PSYCHIATRIC PHYSICIAN ASSISTANTS IN LSCO

Utilization of Psychiatric Physician Assistants in preparation for Large Scale Combat Operation

By CPT James L. Lain

The hallmark of large-scale combat operations (LSCO) is a sustained high-intensity conflict that produces high numbers of casualties. Adversaries will attempt to prevent the evacuation of casualties and rotation of replacement troops to combat units, creating a manpower shortage. Psychiatric casualties represent a potential pool of soldiers that may be returned to duty promptly, rapidly increasing combat power. Current behavioral health resources are inadequate to manage the large numbers of psychiatric casualties, and these resources are concentrated in rear-echelon areas. Evidence from recent conflicts underscore the fact that troop concentrations and resources in rear-echelon areas will make ideal targets. Psychiatric Physician Assistants (PAs) represent a solution to managing psychiatric causalities in LSCO close frontline, reducing the need for evacuation and the concentration of soldiers in rear areas. Psychiatric PAs can be affordably and rapidly trained and subsequently positioned within Brigades, Divisions, Health and Holistic Fitness (H2F) units, and Medical Treatment Facilities to fill the gap currently present in mental health and provide care as close to the point of psychiatric injury as possible in a conflict. To facilitate the integration of psychiatric PAs, the Army's force structure needs to be expeditiously updated to create dedicated positions at each of the identified units for psychiatric PAs.

PSYCHIATRIC INTERVENTIONS IN PAST CONFLICTS

The last major LSCO conflicts in which the U.S. military participated were World War I and World War II. At the start of these conflicts, the Army adopted a strategy to screen out mental health disorders and personnel at risk of developing them during the induction and training phase. In World War I, the armed forces rejected approximately 2 percent of all inductees for mental health reasons.[1] A similar screening plan was implemented during World War II, and 37 percent of potential recruits were excluded for neuropsychiatric reasons. Attempting to screen and eliminate recruits at risk for psychiatric injury was ineffective at reducing psychiatric casualties and resulted in manpower shortages at the start of both conflicts.

In World War I, a 3-tier system was developed for psychiatric disorders with treatment starting at casualty clearing stations a few miles behind the front lines. Second-tier treatment was located 5-15 miles behind the front lines in hospitals and lasted up to 3 weeks. At the third-tier, patients were treated for up to six months in hospitals 50 miles from the front. If there was no recovery after six months, patients were evacuated back to the United States. At each of these stages, affected soldiers were treated with rest, sedation, adequate food, and simple forms of supportive psychotherapy. One front-line psychiatrist estimated that up to 65 percent of soldiers returned to the fighting lines.[2]

During World War II, from January 1942 through 30 June 1945, there were an estimated 1 million admissions for neuropsychiatric disorders or approximately 45 psychiatric admissions per 1,000 troops per year.[3] During the initial Army campaigns in Africa, only 5 percent of psychiatric casualties evacuated to base hospitals hundreds of miles from the front were able to return to duty.[3] This loss of manpower severely impacted combat operations and beginning in 1943, treatment in forward areas, similar to the situation in WWI, became the standard. Results showed between 50-70 percent of psychiatric casualties were able to return to duty with simple interventions close to the front lines.[4]

LIMITATIONS OF CURRENT PSYCHIATRIC RESOURCES

The smallest combat operation unit in which a psychiatrist will serve is a division. The division psychiatrist is the mental health subject matter expert, the advisor to the command team, and is responsible for combat operational stress control (COSC) at the division level and below. Psychiatrists are also deployed in operations across the globe, supporting various national defense and humanitarian missions, providing medical diplomacy alongside colleagues abroad, engaging in research, and educating future clinicians.[5] These examples represent a significant number of responsibilities, yet many of these positions are unfilled because there are only about 100 psychiatrists in the Army's inventory.

Womack Army Medical Center Graduate Medical Education (GME) residents respond to a Soldier as part of their combat operational stress control training during the GME Capstone mass casualty exercise, May 10, 2024, Taylor-Sandri Medical Training Center, Fort Liberty, North Carolina The Capstone event aimed to bridge the gap between medical training and real-world combat scenarios. By providing a comprehensive and immersive training experience, the program prepared military medical personnel to handle complex trauma cases and save lives in combat situations. (Photo by Keisha Frith)

At the Brigade level, there is a behavioral health team; however, it is understrength and primarily tasked to conduct safety assessments, track mental health trends, and conduct therapy rather than provide medical intervention. The closest unit capable of managing combat stress reaction (COSR) is a COSC unit. A COSC is attached to a multifunctional medical battalion and is an Echelon Above Brigade (EAB); unfortunately, it does not specialize in treatment of severe psychiatric casualties. Full stabilization of severe psychiatric injuries is normally the mission of the Role 3 Combat Support Hospital (CSH) specialty clinic's psychiatric service. Full stabilization goes beyond securing the safety of the Soldier and those around him or her. It provides a safe environment for the Soldier to receive treatment interventions, continued evaluation, and assessment for return to duty potential.[6] However, the CSH is in a Corps support consolidation area, and evacuation from the battalion aid-station to the CSH can represent a hazardous and long journey for medical personnel. As evidenced by the recent war in Ukraine, the adversary will target medical infrastructure. Russian forces have targeted the healthcare system through direct attacks on healthcare facilities (186 facilities damaged and 32 destroyed); attacks on ambulances (65); looting and destruction of supplies and medicines, denial of access to healthcare, disruptions of access to utilities; and assaults, unlawful detentions, torture, and ill-treatment of physicians, nurses, paramedics, and other health care workers (62 killed and 52 injured).[7]

PSYCHIATRIC PHYSICIAN ASSISTANTS AS A SOLUTION

The 2017 National Defense Authorization Act (NDAA) authorized the creation of a Psychiatric Physician Assistant Fellowship program[8]; with the first trained Army psychiatric PA graduating in June 2024. Psychiatric PAs represent a low-cost and effective solution that allows the Army to leverage currently available resources to fill the mental health gap that exists in the Army's current force structure. The Army needs to update its modified table of organization and equipment/table of distributions and allowances to create positions specifically for psychiatric PAs. This force design update should be given top priority due to the impact mental health can have on the readiness of a force and expected number of psychiatric casualties in LSCO. These created slots may be rapidly filled given the one-year training program that is currently in place. Specific positions will also encourage the retention of trained psychiatric PAs, create a path forward for promotions, and allow recruiting of civilian-trained psychiatric PAs

A psychiatric PA placed within the brigade combat team may act in the consult and liaison role supporting battalions PAs in managing psychiatric patients and partner with the brigade behavior health officer (BHO) and technicians to provide collaborative outpatient mental health care. This placement of psychiatric PAs will reduce the number of mental health patients needing to be seen at hospitals and specialty clinics and assist the brigade surgeon, PA, BHO, and H2F in developing brigade policy for prevention and resiliency programs. During deployments, psychiatric PAs may combine with the BHO, Techs, and Chaplains to create COSC lite teams, minimizing the number of patients requiring evacuation and maximizing the number of soldiers that may be returned to duty.

The Army Health System (AHS) is moving toward a more modular and mobile 32-bed field hospital.[9] Augmenting the current psychiatric services at the CSH with a psychiatric PA will allow for split operations. The Psychiatrist can stay with the main field hospital while the psychiatric PA moves forward to provide triage and stabilization and reduce evacuations. A Psychiatric PA can work with the Psychiatrist, providing consultation and liaison services for surgical teams and medical staff during initial hospitalizations of patients at CSHs.

Psychiatric PAs can also serve as COSC commanders and have the unique benefit of experience in maneuver operations, logistics, and patient care. In the garrison environment, psychiatric PAs may be utilized in underserved markets such as Alaska, the Republic of Korea, or the National Training Center to increase access to care, reduce referral to the civilian market, and reduce expensive evacuations for specialty care.

CONCLUSION

Psychiatric PAs will provide the Army with a knowledgeable provider who has experience in strategic and tactical operations. These PAs may also provide the Army with a psychiatric expert far forward on the battlefield whose prescribing power will enable stabilization and treatment to occur at role ll or closer. The capabilities psychiatric PAs would bring would support the COSC tenets of brevity, immediacy, contact, expectancy, proximity, and simplicity, which were hard lessons learned in previous conflicts. In the garrison environment, a Psychiatric PA could easily lead a Health and Holistic Fitness team providing preventative classes on sleep, alcohol, and stress management. This would improve readiness and help process fit-for-duty assessments, waivers, and behavior health screenings for chapters. A psychiatric PA quickly fills a need not addressed with current mental health resources before the next large-scale combat operation. The creation of positions for Psychiatric PAs will provide an important resource with numerous benefits in the garrison and deployed setting. Every effort should be made to create dedicated Psychiatric PA positions within the current force structure, ensuring we are ready for the next conflict.

REFERENCES

Strecker, E. A. (1944). Military psychiatry: World War I, 1917–1918. One hundred years of American psychiatry, 391-396.

Pols H, Oak S. War & military mental health: the US psychiatric response in the 20th century. American Journal of Public Health. 2007;97(12):2132-2142. doi:10.2105/AJPH.2006.090910

Appel JW. Incidence of neuropsychiatric disorders in the United States Army in World War II. The American journal of psychiatry. 1946;102:433-436. doi:10.1176/ajp.102.4.433

Crocq M-A, Crocq L. From shell shock and war neurosis to posttraumatic stress disorder: a history of psychotraumatology. Dialogues in Clinical Neuroscience. 2000;2(1):47-55. doi:10.31887/DCNS.2000.2.1/macrocq

Wolfgang AW, Sean L: Psychiatry in the United States Army. Am J Psychiatry Resid J 2019;14(3): 2–4.doi: 10.1176/appi.ajp-rj.2019.140301

U.S. Department of the Army (2013). Casualty Care: Army Techniques Publication 4-02.5 https://armypubs.army.mil/epubs/DR_pubs/DR_a/ARN30121-ATP_4-02.5-001-WEB-3.pdf

Destruction and Devastation: One Year of Russia's Assault on Ukraine's Health Care System. Physicians for Human Rights, Ukrainian Healthcare Center, eyewitness to Atrocities, Media Initiative for Human Rights, and Insecurity Insight; February 2023.https://phr.org/our-work/resources/russias assault-on-Ukraine's-health-care-system/

National Defense Authorization Act. https://www.congress.gov/114/crpt/hrpt840/CRPT-114hrpt840.pdf. Accessed September 20th, 2024.

U.S. Department of the Army (2020). Army Health System: Field Manuel 4-02, https://armypubs.army.mil/epubs/DR_pubs/DR_a/ARN35791-FM_4-02-001-WEB-3.pdf

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