

Crisis in Army Psychopharmacology and Mental Health Care at Fort Hood

Stephen M. Stahl, MD, PhD

NEW TREND IN PSYCHOPHARMACOLOGY

The recent shootings at Ft. Hood, allegedly by an army psychiatrist, have placed much needed focus on army mental health care. Questions are now being raised as to whether longstanding and severe shortages in the number of mental health professionals in the army may have led authorities to overlook danger signals in this psychiatrist, failing to remove him in order to retain a worker with rare and valuable psychiatric credentials for army service. Whether or not this is the case, examination of mental health care in the army shows a system that is indeed understaffed, under tremendous pressure, and near the breaking point.

Earlier this year, and just prior to the shootings, we conducted psychopharmacology and mental health courses at Ft. Hood and learned that many army mental health workers are overwhelmed. This is due to dealing, on a day-to-day basis, with the well publicized spike in the num-

ber of suicides by soldiers and with the estimated one in five warriors from Iraq or Afghanistan returning home who develop a mental illness, such as depression, post traumatic stress, or substance abuse. Not only have patient-soldiers already killed army mental health workers in theater earlier this year at Camp Liberty in Iraq, but now it is possible that a psychiatrist has killed mental health workers and other soldiers on the army base at Ft. Hood, Texas. Nine of the Ft. Hood shooting victims were army therapists, several of whom died. The question now is whether these shootings have brought to light problems in mental health care delivery at Ft. Hood and elsewhere in the army that have so far avoided scrutiny, but now demand remedy to prevent future disasters.

Our findings from interviews, surveys, and educational programs at Ft. Hood, which collected data from over 100 mental health workers and from more than 300 command soldiers just prior to the shootings, showed that both sol-

Dr. Stahl is adjunct professor of psychiatry in the Department of Psychiatry at the University of California–San Diego in La Jolla.

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If you would like to comment on this column or submit a suggestion to Dr. Stahl for future columns, please e-mail lla@mbllcommunications.com.

diers in command and nurses working with psychologically wounded warriors have low levels of confidence in army mental health care. They also showed strong perceptions of excessive psychotropic drug polypharmacy, excessive use of opiates, lack of adequate participation of primary care providers in mental health care delivery, and significant understaffing of mental health services. Our analysis proposes a key and immediate remedy to these problems: namely, redeploy primary care providers and nurse case managers who are already in place at Ft. Hood to roles that make them central rather than peripheral or uninvolved members of the mental health care delivery team there.

This change will result in a considerable force multiplier for mental health staffing, but will require extensive mental health and psychopharmacology training for primary care, nursing, mental health professionals, and army command soldiers. It is also critical for the army to make much more effective efforts to fill more than 1,000 current vacancies in mental health, psychiatry, and substance abuse staff across the army in order to take strain off the system, elevate the standard of mental health care to an acceptable level, and prevent possible dire consequences to our soldiers who need mental health services, as well as to our courageous mental health professional colleagues who deliver these services.

INTRODUCTION

Mental health care in the United States Army is suddenly undergoing intense scrutiny in the wake of the Ft. Hood massacre. The alleged shooter is an army psychiatrist at Ft. Hood and several of the victims were mental health care workers there as well. Questions are now being posed as to whether the stress of providing mental health care services as an army professional contributed to the motivation for the shootings or if the lack of sufficient numbers of psychiatrists in the army led the shooter's

supervisors to retain him in the face of many warning signs over several years that his performance may have been substandard and he was a risk to those around him. Also, questions exist as to how these events might adversely affect surviving mental health workers at Ft. Hood and across the army.

Just prior to the shootings, the Neuroscience Education Institute (NEI) was asked to provide mental health training at Ft. Hood. In the process of developing and delivering numerous programs there, we discovered numerous problems with mental health care at Ft. Hood and found a system in crisis. Here we report our findings from interviews and surveys collected from soldiers in command and mental health workers at Ft. Hood. Elsewhere we have presented the training curriculum and the educational outcomes from this course in a followup report to the army,¹ now available on our website at www.neiglobal.com.

THE WARRIOR TRANSITION UNIT AT FT. HOOD

NEI was contracted to deliver four days of intensive psychopharmacology and mental health training for the warrior transition unit (WTU) at the Ft. Hood Texas Army base. These courses were developed in part by a pre-visit to Ft. Hood of several days duration in order to interview several soldiers with psychiatric problems, physical injuries, or both, as well as to interview numerous members of the "cadre," namely, those soldiers within the hierarchy of command for the WTU. We had access to numerous nurses, psychiatrists, social workers, psychologists, nonpsychiatric physicians, and other medical and mental health professionals across the entire base at Ft. Hood, not just those professionals assigned to the WTU. We also had incredible cooperation and open access to interview many of the cadre, from squad leader and platoon sergeant all the way up to an extended meeting with the base commander, 3 star Lieutenant General Rick Lynch. Later, we were able to bring our findings both in written form and in a face-to-face meeting at the Pentagon with the Vice Chief of the Army, 4 star General Pete Chiarelli.

The WTU is comprised of several hundred soldiers, likely the largest number of psychologically wounded active duty warriors in one location in the entire US military. Ft. Hood, in the central Texas city of Killeen, is the largest mili-

tary base in the world. Physically or psychologically wounded soldiers are assigned to the WTU with only one duty: to heal. Those assigned to the WTU with psychological wounds are generally the most severe and at the highest risk for mental health problems. Other soldiers with similar problems who escape medical attention, who hide their symptoms, or who are not found by their command to be sufficiently disabled to be assigned to the WTU actually stay in their regular combat units. Soldiers outside the WTU may receive counseling or mental health services, and if so, receive treatment from the same psychiatrists who treat the WTU. However, non-WTU soldiers participate in their normal army duties whereas the soldiers in the WTU are excused from these duties and focus on their medical treatment exclusively.

CADRE

The cadre are the soldiers who command any unit in the army; in the WTU, they command wounded warriors. Cadre is built from the bottom up, from squad leader to platoon sergeant to general. Cadre's role in the WTU is to support the wounded warriors in many ways, often serving as proxy family members, helping soldier patients get to medical appointments, answering questions for them, and providing a structured military environment for them while they are healing, rehabilitating for return to duty, or processing out of the army. Most cadre are enlisted soldiers, not officers, without a college education, most of whom who have deployed to Iraq/Afghanistan.

Cadre have a general layman's level of knowledge about mental health issues from their army training at the WTU, particularly in areas such as suicide and stress. However, they do not have sophisticated knowledge of mental health issues beyond this and are especially lacking in the understanding of psychotropics. We found many in the cadre to be quite sensitive, even resentful, of the intense external scrutiny of them in regard to the recent and well publicized spike in the number of suicides. One of the 2009 suicides at Ft. Hood occurred on the very first day of our course for the cadre. It involved a soldier who had sustained a traumatic brain injury, was in rehabilitation for 19 months, but learned at the time of notification of discharge from the army that his injury was judged not service related and that he was not eligible for a pension or

medical benefits. The next day he shot himself. The reaction of the cadre was more detachment and preparing themselves for criticism rather than sadness or anger.

We designed two days of courses for the cadre, one held in March and the other in April, with 310 soldiers who attended both days. These courses had the objective of familiarizing the cadre with mental illnesses, showing them videotapes of how these illnesses present, giving them tips on management issues (such as how to deal with patients with different diagnoses), and providing them some useful but rudimentary facts about the most commonly used psychotropics.

NURSES

Nurse case managers also serve the WTU, with each nurse assigned to several wounded warriors. They are usually registered nurses with general medical but not psychiatric backgrounds, who do not have prescribing privileges, and are a mixture of active duty nurses and civilian contractors. Nurse case managers for the WTU serve more of an administrative role than a medical function. They help wounded warriors navigate through the complex bureaucratic maze of getting medical care in the army, cut through red tape whenever possible to help wounded soldiers get needed access to doctors, specialists, medications, therapy, and other medical services, and help with the inevitable mountain of paperwork required for each wounded warrior assigned to them. Most nurses we met were highly motivated and competent medical professionals. They had a general but not sophisticated grasp of mental illnesses and their treatments, yet proved to be rapid and voracious learners.¹ There were 101 participants on the first day of training and 138 on the second day. In both cases most participants were nurse case managers, but various other medical and mental health professionals also attended, especially on the second day.

PRIMARY CARE

The nurse case managers, along with the cadre comprise two of the three legs of a system that the WTU calls its "triad of care." The third leg of this triad of care is the primary care provider, some of whom are family physicians, but many of whom are nurse practitioners or

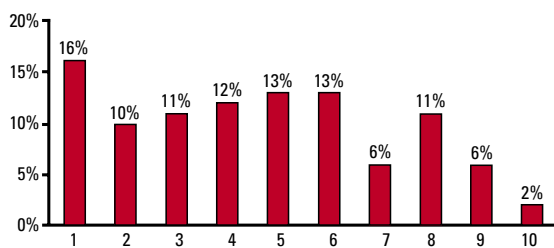
physicians assistants. The WTU has its own dedicated primary care providers, but no dedicated psychiatrists. Although conceptually the role of WTU primary care providers is to quarterback the medical issues, in practice they do this for medical illnesses but not for psychiatric illnesses. Thus, primary care providers tend to concentrate on soldiers in the WTU with physical injuries. For soldiers with psychiatric issues, the primary care providers of the WTU are relatively detached from the psychological care of wounded warriors and especially detached from making of psychiatric diagnoses and managing psychotropics for these soldiers. They prescribe few if any of the psychotropic drugs but almost all of the opiates for them.

This practice pattern is much different from civilian medical practice, where psychiatrists write fewer than 1 in 4 psychoactive prescriptions, using primary care providers essentially as a civilian force multiplier. However, at Ft. Hood, the great majority of psychoactive prescriptions are written by the dozen or so psychiatrists on staff who have to serve all ~50,000 soldiers, not just the WTU soldiers. This seems to be the case for mental health care across all of Ft. Hood where the more than 1,000 primary care providers prescribe a distinct minority of psychoactive drugs other than opiates. This practice pattern produces very severe limitations in the access a soldier has to psychiatric medications, resulting in long delays to get only a short appointment with a psychiatrist. A bit like starving in the midst of plenty given the low level of involvement by the many fold more primary care providers than psychiatrists at Ft. Hood.

To compensate for a dearth of psychotropic drug prescribers, many times WTU soldiers short circuit the army system by accessing psychotropics from civilian doctors off base in neighboring Killeen, Texas. Although this is often seen by the wounded warrior as having the additional advantage of keeping this information out of their official army medical records, in practice it complicates the ability of army professionals to know all the medications any given soldier is prescribed. Furthermore, neither cadre (Figure 1) nor to a lesser extent the nurse group (Figure 2) has high confidence that they have ready access to army mental health records despite army policy that these records be made available to them.

The relative lack of involvement of primary care providers at Ft. Hood in prescribing psychotropics is also in stark contrast to our experience while conducting mental health training at either the Marine Base Camp Pendelton or at Balboa Navy Hospital, both staffed by Navy professionals. There the primary care physician serves as the first line provider for mental health services and psychotropic drug prescribing, extending these services even to dependents of marines. In the marines, therefore, your civilian wife can get psychiatric care from your family active duty primary care physician, but at Ft. Hood even you, the active duty soldier, cannot get these services from your primary care provider. This results in the irony that it is easier for you to get a prescription for an opiate from your primary care physician at Ft. Hood than to get an antidepressant. Primary care providers at Ft. Hood seem open to more involvement in psychiatric management, so it remains a quandary why the situation exists as it does in a situation with such limited resources.

FIGURE 1.

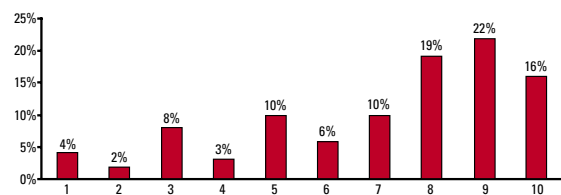


How confident are you in the ability of nurse case managers to readily access mental health records for your soldiers including all their medications and why they are given them?

Asked of the cadre (n=310). On a scale of 1-10, 1=little or no confidence, 10=extremely confident.

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FIGURE 2.



How confident are you in your ability to readily access mental health records for your soldiers including all their mental health medications and why they are given?

Asked of the nurse group (n=138). On a scale of 1-10, 1=little or no confidence, 10=extremely confident.

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CONTINUING STIGMA OF MENTAL ILLNESS AT FT. HOOD

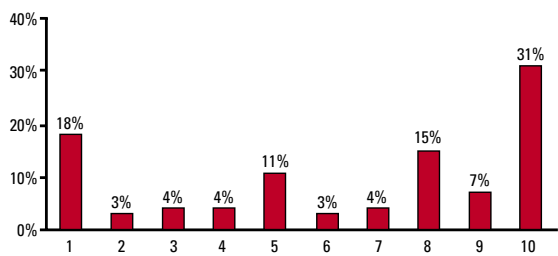
Although various programs of destigmatization have been implemented by the Army, a high degree of stigma still remains about mental illnesses and any soldier labeled with a mental illness. For example, the WTU cadre, supposedly due to their current assignment, should theoretically be among the most sophisticated in the army in terms of knowledge and direct contact with mental illness. Nevertheless a significant subset of them are not confident that posttraumatic stress disorder (PTSD) is even a real illness caused by military service (Figure 3). They also think that that $\geq 50\%$ of soldiers diagnosed with PTSD are faking or exaggerating their symptoms (Figure 4). This is in contrast to the nurse group who are much more confident that PTSD is a real illness caused by medical service (Figure 5) and

that only a minority of soldiers with PTSD are faking or exaggerating their symptoms (Figure 6). If a wounded soldier's commanders feel he/she is not really ill or that his/her problem was not caused by his service in the Army, this could create tensions within the triad of care and interfere with the soldier going forward to get treatment for PTSD. Stigma combined with limited mental health staff availability can create formidable barriers to receiving psychiatric care for many soldiers. This may contribute to the fact that most soldiers who commit suicide in the army have never seen a mental health professional.

SHOULD MENTAL ILLNESS BE PREVENTED OR TREATED?

The army presents a dilemma for soldiers trying to accept mental illness as legitimate and treatable, and different from laziness or being a "slacker." On the one hand, there are destigmatization programs. On the other hand, there is more

FIGURE 3.

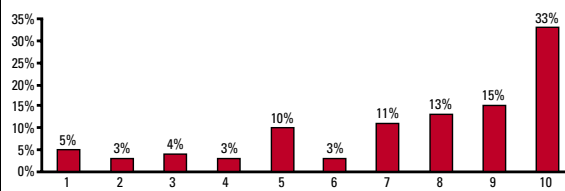


How confident are you that PTSD is a real illness caused by military service?

Asked of the cadre (n=310). On a scale of 1-10, 1=little or no confidence, 10=extremely confident.

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FIGURE 5.

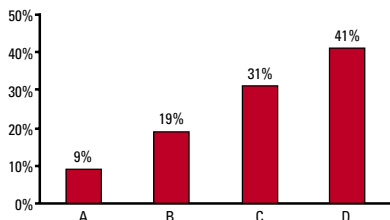


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Asked of the nurse group (n=138). On a scale of 1-10, 1=little or no confidence, 10=extremely confident.

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FIGURE 4.



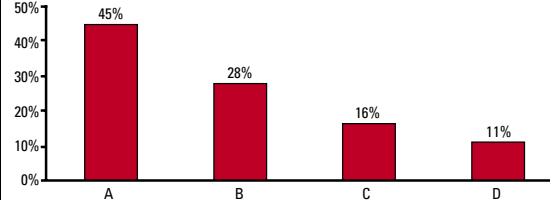
What percentage of soldiers claiming to have symptoms of PTSD do you think are faking or exaggerating?

- A. 10% or less
- B. One third
- C. About half
- D. More than half

(Asked of cadre) n=310

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FIGURE 6.



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(asked of nurse group) n=138

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emphasis on resilience training to prevent mental illnesses than on treatment of mental illnesses once they do occur. The notion exists among many in the army that mental illnesses are due to recruiting the wrong people as soldiers and inadequate training to manage stress. Thus, the idea here is that the army may be able to train its way out of mental illness by preventing mental illness in the first place. This would solve the problem of having to increase mental health staff because there would be no need for more staff once the resilience training kicks in and the numbers of psychiatrically afflicted soldiers dwindle.

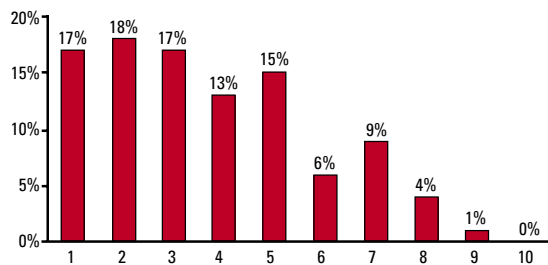
The reality is that there is still the threat of loss of prestige, career advancement, or even the ability to return to combat for those diagnosed with a mental illness in the army, and this can keep many soldiers from seeking help. Many in the WTU were referred there against their wishes. Thus, soldiers are still receiving mixed messages

about the legitimacy of mental illness and may understandably be confused or ambivalent about whether to seek care. A more enlightened point of view is that perhaps one out of every four or five of us is vulnerable to developing a medical illness during military service through no fault of our own and not because of deficient training.²

DYSFUNCTION IN THE TRIAD OF CARE?

A troubling finding from our survey is that especially the cadre (Figure 7) but also the nurses (Figure 8) lacked high confidence in the triad of care to deliver mental health care. Furthermore, neither the cadre nor especially the nurses had confidence in each other (Figures 9 and 10). This can spell problems in working relationships and in morale.

FIGURE 7.

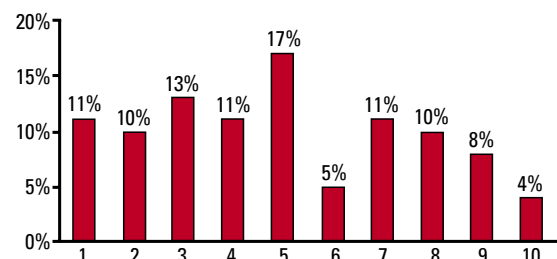


How confident are you in the army's mental health care diagnosis and treatment programs for your soldiers?

Asked of the cadre (n=310). On a scale of 1-10, 1=little or no confidence, 10=extremely confident.

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FIGURE 9.

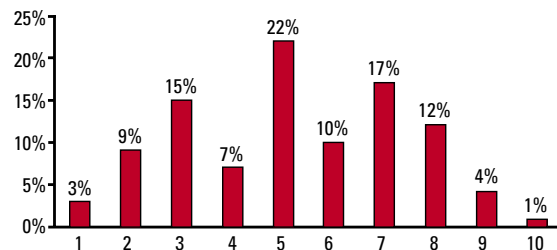


How confident are you in the knowledge and ability of nurse case managers to manage your soldiers with mental illnesses and the drugs that treat them?

Asked of the cadre (n=310). On a scale of 1-10, 1=little or no confidence, 10=extremely confident.

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FIGURE 8.

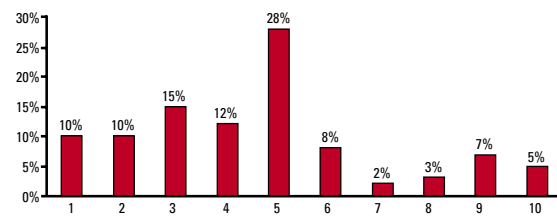


To what extent do you agree with this statement: The triad of care system provides effective behavioral health care.

Asked of the nurse group (n=138). On a scale of 1-10, 1=little or no confidence, 10=extremely confident.

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FIGURE 10.



How confident are you in the knowledge and ability of the cadre to recognize and monitor mental illnesses and their treatments in their soldiers?

Asked of the nurse group (n=138). On a scale of 1-10, 1=little or no confidence, 10=extremely confident.

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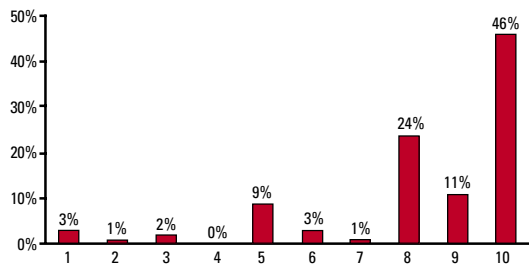
CONFIDENCE IN PSYCHOTROPIC AND OPIATE PRESCRIBING

Both the nurses (Figure 11) and the cadre (Figure 12) feel that soldiers in the WTU are prescribed too many psychotropics. There is also the perception that patients in the WTU have limited access to psychiatric appointments (Figures 11 and 12). Since these appointments are the principle times when these medications are managed, there is lack of confidence that they are thoughtfully prescribed. There is a similar perception by both the nurses (Figure 13) and the cadre (Figure 14) that opiates are overprescribed. Thus, despite the perceived lack of prescribers, there is the sense that too many medications are prescribed, perhaps by hurried psychiatrists with too little time to fully assess their patients and more carefully choose their

psychotropics, or to spend time giving psychotherapy rather than prescribing drugs.

We reviewed many cases where the soldier was receiving over a dozen drugs and almost all of the individual cases we reviewed were receiving ≥ 6 . Opiates were frequently prescribed concomitantly with other psychotropics and were a frequent element in the suicide attempts by overdose that we reviewed among the serious incident reports at Ft. Hood. We did not systematically evaluate polypharmacy but in several cases we did review the number of drugs did appear excessive. In other cases, the patients had complex and treatment resistant comorbidities justifying multiple concomitant medication treatment. Both nurses and cadre often see their soldiers "drugged" and overmedicated, and neither has the sense that they have the power to modify or improve prescribing for their patients.

FIGURE 11.

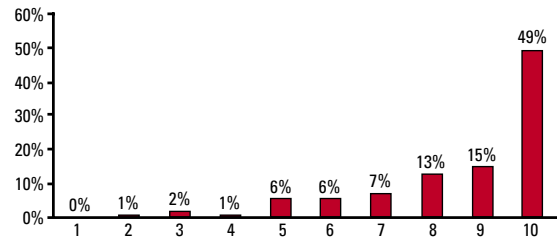


To what extent do you agree with this statement: Soldiers with behavioral health problems are prescribed too many psychiatric drugs with too little access to time and rapid appointments with psychiatric professionals.

Asked of the nurse group (n=138). On a scale of 1-10, 1=little or no confidence, 10=extremely confident.

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FIGURE 13.

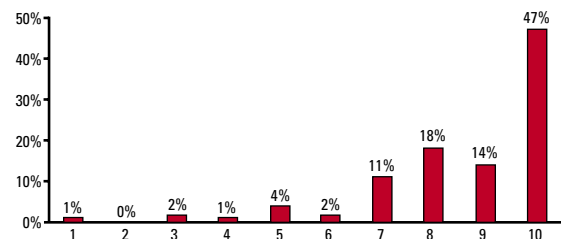


To what extent do you agree with this statement: Soldiers with behavioral health problems are prescribed too many pain killers (opiate drugs).

Asked of the nurse group (n=138). On a scale of 1-10, 1=little or no confidence, 10=extremely confident.

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FIGURE 12.

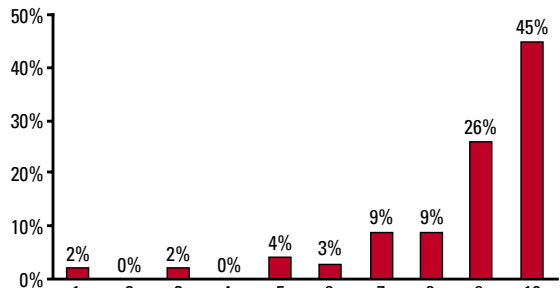


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Asked of the cadre (n=310). On a scale of 1-10, 1=little or no confidence, 10=extremely confident.

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INSUFFICIENT NUMBERS OF MENTAL HEALTH STAFFING

Another consistent finding from almost everyone we met at Ft. Hood was the feeling that there is currently a major deficiency in mental health staffing not just at Ft. Hood but throughout the army. Incredibly, the army has not increased the number of psychiatrists beyond the 400 that were there before the Iraq/Afghanistan conflicts started, despite reliable estimates that over 400,000 psychologically wounded warriors have accumulated over the ensuing 8 years.² The army admits that they are short about 800 mental health professionals as well as 300 substance abuse counselors. There are fewer psychiatrists in the entire US army today than there are in San Diego. There are 10 times more psychiatrists in Manhattan than there are in the army.

The crisis in army mental health staffing can only be projected to worsen over time, as the same troops in the current army are asked to take deployments in numbers and durations never seen before in history, and likely to only increase further if the expected surge of troops in Afghanistan currently under consideration by the Obama administration materializes. The army reports that the number of mentally ill soldiers increases from 1 in 5 to 1 in 4 for those with ≥ 3 deployments.² There is no telling what a cumulative half dozen or more deployments over a 10 year combat career will mean for the thousands of troops and their mental health workers who face this going forward.

POSSIBLE SOLUTIONS

The army does not believe that it is able to recruit and fill their mental health vacancies due to a perceived shortage of available professionals. Instead it is trying to use the internet to avoid the use of mental health staff and is

trying to prevent mental illnesses from occurring in the first place by widespread resilience training supposedly to avoid the need for treatment. Our suggestion instead is for the army to make mental health staff multipliers out of primary care providers and nurses. Such a redeployment of primary care and medical nurses to much greater roles and responsibilities in mental health care for the army in general and for Ft. Hood in particular, accompanied by high quality mental health care training would immediately take some of the load off current psychiatrists and mental health workers. This could have the additional benefit of increasing the attractiveness of serving as a mental health care practitioner for the army and thus aid in the recruitment of additional mental health staff to fill the large number of vacancies.

CONCLUSION

Mental health care at Ft. Hood is understaffed, leading to a current crisis in mental health care delivery there. Current medical staff and commanders lack confidence in army mental health care for soldiers who are in the WTU and believe that too many psychotropic drugs and opiates are prescribed. The situation calls for interventions that could multiply the number of available mental health care providers. One suggestion is to give primary care providers and nurses more responsibility for delivering mental health care services. This could take strain off the system, improve morale, and increase the chances of recruiting additional mental health professionals.

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