Vulnerability and Determining Fitness for Duty

For individuals desiring to enter the military, their first encounter with medical personnel will generally be at the Military Entrance Processing Station. Here new recruits complete a thorough medical evaluation that includes answering questions regarding mental health. Certain individuals may be barred from entry to service or require further evaluation prior to entering the military. This process, a reflection of the recognized need to screen military personnel for psychiatric vulnerabilities, dates back to the mid-18th century.

"Nostalgia," which was the recognized ailment defined by Aurenbrugger in 1761, was the term used to describe the "disease" where soldiers lost hope, became sad, isolative, inattentive, and apathetic—what today is commonly termed "combat stress."[2] French physicians of the Napoleonic era recognized factors associated with producing and preventing nostalgia, and began screening soldiers accordingly.[2]

The US military began psychological screening in the early 20th century. During World War I, the famous Army Alpha and Beta testing and psychiatric interviews were applied to screen the massive influx of military recruits needed to fight the war.[3] At that time, the personality and estimated intellectual functioning of each individual was assessed, and recommendations regarding suitability for military service and service specialties were made. The decisions made concerning suitability largely reflected the belief that psychiatric symptoms and illnesses reflected a "weak personality"; individuals with psychoneurotic illness were not normal, and thus not capable of marshalling defenses needed to serve during war.[3] This method of screening military soldiers for service is largely viewed by historians as a failure.[4] However, as a consequence of the efforts, the perception of psychology as a valuable science capable of producing results of immediate and practical significance to command was substantially bolstered.[5]

In 1941, Harry Stack Sullivan was appointed as a psychiatric consultant to the Selective Service Program and helped develop a more comprehensive system that incorporated screening interviews.[6] However, over the course of World War II, attitudes changed about the effectiveness of these screening methods and many began to view them as excessive, ineffective in accurately predicting the resilience of individuals to withstand the risks of war, and resulting in a substantial and excessive loss of potential soldiers.[6–8] After World War II, psychiatric screening methods were modified to focus on identifying and disqualifying only gross psychiatric disorders. This process has remained in place since then, with varying modifications over time.

Although the screening purpose has remained relatively unchanged, the debate continues over the role that preexisting medical and psychiatric conditions have in making individuals more vulnerable to negative outcomes in times of stress. Conflicting data

continue to exist as to whether preexisting psychological conditions are a contributing factor to psychiatric attrition in a combat zone.[9–18] This debate is especially salient given the estimated rates of depression, anxiety, and posttraumatic stress disorder in returning Operation Iraqi Freedom and Operation Enduring Freedom veterans.[19]

What remains unclear is what number of service personnel experiencing psychiatric problems upon return from combat had preexisting mental health conditions before deployment and, more specifically, what number had conditions that existed prior to entry into the service. The psychiatric conditions that should perhaps preclude service because of vulnerability under stress, which may only have minimal effects on the well-being of soldiers in combat, are not yet understood.

Since the establishment of the Office of Strategic Services in World War II, screening processes have also been conducted in soldiers seeking special duties. Through the years, the role of behavioral health professionals has evolved with expansion of special operations and special missions. Not only do psychologists screen applicants for suitability for special operations, they also monitor progress throughout special operations training.[20] After training has been completed, psychologists screen soldiers for special missions, which requires these behavioral health professionals to carefully assess the "biopsychosocial fit" of individuals to their specified mission tasks. Mental health providers must become familiar with the demands that will be placed on the soldier (ie, isolation from others, exposure to extreme conditions), and work intimately with command regarding the establishment of desired competency for the mission. This aspect of command consultation is unique in that the commander of the mission will often dictate aspects of required competencies. It is the job of the mental health professional to apply these principles in a psychiatric framework for screening. Assessments are presently performed for a variety of special missions (special operations service members) or specialty job requirements (security clearance evaluations, intelligence positions, nuclear weapons specialists).

**Preventive Psychiatry**

Military psychiatrists were the first to focus on the total social environment of the individual in establishing programs not only for the treatment, but also the prevention, of mental illness.[11] This shift in focus came in 1944, when the Army began using psychiatrists in a preventive fashion, morphing the role of psychiatry from overseeing straight disposition of personnel into recommending how to use marginal personnel and implementing mental hygiene training programs.[21] Furthermore, the Vietnam War provided a unique opportunity to understand combat, from which significant understanding of the individual's response to extreme conditions was gained.[11] Thus, the role of psychiatry in providing primary, secondary, and tertiary prevention training based on understanding the biopsychosocial influences on behavior was established. The effectiveness of preventive psychiatry was later shown by the Group for the Advancement of Psychiatry when it reported that preventive psychiatry could reduce combat ineffectiveness through early recognition and prompt outpatient treatment of emotional difficulties during combat and noncombat situations.[22]

Much of what is understood about prevention of psychiatric casualties comes from the work of William C Menninger, who identified the failure to meet basic needs (such as food, water, sleep, social interaction, and recreation) as a significant contributor to the incidence of psychiatric casualties in combat.[7] Likewise, unit cohesion and morale have repeatedly been found important in supporting individual coping behavior and unit performance, both in wartime and in peacetime.[23,24] Although morale remains difficult to operationally define, it may be considered to represent the general sense of unit cohesion, confidence in ability, and overall well-being of a unit. Failure to experience positive morale in a group (because of a lack of order and security, a lack of fusion with the group, having insufficient leadership, or lack of absorption into the unit's work) has been associated with increased psychiatric referral, at least upon initial deployment.[23] Morale and unit cohesion are often synonymous; one of the greatest defenses against breakdown in combat is the development and reinforcement of group cohesiveness.[25]

Additionally, it has been well documented throughout history that the time spent exposed to combat correlates with the number of psychiatric casualties.[21–26] This was perhaps most salient in the Vietnam War, where soldiers knew that if they could survive for 12 months, their removal from combat was assured. The rest-and-recreation policy, which sought to reduce continued exposure, was also widely implemented. The effect of time on psychiatric visits has also been seen in recent conflicts, where multiple studies have noted an increase in combat operational stress reactions after 6 months of deployment.[26,27] Understanding these factors, as well as their historical context, provides a framework for application of current principles and avoidance of prior pitfalls.

## FACTORS ASSOCIATED WITH COMMAND CONSULTATION

As the consultant prepares to perform an evaluation, there are several factors that must be considered. These include the environment, the nature of the request, and the proximity of the consultant to the unit or individual being evaluated.

### Deployed Versus Garrison

Consultations can vary significantly depending on the environment. In a garrison environment, commanders are generally looking for risk reduction methods and to determine if a soldier is fit for duty or deployment. During deployment, commanders are more focused on interventions for maintaining their combat power and assessing the levels of unit cohesion and soldier quality of life to maintain soldier readiness.

### Level of Preventive Consultation

Preventive consultative advising involves using the threats identified during the planning and oversight phases of operations and making recommendations to the medical staff and command on measures to be taken and areas requiring command emphasis. Three categories of prevention can generally occur both in the garrison and deployed environment: (1) primary prevention, (2) secondary prevention, and (3) tertiary prevention. These prevention activities are especially critical in the deployed environment given that resources may be limited.

#### *Primary Prevention*

Primary prevention generally comes in the form of education. Most units regularly employ periodic training on topics such as prevention of sexual assault, suicide, and substance abuse. These training sessions allow behavioral health professionals an opportunity to gain visibility with command and soldiers alike. Furthermore, behavioral health professionals can play key advisory roles in preparation for deployment, as well as during deployment, in such areas as training (including training schedules), personnel issues, discipline, crosscultural issues, and, most importantly, the morale of the unit. All preventive services provided in garrison and during deployment establish credibility with the command.

Recently, in response to evolving technology and the recognition that soldiers and commanders are presented with differing stressors throughout the deployment cycle, the Army Medical Department designed an educational series called "Battlemind" training.[28] These modules were designed for specific portions of the deployment cycle, to build upon a soldier's strength, help soldiers develop resiliency in stressful situations, and to teach soldiers how to utilize their strengths during times of transition. Modules for both soldiers and their families were designed for predeployment, reintegration (immediate return from a deployment), and reconstitution (90–180 days after return from deployment).[28] Initial research on the effectiveness of "Battlemind" training appears promising; this effectiveness will continue to be explored.[26,29]

#### *Secondary Prevention*

Secondary prevention involves identifying as early as possible those soldiers who are at risk to develop mental health problems and intervening to prevent the development or worsening of symptoms after exposure. These types of procedures are accomplished both through individual and unit-level screening and also through traumatic event management.

Postdeployment psychological screening has been growing in importance since Operation Desert Storm in 1991 and became mandatory in 1997.[30,31] Shortly thereafter, the Department of Defense introduced the Post-Deployment Health Assessment, which screened soldiers for physical and mental health problems upon return from deployment. It was a method for early identification of problems and for decreasing the stigma associated with behavioral healthcare. However, few studies have looked at validating the postdeployment screening instrument against other measures or functional outcomes.[32,33] Furthermore, experiences from other samples of returning soldiers indicate that rates of reported deployment-related symptoms increased with time after returning from deployment.[19,34,35] This led to an extension of the Post-Deployment Health Assessment program to include a reevaluation (the Post-Deployment Health Reassessment) at 3 to 6 months after return from a combat zone.[36] These programs allow for early identification; however, there has been notable criticism that effective follow-up of the concerns identified has not occurred.[37] It is important that consultants be engaged throughout these screening processes and that commanders be very involved. Both occurrences will increase soldier participation and help decrease the potential for soldiers to "fall through the cracks."[38]

Other assessment methods allow for broad unit-wide assessments rather than individual screenings. An example of this type of method is the Unit Behav-

ioral Health Needs Assessment. This tool allows the consultant to take a sampling of a unit, employing a standardized survey that assesses areas such as morale, cohesion, ongoing stressors, and soldier concerns, as well as current levels of need and barriers to care. This allows the consultant to provide the commander with clear objective findings and provide customized recommendations specific to the unit. Additionally, the Unit Behavioral Health Needs Assessment has comparison data that have been collected from multiple units at varying stages throughout Operation Iraqi Freedom to serve as a gauge.[39]

Another area of secondary preventive psychiatric consultation is that of traumatic event management (TEM). TEM involves intervening after a potentially traumatic event has occurred, with the purpose of seeking to decrease the effect of the event and prevent long-term negative consequences. Considerable debate continues between both military and civilian behavioral health providers about the utility and efficacy of debriefings (which are traditionally part of an overall TEM strategy) as preventative interventions. Traditionally, the TEM process is conducted at the request of a unit supervisor to begin the process of integrating a traumatic experience into the individual and group experience. Debriefings involve a structured meeting of all parties directly involved with a traumatic event. Members of the group tell their individual stories about what happened in the presence of trained behavioral health providers or chaplains, followed by processing of the cognitive and emotional components of the event.

Currently there are many different models for debriefings. Most evolved out of Marshall's work in World War II when he attempted to record accounts of unit operations for historical purposes.[40] Interestingly, these initial sessions were not for the expressed purpose of psychological benefits to the involved parties. Marshall noted, however, that during the process of debriefing many misperceptions were corrected by other individuals involved in the traumatic event, and the debriefing appeared to render social support and decrease the development of combat stress reactions.[40]

Although debriefings have been used throughout military conflicts, their effectiveness has not been well documented in research studies and they have not been proven to prevent posttraumatic stress disorder.[41–44] Part of the problem in examining the utility of debriefings is the evolution of what TEM actually entails. In fact, "debriefings" are now thought to take many forms commonly used by all military personnel, to include after-action reviews, which are now a standard operating procedure for all US Army teams and small units following any training exercise.[40] Other forms of debriefings include defusing, critical event debriefing, critical incident stress debriefing, psychiatric debriefing, historical debriefing, and intelligence debriefing. Thus, one of the inherent problems in determining the effectiveness of TEM is the lack of consistent standardized protocols across providers and across organizations. Furthermore, what constitutes a debriefing, or what form of a debriefing to use for a particular circumstance, often varies.

Despite all of the inherent problems in TEM definition, standardization, and demonstrable utility, TEM nonetheless remains a common consultation task that is expected of behavioral health providers, and thus it is imperative that behavioral health providers be proficient in TEM. US Army Field Manual 4-02.51, *Combat and Operational Stress Control*,[45] provides a standardized outline and structure for current TEM operations. The Army has recently introduced Battlemind psychological debriefings.[46] These debriefings take into account military rank and structure and incorporate resiliency based educational principles that help to build upon the soldier's strengths during the process. As with other debriefing methods, the effectiveness of this process is not known at this time.

### *Tertiary Prevention*

Disease nonbattle injuries—specifically combat operational stress and psychiatric casualties—have long accounted for vast numbers of non–mission-capable soldiers. Indeed, one of the defining principles of history's victorious commanders has been to "break the enemy's will to fight," and thus produce combat stress and psychiatric casualties in the opposing force. History has revealed consistent themes in soldiers who persevere in combat compared with those who break down in combat, with the difference in outcome often being reduced to adaptability and cohesion.[23,24] Tertiary prevention involves the treatment of those who have ongoing issues, with the goal to return soldiers to duty and to advise commanders on who should be removed from the combat operations.

### Internal (Division Mental Health) Versus External (Combat Stress Detachment) Resources

The primary resources responsible for preventive psychiatry missions and the control of combat operational stress during both garrison and deployment are the combat stress control (CSC) and division mental health (DMH) units. These units establish a diplomatic relationship with command to earn credibility in the consultative role. Preventive missions of both of these

units are defined by US Army doctrine as the following: consultation-liaison services; reorganization and reconstitution support; proximate neuropsychiatry triage; and stabilization, restoration, and reconditioning and retraining.[23]

Although the mission is the same, the two units have notable differences that present varying challenges. DMH units are organic to the organization and have been deploying in that structure since World War II.[47,48] Recently, the transformation of the US Army from a division-centric focus to one in which the brigade combat team is the primary unit of action has resulted in the expansion of the DMH organization and mission. (In this volume, Chapter 6, The Division Psychiatrist and Brigade Behavioral Health Officers, discusses DMH and the positions within it at much greater length.) DMH units are with the larger organization both in garrison and during deployment and thus have the ability to establish long-term relationships with commanders and implement long-term prevention plans. These units, however, tend to be smaller and more limited in capability than CSC units.

Like DMH units, CSC detachments have been evolving for quite some time in the US Army. They first appeared during the Korean War when Colonel Albert Glass established these teams to augment existing DMH assets.[47] Glass, drawing on his own experiences from World War II, organized what were called "KO" teams (the "KO" designation refers to one in a series of hospital augmentation detachments). They provided mobile consultation throughout the corps and US Army areas.[47] The first KO teams were deployed to Korea; CSCs have augmented organic mental health assets in every major conflict since that time. They officially became known as CSCs in the mid-1980s. Presently, the CSC model remains largely unchanged from that originally established by Colonel Glass; however, the mission has expanded to include additional preventive psychiatric care and restoration capabilities. Today, CSC detachments and companies traditionally provide US Army Echelon II or III care during deployed operations and are external to the brigade, division, or other unit.[45]

### Local Versus Remote Behavioral Health Resource

The type of consultation may dictate the use of a local versus a remote behavioral health resource. For issues that will require ongoing follow-up and will require a relationship with a commander, it is best to use local resources. These individuals are more apt to have some familiarity with the systems, personnel, and processes involved and can develop ongoing relationships with the commanders and provide follow-up.

An excellent example of this process is the use by a brigade behavioral health officer of a unit behavioral health needs assessment within a battalion. The officer may have only a limited relationship with that commander but has some familiarity with the brigade. The officer performs the assessment and informs the command of the key findings and recommendations. As a local resource, the brigade behavioral health officer is then able to follow up with the unit and continue to both monitor and reassess the situation to provide continued feedback to the leadership. These processes allow for identification of such items as barriers to care, stigma about using mental healthcare, and leadership issues.

In contrast, remote consultations will generally require mobilization of a team to conduct an evaluation, make recommendations, and then return to its home station, likely not to follow up again or with limited follow-up. These types of consultations tend to occur in units that have minimal mental health contacts or desire an independent assessment from someone who has minimal to no knowledge of the unit or its experiences.

Examples of these types of consultation can be seen in the site assistance visit or with the epidemiologic consultation team evaluations of suicide behaviors that have occurred at several sites throughout the Army in the past several years. In these cases, the team arrives, does a thorough analysis of potential factors, interviews individuals from the unit, and then provides a report of its findings and recommendations. It is left to the unit and local personnel to enact and follow up those recommendations.

## PERFORMING THE CONSULTATION

### Forming a Consultative Team

A consultation can be completed by either an individual clinician or by a team. If forming a team, the lead consultant should seek individuals who either have areas of expertise that will be needed to answer the consultation question, or with similarities in experience or background to the group requesting the consult. When assembling a team, it is also important to ensure it can work cohesively. The lead consultant must make clear the roles and duties of each team member. This can be especially difficult if the members have not worked together before and are coming together solely for the purpose of a consultation. It is often immediately evident if a team is or is not working together. Team cohesion will often

determine success of the consultation process and whether the consultation is performed adequately, effectively, and efficiently.

**Formulating the Consultation Question**

Prior to performing the consultation, the clinician should ensure that the question being asked has been clarified. For instance, the consultative question can concern clinical care requirements or the deployability of a particular soldier, or it may include a broader question of unit policy, behaviors, or actions. The consultative team needs to ensure that it focuses its efforts to meet the needs of the requesting commander. The team should only give additional information about individuals on a need-to-know basis. Once the nature of the request is determined, specific goals of the consultation must be established. Often command and other military personnel are unclear of their desired "goals," and are best able to describe a "desired end state." Setting specific goals at the onset of the consultation will ensure that expectations are met. It will also help prevent any misperceptions of what the consultative team is doing or its capabilities. In addition to setting goals, it is also important to explain the limitations of the consultative team. One specific difficulty can arise if the requesting commander believes that a consultation also provides treatment. An illustration of this misperception is discussed below.

***Case Study 12-1:*** A company commander came to the brigade behavioral health office during a deployment in Iraq. He stated that one of his route clearance platoons was recently having behavioral problems. It was also failing to find as many improvised explosive devices as it had on previous missions. After the brigade behavioral health officer went on a route clearance mission with the platoon members, it became evident they were fatigued—arguing with each other instead of focusing on the mission—and frustrated about not having had a day off in weeks. When this information was shared with the company commander, the command expressed confusion with regards to the outcome of the consultation. Specifically, the command in this instance had expected the brigade behavioral health officer would "fix" the soldiers by just spending time with them. Instead, the behavioral health officer had taken the consultative question and developed recommended changes in the soldiers' schedules. This example highlights the need for the consulting provider to clarify the request, set clear goals, and explain the limitations of the consultation services. Attention to these processes can ensure both parties are clear about the goals of the consultation and satisfied with its outcome.

**Gaining Entry to the Unit**

A consultation generally occurs at the request of the unit's commander. First and foremost, an appropriate member of the chain of command must request the consultation. During deployments, this can be difficult, because many individuals, especially those in combat stress detachments, want to assist the unit. However, if their participation is not invited, the "consultation" may develop into a confrontational relationship with the commander.

Additionally, the consultation team must establish rapport with the soldiers being evaluated. It should be clear that the team is there to help the unit, not to blame or hold certain members responsible for any problems that the unit may have. Demonstrating that the team cares and wants to make improvements will increase the willingness of the unit to disclose factual as well as emotional material, thus providing information that may assist in answering the consultation question.

It is important that the unit views the consultant as someone who is genuine; available not only in the moment, but for future involvement; supportive of their needs; and perceived as someone recognized in the field in which the consultant is asked to evaluate. Additionally, being someone who has provided assistance previously or spent time with members of the unit helps to establish an early rapport. By ensuring the behavioral health consultant possesses these qualities, there is an increased likelihood of being asked into the unit, as well as ensuring the consultant will be used again in the future.

In Case Study 12-1, concerning the evaluation of the route clearance platoon, the consultant had previously gone on a few route clearance missions with the soldiers for no other reason than to understand what their mission was and experience what it was like. Not only did this permit the consultant to earn the respect of the soldiers, it also solidified the consultant's credibility with command and led to numerous consultations in which the consultant was able to assist the unit.

**Explaining the Purpose of the Consultation**

Before gathering information from soldiers, it is necessary to explain the purpose of the consultation, including who requested it, what information is being gathered, and what will be done with that information. It is imperative for all parties in the evaluation to be clear about all the issues involved, including legal and ethical ones, and potential consequences. Knowing the basic legal rights of the individuals undergoing the process, as well as to whom to refer service members if issues arise, is also important. Furthermore, walking the involved parties through a step-by-step overview of the process and then performing a "back brief" will also ensure that command understands the consulta-

tion process. Finally, clarifying the scope of the consultation process as it is occurring is essential.

**Cross-Service Consultations**

In some cases, individuals may be required to perform consultations for another US military service. The consultative team should review the doctrine, regulations, and mission-specific goals for sister services and their units because there may be significant differences in how information is gathered, what documents are used, and how information is shared. Additionally, consultants should take time to learn about the differences in a particular service's systems, as well as the differences in unit functions. Consultants can demonstrate interest by explaining what information they have already learned, then asking questions that may assist in better understanding the sister branch. This process will likely guide the consultation while building rapport.

**Uniform**

One of the greatest challenges for a consultative team is to establish trust and mutual respect with the leadership requesting the consultation. To further this end, team members should determine the current uniform status of the unit to which they are consulting and dress accordingly. For example, if the consultative team was meeting with a number of line commanders in a field environment, the Army Class B uniform would not be appropriate.

Additionally, members of the consultative team need to ensure that they display the proper wear, fit, and appearance of the uniform. Commanders may see it as a sign of disrespect and lack of concern about their military mission if consultative team members do not pay attention to what is the proper uniform; this can have a negative effect on the relationship developed between the team and the command. In a deployment setting, knowing what the proper uniform is and wearing it appropriately may also be a safety concern because some locations are at high-risk for attacks, therefore requiring more extensive gear and protective wear. Moreover, it can provide yet another segue in building rapport with the unit by showing interest in how it operates, while decreasing the psychological distance between the consultant and unit members.

**Language**

The consultative team members should identify the common terminology, slang, and descriptive terms that are frequently used by the organization requesting the consult and adapt their own language to those with whom they are speaking. Not only does this require adapting to the language of the command, but also to that of the members of the unit. Speaking in simple language, minimizing medical jargon, and not using "psychobabble" are recommended. However, when trying to adapt one's own communication style to that of the group, do not use obscene or coarse language that may jeopardize professional credibility.

**Understanding Unit Structures and Functions**

Prior to providing a unit with recommendations for intervention and ideally prior to beginning the consultation, consulting clinicians should educate themselves about the unit or organization requesting the consultation. Understanding the unit and its mission will guide how the consultant engages with the participating soldiers and the interventions that might be recommended. It is helpful to know the formal and informal structure of the unit and how it directly and indirectly affects the unit. Relying solely on an organizational chart of the unit would be remiss. Many subgroups and personalities frequently play a significant role in how the unit runs and operates. Gaining knowledge on how communication is relayed and who has the power in the unit is also of utmost significance. Making assumptions due to rank (enlisted or officer) and branch could lead to false or inappropriate conclusions. Additionally, the consultant must be cognizant of the limitations that these functions place on their recommendations; otherwise, it may set the unit up for failure or not have the intended result.

***Case Study 12-2:*** A company commander at a patrol base in Iraq stated that morale was down and he wasn't exactly sure why. He asked the brigade behavioral health officer if she could assess the situation and give him some feedback and recommendations. After surveying the unit and talking to the soldiers at length, the consultant determined that the soldiers were frustrated with their leadership because they felt they were not receiving information on missions and they were doing missions that were not necessary, thus putting them in harm's way. This information was back briefed to the commander. When the situation was reassessed a week later, nothing had changed; the soldiers continued to be frustrated and unmotivated. During the reassessment, the behavioral health officer determined that the first sergeant was failing to provide information to the soldiers, leading to a breakdown in information flow within the unit. Until the first sergeant was briefed directly, none of the feedback from the consultation had been discussed or implemented at his level. Once he fully understood the recommendations, he began making changes on the patrol base and morale began improving.

**Engaging With Soldiers**

Consultants need to be cautious about how they begin a visit. Many times the participating soldiers will decide within the first 5 minutes whether they feel the effort of talking with a consultant is relevant to them and if they will participate. It is the job of the consultant to get service members to "buy in" to the consultation process. Many times it is effective to begin by opening with a question and seeking the participants' responses and input rather than talking to them at length. Zeroing in on key leaders and getting them engaged in the process will lower the barriers and intimidation of other soldiers who may be reluctant to get involved. Consultants should inform the unit of how they want to help the unit and the soldiers, while telling the soldiers that they are the true experts and allowing them to inform the consultant. Taking the time to sit back and listen to them in their element (ie, motor pool, guard towers, etc) will assist in making soldiers feel comfortable and further reinforce how the consultant values their opinions and knowledge. Soldiers are trained and conditioned to listen and take orders, so when somebody sits back and genuinely listens, a lot of valuable information and insight can quickly and easily be gathered.

**Interventions**

The consultant must consider realistic interventions that are not only applicable to the current conditions, mission, operational tempo, and resources available, but also with realistic implementation strategies. As one division commander in combat expressed to a visiting consultation team, "Don't tell me it's hard here or that conditions suck, we all know that. Don't give me platitudes, give me clear and specific guidance that my commanders can actually use to help my soldiers."

To meet these goals, the consultant must consider realistic interventions that will address function as opposed to pathology. These include educating the unit as well as the command on how the intention of the intervention is to keep soldiers ready to fight and make them more productive for the mission; briefing the commander with simple, objective, and clear-cut ways that the situation can be improved using clearly defined recommendations that can be easily implemented; and reinforcing in a step-by-step method how the recommendations will be executed and how they will ultimately improve the unit's ability to accomplish its mission. Once the interventions have been made, it is imperative that the consultant remains available to clarify any ambiguities or address any questions that arise during the implementation process.

**Terminating the Consultation**

The type of consultation determines the number of sessions required. Some consultations will be over after one visit, others might last several months. As part of terminating the consultation, a final report should be provided to the requestor, the participants should be thanked, and those who may have developed relationships during the consultation experience should have an opportunity to say goodbye. Consultants must ensure all of their questions have been addressed, and make certain they have provided information for future contacts while imparting other resources that may be of assistance. It is preferable that the consultants talk to all parties involved in the consultation process to close all the loops of communication. Consultants use valuable unit resources such as time, energy, and information. Therefore, it is important to include the contributing parties in the termination process.

A good consultation can be ruined by a poor termination. If consultants leave the group feeling "used" or "no longer important" then they will lose credibility. It is probable that the long-term benefit of their interventions will fail because they are likely to lack unit acceptance. Additionally, it can make it more difficult to gain access to future groups for establishing consultative relationships.

**Reporting the Consultation**

As part of the termination process, a report should be given to the requestor. This may not initially be in written form, but should at least be via a back brief and then followed at a later date by a written brief with recommendations. A formal out brief should always be offered to the commander who has allowed access into the unit. This not only shows respect and understanding of the command relationship, it also provides access to the person who can implement the recommendations and programs suggested. Furthermore, it is an opportunity to gain insight into areas that may have been missed or may require further study. This should be followed by sending a written brief subsequent to the back brief, which guarantees that consultants have had time to reflect and consider all aspects of the group; think things through more carefully; and consult with a trusted colleague if any reservations have arisen.[49] It will also provide the consultant with an opportunity to ensure that the consultation question has been answered clearly and concisely while ensuring the commander's objectives were met.

Additionally, if the consultant intends to use the information from this report for any other endeavor, such as publication or report to any outside agencies, then permission should be gained from the unit.

## DETERMINING FITNESS FOR DUTY AND DEPLOYMENT CLEARANCE

At times, consultants are requested by commanders to determine if a soldier is fit for continued military service or deployment. There are several aspects associated with determining fitness for duty and deployment clearance.

### Disqualifying Conditions

The first step is to have a thorough and detailed understanding of Army Regulation 40-501, *Standards of Medical Fitness,* particularly Chapters 3 and 7.[50] Chapter 3 outlines the standards for medical fitness and separation. Chapter 7 provides guidance on profiling.[50] Current Army regulations require soldiers with disorders with psychotic features not caused by organic pathology or toxic substances to undergo a medical board to determine fitness for continued service in the military. This includes bipolar disorder and schizophrenia or any other mental disorder that causes gross impairment in reality testing. There is further guidance regarding other diagnoses and the criteria for referral to a medical board. In general, mood, anxiety, somatoform, and dissociative disorders are disqualifying if they necessitate recurrent hospitalization, persistently limit duty, or interfere with effective military performance.[50]

Personality, substance-related, and adjustment disorders are generally not disqualifying through the physical disability system, but may be cause for administrative separation. Before recommending administrative separation for these conditions, a detailed exploration for potential posttraumatic stress should be performed, particularly in previously deployed soldiers with changes in behavior patterns, because the outcome of the evaluation may significantly affect postseparation benefits and access to ongoing medical care.

### Medical Profiling

Army Regulation 40-501, Chapter 7, details physical profiling and is an area of ongoing confusion and contention among soldiers, providers, and commanders.[50] A thorough knowledge of the regulations will enable providers to clearly articulate both the limitations of the profile and the regulatory responsibilities of command, and ensure expectation management on the part of the profiled soldier.

The profile serial system (P-U-L-H-E-S, which stands for **P**hysical capacity or stamina; **U**pper extremities; **L**ower extremities; **H**earing and ears; **E**yes; and p**S**ychiatric) is used to define the effects of a soldier's medical condition in relation to the performance of duties. Psychiatric disorders are denoted in the "S" section and rated from 1 to 4. This rating is to provide an assessment of overall functioning and is not based on the diagnosis itself. When determining the rating, the provider must consider the type, severity, and duration of symptoms, amount of external stressors, predisposition, intelligence, prior psychiatric history, and current duty performance. Additionally, the regulation provides some specific guidance for conditions that require a particular rating to be given, including when (*a*) no psychiatric pathology is evident; (*b*) there is a history of recovery of an acute psychotic reaction from external but non–substance-abuse-related cause; (*c*) there has been remission of a mental health disorder that is not otherwise disqualifying, but requires either limitations of assignments or duties; and (*d*) a rating of "3" cannot be met.[50] Assignment of a permanent S3 or S4 rating requires a medical board to be performed.

The specific limitations recommended on the profile are as important as the profile designator. According to Army Regulation 40-501, the condition itself should not be the sole consideration when recommending limitations. The profiling officer must also consider the prognosis, the possibility of aggravation, and the effects the profile will have on the soldier's ability to perform required duties.[50] The regulation states specifically that profiles "must be realistic."[50(p73)] Profiles are required to be specific and written in lay terms.[50]

It should be clearly articulated to a soldier being profiled that determination of duties, assignments, and deployment are command matters. Given this, profiles such as no deployment, no field duty, or no overseas duty are "not proper medical recommendations"[50(p73)] to be written on a profile. It is incumbent upon the profiling officer to provide adequate and clear recommendations so the commander can make an informed decision based on medical limitations and capacities, duty requirements, assignment limitations, mission requirements, and duties of the soldier among other command and mission-related issues.

If the commander does not feel the soldier can perform within the profile, reconsideration can be requested. If requested, reconsideration must be accomplished and will either amend the profile or re-

validate it. This can be requested for both temporary and permanent profiles.

**Deployment Clearance**

In the fall of 2006, the Assistant Secretary of Defense for Health Affairs and The Surgeon General, US Army, provided guidance on the minimum mental health standards for deployment.[51] This policy was outlined in a memorandum, "Policy Guidance for Deployment Limiting Psychiatric Conditions and Medications." This guidance came in response to a congressional directive[52] after several media reports stated that mentally ill soldiers were being deployed who were unstable or taking medications without follow-on care. Additionally, some media reports cited soldiers being started on medications shortly before deployment and receiving a year supply of medication without monitoring.

Key factors in the policy related to mental health conditions and medications included: (*a*) soldiers currently being treated for psychosis or bipolar disorder were not deployable; (*b*) soldiers who were taking medications that require laboratory monitoring, such as lithium or valproic acid, were not deployable; (*c*) soldiers who are taking antipsychotic medications to control psychotic, bipolar, or chronic insomnia conditions were not deployable; (*d*) the continued use of psychotropic medications that are clinically and operationally problematic during deployments, including short half-life benzodiazepines and stimulants, should be balanced between the necessity for successful functioning in the theater of operations and the ability to obtain the medication, the potential for withdrawal, and the potential for abuse; (*e*) soldiers with significant mental health conditions require 3 months of stability prior to deployment; and (*f*) if a soldier is placed on a psychotropic medication within 3 months of deployment, then that soldier must be improving, stable, and tolerating the medication without significant side effects to deploy.[51] Although not articulated in the policy, consideration should be given to monitoring, for at least 1 month prior to deployment, any soldier on medication for anxiety, depression, or insomnia.

Screening for conditions that preclude deployment as part of the predeployment health process enables identification of soldiers not meeting minimum criteria for deployment. The screening process in one deploying unit prior to Operation Iraqi Freedom in 2007 consisted of an initial survey that was filled out concurrently with the predeployment health assessment. This process identified any soldier who was currently on any psychiatric medication, under psychiatric care, or experiencing significant stressors. Soldiers who screened positive were referred to mental health services for an evaluation for deployability based on the outlined minimum standards for deployment. Those who met standards were cleared. Those who did not were either referred to a medical board or the provider met with command to discuss limitations. Soldiers were then either left on rear detachment (delayed in deployment until stable on medications [typically 1–2 months]) or a waiver was granted through the combatant command surgeon. In general, the number of soldiers requiring clearance was minimal (less than 20/3,500 soldiers) because the majority who were unable to deploy were identified prior to beginning the predeployment screening process. However, this is an important safety mechanism that is recommended to all deploying units, and it is likely that a standardized procedure and survey will be implemented in the near future.[53]

**Separation From the Military**

At times soldiers may have mental health conditions that make them unfit for duty, although they do not require a medical board per se. These conditions are defined in Army Regulation 635-200, *Enlisted Separations*.[54] Although these separations are primarily a command function, an evaluation and diagnosis by an appropriately credentialed provider is required. Functional knowledge of these chapters and the separation process will enable consultants to counsel commanders—who may be junior or facing other more pressing issues—regarding the appropriate and judicious use of these actions, thus avoiding unnecessary delays, misdiagnoses, inappropriate separations, and potential procedural errors.

Mental health providers will predominantly be involved with Chapter 5-13 (personality disorders) and Chapter 5-17 (other mental or physical disorders).[54] Both of these chapters require that the soldier not have a condition that amounts to disability, and both require that the soldier be formally counseled and afforded "ample opportunity to overcome those deficiencies."[54(p56)] These mechanisms should not be used in lieu of judicial actions or other administrative separations.

Chapter 5-13 states that a soldier can be separated for personality disorder if the condition severely impairs the soldier's ability to function in the military environment. It further states it must be a long-standing and deeply ingrained condition.[54] This is particularly important when dealing with the postdeployment soldier who may have confounding posttraumatic stress issues, mild traumatic brain injury, or acute situational issues.

Chapter 5-17 deals with physical or mental is-

sues that "potentially interfere with assignment to or performance of duty"[54(p57)] and are not covered under other areas of the separation regulations. This includes conditions such as claustrophobia; disturbances of perception, emotional control, or behavior; dyslexia; sleepwalking; or other disorders that may significantly impair the performance of military duties.

## COMMAND-DIRECTED EVALUATIONS

Command-directed mental health evaluations are defined in DoD Instruction 6490.4,[55] DoD Directive 6490.1,[56] and US Army Medical Command Regulation 40-38,[57] which outline rules for both discretionary and nondiscretionary command-directed referrals. Nondiscretionary evaluations are those required by regulation to include the positions of drill sergeant, recruiter, and sniper. Additionally, all soldiers undergoing certain chapter separations require mental status evaluations. However, when commanders request evaluations for soldiers who do not require assessment by regulation, they use their discretionary authority to request evaluation and feedback.

When performing a command-directed evaluation, commanders should be provided a formal "Report of Mental Status" outlining feedback and recommendations. At a minimum, the report should address if a diagnosis exists, a prognosis for the soldier's condition, any limitations, a review of soldier safety and any safety interventions required, and the soldier's fitness for duty. Regulations require that the commander receive that report no later than 24 hours after completion of the evaluation.

Additionally, evaluating providers must be familiar with the restrictions that their level of professional degree places on their ability to perform and sign command-directed evaluations. In general, non–doctoral-level social workers are able to perform and sign nondiscretionary evaluations. Discretionary evaluations and those recommending a Chapter 5-13 (personality disorder) or Chapter 5-17 (failure to adapt) discharges require a doctoral-level social worker, a psychologist, or a psychiatrist. If there is a condition in which the only available mental health provider does not have signing authority, such as during a deployment or in a remote location, then a physician may serve as the signing authority.

## RISKS TO THE CONSULTANT AND ETHICAL ISSUES IN CONSULTATION

As previously mentioned, serving in the role of a command consultant is very different from a typical doctor–patient encounter. The role of the consultant can at times present ethical challenges and difficult situations.

### Double Agency

In command consultation, the military mental health provider is frequently called upon to simultaneously address the needs of both the unit and the soldier-patient. This dual responsibility is termed "double agency." Sometimes in command consultation, the only "patient" is the unit, and there is not an identified soldier of concern. In other cases, a soldier is identified as the patient, and the provider has a responsibility to provide treatment and, at the same time, to advise the commander regarding the military's most favorable course of action. The two are synchronous a majority of the time: that is, what is good for the soldier is also good for the military. For example, a soldier with permanent cognitive impairment from a brain injury should not remain in the military, because it would not be safe for that soldier to function in combat. Thus, the soldier is recommended for a medical evaluation board to determine the level of disability and ensure that this individual receives the appropriate long-term medical and financial benefits. Additionally, the unit's needs are met because having an impaired soldier in combat poses greater risk for fellow soldiers, and by medically boarding such a soldier, the unit is able to receive a healthy replacement.

However, a mutually beneficial course of action does not always exist. Such is the case when a dysfunctional soldier will suffer financial hardship, or the family will lose needed medical benefits due to separation from the military. When making recommendations concerning treatment, limitations, or separation/evacuation, the behavioral health officer must keep in mind the soldier's ability to perform assigned tasks in a combat environment. This becomes more difficult in the case of soldiers who are struggling with the psychological effects of combat. The provider may find it very difficult to determine when is the proper time to remove a soldier from continued combat exposure while also keeping in mind the unit's mission and current needs.

These situations must be carefully examined and, as with many ethical issues, there is no single correct answer. Discussion with colleagues or senior behavioral

health providers, including the theater mental health consultant, can be helpful in processing these issues and is recommended.

**Confidentiality**

The commander has a right to know a soldier's diagnosis, prognosis, treatment plan, and duty limitations. Beyond these concise details, the behavioral health providers must be very careful concerning what information is provided to the commander. However, the commander is under no such restriction and can provide a great deal of information to the behavioral health provider, including reports about the soldier's ability to function at work, relationships with peers and supervisors, past occupational counseling, and the "other side" of the story. If viewed as partners on a team, rather than as adversaries, the consulting relationship between behavioral health providers and commanders can be mutually beneficial to each party, as well as to soldiers. Frequently, both the commander and the behavioral health provider can work together to help a soldier function better.

Thus, even though a commander has a right to know a soldier's diagnosis, prognosis, treatment plan, and duty limitations, behavioral health providers certainly do not contact every patient's commander with that information. If soldiers have mild symptoms that neither impair their functioning at work nor require duty limitations, there is no need to contact the commander. However, if there is risk to the unit, mission, or soldier, it is incumbent upon the provider to be certain that command is aware to ensure the ongoing safety and treatment of the patient, as well as that of the unit.

**Objectivity Versus Intimacy**

When the mental health provider is closely integrated into the unit, ongoing relationships are established with commanders that significantly improve the effectiveness of the consultative process. However, because of this intimacy, some objectivity may be lost. The behavioral health provider needs to continually ask the question, "What is my role in this situation?" to ensure that appropriate impartiality is being maintained. As a result of the intimacy, the provider is also vulnerable to the same stressors and tragedies as the unit. Closely aligned behavioral health providers can still be able to help the unit during times of crisis, but also need to be aware of their own stressors and limitations. In some circumstances, behavioral health providers may need their own treatment or intervention as a part of the unit.

**Short Versus Long Consultations and the Development of Relationships**

Some consultation relationships exist over an extended period of time, such as that of DMH officers with the commanders in their division. Others by nature are of a limited or one-time duration, such as a soldier who is seen for a command-directed mental health evaluation. Although a behavioral health provider may only plan to see a particular soldier for a single evaluation, frequently the provider ultimately has further contact with the command regarding other soldiers. This fosters the long-term consultative relationship.

Every interaction with a commander has the potential to help a particular soldier, but also to "take the pulse" of the unit's climate, to cultivate future cooperative relations, and to educate commanders about leader actions for decreasing combat operational stress within their units. The behavioral health provider's conscious grooming of this relationship allows commanders to begin to feel more comfortable accepting behavioral health interventions for their soldiers, as well as for themselves.

**Investigation Verus Consultation**

It can be easy for commanders to feel that they or their practices are being investigated during the information-gathering portion of a consult. This can feel intrusive and cause anxiety. For example, a commander in Iraq referred a soldier who had allegedly assaulted the unit's first sergeant. The soldier reported having assaulted the first sergeant only after the first sergeant had pushed him against the wall in a chokehold. This situation required a careful consultative approach to balance advocating for the soldier, defusing tension at the unit, and promoting future consultation. Generally, approaching the situation from a shared problem-solving stance, rather than seeking to find blame, is more productive.

**Impact of HIPAA on Command Consultation**

Aspects of the Health Insurance Portability and Accountability Act (HIPAA) address safeguarding the security and privacy of protected health information, including names, Social Security numbers, dates of birth, and other patient identifying data. Soldiers are commonly designated on military records by this information. Military hospitals and clinics are required to comply with HIPAA, and generally have the required safeguards in place. Providers need to ensure that any protected health information sent

electronically to commanders is either sent over a closed network, or that some form of encryption is used. Routine measures for HIPAA compliance ensuring patient privacy include placing computer workstations out of the public view and locking them when not in use, securing charts behind locked doors, and protecting identifying information on charts from being seen by others during an office visit.

## NOTABLE CONSULTATIVE POSITIONS IN THE ARMY

Most military behavioral health providers will be placed in a command consultative role at some time in their careers, whether it is simply to evaluate one soldier or to provide an overview of a large unit. Three particular consultative roles merit further discussion: (1) Consultant to The Surgeon General of the Army; (2) member of a Mental Health Advisory Team (MHAT); and (3) division psychiatrist/brigade behavioral health officer.

### Consultant to The Surgeon General, US Army

This assignment is generally a 4-year tasking, which the consultant undertakes in addition to usual assigned duties. In behavioral health, these consultant positions include research and clinical psychology, social work, psychiatric nursing, and occupational therapy. There are four consultant positions in psychiatry: general, child, forensics, and addiction. There is also a consultant for the Exceptional Family Member Program, which usually is either a pediatrician or a psychiatrist. Functionally, the consultant positions in general and child psychiatry, research and clinical psychology, social work, and psychiatric nursing contribute to assignment determinations for personnel in these specialties.

For the last 20 years, these behavioral health consultants have been located throughout the United States, although principally at the US Army Medical Command Headquarters in San Antonio, Texas. After the attacks on September 11, 2001, the respective behavioral health consultants spent numerous weeks and months at the Office of The Surgeon General in Washington, DC. In 2007, a new Proponency for Behavioral Health was established, solidifying a requirement for a behavioral health consultant at the Office of The Surgeon General.

Key functions of the behavioral health Consultants to The Surgeon General of the Army include assignments, taskings for deployment, review of records, and strategic communications.

#### *Assignments*

The most important function of a Consultant to The Surgeon General is the task of assignments. The consultant recommends assignments to the specialty branch manager who makes the assignment decision. In general, the recommendations of the consultant are followed. The assignment process, however, involves several matrices. The current psychiatry consultant, for instance, asks graduating residents and staff who are eligible to move for a list of ten desired assignments as well as any family considerations. The consultant then generates a list of potential assignments. Additional related issues, such as whether candidates are medically deployable, are also considered. (It is essential to put deployable psychiatrists and other behavioral health assets in divisions and CSC units.) Following the Graduate Medical Education Selection Board and the Officer Distribution Plan conference (where Board decisions are made and announced), the draft assignments can be distributed. Request for orders and the actual orders subsequently follow. These orders may be modified in the event of unanticipated personnel changes or in the event of new, emergent missions.

The priorities for assignment are: first the needs of the Army and second the needs of the soldier. Army needs include the two graduate medical education programs (National Capital Area and Tripler Army Medical Center) and power projection platforms, such as Fort Hood, Texas; Fort Benning, Georgia; Fort Riley, Kansas; Fort Stewart, Georgia; and Fort Bragg, North Carolina.

Many assignment choices are dominated by family needs. Those couples with small children usually want to live as close as possible to their extended families. Spouses who are employed usually want to be able to find good career-related jobs. Some have aged parents or ill siblings to tend for. The consultant works to take all these needs into account, but the needs of the Army are still paramount.

#### *Tasking for Deployment*

For "Tier I specialties," including psychiatry, psychology, and social work, the consultant is now intimately involved in deciding who will be tasked to deploy. The "cardinal rule" for the Medical Command is that no one should go twice until all have gone once. The deployment decisions are now made at the Professional Officer Filler Information System support conference, with the input of the regional medical consultants. However, it is not infrequent that last-minute

taskings will arise due to unforeseen illness, injury, or other factors that make a projected officer unable to deploy, requiring the consultant to review the entire provider inventory and adjust priorities of need.

### *Review of Records*

Another function of the psychiatry consultant is to review mental health records. These are received for a multitude of purposes, including: (*a*) waivers for accessions to both the officer and enlisted ranks; (*b*) determinations on line-of-duty investigations, especially following suicides; (*c*) review of completed investigations; and (*d*) review of cases where there is a question as to whether someone should have received a medical board or chapter.

### *Strategic Communications*

The consultant functions in numerous roles to include reviewing scientific papers, answering media inquiries, advising on the suitability of others to participate in media interviews, and advising the public affairs officer. The position presents numerous challenges. A major one is that of recruiting and retaining medical personnel with the Army's current operation tempo.

### Mental Health Advisory Team Member

Since 2003, the Army Surgeon General has annually deployed an MHAT at the request of the US Central Command commanding general to evaluate the behavioral health needs of soldiers during deployment. The initial team performed their evaluation during Operation Iraqi Freedom 1 after there were reports of elevated suicide rates in theater. More recently, MHAT teams have focused on the quality of care provided and the behavioral healthcare system of delivery within the theater of operations.

The MHATs have varied in their composition, at times consisting of large multidisciplinary mental health teams while more recent MHATs have only had a few research psychologists. The MHAT teams utilize methods of paper surveys and focus groups, and each year issue a report of findings with recommendations. Key recommendations have included the establishment of a theater suicide prevention program, implementation of "Battlemind" training, institution of unit behavioral health needs assessments, and battlefield ethics training. The MHAT teams and their recommendations are discussed in greater detail in Chapter 5, Walter Reed Army Institute of Research Contributions During Operations Iraqi Freedom and Enduring Freedom: From Research to Public Health Policy, in this volume.

### Division Psychiatrist/Brigade Behavioral Health Officer

Chapter 6, The Division Psychiatrist and Brigade Behavioral Health Officers, in this volume details the role of these mental health specialists. However, this unique position places a behavioral health officer within a combat unit working directly as an ongoing consultant to a combat commander rather than working for the medical command. This position entails continuing responsibilities to the command as a consultant on issues such as how and where to deploy behavioral health resources, methods and techniques for controlling combat operational stress, and determining plans for prevention of behavioral casualties.

## SUMMARY

Military mental health professionals provide critical consultation to command when psychiatric casualties are seen in garrison or during deployment. The challenge to the mental health consultant is to balance the need of the unit with what is in the best interest of the soldier's short-term and long-term mental health. Commanders have the utmost concern for their soldiers; it is therefore imperative that they trust the judgment of their consulting behavioral health officer in the decisions that they are making on the treatment of their soldiers. In addition, these same challenges exist in garrison because the consultant has to determine if a soldier is no longer fit to continue in service and requires a medical evaluation board or if this soldier might have a more favorable prognosis for recovery and continued military service.

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