Lessons Learned by Forward-Deployed Psychologists during Pacific Pathways 2022

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Overview

Pacific Pathways is an overarching series of exercises conducted between the United States military and the militaries of other partner nations within the Pacific, with a single Corps level headquarters (CALL, 2016). The purpose of Pathways is to build partnership and support a stronger, open, and more stable Pacific. By bringing together dozens of foreign armed forces, Servicemembers around the world forge partnerships that improve the scope and quality of military engagements. The task force for Pacific Pathways 2022 contained over 2000 troops from the United States military from locations within Pacific Command (PACOM) to include Japan, Guam, New Zealand, Hawaii, Alaska, and Washington. For this iteration of Pacific Pathways, troops were deployed simultaneously across military sites in both Thailand and the Philippines. Efforts in each country were anchored around longstanding training events in each country – specifically, Cobra Gold and Hanuman Guardian in Thailand, and Balikatan and Salaknib in the Philippines.

In 2022, for the first time in the history of these exercises, two psychologists, organically assigned to the 25th Infantry Division as Behavioral Health Officers (BHOs), were incorporated into mission/medical logistics planning and deployed in support of operations in both countries. CPT Adam Freed was assigned to the 3rd Infantry Brigade (3IBCT) and CPT Christina Hein was assigned to the 25th Combat Aviation Brigade (25CAB). The two BH providers were deployed for over two months and provided coverage for the task force simultaneously in Thailand, the Philippines, Guam, and back at home station in Oahu, Hawaii. This paper will focus on behavioral health support leading up to, during, and after deployment to these countries and will address processes developed and implemented, observed trends, and lessons learned.

Overview of Exercises

THAILAND: Cobra Gold is one of the world's largest annual multi-national military exercises, including countries such as the US, Indonesia, Japan, and Thailand. Hanuman Guardian is smaller in scope, more specialized, and exclusive to the Thai and US Armed Forces. US troops deployed to Thailand were stationed across the country with up to six hours of driving time between units.

PHILIPPINES: Balikatan 2022 marked the 37th iteration of the exercise between the Philippines and the United States, and Salaknib focuses on subject matter exchanges on a vast array of topics. US troops deployed to the Philippines were generally in closer physical proximity to each other than were those in Thailand, but were situated in ten distinct locations throughout the country.

Behavioral Health Integration – Pre-Deployment

Prior to deployment, it became clear that behavioral health (BH) clearance was not a standardized component of the pre-deployment Soldier Readiness Process (SRP) within PACOM. Historically, Servicemembers (SMs) who are medically evacuated for psychiatric causes have extremely low odds of being returned to duty (RTD; *OR* = 0.28 [95% CI: .18, .43], Cohen et al., 2010); as a result, the deploying providers deemed it essential to conduct a pre-screening to identify those SMs who may be of elevated risk for psychiatric distress upon deployment.

In order to decrease risk downrange, the authors established a method to screen the Soldiers deploying from their individual brigades utilizing the recommendations and procedures developed by other BH providers. Manifest lists were obtained and compared to lists of those who had sought BH services within the past 90 days. Additionally, BH profiles were evaluated. For those with BH utilization, records were reviewed and those with perceived elevated risk for decompensation upon deployment were evaluated by a BH provider.

From the 25CAB, a manifest list of over 400 Soldiers was reviewed. A total of 42 of these Soldiers were identified as having had BH contact within the identified window of time, of which 11 required a BH evaluation. Ultimately, three CAB personnel (0.5% of the total deploying roster) were deemed nondeployable for the current exercises.

3IBCT, which assumed responsibility as the higher headquarters for all Army forces (ARFOR) during the exercise, sent forward a manifest of over 600 Soldiers organic to the brigade. After removing eight Servicemembers who did not meet medical requirements, the medical team identified 22 Servicemembers who were engaged in ongoing BH care. Deployment waivers for these personnel were recommended by 3IBCT's BHO and brigade surgeon, with future encounters and treatment sessions planned in advance.

During Deployment

During Pacific Pathways 2022, medical resources for the task force were both limited and field expedient, with urgent and surgical care coming from local host nation hos-

pitals. A medical facility site survey was conducted by the ARFOR medical cell, specifically assessing the capabilities of major hospitals within the area of operations across both Thailand and the Philippines. In both countries, these facilities were assessed to not have adequate behavioral health capabilities beyond a psychiatric emergency, indicating that the behavioral health support for the entire task force consisted of only the two authors. As such, long term care, high acuity cases, or risk beyond outpatient visits would require Servicemembers to be evacuated out of the area to facilities outside of the host countries.

Historically, the presence of forward-deployed behavioral health support circulating amongst troops is associated with decreased medical evacuations for psychiatric conditions, while the drawdown or absence of behavioral health support is associated with increases in psychiatric evacuations (Armed Forces Health Surveillance Branch, 2018; Williams, Stahlman, and Oh, 2017). While RTD rates for those who are psychiatrically MEDEVACd are exceptionally low, the RTD rates when forward psychiatric treatment is available are substantial, with RTD typically hovering around 90% (Ogle et al., 2012).

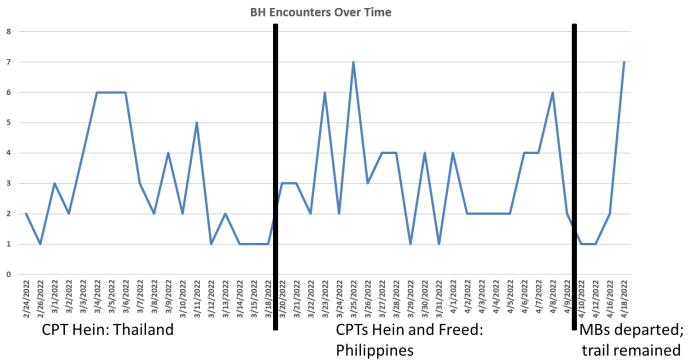
The approach taken by the BH team was to provide both emergent (e.g., suicidal or homicidal risk, substance abuse, risk to mission) as well as routine care (e.g., diagnosis/care of common BH disorders, conduct trainings as indicated) to all US troops deployed. Overall, the BH team provided treatment to about 4% of the deployed US troops, and providers maintained a 100% return to duty rate. The majority of treatment was focused on operational stress control and forward patient care.

The operational stress control approach has three distinct aspects: universal prevention, indicated prevention, and treatment prevention (Department of the Army, 2015). For universal prevention, the BH team taught key leaders on the normative range of stress reactions, provided instruction for physician assistants and medics on how to implement cognitive behavioral therapy, conducted mindfulness practice exercises, trained personnel on redeployment stressors, and also conducted a biweekly update on trends within the task force to the command team. Indicated prevention, the second component of the operational stress control approach, made up the lion's share of encounters and primarily focused on work and relationship stress. BH providers scheduled regular check-ins/appointments with both the individual SM and his/her commander or first line leader as indicated. Formal treatment, the third component of the operational stress control approach, ranged from concerned referrals from the task force surgeon to acute care in the face of crisis. Forward patient care was both previously arranged with the BH providers (with regular appointments being a requirement in order for the SM to deploy forward) or was provided ad hoc

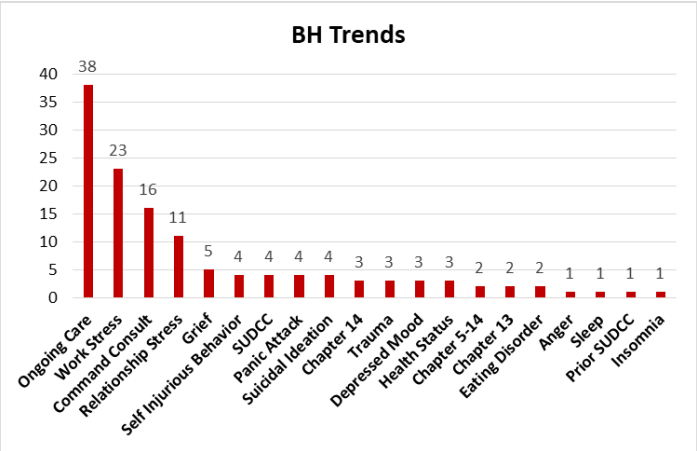
Evidence based treatment in a deployed setting is not only possible (Hoyt, 2015), but the deployed context itself can be incorporated as a unique component of treatment; the authors utilized the opportunities exclusive to a deployed setting to enhance, as opposed to potentially inhibit, treatment options. A senior noncommissioned officer's panic disorder was treated via a course of interoceptive exposure, as the region's high temperatures, terrain, and humidity could all be recruited to produce the somatic symptoms he was struggling to manage. A successful course of treatment allowed him to be able to attend, and successfully complete, jungle school with his platoon (Colson, 2022). In another case, a Soldier endorsed a specific phobia in the form of heights. Through a consolidated treatment protocol utilizing cognitive behavioral therapy for phobias, SM ultimately volunteered for a unique opportunity to be strapped into a jungle extraction device and lifted from the ground to a helicopter hovering at 80 feet.

Trends Identified

Over the course of both formal and informal behavioral health contacts in both countries, a number of unique trends were identified. While around half of the task force deployed from within 25th Infantry Division, approximately 1000 SMs did not, and as such were not assessed or screened by either of the authors prior to deployment. Task force units that did not have pre-deployment screening by an organic BH provider accounted for approximately 25% of all BH contacts, and accounted for the most severe cases seen during Pathways. Additionally, CPT Hein and CPT Freed documented the frequency of BH contacts across both countries (see graph below); the providers identified a 5-10 day lag that occurred between provider arrival and consistency of utilization as a BH provider. Utilization had more peaks earlier in the deployment, with a significant decrease just before/during redeployment. Additionally, providers observed lulls or reset periods between the named exercises. Finally, a significant increase in BH contacts occurred among those individuals who remained in-country after the majority of SMs redeployed to their home stations ("trail").



Over the course of the deployment, CPTs Freed and Hein tracked the primary reason for BH contacts by chief complaint. The majority (n = 38, 31%) of contacts were due to ongoing care (i.e., continuation of treatment initiated prior to deployment or were follow-up contacts during the exercise). Primary reasons for initial contact were work stress (n = 23, 19%), command consultations (n = 16, 13%), or relationship stress (n = 11, 9%). Additional reasons for BH contacts while deployed can be seen in the graph below.



Issues Faced and Lessons Learned

A significant lesson learned by these providers is the importance of engaging in and utilizing pre-deployment BH syncs which would provide several benefits. Foremost, this allows providers and commanders to align and share knowledge regarding specific troops who are likely to require services, and weigh this against the available resources within the local area and the task force. For example, a unit outside of the two author's brigades sent forward a Soldier who had finished in-processing to his new unit only a month before arriving in the Philippines. Within two days of deployment, he presented to the Role 1 with a request to have his prescribed antidepressant adjusted, as he was told there would be a psychiatrist available. His commander, who was not forward deployed, echoed the belief that psychiatric care would be available. This presented a preventable risk that had to be managed throughout the exercises with the leadership under whom this Soldier was temporarily attached. This challenge was easily preventable had the medical team from that unit coordinated with the BHOs. Furthermore, early BHO syncs ensure that each BHO may take the contact information for their counterparts to their units. This ensures that all stakeholders are aware of and have access to their respective BHO, which may or may not be their organic BHO, upon deployment. With limited BH resources in the region, both of the authors saw the others' personnel interchangeably and consulted with leadership normally outside of their brigade.

Prior to deployment, synchronizing the behavioral health needs of task force personnel with the forward behavioral health team is crucial, in order to ensure that their care needs can be met during regular circulation and travel in the region. While virtual care and telehealth solutions could potentially lean out the forward BH team, difficulties with stable communication platforms, as well as deliberate management of "on call" personnel in the rear due to the time zone, must be considered.

In addition to BHO syncs, BHOs must ensure that they are engaged in mission planning conferences (both at the tactical and strategic levels) leading up to a deployment in order to ensure a global informed assessment and understanding of a region's psychiatric capabilities. This was found to be especially important within the Pacific area of responsibility, where treatment and evacuation for behavioral health was assessed to be less mature than locations where forces have traditionally been deployed over the past two decades.

A primary issue that both providers faced was developing a battle rhythm while providing care, particularly as training locations were far-dispersed with unreliable transportation amongst them. The battle rhythm that was established, was using the daylight hours when troops were dispersed and involved with missions to engage in battlefield circulation, increasing the awareness of Soldiers of the presence of BH. Then appointments were typically scheduled in the evenings during periods of relative downtime. This allowed Soldiers to receive care without interfering with their daily tasks and responsibilities. However, the lack of a dedicated schedule and clear on- and off-duty hours for patient care placed a burden on the BHOs to cover one another's downtime in order to manage professional obligations as well as personal needs. While the embedded model of BH surely increases ease of access, it also restricts the providers' ability to professionally and personally disengage. A week long staff exercise with a partner nation or a two day knowledge exchange on the embedded behavioral health model were great opportunities to learn and share best practices with allies, but patient care still had to be conducted and command consults still had to be answered.

Summary

Pacific Pathways and other exercises provide a great opportunity for expeditionary medicine and BH support. It is a unique experience for providers to implement and further best practices within the constraints of the resources available in an austere non-garrison environment. For the first time, two psychologists were deployed to Pacific Pathways to support well over 2000 US troops across two countries. Despite the austere conditions and difficulty experienced by providers in terms of coordinating travel to outposts, nearly 4% of the deployed troops obtained at least one BH contact during the exercises, and outcomes as documented by the authors and described above were positive. Overall, many lessons were learned, to include recommendations beginning well before deployment all the way through redeployment. Pre-deployment screenings and forward behavioral health support throughout Pacific Pathways 2022 ensured a 100% return to duty rate among US troops deployed in support of the four exercises and should be considered a best practice for future iterations of the exercise.

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