Appendix: Dissertation Research Findings Summary

Command-Provider Relationships in Embedded Behavioral Health

Julia DiBenigno\textsuperscript{1}

PhD Candidate in Work and Organization Studies

MIT Sloan School of Management

\textsuperscript{1}I am especially grateful for the support of Jayakanth Srinivasan on all stages of this research as well as the Army Behavioral Health leadership, mental health providers, soldiers and commanders who made this study possible. This research also benefited from the generous feedback and guidance of Kate Kellogg, Lotte Bailyn, Ezra Zuckerman, John Van Maanen, John Carroll, and members of the PTSI team. This study was supported by grant cooperative agreement W81XWH-12-2-0016. The views and conclusions contained herein are those of the author and do not necessarily reflect the views of the US Government or US Army.
STUDY OBJECTIVES OVERVIEW

A major research objective of the Massachusetts Institute of Technology (MIT) study of the mental healthcare delivery system of the U.S. Military Enterprise is to examine the implementation of Embedded Behavioral Health at select target installations and understand success factors and barriers to change to improve EBH effectiveness and change adoption at other installations. Based on early fieldwork by the MIT team, there has been variance in the degree to which installations have been able to successfully adopt EBH, notably the extent to which civilian providers are able to effectively operate in this new care model. Early adopters of EBH have noted that EBH asks more of behavioral health providers by expecting them to devote twelve hours a week interacting with command, up from zero previously. As a result, there has been an increase in provider turnover, particularly among civilian providers for whom this is a more radical change.

For this dissertation study, I conducted in depth fieldwork of select EBH teams and their aligned Brigade Combat Teams to provide a detailed understanding of the key issues facing stakeholders operating in the new Embedded Behavioral Health model. This research sought to identify practices associated with effective performance, in addition to understanding how providers can build (and re-build as command changes) credible provider-command relationships that improve command’s knowledge and support of behavioral health and providers’ understanding of Army needs, ultimately helping to dispel stigma and ensure care is given to those who need it most. This research is also intended to inform the development of Army onboarding and training materials for EBH providers on how to work effectively in the
EBH model which requires greater teaming and interaction with command. It is hoped that this research will also improve provider retention and reduce turnover by improving the hiring, onboarding and training of providers to work in EBH. There is a shortage of qualified providers and hiring a poor fit is especially costly to replace due to significant hiring lags.

In this report, I focus on data from one of four Army posts studied that provided an ideal opportunity to compare different approaches to EBH on the same installation to isolate the effects of one particular practice—that of assigning Points of Contact or “POCs” from Behavioral Health to serve as liaisons to support specific battalions.

**RESEARCH CONTEXT**

During the wars in Iraq and Afghanistan, the US Army encountered an unanticipated increase in soldier mental health issues—notably Post Traumatic Stress Disorder (PTSD) and suicide. Prior to the wars in Iraq and Afghanistan, Army mental health services were limited. If soldiers had mental health problems that interfered with their ability to perform their jobs, they had limited options for rehabilitation while remaining on active-duty. In contrast, today, active duty US soldiers are offered some of the most extensive rehabilitative mental healthcare services in the world (e.g., same-day walk-in access to mental health specialists).² Today, soldiers are provided the opportunity to recover from a mental health problem while remaining in service in the same way as if they had a physical injury such as a broken bone.

---

² Please see the work of Jayakanth Srinivasan for a detailed account of the system level transformation of Army Behavioral Health that occurred from 2009-2015.
Top Leadership Support for Improving Army Mental Health Services

In response to the unexpected increase in mental health problems and suicide, the US dedicated unprecedented resources and support for the Army to provide more extensive rehabilitative mental healthcare to active duty soldiers. In particular, between 2007 and 2015, the Army increased the number of mental health professionals by over 400 percent and spent billions of dollars on initiatives to improve mental health services. Most of the new mental health professionals hired were full-time civilian employees. As a result, approximately 80 percent of Army mental health professionals are now civilians, while prior to 2007, the majority were uniformed Army providers. Today, the remaining 20 percent are uniformed Army providers, either officers who train and deploy with each brigade (Behavioral Health Officers), or other uniformed personnel who work side-by-side with their civilian counterparts in the same clinical environments on post.

To improve access to care, the Army implemented an initiative to move outpatient mental health providers out of centralized post hospitals and into free-standing clinics co-located within the “footprint” of the different brigades on post so that soldiers could more easily “walk-in” and attend appointments near where they lived and worked. This initiative was known as Embedded Behavioral Health. Each clinic was aligned to serve a brigade on post (most posts have 3-6 brigades, with each brigade located in a separate part of the post) and was comprised of a team of mental health professionals including therapists (licensed clinical social workers and psychologists), a psychiatrist for prescribing medications, and a team lead to oversee the clinic. Please see Figure 1 for a visual depiction of this change.
Increased Accountability for Commanders to Ensure Soldiers Get Care

At the same time, commanders were held increasingly accountable for soldier suicides and championing mental healthcare during the course of this study. Two “leader books” on suicide, mental health, and managing soldiers labeled “high risk” were published by the Army Vice Chief of Staff and were required reading for all commanders. Company commanders were expected to identify and track “high risk” soldiers, including those flagged by mental health services as at risk of harming themselves or others. If a “negative event” occurred such as a suicide, company commanders were held accountable and asked whether the soldier had been identified as “high risk”, whether their unit had documentation of completing mandatory suicide prevention trainings, and what “mitigating actions” had been taken to support the soldier. Yet, as I will explain below, these commanders were still accountable for training a mission-ready unit.

METHODS

I collected data over a 30-month period from 2012 to 2015. I spent the first twelve months of data collection as part of an interdisciplinary team at MIT that was engaged to study the US Army’s mental health system where I served as a note taker or co-interviewer for 132 interviews, 46 focus groups (averaging approximately seven participants each), and dozens of informal and formal meetings with mental health and Army stakeholders at all levels of the organization at seven US Army posts. Multiple active-duty US Army officers pursuing advanced degrees at MIT were also a part of the team who provided critical background information. This first year provided an opportunity to learn to “speak Army” and develop my ability to converse with commanders and soldiers, as well as with mental health professionals.
After a year of preliminary fieldwork as part of the team, I spent the remaining 18 months conducting my own dissertation study to uncover mechanisms accounting for differences in provider and clinic effectiveness at improving mental healthcare services for soldiers. I used a relational ethnographic approach (Desmond, 2014) in which I studied the relations between multiple groups mutually dependent on and in conflict with one another—company commanders and outpatient mental health professionals. I also conducted interviews with stakeholders in the broader ecosystem (e.g., chaplains, higher level commanders, and mental health leadership).

The data for this paper primarily come from one US Army post (out of seven visited as part of the larger project, and out of 11 possible “force projection platforms” that US troops deploy from), where I spent over 180 hours on post and conducted 69 interviews, 14 focus groups and ten observational sessions. At this post, I selected four (out of six) mental health clinics to study (Clinics A, B, C, and D) because they were similar on a number of important dimensions.

I first traveled to the post featured in this paper as part of the interdisciplinary research team when this post was transitioning to the Embedded Behavioral Health model—from housing all mental health providers together in one hospital on post to moving providers into smaller teams in free-standing clinics to support each brigade. Relations between mental health providers and commanders were poor at the time, and commanders were resistant to provider recommendations for soldier care. When I returned 18 months later, I was surprised to find that two of the four clinics on post had positive command-provider relations, with commanders at these clinics now supportive of their providers’ care recommendations for their soldiers. I
spent the remainder of my time at this post with each of the four clinic teams, as well as the commanders and Behavioral Health Officers in each brigade, to understand why some clinics were achieving better outcomes than others.

My sampling strategy was to interview the majority of mental health providers in each of the four clinics, and a representative sample of commanders they engaged with by interviewing at least one commander from each of the battalion in each brigade. I also interviewed all Behavioral Health Officers assigned to each brigade in addition to mental health and command leadership that oversaw the entire post. Interviews were semi-structured and lasted between one and three hours, with most lasting an hour. During my second visit to this post in 2014, I conducted 50 in-depth interviews and 8 observational sessions in addition to dozens of informal interviews and observations, and attendance at social events. Interviews could then be triangulated against one another to corroborate different points of view within clinics and brigades. A summary of my data collection at this post is reported in Table 1.

Inductive Data Analysis

My inductive analysis (Glaser and Strauss, 1967) consisted of multiple readings of field and interview notes, the writing of analytical memos, and the tracking of patterned activities and issues related to command-provider relationships in each clinic and brigade. Once I determined that more effective command-provider relationships were occurring in Clinics A and B, but not C or D, I contrasted these cases to identify practices associated with success. Specifically, I identified twenty common types of conflict facing mental health professionals and commanders. These conflict types fell into four major categories: conflicting goals, conflicting
rules, conflicting contexts, and conflicting language. I compared how providers in the four
clinics resolved similar types of conflicts, as well as the outcomes of each conflict. I did this by
writing a summary of each conflict, triangulating accounts from providers, their clinic
colleagues, and commanders involved in the same conflicts when possible to create a holistic
account of the conflict, provider care decisions in response to the conflict, and the outcome of
each conflict.

SUMMARY OF FINDINGS

Different Command-Provider Relationships Observed in Clinics A/B and C/D

Strong command-provider relations and positive outcomes were observed in Clinics A
and B but not in Clinics C and D. Mental health professionals working in Clinics C and D were
more likely to have commanders ignore their care recommendations for soldiers (e.g., to
excuse them from a stressful training exercise) they considered to be “out of touch” or
“unnecessary.” Most notably, care decisions from providers in Clinics C/D often inadvertently
hurt soldiers’ recoveries and desired career prospects according to commanders and Behavioral
Health Officer reports, which often increased the stigma of seeking care and reduced
commander support for soldiers seeking care.3 For example, providers in Clinics C/ D often
recommended the safest precautions in the name of patient health and safety, such as leaving
a soldier behind on an important training exercise, but in the context of an active-duty Army
post, these recommendations often inadvertently caused soldiers to feel humiliated and
isolated from losing standing among their peers, scared other soldiers away from seeking care,
and discouraged commanders from recommending soldiers get help. In contrast, in Clinics A

3 Many soldiers were not only concerned about their mental health, but also about their career in the Army and
staying in long enough to meet tenure milestones to receive benefits (e.g., pensions). One of the top reasons cited
by soldiers for not seeking care is concern about how doing so will affect their career (e.g., Warner et al., 2008).
and B, providers responded to these same situations by making care decisions that not only helped soldier recoveries but also protected their desired career prospects, reduced the stigma of seeking care and improved commander support for mental health care usage.

Of the 132 situations I analyzed in which professional objectives conflicted with organizational performance objectives, providers in Clinics C/D resolved these conflicts by developing solutions that led to integrative outcomes the minority of the time, while providers in Clinics A/B achieved an integrative outcome the majority of the time. I define an integrative outcome as one that achieved both the objectives of the change effort according to the provider (i.e., improved soldier recoveries, reduced stigma of seeking care, and improved commander support and compliance with soldier care recommendations) and organizational performance objectives according to the commander (i.e., whether the recommendation accounted for soldier career implications and unit mission readiness).

CONFLICT AT ALL CLINICS BUT SUCCESSFUL COMMAND-PROVIDER RELATIONS ONLY AT CLINICS A AND B

Conflicting Goals, Rules, Contexts, and Languages

What makes the difference in levels of change achieved across clinics so striking is that the clinics faced the same initial resistance from commanders to provider recommendations due to conflicting goals, rules, contexts, and languages. This generated role conflict for all of the mental health professionals I interviewed on post.

Conflicting Goals. For example, in the case of conflicting goals, the goal of mental health professionals was to provide rehabilitative mental healthcare to patients, which could take six months or longer to provide. The mental health profession in the last forty years has been guided by the professional belief that patients can recover from mental health conditions by
using evidence-based practices including therapy and/or medication to manage and treat symptoms (Rogers and Pilgrim, 2014). In contrast, the goal of Army commanders was to “field a mission-ready force,” and commanders were regularly assessed on whether their units were at least 90 percent deployable (p-level or “personnel level” of .9) and 85 percent trained on “mission-essential” tasks (t-level or “training level” of .85). The other 10 percent of the unit was left behind during deployments in “the rear.” P- and t-levels were reported monthly; commanders unable to maintain these levels were removed from command. Many commanders reported frustration when their soldiers sought care for any medical problems because these soldiers “counted against their books” toward meeting their 90 percent goal.

**Conflicting Rules.** Second, professionals and commanders had conflicting interpretations of rules regarding sharing information about soldiers and whether “soldier misconduct” (e.g., violent acts, etc.) should be treated as a “discipline” problem or a “medical” problem. Mental health professionals are taught that following rules protecting patient privacy are not only a legal requirement under HIPAA laws (Health Insurance Portability and Accountability Act), but also a sacred part of the patient-provider contract for effective therapy. These professionals are trained to view patient privacy and confidentiality as essential to creating a trusting environment where patients feel comfortable opening up and sharing personal and traumatic experiences and emotions. One professional related:

> Command wants to know everything. But we were trained to protect patient confidentiality, otherwise patients won’t trust us and they won’t come. ...So a lot of conflict emerges.

---

4 One may wonder why the Army did not simply reduce the required p- and t-levels if they were really serious about reducing soldier mental health problems. However, p- and t-levels remained high given the chronic shortage of active duty soldiers beginning in mid-2000s to fight these wars without instituting a draft, followed by sequestration and a severe reduction in the size of the force in 2013.
In contrast, the Army has rules that formally limit soldier privacy. Under the Privacy Act in the Uniform Code of Military Justice (UCMJ), soldiers waive the right to the same medical privacy protections enjoyed by civilians. Army medical professionals can share information about a soldier’s mental health condition with their commander if that soldier is considered at risk of harming themselves or others, or if the soldier’s condition might impact the unit’s mission. While a soldier may not want their mental health condition disclosed to their commander, commanders claim they need that information to make informed decisions about whether they can safely deploy that soldier and trust them to operate expensive equipment, manage sensitive security information, or lead other soldiers in dangerous and stressful situations, and because command is responsible for the soldier’s well-being and held accountable for any “negative events” (i.e., suicide, homicide, crime, etc.). For example, one commander explained his frustration with how providers’ invocation of professional rules related to HIPAA prevented sharing information he perceived contributed to a soldier’s suicide in his unit:

My number one challenge is HIPAA because it puts up barriers between the person who has the information and the person who needs the information. ...For example, I had a <soldier> who had a trauma in Afghanistan and committed suicide. ...He had been making appointments on his own and had been seeing shadows and hearing voices and having up to 15 drinks a day. And his company commander didn’t know about it because of HIPAA! I’ll tell you, <mental health services> really pissed me off! There is a line somewhere and we were not told because of HIPAA.

**Conflicting Contexts.** Third, mental health professionals and commanders operated in conflicting contexts. While the organizational context of an active-duty Army post is oriented toward preparing soldiers for war, the mental health context of the clinic is removed from the
daily stressors facing soldiers. And while clinics were located on Army posts, most providers rarely left the walls of their clinic, which was in a free-standing building less than a half mile from the rest of the brigade buildings. Mental health providers view soldiers as patients or clients, while the organization views them as soldiers who are missing work to receive care. Medical professionals see and treat patients as equals, while the organization treats soldiers differently based on rank, unit, and merit and deployment badges. And while commanders believed they knew their soldiers better than mental health providers, mental health providers believed they knew soldiers better than commanders. One commander explained: “I mean we know soldiers best. We see them on a day-to-day basis while they see them what, one hour every few weeks?! So it's hard for them to really know what's going on.” While a provider notes in contrast: “No one wears a sign saying, ‘I have depression’ or ‘I'm thinking about killing myself,’ or ‘my mom died and I ran through a wall.’ Soldiers keep it inside and command doesn't know.”

In addition, in this closed community, even though providers did not disclose to command which soldiers they were seeing unless under special circumstances, in this context, it is difficult for a soldier’s whereabouts to be kept private since leaders are accountable for knowing where their soldiers are at all times. And when soldiers are not at work, typically their fellow soldiers cover for them, which can create resentment. In this context, seeking medical care for any reason is viewed negatively, since soldiers can be perceived as putting themselves ahead of their “brothers” by dumping extra work on them, or as weak and unable to be counted on for deployment. And while mental health providers were concerned with doing
what is right for an individual soldier, the Army culture regards self-sacrifice for the good of the team as one of its highest virtues. One commander explained:

You don't want to be a dirt bag. You don't want to let anyone down. There's always lots to do, and if you take time for yourself, you're being selfish. You don't want to let people down. It's like being on a pro sports team. If I twist my ankle, well, I'll tie it up and keep going. That might be bad for my ankle in the long term, but the team comes first.

**Conflicting Languages.** Fourth, professionals and commanders used conflicting languages. The technical medical terminology used by the mental health profession is filled with jargon and acronyms and highly specific usages of words. For example, to a mental health professional, “suicidal intent,” passive vs. active “suicidal ideation”, “suicidal gesture”, and “suicide attempt” all have specific and distinct meanings that an outsider might lump together as suicide. The Army organizational language is so extensive and filled with jargon and acronyms that most newcomers talk about learning to “speak Army” or will say, “I speak a little ‘AirForce’,” as if they were actual foreign languages. In addition, there are a myriad of Army-specific idioms and expressions that are regularly used in conversation. Conversational norms in the Army favor direct, unambiguous speech that is immediately actionable. Officers are taught to always begin any briefing with the “BLUF”, meaning to share the “bottom line up front” and are generally intolerant of long-winded, inductive and ambiguous speech.

The organizational Army language and medical language of mental health professionals causes conflict in a few ways. While the medical language of mental health professionals accounts for complex constellations of symptoms and preliminary diagnoses that may change over time and for which the criteria are subjective, the organization demands providers make black and white decisions on whether a soldier is “fit or unfit” for duty or has or does not have
restrictions on the work they can do. Many standard organizational forms—such as psychiatric profiles or mental status evaluations—require providers to make concrete decisions which often clash with their professional judgment and the language they would use to describe the patient’s condition and limitations. In addition, both medical and military languages are “insider” languages, difficult for outsiders to comprehend, making communication difficult and misunderstandings plentiful.

**KEY DIFFERENCE: ASSIGNMENT OF POINTS OF CONTACT LIAISONS (POCs)**

I found that most mental health professionals in Clinics A/B developed strong relations of mutual trust and respect with their command counterparts. In contrast, mental health professionals in Clinics C/D did not develop strong relationships. My data suggest this difference led to the productive management of tensions between these groups in Clinics A/B and not Clinics C/D in ways that were beneficial for soldier health and wellness while sensitive to mission readiness.

These differences stemmed from the different role assignment structures of mental health professionals. In Clinics A/B, each mental health professional was assigned as the Point of Contact (POC) for one or two specific battalions within their brigade and only worked with soldiers and commanders from those units (~6 commanders per unit). This structural arrangement allowed providers in Clinics A/B to develop personal relationships with a small set of commanders through repeated interaction in which they came to know one another by name and reported meeting regularly. Over time, Clinic A/B providers came to identify positively with the objectives of the other group (commanders). These providers avoided cooptation despite personal relationships with commanders through regular interaction with
their professional colleagues in their clinics. Their colleagues served as an anchor, keeping providers grounded within their profession by holding one another accountable for satisfactory professional role performance and commitment to professional objectives.

In contrast, in Clinics C/D, mental health professionals served all organizational units within their brigades, as depicted in Figure 2. While there were efficiency gains from not assigning POCs in Clinics C/D since more patients could be seen when providers treated soldiers from any unit as needs arose, providers in Clinics C/D interacted with dozens of commanders, and these commanders dealt with many different mental health professionals treating their soldiers. Providers interacted with so many commanders that they did not develop meaningful personal relationships and reported interacting primarily when conflicts arose. While at little risk of cooptation, Clinic C/D providers’ professional colleagues created an echo chamber of indifference toward organizational objectives and amplified the historically negative relations between mental health providers and commanders.

Effective Relations Between Most Commanders and Providers in Clinics A/B But Not in Clinics C/D

5 One may wonder why Clinics A/B assigned Points of Contact (POCs) while Clinics C/D did not. As explained above, all Army posts were implementing the same initiative to improve access to mental health services for soldiers by establishing clinics co-located near each brigade on post. Army-wide, a post generally considered its change implementation successful if it had physical clinics built and operating and were fully staffed. Less emphasis was placed on how providers were assigned. At the Army post being analyzed in this paper, all brigades had their own separate clinic by the end of 2012 and viewed staffing the clinics as their number one impediment to success. The original guidelines called for assigning one provider to support one unit within each brigade, yet due to Army-wide shortages of mental health professionals, no Army post ever reached full staffing levels. However, some clinics still decided to assign POCs, but had mental health professionals serve two (vs. one) units, as did Clinics A/B. Team leads in Clinics C/D reported that they considered assigning POCs as a “nice to have” but not necessary for running a successful clinic, and claimed they would consider adding POCs when they had more staff (even though they had the same number of staff as Clinics A/B). In addition, assigning POCs led to inefficiencies in terms of throughput since a clinic can see more patients overall if providers can see patients from any unit and can “cover” for one another, rather than only seeing soldiers from the units for which they are POCs.
In Clinics A/B, most providers developed strong relationships with commanders while maintaining their professional identification with colleagues in their clinics. These mental health professionals developed an understanding of and respect for the different objectives of commanders while maintaining a grounding in their professional commitment to improve soldier mental health. One A/B provider related:

I can see both sides. I feel the pressure they are under when I think about the pressure to deploy, I get that. But the other side of me is a member of this clinic... Clinically, it may not be right for that patient to deploy. So it creates conflict, but I can see it both ways.

Another noted:

It's hard; it really is hard. With civilian training, it's only about the patient—that's really only what you're concerned about, and there's no bigger picture to it. (But after being assigned as a POC)...to me the patient still comes first, but the Army is part of it, too. So I have to look out not only for the patient, but also whether it will harm the Army.

Providers in Clinics A/B reported that their assignment as POCs allowed them to develop personal relationships with commanders, while also maintaining positive identification with their professional objectives and colleagues. Such positive relationships with commanders were especially surprising given that provider-commander relations had historically been poor for the past decade across the Army, and I had observed these poor relationships during my first visit to this Army post before clinics were established for each brigade. One A/B provider explained:

In the past, I'd had some negative interactions with commanders. But things change once you get to know them. I have a much greater respect and understanding of what they do and the pressures facing them. But at the same time, I love my team (of professional colleagues). I couldn't do this job without them.

---

6 One may also wonder whether mental health professionals in Clinics A/B performed better because they were held accountable and evaluated differently as POC providers than non-POC providers in Clinics C/D. However, providers in all clinics were evaluated the same way, by a senior provider of their same mental health discipline (e.g., social work evaluates social work) on the clinical soundness of their notes and on meeting various documentation requirements (e.g., completing patient notes within 72 hours) and not based on any outcomes tied to the soldiers or units they saw.
Another provider explained this transformation:

Now it’s much better... we can get to know command and our own group of soldiers. I’m at the point that I have them all (commanders) on speed-dial and they have me on speed-dial. ...That’s how profound it can be. Before (I was assigned as POC), command and soldiers were hesitant to come to us.

Providers also described the increased feeling of ownership and identification with commanders and their units after being assigned as the POC: “I own it more. These are my guys. I’m taking care of my guys.” Another provider explained how these relationships and sense of ownership developed after she was assigned as the POC. She explained:

Before (being assigned as POC to a unit), I was seeing different people (commanders). I was not identified as a POC. Now that I am, it’s, “Go see (her name),’ and they get to know you because they see you. Or they see me over there and they can say, ‘That's (her first name).’

While providers in Clinics A/B developed positive relationships with commanders and a respectful understanding of their objectives and intent, their clinic colleagues helped them maintain identification with their professional objectives. Their colleagues helped prevent cooptation by anchoring them to their professional community and holding them accountable for professional objectives. Many professionals in Clinics A/B mentioned a key benefit of having a clinic “team” while serving as POC for a unit was that their clinic colleagues “kept you grounded” or “pulled you back” if they saw a provider beginning to get “too caught up in what command wanted.” One provider noted:

While developing friendships and relationships with leaders (commanders) are important, you need to make sure to distinguish yourself as a professional, and establish clear boundaries, and not become too enmeshed with them. If you don’t keep your boundaries clear, leaders will think of you as a tool ...to get what they want done. ...I advocate for both the Army and the patient. ...it can be easy as you get to know command to start going along with what they want. But your team can help with that. They’ll pull you back when you need it.

Another A/B provider echoed these comments:
Being on the (clinic) team has been wonderful, a real benefit. Hands down, I personally find it highly advantageous especially with all these tensions with the mission and patient care and talking with leadership. It helps you maintain your professional distance. ...I would be afraid to practice independently, because I would lose the opportunity to have this kind of fluid consultation with peers.

**Few Positive Relationships Between Commanders and Providers in Clinics C/D**

Because mental health professionals in Clinics C/D served the entire brigade, they worked with so many commanders they did not develop meaningful personal relationships, and did not come to positively identify with commanders or their objectives. For example, commanders were generally unable to name the mental health providers they interacted with. One noted, “I don’t know the people over there (in the clinic). I get a different person every time...I couldn’t tell you their names.” The relations between providers and commanders served by Clinics C/D remained negative and marked by distrust and hostility. One C/D provider explained how working for one brigade (without being a POC) had not led to any change:

> Now we serve one brigade, but it’s really not that different than when I sat up in the hospital and saw everyone (all brigades). There’s too many of them to really feel any sense of ownership, which is what I thought the new model (one clinic per brigade) was supposed to promote. So it’s not that different at all.

Providers in Clinics C/D exhibited distrust toward the commanders they worked with and noted that commanders were unsupportive of soldiers with mental health problems. One of the top reasons soldiers came to the clinic was to complain about the Army, so providers (at all clinics) were bombarded with negative stories of commanders. One provider noted:

> Why should I care about good rapport with command? ...The number one reason my patients are unhappy is complaints about command.

In contrast to Clinics A/B, where providers came to care about the objectives of the organizational units they were assigned to as POCs, mental health professionals in Clinics C/D
reported experiencing strong feelings of personal allegiance only toward their patients and fellow professional peers, and not toward commanders. One explained:

I love my patients, I love my team—the clinicians here are all good. (What about command?) Command? Not so much (laughs). Dealing with command is one of the more unpleasant parts of my job.

Mental health professionals in Clinics C/D also expressed a limited ability to empathize with commander objectives and take into account their point of view. For example, one provider shared how she considered it outside the scope of her responsibility to learn about the objectives of commanders and soldiers in her clinic’s brigade:

That’s not my lane (knowing the brigades’ mission sets). I don’t see how that’s relevant. I’m here for patient care. ...My mission is therapy with my client, the patient.

When conflicts emerged between professional and organizational objectives, C/D providers regularly sided with their professional training and objectives. For example, one mental health professional in Clinics C/D shared:

To me, first and foremost it’s about my patients. I’m here for soldiers. I’m not paid to do what command wants. I’m paid to use my clinical judgment. That’s what I’m here to use.

While on the surface, such strong commitment to professional objectives may seem desirable to prevent cooptation and ensure the best patient care outcomes, the open indifference of providers in Clinics C/D to commander’s objectives and points of view led many providers to be sidelined by commanders who often ignored their care recommendations for soldiers. One commander justified his hesitancy to refer soldiers he knew were struggling to the mental health clinic by saying he did not trust the providers there: “I think there is a stigma against these providers (in Clinic C). And it’s stopping guys from getting help.”
For providers in Clinics C/D, their fellow professional colleagues in their clinics also served as a check against cooptation. But, since these professionals were at little risk of this given their lack of opportunity to form relationships with commanders, their regular interaction with colleagues created an echo chamber of indifference toward command objectives and amplified negative relations and stereotypes about commanders as “bullies” or “adversaries” hurting their patients. One provider, who later switched to Clinics A/B, explained how she and her former C/D clinic colleagues viewed commanders:

Before, we thought of them (command) as an adversary because they were kind of always on the other side of things, and we’re serving the soldiers. And command—we we were trying to keep them more at a distance.

The Importance of Colleagues in Preventing Cooptation

Lest one think all that matters for success is the opportunity to form a personal relationship and positively identify with a commander, and that positive identification with professional colleagues to prevent cooptation is not necessary for success, I provide additional evidence from interviews and observations of another group of mental health professionals in my dataset—Behavioral Health Officers (BHOs). BHO providers were officer psychologists or social workers assigned to train and deploy with each brigade who spent limited time with colleagues in the clinics. The BHOs I interviewed reported that they identified more with their organizational units than with their professional group. Without the same full-time interaction with professional colleagues that clinic providers had, BHOs exhibited signs of cooptation. They pursued organizational objectives sometimes at the expense of those of the change effort, resulting in failed change. BHOs were not evaluated by a senior member of their mental health specialty in the way all other mental health professionals on post were, but instead were evaluated exclusively by more senior officers in their brigade who lacked expertise in mental
health. Most BHOs reported little sense of inner conflict or turmoil over conflicting organizational and professional objectives. They easily resolved conflicts by siding with organizational objectives. One BHO explained:

To me, we really have one client – the Army. There really isn’t a conflict. ...I've never had an ethical dilemma. It's not like that. What's good for the Army is typically good for the soldier.

BHOs also exhibited a limited ability to empathize with professional objectives related to the goals of prioritizing patient rehabilitation and generally expressed greater empathy for the needs of commanders in their brigades than for their patients. One BHO explained:

Command is your patient. ...We should always be thinking – how do I ease the suffering of command? We need to be viewed as subject matter experts who can be consulted. Commanders care about one thing – am I ready to go to war?

Finally, BHOs also reported experiencing stronger feelings of personal allegiance to the organizational stakeholders in their brigade rather than professional clinical peers, as exemplified in the officer training they underwent. One BHO explained:

You learn from day one it’s, ‘Officer first, clinician second.’ You have to keep that in mind in all you do. You are an officer in this brigade first and foremost, then a clinician.

BHOs often privileged the goals, rules, contexts, and languages of the Army over those of their mental health profession when faced with similar situations as mental health professionals working in the clinics. For example, BHOs said they handled conflicting privacy rules by erring on the side of sharing whatever information command wanted to know in the name of the mission. BHOs said they felt obligated to provide commanders with this requested “situational awareness.” They reported sharing this information regardless of whether it was likely to affect the mission or unit safety. Soldiers reported that when they learned BHOs were “lax” with sharing information with command, soldiers were more hesitant to seek care.
SUCCESSFUL MANAGEMENT OF TENSIONS TO CO-CONSTRUCT INTEGRATIVE SOLUTIONS TO CONFLICTS IN CLINICS A/B BUT NOT IN CLINICS C/D

Professionals in Clinics A/B enhanced their capacity for developing integrative solutions to the regular conflicts they faced with commanders to develop more creative, flexible, and empathetic responses to conflicting demands. These practices led to positive change by reducing the stigma of seeking mental healthcare, improving commander support for soldier care, improving commander compliance with provider treatment recommendations and facilitating soldier recoveries while being sensitive to soldier career goals. Specifically, providers in Clinics A/B creatively developed integrative solutions to conflicting goals, flexibly interpreted the “spirit” of conflicting rules, empathetically related to and immersed themselves in both organizational and professional contexts, and became bi-lingual to fluently switch between organizational and professional languages. In contrast, in Clinics C/D, providers privileged the goals, rules, contexts, and languages of their professional colleagues and disregarded those of commanders in ways that reduced commander support for soldier care and compliance with their care recommendations for soldiers and often inadvertently worsened the stigma of seeking care (Please see DiBenigno, 2016 for full details). Overall, point of contact providers were better able to identify with the commanders’ perspectives without sacrificing their professional norms and relationships with fellow providers.

CONCLUSION & IMPLICATIONS FOR IMPROVING ARMY BEHAVIORAL HEALTH
While the data presented is limited to a single post, the same general pattern was observed at three other posts where brigades with a single point of contact arrangement were observed to manage these tensions between commanders and providers better than brigades without this structure. This demonstrates the need to manage the natural and on-going political and cultural differences in goals and professional norms in command-provider relationships. In this case the single point of contact structural arrangement allowed commanders and providers to develop the trust, mutual respect, and understanding of each other’s needs and responsibilities.

This dissertation research supports continued adoption of “Points of Contact” liaisons in Embedded Behavioral Health, even when not fully staffed as long as providers are responsible for no more than two battalions, as providers in Clinics A and B were. This important structural element of the EBH model has been inconsistently implemented across the Army. In addition, mental health providers need time allocated to interact with commanders to realize the full benefits of these liaison relationships. Assigning “Points of Contact” without giving providers the recommended twelve hours a week for command consultation per EBH guidelines will not provide sufficient time for strong and productive relationships to develop. In addition, it is recommended that EBH teams develop clear transition plans for maintaining the Point of Contact model while ensuring continuity of care when units deploy, move or deactivate. In conclusion, while commanders and providers face many tensions given the conflicting goals, rules, contexts, and languages discussed in this report, they ultimately share the desire for healthy and productive soldiers. Providing the right structural arrangement—in the form of assigning Point of Contact liaisons—can allow providers and commanders to overcome these
perceived differences to discover and co-create integrative solutions that promote both soldier health and mission readiness.

Figure 1: Embedded Behavioral Health: Army-wide Initiative to Provide One Mental Health Clinic Per Brigade
Pre-Change: Mental Health Providers Work in Post Hospital Serving All Brigades

Post-Change: Mental Health Providers Work in Clinics Co-located By Each Brigade

KEY
- Brigade
- Provider
- Unit
- Clinic
- Behavioral Health Officer (BHO)
Table 1: Data Collection Summary at Featured Army Post

<table>
<thead>
<tr>
<th>Data source</th>
<th>Clinic A &amp; Brigade A</th>
<th>Clinic B &amp; Brigade B</th>
<th>Clinic C &amp; Brigade C</th>
<th>Clinic D &amp; Brigade D</th>
</tr>
</thead>
<tbody>
<tr>
<td># of Providers Interviewed</td>
<td>5 of 5</td>
<td>4 of 5</td>
<td>4 of 5</td>
<td>4 of 4</td>
</tr>
<tr>
<td># of Commanders Interviewed</td>
<td>7; 1-2 from each unit</td>
<td>7; 1-2 from each unit</td>
<td>6; 1 from each unit</td>
<td>4; 1 from each unit on post at time</td>
</tr>
<tr>
<td># of BHOs Interviewed</td>
<td>1 of 1</td>
<td>1 of 1</td>
<td>1 of 1</td>
<td>1 of 2</td>
</tr>
<tr>
<td># of Observational Sessions</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Total Interviews &amp; Observational Sessions</td>
<td>16</td>
<td>14</td>
<td>12</td>
<td>11</td>
</tr>
<tr>
<td>Other Interviews</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interviews, Focus Groups, and Meetings 18 months prior, before Clinics began operating separately</td>
<td>19 interviews, 7 focus groups and dozens of informal meetings with 79 stakeholders from across the post, including providers, behavioral health officers, soldiers, and commanders</td>
<td>19 interviews, 7 focus groups and dozens of informal meetings with 79 stakeholders from across the post, including providers, behavioral health officers, soldiers, and commanders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Interviews/ Observational Sessions</td>
<td>69 one-on-one interviews, 7 focus groups and 10 observational sessions; 180+ hours on post</td>
<td>69 one-on-one interviews, 7 focus groups and 10 observational sessions; 180+ hours on post</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Figure 2: Difference between Clinics A/B and Clinics C/D

Clinic A & B Providers Assigned as Points of Contact (POCs) to Specific Units in the Brigade

Clinic C & D Providers Serve all Units in Brigade (No POCs)