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Death of Psychiatrist and Other Soldiers Triggers Inquiry Into Military's Mental Health Care

Arline Kaplan

Alarmed by the rising suicide rate among soldiers returning from Iraq and Afghanistan and "wanting to help," Matthew "Matt" Houseal, MD, a psychiatrist with the Texas Panhandle Mental Health Mental Retardation Center (TPMHMR), reenlisted as an Army Reservist and volunteered to serve in Iraq.

Last month, Houseal, 54, of Amarillo, Tex, and Navy Cdr Charles "Keith" Springle, PhD, 52, a clinical social worker from Wilmington, NC, were working in the combat stress center at Camp Liberty in Baghdad when Army Sgt John M. Russell allegedly opened fire. Houseal and Springle were killed along with 3 soldiers awaiting treatment: Pfc Michael E. Yates Jr, 19, of Maryland; Spc Jacob D. Barton, 20, of Missouri; and Sgt Christian E. Bueno-Galdos, 25, of New Jersey.



News reports and an interview with Jim Womack, Houseal's former co-worker at TPMHMR, reveal that Houseal, father of 7 and husband of nephrologist Luzma Houseal, MD, was a compassionate and multitalented man. Houseal was board-certified in emergency medicine, psychiatry, and geriatric psychiatry and had helped establish a telepsychiatry network for rural regions of Texas. At TPMHMR, he had most recently been working with patients with depression, schizophrenia, and bipolar disorder. A former Navy pilot, Houseal was known to fly himself to remote parts of the Panhandle to treat indigent patients. He had served as a "winter-over" physician at the US South Pole Station.

Like Houseal, Springle had volunteered for deployment in Iraq because, according to news reports, he felt that the greatest need for his services was at the heart of the battle. Springle had served as director of the Community Counseling Center at Camp Lejeune in North Carolina and helped train mental health workers, clinical clergy, substance abuse

counselors, and others to recognize and assess individuals with PTSD. Springle was married 26 years and had a daughter and son. His son and son-in-law are Marines.

Houseal and Springle were assigned to the 55th Medical Company in Indianapolis. Joe Sitler, the 55th's unit administrator, told *Psychiatric Times* that 83 service members of the 55th, which included 6 psychiatrists and 62 other mental health workers, had been dispersed to various locations throughout Iraq. Houseal, on a 90-day rotation, was due to return home this month.

What happened?

The shootings at Camp Liberty marked the sixth incident in which a service member killed a comrade since Operation Iraqi Freedom began. It was the worst such attack.

As described in Army briefings, Russell, 44, a soldier from the 54th Engineer Battalion on his third Iraq deployment, had undergone some counseling within his unit. Roughly a week before the shooting, Russell had been referred to the combat stress center for outpatient treatment. His commanding officer had ordered that Russell's weapon be confiscated. No details were available on whether Russell was taking any prescribed medication, said Maj Gen David Perkins, director for Strategic Effects, Multi-National Force-Iraq, during an Army briefing. According to Russell's father, his son was facing financial difficulties and feared he was about to be discharged from the Army.

On May 11, Russell was escorted to the combat stress clinic. He became involved in a verbal altercation with staff and was asked to leave. Russell and his escort returned to a vehicle and began to drive away. Somehow, Russell wrested control of his escort's weapon, ordered the escort out of the vehicle, drove back to the clinic—and began to shoot, news reports said.

Military police arrested Russell outside the clinic. Russell is now in pretrial confinement and is undergoing medical evaluation. He has been charged with 5 counts of murder and 1 of aggravated assault.

The US Army Criminal Investigation Command is investigating. "We have many different accounts as to exactly what happened and the sequence in which it happened," Perkins said during a press briefing.

An executive-level officer has been appointed to conduct an internal investigation to determine what happened, make recommendations for preventing similar incidents, and assess the general availability and delivery of behavioral health services, said Army Lt Col Brian Tribus, Multi-National Corps-Iraq media operations chief, in an interview with *Psychiatric Times*. In addition, the Army's Inspector General has been asked to review all mental health services available to troops in Iraq.

Witnesses and others affected by the shooting received comprehensive psychological first aid immediately and in the days following the incident, Tribus said.

Issues and care

For years, the military and others have been assessing the mental health needs of service members and quality of care. A large-scale, nongovernmental assessment of the psychological and cognitive needs of military service members conducted by RAND Corporation found that nearly 20% of military service members who have returned from Iraq and Afghanistan—300,000 in all—reported symptoms of PTSD or major depression. Nevertheless, only slightly more than half have sought treatment.

Rising suicide rates among the troops have prompted a 5-year, \$50 million collaboration between the Army and NIMH to identify causes and risk factors. In 2008, the Army reported 140 confirmed or suspected suicides (20.2 suicides per 100,000 troops—nearly twice the national rate of 11.01 suicides per 100,000 US population). As of press time, the Army has reported 64 potential active-duty suicides for 2009.

Since 2003, the Army Surgeon General has dispatched Mental Health Advisory Teams (MHATs) to survey soldiers as well as health care and unit ministry team members, particularly in Iraq and Afghanistan, said Lt Col Paul D. Bliese, chief of military psychiatry at the Walter Reed Army Institute of Research. Bliese was project director for MHAT-V, which was released last year (http://www.armymedicine.army.mil/reports/mhat/mhat_v/mhat-v.cfm).

“The MHAT reports systematically quantify mental health concerns and go a long way toward informing policies such as deployment length and behavioral health resourcing,” Bliese told *Psychiatric Times*. A report on the MHAT-VI mission to Iraq is now being finalized.

The top finding of MHAT-V, Bliese said, was the degree to which combat intensity and mental health demands had increased in Afghanistan. A second key finding linked mental health and family-related concerns to deployment duration.

“By the end of a 15-month deployment, the statistical models predicted that approximately 30% of junior enlisted intended to divorce or separate, up from 10% at the beginning of the deployment,” Bliese said. “Likewise, the data showed the degree to which mental health problems tended to peak about two-thirds of the way through a deployment, but even with some lowering of problems in the 3 or so months immediately before returning (‘redeployment optimism’), the rates of problems roughly tripled from initial levels at the end of 15 months.”

Noncommissioned officers (NCOs) on their third or fourth deployment had significantly lower morale, more mental health problems, and more stress-related work problems than NCOs on their first deployment, according to the MHAT-V report. For example, among male NCOs, 27.2% reported mental health problems on their third or fourth deployment compared with 11.9% on their first deployment.

The issue of adequacy of behavioral health staffing for the troops was also raised in the MHAT-V report. At least 1 behavioral health provider (officer or enlisted) is needed per

1000 service members, according to the report. The current staffing ratio for Army and Navy behavioral health personnel to soldiers or Marines is 1:1426.

Asked about the MHAT-V recommendations, Bliese said several were already implemented.

“The report recommended developing and implementing a training system that would help Army medics become more familiar and comfortable dealing with mental health issues of the soldiers in their units. The idea was to use medics as a force-multiplier for identifying and treating mental health problems at the lowest levels. This program was implemented in 2008, and medics have reported high satisfaction with the program,” he said.

Help in Iraq

Most service members who seek behavioral health/combat and operational stress control services, Tribus told *Psychiatric Times*, have transient conditions (eg, adjustment disorders) and are seeking supportive counseling for marital or occupational problems. Some seek behavioral health support for mood and anxiety disorders (eg, PTSD and acute stress disorder). Throughout Iraq, teams of behavioral health personnel are dispersed to provide combat and operational stress control to service members.

Service members in need of more intensive services are referred to 1 of 4 Combat and Operational Stress Control restoration centers in Iraq, such as the one at Camp Liberty, Tribus said.

Restoration centers are “akin to intensive day-treatment centers,” Tribus said. They provide brief respite and rehabilitation for acute combat and operational stress reactions and moderate behavioral health diagnoses.

The staff is trained to provide stabilization of acute psychiatric emergencies, and a multidisciplinary team provides comprehensive evaluations. Treatment generally lasts from 3 to 7 days. Individual and group therapy is offered as are classes in life skills, coping, and anger and stress management. Service members with extremely serious psychiatric problems can be medevaced to hospitals, explained Capt Paul Hammer, MD, director of the Naval Center for Combat and Operational Stress Control at the Naval Medical Center San Diego (<http://www.nccosc.navy.mil>).

Hammer, a board-certified psychiatrist, has been deployed to Iraq twice. During his second tour, he oversaw mental health care for 33,000 Marines and sailors of the 1st Marine Expeditionary Force.

He discussed with *Psychiatric Times* the many stressors service members experience while serving in Iraq.

“The longer you stay outside the wire (away from the base), the higher the risk of seeing your peers killed or wounded or getting wounded or killed yourself,” he said. “Beyond the stress of being harmed, there are environmental stressors that the public rarely appreciates,” he added.

Some of those stressors Hammer personally experienced while traveling around in a Humvee for 3 weeks to visit the border force in western Iraq. “Wearing body armor, climbing in and out of Humvees, the jarring, the exposure to exhaust fumes, enduring extremes of weather—it is just hard living,” he said.

Burnout is a frequent risk. When you are in Iraq, you are basically working 7 days a week with long hours each day. You just get tired and burned out, particularly when you have repeated or prolonged deployments, he said.

Typically, according to Hammer, the Navy and Marine Corps deploy for 6 or 7 months. The Army deploys for a year; but during the surge, the period of deployment went up to about 15 months.

It is important to balance time in theater with time at home, “where you can reset and recharge,” he said. “The ideal dwell time is usually 2:1—twice as much time at home for the amount of time deployed, and I don’t think we have been able to achieve that. . . . We also wear out families, much like we wear out the fighting force,” said Hammer.

The more service members are deployed, he explained, the more their families have to take up the slack. Often, service members are stressed by what’s going on back home, he added.

Anti-stigma

Stigma is often cited as the reason service members, veterans, and their families don’t seek mental health care. Last month, the Department of Defense launched the Real Warriors Campaign, a multimedia public education effort designed to combat stigma.

Institutional or external stigma has become less of a concern for service members than internal stigma, Hammer believes. “If service members want treatment, they can usually get it. The biggest block is their feelings of not wanting to be seen as crazy,” he said.

Hammer added, “We are being very proactive in trying to bring mental health care as far down to the deck plates as we can and to make it as acceptable as we can. We have made advances in screening and detection, are really trying to train people in better treatments for PTSD and traumatic brain injury, and have initiatives to develop resilience.”

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