Experience of a Behavioral Health Officer during a Brigade-Level Field Exercise

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Similar to other Army Brigade Combat Teams (BCTs) the 2d Cavalry Regiment (2CR) Stryker Brigade Combat Team (SBCT) conducts brigade-wide large scale training events semiannually in order to achieve its readiness goals and prepare for contingency missions in the EUCOM theater. The Joint Multinational Readiness Center (JMRC), located in Europe, hosts and provides feedback to BCTs and other rotational training units (RTUs) who are training mission essential tasks (METs). 2CR recently completed an event called "Dragoon Ready 23" (DR23) where observer controllers (OCs) were present to give our unit feedback on how we preformed our METs. OCs are active-duty Officers or NCOs, either permanently assigned or tasked as an augmentee (on temporary duty orders) to the training installation (JMRC), who specialize in observing and controlling the exercise and enabling the full-spectrum of a training environment. OCs ensure control of the exercise by following RTU planning closely, adjudicating force-on-force actions, and providing valuable feedback to the RTU during and after the exercise. For medical personnel, including the behavioral health section, the primary doctrine upon which the OCs base their feedback about expected functions and requirements for a Role 2 medical facility can be found in Army Techniques Publication (ATP) 4-02.6 (Department of the Army, 2022).

In addition to training METs, field training exercises (FTXs) also have supplemental foci of maintaining critical relations with partnered nations and of testing specific capabilities. For example, during 2CR's FTX in February 2022, we conducted a multiday tactical road march (TRM) across bordering countries to demonstrate our ability to move equipment and personnel across Europe to a foreign battlefield. More recently, an additional function of DR23 was to validate new and updated communications systems and technology. Because 2CR is located in Germany, our exercises regularly involve training with partner nations, such as Slovakia, Poland, Latvia, and Hungary. 2CR is the only mechanized BCT located in Europe and plays a critical role in maintaining essential relationships with our partnered and allied nations and providing the framework for NATO's enhanced forward presence (eFP) multinational battle groups.

Phases of an FTX

Brigade FTXs typically take place over the course of three phases: (1) reception, staging, onward movement, and integration (RSOI), (2) deployment to the "Box," and (3) reverse RSOI. These phases are arranged and facilitated by JMRC, but are planned and executed by RTU leadership, and medical sections must nest their services and operations within each phase. During DR23, RSOI included unit movement to the barracks at Hohenfels (JMRC), equipment preparation for the Box, and leader engagement in the military decision-making process (MDMP), which took approximately one week.

After completion of RSOI, the RTU deploys to the Box, or forward attack area. This phase is the cornerstone of the FTX and includes force-on-force operations, as well as a focus on the line units training various types of tactics (e.g., offense, defense) and support operations. Medical exercises focus on training activities such as responding to mass casualty (MASCAL) events, medical evacuation, patient movement communications, and equipment maintenance. This phase of training typically lasts 9 to 14 days, is the most taxing, and is the primary venue for demonstration of capabilities and skills. During reverse RSOI, 2CR redeployed back to the Hohenfels barracks and prepared to return garrison. Primary tasks during reverse RSOI include turning in all equipment used for the Box, cleaning vehicles and equipment, conducting after action reviews (AARs), and receiving final feedback from the OCs about performance during the Box. Once reverse RSOI is complete, the RTU returns to its home station.

Behavioral Health Section in a Brigade FTX

The unit has a mission essential task list (METL) which helps commanders prioritize training requirements and establishes structure and purpose for the team. During training exercises, the behavioral health (BH) section also has a task list that should be the focus of organizing training goals and generating outcomes for the team. Some items listed on the BH task list are familiar to the BH section and frequently completed in garrison including: conducting a BH consultation (for chain of command and medical staff), facilitating a BH group, administering and scoring psychological testing, and conducting a counseling session. Other tasks may be less common for the BH section to complete in garrison settings, such as performing line of site observation of psychiatric patients, assisting in mechanical restraints, providing BH support in response to a potentially traumatic event, conducting a collateral interview, providing neuropsychiatric triage, and assessing for substance abuse. The task list is not solely a practical exercise for the BH section; each task has a specific standard of performance and is graded as "GO/NO GO." The BH section is ultimately graded on whether it can execute tasks to standard during the FTX, which is essential preparation in the event of a deployment (see Hoyt et al., 2015 for a review of BH trends during a deployment).

For the BH section to adequately prepare for an FTX, the team needs a sound understanding of the METL and BH-specific tasks. For example, the BH section must ensure that copies of important forms used for the FTX are printed, psychological testing and any other BH equipment (e.g., Alpha-Stim kit) are gathered, and supplies that would generally be needed (e.g., notebooks, pens, hand sanitizer) are packed. As such, consideration of equipment needed to execute tasks is the first step in preparation. A second important consideration for BH team preparation is the location and logistics of where BH services will be offered in the Box. During previous 2CR training events, our BH section has been located in different areas each time, to include: sharing a tent with the command post (CP), having a separate standalone tent, sharing the annex tent with physical therapy (using hanging blankets to create privacy), and providing patient care in the back of a field litter ambulance (FLA). Although this variability may not be common across BCTs and accompanying Role 2 facilities, we recommend understanding where the BH section will be located in order to prepare equipment needed (e.g., chairs, table, privacy curtains) to facilitate tasks.

Teachings/Trainings for Behavioral Health Technicians (68Xs)

A primary objective for the behavioral health officers (BHOs) is training the 68Xs to act as paraprofessionals and service extenders in a wide range of settings (Hoyt, 2018). As such, training on BH tasks not frequently employed in garrison, in addition to adapting common clinical tasks to a field setting, is required. For example, when in garrison, our 68Xs assist with triage by screening patients, determining their acute risk level, and scheduling or referring patients to appropriate care. In a simulated combat environment, the 68Xs still provide triage and determine risk, but are also trained to assess patient disposition (e.g., return to duty, stay at Role 2 for monitoring with potential for return to duty, or evacuate). We trained our 68Xs on completing tasks more unique to a simulated combat environment, such as administering the Military Acute Concussion Evaluation (MACE) and conducting a mini-mental status exam (MMSE). Additionally, 68Xs are more likely to provide consultation to other medical providers, medics, and NCOs of patients in a simulated combat environment. Role playing consultation questions and reviewing confidentiality best practices were aspects of trainings during this FTX. Responding to a traumatic event (or trauma event management; TEM), which is covered in various military BH trainings, was important to review and practice as well. Finally, during unscheduled time in the field, we discussed reading materials and important military psychology concepts (e.g., common psychopathology in military settings) with the 68Xs.

Behavioral Health During an FTX

Similar to medical assets nesting with higher command operations, the BH section must conduct activities in accordance with unit plans. For this training exercise, BH support for RSOI and reverse RSOI were similar clinically and logistically. During RSOI and reverse RSOI, the BH section was located in a medical clinic designated for the RTU; our section worked alongside the battalion medical teams with our own office in the clinic. Services offered during these two phases (RSOI and reverse RSOI) were primarily triage, supportive therapy, brief psychoeducation interventions (e.g., grounding, diaphragmatic breathing, self-talk – similar to those offered by Combat Operation Stress Control; Hoyt and Hein, 2021), and consultation to medical and command teams. Patients were seen during our "walk-in" hours and were either self-referred or referred by their medical or command teams. We had two periods each day for walk-in hours: morning hours aligned with the battalion medical teams and afternoon hours for patients who had work schedules precluding them from attending morning sick call hours. During RSOI and reverse RSOI, we saw the largest volume of patients. Understanding the schedule and requirements of your unit allows the BH section to appropriate schedule hours to maximize patient access to care.

During the Box, consultation services were limited by lines of communication (LOCs). During DR23, one objective of the brigade was to pilot and employ new communication devices and completely eliminate personal electronic device (PED) use. PED use increases the risk of enemy targeting, tracking troop movements, and unauthorized access to mobile devices. In a simulated combat environment, units train to employ LOCs that do not emit traceable signals and limit the enemy's ability to leverage PEDs in warfare. Due to limited LOCs, consultation was not a service offered. During the Box, we primarily offered patient-focused clinical services, such as triage, Alpha-Stim treatment, supportive therapy, TEM, and review of coping strategies. If the unit were to deploy for a longer period of time (i.e., longer than the 9 to 14 days typical of the Box), the BH section would also offer options for ongoing BH care, such as Cognitive Behavioral Therapy and Solution-Focused Therapy. However, the brevity of an FTX limits the actual scope of clinical services offered by the BH section. During the Box, our patient volume decreased since the only patients who could be seen during this phase were those who were medically evacuated from Role 1 to Role 2 facilities by Role 1 providers or by those who were co-located with the Role 2 (e.g., medics, supply technicians).

In addition to providing BH-specific services during the FTX, our section was expected to assist the medical company with broader operations. For example, during setup and breakdown of equipment (i.e., when first arriving to the Box or when "jumping" to a new location), the BH section is tasked with assisting other medical platoons set up their tents and equipment. Additionally, during a MASCAL event, the BHOs are expected to treat any acute BH patients, assist with triaging the incoming patients to Role 2 (i.e., immediate, delayed, minimal, or expectant), and help the evacuation teams move litters as

needed. Finally, in 2CR, the BH section is assigned a two-seater joint light tactical vehicle (JLTV), and one of the BHOs is expected to serve as a truck commander (TC) for all vehicle movements. One or both of the 68Xs must therefore be licensed on the JLTV and serve as drivers, which facilitates half of the BH section (one BHO and one 68X) maneuvering independently as needed during exercises and deployments. A BH section maintains more autonomy when a vehicle is assigned to the section and the team is qualified to operate the vehicle and its associated equipment, such as the radio. Overall, in addition to the BH clinical services provided by the section, BH team members are expected to assist in medical operations, set up and break down equipment, and self-transport during exercises.

Themes of Patient Presenting Concerns

During DR23, patients typically presented to our section with presenting problems in one of three categories. First were patients who did not want to participate in the FTX. These patients were generally either new to the Army, with subsequent and appropriate anxiety about the unknowns of a field exercise or were individuals who had previously completed an FTX and anticipated the exercise being a significant stressor. Most of these patients had made previous unsuccessful attempts to be excluded from the field exercise – such as getting a medical profile or requesting to be on the rear detachment – and hoped that our team would put them on a BH profile so they were not allowed to participate in the Box. A second theme of patients included those who were currently enrolled in BH services at our garrison clinic and wanted to continue therapy while in the field. During RSOI phases, these patients sought supportive therapy and brief solution-focused therapy applied in a training environment. A third subset of patients had no history of seeking BH in the past but felt overwhelmed or acutely distressed, typically due to stressors while in the field or difficulties at home and presented during RSOI phases. For those patients, we gave brief psychoeducation interventions, introduced new coping and stress management strategies, and sometimes scheduled a full intake to be completed after returning to garrison.

In addition to presenting concerns noted above, we observed other themes in patients presenting for BH services. Most patients described frustration with their leadership, such as not feeling included in decision-making processes or not agreeing with priorities and tasks delegated by leadership. Patients also frequently felt overwhelmed by the amount of work assigned, some remarking that they weren't given enough time to eat or perform basic hygiene and others noting they felt too stressed and anxious to focus. During RSOI, anticipatory anxiety for the next phase of the exercise was also a significant concern. Finally, our team also worked with patients who reported symptoms with questionable validity, such as memory loss subsequent to an unwitnessed fall.

During the exercise, our primary barrier in providing patient care was the LOC. Because of these difficulties, we were frequently unable to communicate with our referral sources (e.g., Role 1 providers, command teams) and instead relied primarily on information reported by the patient. We were also unable to coordinate with command teams to set up patient care management plans, which led to the BH section keeping patients at Role 2 until we could conclusively return them to duty with no restrictions or medically evacuate them if needed. To assist with this effort, we strongly recommend that BHOs have a good understanding of the risk tolerance of the unit's command teams. Building relationships in advance and having a pulse on the climate of the units facilitates more rapid patient dispositioning in field medicine. For example, some command teams want any Soldier with a BH limitation to be evacuated to garrison; other command teams, however, worked arduously to meet patient limitations related to BH concerns in order to keep all hands-on deck in the FTX.

Conclusion

In summary, preparation prior to deploying to an FTX and having appropriate expectations during an FTX are essential for new BHOs. Some key tasks for the BH section prior to deployment include building relationships with provider and command teams, having appropriate paperwork and equipment ready, and understanding the logistics and planning of the Role 2 setup. BHOs should expect to assist in tasks unique to Army BH providers (e.g., packing and unpacking equipment, driving vehicles), have plenty of time to train their 68Xs, and be flexible in responding the shifting demands of the environment and unit mission.

Disclaimer

The opinions or assertions contained herein are the private views of the authors and are not to be construed as official or reflecting the views of the U.S. Government, the Department of the Army, or the Department of Defense.

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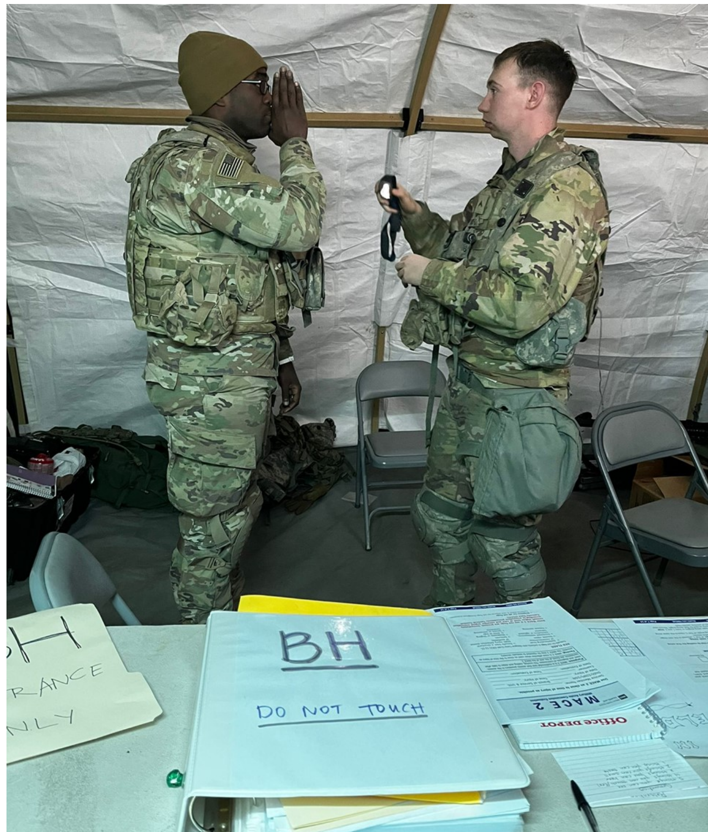
The Behavioral Health Team from 2nd Cavalry Regiment



Military Acute Concussion Evaluation in the Field