

Making Mental Health Aerovac Decisions in Afghanistan: A Field Report

LCDR Kenneth E. Richter Jr., MC USN; CAPT David E. Jones, MSC USN†; CDR David M. Oliver, MC USN**

ABSTRACT This article focuses on the clinical and administrative decision-making processes involved in medevac-ing psychiatric patients from Kandahar Airfield, Afghanistan, during major surge operations. This article highlights organizational realities pertaining to the medevac process and offers recommendations for incoming providers to optimize their effectiveness in managing at-risk patients in a combat zone.

INTRODUCTION

Combat stress doctrine seeks to minimize troop losses as a result of psychiatric causes and emphasizes the importance of providing support services in forward areas to increase the likelihood of returning troops to duty.¹ Despite the best efforts of combat stress, mental health, and command personnel to minimize psychiatric casualties, some troops will require psychiatric evacuation from theater. A large-scale epidemiological study from Operation Iraqi Freedom and Operation Enduring Freedom indicated that psychiatric reasons for evacuation were among the top 5 causes for removal from theater and that such psychiatric casualties increased by 32.4% during 2004–2005, 3.0% during 2005–2006, and 61.9% during 2006–2007.² In contrast to the end of World War II (1945) where about 25% of patients (of all injury or diagnostic types) returned to the United States via aircraft, today virtually all (100%) patients leave Iraq or Afghanistan via the aeromedical evacuation system (medevac).³

In this article, we present a “boots on ground” perspective regarding clinical and administrative decisions we faced concerning psychiatric medevacs from Afghanistan during a period of intensive surge operations at Kandahar Airfield (KAF) in southern Afghanistan in 2009–2011. This article presents the first published report on clinical decision-making regarding psychiatric medevacs from Afghanistan. As forward-deployed combat mental health providers, we found that the issues concerning psychiatric evacuations

were among the most complex decisions we had to make during our time at the NATO Role III Medical Unit in Kandahar. In most psychiatric medevac cases, the central issue was whether troops who were experiencing psychiatric crises in theater should be maintained in theater or moved to higher echelons of care (usually outside theater) via aeromedevac. As a set of personal reflections, this article highlights clinical and organizational realities related to psychiatric medevacs that might not be readily discernible through large-scale aggregated studies such as the one noted above. This article offers background on the Role 3 hospital at Kandahar and explores various ways that service members can leave theater for mental health reasons with attention to how these modalities differ. Next, observations on how various commands respond to medevac decisions are presented. Lastly, conclusions and recommendations are noted for providers who may find themselves involved in making psychiatric medevac decisions in future deployments or conflicts.

BACKGROUND

The first two authors (KR and DJ) served as mental health providers at the NATO Role III Medical Unit at KAF in southern Afghanistan from September 2009 to March 2010 while the third (DO) served from February 2011 to August 2011. During the period of time from fall 2009 to spring 2010 the rate of psychiatric medevacs was 11.25 per month later declining to 6.58 per month (from spring 2010 to spring 2011) as mental health programs and services matured in theater. The Role 3 Hospital served as a Level 3 facility with specialist diagnostic and surgical services. Over 200 personnel staffed the hospital, which was the main trauma center for the region and functioned as an aeromedical evacuation hub for southern Afghanistan. During our deployment in October 2009, the U.S. Navy assumed leadership of the NATO Role III Medical Unit from Canadian Medical Forces. The mental health team at KAF consisted of a multidisciplinary and multinational team including two psychiatrists, a psychiatric nurse practitioner, a clinical psychologist, four psychiatric technicians (all from the United States), a Canadian social worker, and

*Directorate of Mental Health, Naval Medical Center San Diego, 34520 Bob Wilson Drive, San Diego, CA 92134.

†Navy Medicine East, 620 John Paul Jones Circle, Suite 14, Portsmouth, VA 23708.

The authors are military service members. This work was prepared as part of their official duties. Title 17 U.S.C. 105 provides that “Copyright protection under this title is not available for any work of the United States Government.” Title 17 U.S.C. 101 defines a United States Government work as a work prepared by a military service member or employee of the United States Government as part of that person’s official duties.

The views expressed in this chapter are those of the authors and do not necessarily reflect the official policy or position of the Department of the Navy, Department of Defense, or the U.S. Government.

Report Documentation Page				Form Approved OMB No. 0704-0188	
Public reporting burden for the collection of information is estimated to average 1 hour per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to Washington Headquarters Services, Directorate for Information Operations and Reports, 1215 Jefferson Davis Highway, Suite 1204, Arlington VA 22202-4302. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to a penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.					
1. REPORT DATE MAY 2012		2. REPORT TYPE		3. DATES COVERED 00-00-2012 to 00-00-2012	
4. TITLE AND SUBTITLE Making Mental Health Aerovac Decisions in Afghanistan: A Field Report				5a. CONTRACT NUMBER	
				5b. GRANT NUMBER	
				5c. PROGRAM ELEMENT NUMBER	
6. AUTHOR(S)				5d. PROJECT NUMBER	
				5e. TASK NUMBER	
				5f. WORK UNIT NUMBER	
7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES) Directorate of Mental Health, Naval Medical Center San Diego,34520 Bob Wilson Drive,San Diego,CA,92134				8. PERFORMING ORGANIZATION REPORT NUMBER	
9. SPONSORING/MONITORING AGENCY NAME(S) AND ADDRESS(ES)				10. SPONSOR/MONITOR'S ACRONYM(S)	
				11. SPONSOR/MONITOR'S REPORT NUMBER(S)	
12. DISTRIBUTION/AVAILABILITY STATEMENT Approved for public release; distribution unlimited					
13. SUPPLEMENTARY NOTES MILITARY MEDICINE, Vol. 177, No. 5, May 2012					
14. ABSTRACT					
15. SUBJECT TERMS					
16. SECURITY CLASSIFICATION OF:			17. LIMITATION OF ABSTRACT Same as Report (SAR)	18. NUMBER OF PAGES 5	19a. NAME OF RESPONSIBLE PERSON
a. REPORT unclassified	b. ABSTRACT unclassified	c. THIS PAGE unclassified			

a British psychiatric nurse who was moved to support British troops at Camp Bastion in Helmand Province in December 2009.

The U.S. Air Force manages the aeromedevac system.⁴ Medevac processing starts with completion of a patient movement request (PMR). The PMR document is coordinated at the local hospital level and entered into the TransCom Regulating Command and Control Evacuation System, a computer tracking system monitored by facilities within the aeromedical evacuation system. Each PMR must be cosigned by a flight surgeon who ensures that the patient is physically able to fly and has appropriate medication orders for flight.

CATEGORIES OF MEDEVAC

Psychiatric medevac patients are classified into six different categories depending on their diagnoses and risk level. Three of these categories (i.e., 1A, 1B, and 1C) are the most pertinent for this discussion. These three routes of departure differ in their rate of response and in their degree of requisite command consent and involvement. Patients classified as 1A are those with severe psychiatric disorders who require the use of physical restraints on a litter, sedation, and close supervision. Patients assessed as 1B have moderately severe psychiatric conditions and are medevaced unrestrained on litters, however, restraints, remain immediately available. These patients require sedation for the flight. Categories 1A and 1B are “urgent medevacs” and represent the highest level of risk, and in these cases, no command agreement or concurrence on the transportation decision is needed. An example of such a case would be an actively suicidal Marine who has had his weapon taken for him and has been emergently brought into the hospital. In such a case, action to ensure safety is taken (i.e., de-escalation techniques, psychopharmacologic intervention, or physical restraint), and then the patient is hospitalized in preparation for imminent transportation to a higher level of care. Although surprising to some, urgent medevacs are fairly uncommon and comprised only 3.6% of the cases we medically evacuated (6 of 167).

Psychiatric patients classified as 1C are ambulatory and reliable and are deemed as no threat to self or others and consequently require minimal supervision. Routine medevacs (Category 1C) were our most common method of removing service members from theater (96.4 percent of medevac cases) and were often the most problematic. These types of psychiatric medevacs occur when a long-term or newly assessed patient is deemed to present a significant level of risk for dangerous behavior (has required sustained one-to-one watches with the patient having their weapon removed from them), or, their condition and/or treatment course presents an unfavorable prognosis particularly in a combat environment. When mental health providers make the decision for routine medevacs, they initiate the same type of PMR as discussed earlier. While this type of medevac

is deemed an elevated long-term risk, the level of risk does not cross the threshold that would require an “urgent” medevac, as the risk is not deemed imminent. As a matter of procedure, the routine (1C) type of psychiatric medevac requires command concurrence with the decision to medevac the patient. Commands can be quick to agree with the mental health providers regarding the need for medevac or may have deliberate concerns about the medevac, which may take weeks to fully address. The third and final avenue of departure from theater for psychiatric patients is through a mental health recommendation for administrative separation. This route provides commands a means for processing out individuals who as a result of persistent personality and coping problems are unsuitable to remain in the military. In some cases, these individuals may have been a poor fit for the military and had the wherewithal to get into theater, but not complete their deployment.

Troops who have chronic problems adapting to military service can present a significant administrative burden to their commands and can consume a disproportionate amount of mental health resources in coping with their personal life problems and/or difficulties in adjusting to military requirements. In the current wartime climate, these medevacs present an increasing challenge because the administrative separation process has been considerably delayed with separation decisions requiring flag officer concurrence. This measure safeguards troops who have served in combat zones and ensures that those with post-traumatic stress disorder or traumatic brain injury do not have their pathology overlooked. The Department of Defense has reviewed the volume of administrative separation recommendations for personality and adjustment disorders earlier in the Iraq and Afghanistan Wars and placed new requirements such as flag officer review of such recommendations before the separation of service members with personality disorders. We experienced that these additional well-intentioned requirements made the evacuation of patients with elevated but not severe psychiatric risk challenging.

COMMAND RESPONSES TO MEDEVAC RECOMMENDATIONS

It is normal and expected for commands in combat settings to look for as many ways as possible to retain troops in theater and preserve combat strength. Although commands are reluctant to lose their troops to any type of threat, mental health reasons can be the most troubling for commands to accept. Contemplating losing a service member for mental health reasons often raises many questions that would not be asked with more apparent physical injuries: Is he really sick enough that he needs to go? Will evacuating him lead to an avalanche of other people trying to leave for the same reason? Is he malingering or exaggerating his symptoms?

In focusing on command reservations about removal, it must be understood that although leaders have regard for the

health of their service members, commanders also have important personnel requirements in combat. We observed that some commands would engage in efforts to slow the course of any potential loss of a Soldier, Sailor, Airman, or Marine. In addition to increased delays in administratively separating service members for adjustment or personality disorders, other observed actions included: pursuing punishment for Uniform Code of Military Justice offenses rather than allowing treatment, moving slowly to approve PMRs (sometimes seeking a second or third mental health opinion), or seeking further clarification (i.e., requesting a more compelling case be made or additional information).

In one example of a command's decision to pursue punishment and punitive discharge from the military as opposed to medevac, a Soldier who had been doctor shopping and misusing controlled substances was kept in theater without his PMR being formally declined while the command prepared administrative action. The command's plan was not communicated to the patient, and he was allowed to believe that his PMR paperwork was simply languishing. This ambiguity presented a great deal of anxiety in an already detoxing patient with a substance-induced mood disorder. Thus, this presented a combination of delaying a PMR while covertly shifting focus toward a punitive course.

Commands may not act on a provider's recommendations for several reasons. For one, mental health providers have various degrees of experience and proficiency liaising with the operational community, which sometimes results in a failure to properly convince a commander of the merits of the recommendation for evacuation. Furthermore, communication failures can result from the perception of the provider being an "outsider" and disconnected from the needs of the unit. Additionally, commanders may feel that the patient is exaggerating his or her symptoms or leaders may be concerned with a possible "domino effect" of additional casualties with other troops. We found that psychological testing could be particularly helpful in supporting a medevac. For example, the image of one patient's spiking Suicide Scale on the Personality Assessment Inventory persuaded a commander who previously resisted efforts toward medevacing an exhaustively managed and chronically suicidal Soldier.

RECOMMENDATIONS FOR IMPROVING COMMUNICATION BETWEEN MENTAL HEALTH PROVIDERS AND COMMANDS

In the face of mental health pressure to evacuate service members from theater, there is a particular psychology to the command's overall response. The outwardly murky domain of psychological recommendations can elicit an institutional pushback before fully appreciating the risks associated with that decision. The skilled clinical liaison must empathetically emphasize and compellingly convey a common goal with the line commander and show the provider's role to help the command mitigate the risk to the service member and their unit. It is imperative for pro-

viders to illuminate the number of personnel who have received treatment in theater and kept-in-the-fight because of effective risk management and therapy. Specifically, we recommend mental health providers make a practice of not only speaking with commanders at the time of a decision to remove a service member, but also frequently reaching out to commands throughout the treatment process, all the while pointing out how their skills and services are facilitating the command's goal of preserving combat effectiveness and optimizing a patient's ability to remain effective in theater.

Mental health specialty leaders should endeavor to deploy operationally naïve and first time deployers alongside with operationally experienced clinicians who can mentor the inexperienced in the subtleties of operational liaison and communication. First time deploying mental health providers arriving to theater would then have an opportunity to quickly develop a command-liaison style that optimizes their effectiveness in successfully and convincingly communicating with commands.

Beyond what has already been stated, our experience prepares us to offer the following additional counsel to new mental health providers: (1) in a large catchment area with numerous sizable commands, consider a clinic strategy of designating providers to liaise primarily with specific commands, (2) communicating early and often with commanders of personnel with a high medevac probability to avoid blindsiding commands with a medevac recommendation, and (3) being mindful of the unique culture of the operational leadership community and attempting to spend some off-time or meal time socializing and interacting with the line officers, learning to speak their language, noting how this community talks about personnel decisions (e.g., "we need to get some bodies over to Bravo Company"). The enhanced credibility that develops from an appreciation of these style points is truly invaluable. Additionally, when possible, personal face-to-face conversations with commanders convey trust and break down communication barriers inherent in e-mail and telephone communication.

In conclusion, given the nature and duration of the current conflict, organizational resistances to personnel losses from any route are to be expected. When mental health providers make the difficult decision to remove a patient from theater, it is important that they have a proper understanding of the avenues of removal and the challenges inherent in each of them. Providers must also be effective communicators with commands, well schooled in the various challenges therein and good at pointing to the accomplishment of all of the service members they have kept on the frontlines. Further, commanders should understand the value of mental health counsel and the dynamic nature of mental health advice. That is to say, a patient documented to not be suicidal one week prior may still be very concerning at a different time point. Further, mental health professionals need to continue to work hard to maintain service members in theater, utilizing all the recourses of psychotherapy,

medication, and command leadership to continue to preserve our fighting strength.

REFERENCES

1. U.S. Department of the Army: Combat and operational stress control. (Field Manual 4-02.51 [FM 8-51], July 2006. Available at <http://www.fas.org/irp/doddir/army/fm4-02-51.pdf>; accessed September 2, 2011.
2. Cohen SP, Brown C, Kurihara C, Plunkett A, Nguyen C, Strassel SA: Diagnoses and factors associated with medical evacuation and return to duty for service member participating in Operation Iraqi Freedom or Operation Enduring Freedom: a prospective cohort study. *Lancet* 2010; 375: 301–9.
3. Peterson AL, Baker MT, McCarthy KR: Combat stress casualties in Iraq. Part 1: behavioral health consultation at an expeditionary medical group. *Perspect Psychiatr Care* 2008; 44(3): 146–58.
4. Department of the Air Force: Aeromedical evacuation patient considerations and standards of care, Attachment 6. (Air Force Instruction 41-307, August 2003. Available at <http://www.e-publishing.af.mil/shared/media/epubs/AFI44-165.pdf>; accessed February 3, 2011.



IDGA
Institute for Defense and
Government Advancement

Presents a training
conference:

**ALL New this year: 2 Focus
Workshops on TBI and Telehealth**



Military Healthcare CONVENTION & CONFERENCE

May 21-24, 2012 | Henry B. Gonzalez Convention Center, San Antonio, TX

+ Discuss the latest tactics, strategies, technologies, systems, treatments, processes and services for patient care

+ Integrate advancements in medical care for military personnel and their families into existing treatments/programs

+ Learn best practices and new developments in battlefield healthcare treatment of injuries

Featuring key presentations from:

Major General Robert Kasulke, USA, Commanding General of AR-MEDCOM Brigadier General Paul S Dwan, USAF, Deputy Joint Staff Surgeon, MC The Honorable Ward Casscells, Former Assistant Secretary of Defense for Health Affairs, CEO of Casscells & Associates	Major Jon Greuel, USAF, Air Force Instructor Pilot and Founder of Yoga Warriors Colonel Lee Cancio, MD, USA, Surgeon, US Army Burn Center Colonel Noel Cardenas, USA, Deputy Commander, Brooke Army Medical Center	Colonel Robert D. Mitchell, USA, MS, Director of Medevac Proponency and Aviation Consultant to the Army Surgeon General Colonel Harry P Marshall Jr, MD FACS, Deputy Commander, District of Columbia National Guard – Medical Detachment
--	--	--

Get your FREE Expo Pass Today!

www.militaryhealthcareconvention.com/AMSUS

