

BEHAVIORAL HEALTH: *A PRIMER FOR COMPANY-LEVEL LEADERSHIP*

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The purpose of this article is to educate company-level leadership on behavioral health resources available within a brigade combat team (BCT) and to provide guidance in effectively employing all available assets. There are currently insufficient programs of instruction or publications available to develop a leader's knowledge prior to assuming command or responsibility. This article will provide an overview of behavioral health assets and recommendations for working with these assets.

Behavioral Health Assets

The BCT has an Army psychologist and a social worker organic to the unit and an embedded behavioral health (EBH) clinic that is an extension of the hospital's behavioral health department which is situated within the BCT footprint. Despite being organic to the BCT, both the psychologist and the social worker, per an Office of the Surgeon General (OTSG) memo, are required to commit a minimum of 20 hours per week to the EBH clinic, which significantly diminishes their ability to be flexible and responsive to leaders. The EBH clinic is composed of civilian psychologists, social workers, and a medication prescriber (typically a nurse practitioner) with a rigid 40-hour work week. While civilian providers are often not compensated for overtime and therefore rarely available after hours or on the weekends, Army organic providers are an around-the-clock asset — available day or night.

It is important to be aware of the significant difference in experience when dealing with EBH staff. They are working from a perspective of patient care within the confines of a hospital environment, which leaves little, if any, experience interacting with military leaders. This lack of experience extends to the civilian providers and is even more apparent because they additionally may lack any formal military training or understanding of Army regulations and policies to help guide their clinical work. For example, EBH providers are generally unfamiliar with required processes to conduct an evaluation for a sniper school candidate or the procedures to separate a Soldier for behavioral health reasons.

The different perspective that EBH providers bring to the table often favors Soldier care at the detriment of Army needs. This more often than not leads to EBH providing partial or limited information related to a Soldier's behavioral health history to assist you in deciding how to manage the health, welfare, and morale of your affected Soldier. This can be seen when a Soldier is put on an indefinite treatment plan and given a profile as opposed to being properly discharged from the military or when an NCO is cleared for the rigors of drill sergeant duty without being mentally stable enough for such an environment. This overall lack of communication and understanding between leaders and providers has greatly increased the potential for misunderstanding one another's roles and responsibilities when working to improve the health and welfare of Soldiers. In both of our experience, it is not uncommon for providers to not tell you if your Soldier has a history of or is currently experiencing self-harm thoughts. Limited information sharing such as this is contributed to a lack of mutual understanding on how the commander's need-to-know supersedes HIPPA (Health Insurance Portability and Accountability Act) restrictions. Bridging this gap to enable providers to assist leaders begins with company-level leadership being proactive in the relationship and effectively communicating needs.

Providers will first and foremost protect and treat the patient; in order to glean the information you need as a leader to make sound decisions, you have to be proactive. This means understanding the roles of all EBH players and your role as a leader, and most importantly, setting up rehabilitation team meetings (RTM) to discuss the bottom line up front (BLUF) of your Soldier's situation (i.e. any suicidal thoughts or gestures) and the way ahead (can this Soldier return to duty, what is being treated, how many sessions, how many times per week, prognosis, a set date to reassess). The key element in interacting with the EBH staff is a proactive leader at the company level.

Brigade Psychologist

Having a psychologist at the brigade level is an artifact of the war as psychologists were previously found only at the division level. This position is unique because it is only found in U.S. Army Forces Command (FORSCOM) units, and this officer is only rated by FORSCOM commanders — not by hospital personnel. The significance of this is insight to mission readiness versus solely Soldier care which provides military leadership with a direct behavioral health consultant. Unfortunately, the previously mentioned OTSG memo dictates that this officer will work in the EBH clinic 20 hours per week, significantly impacting the psychologist's ability to have a schedule that is flexible and responsive to commanders.

The primary function of the psychologist is to be a consultant to command on behavioral health topics (e.g. suicide). The irony here is that the prototypical psychologist is direct-commissioned and has spent two years in the Army prior to becoming a brigade psychologist, with those years being in a hospital. This begs the question: what does the psychologist know about the Army, let alone FORSCOM, that would make him or her an effective consultant? A cautionary statement about psychologists is that many do not have specialized training and/or experience in topics that are politically important to senior Army leaders (e.g. suicide, sexual assault, post-traumatic stress disorder [PTSD]). Research has demonstrated that behavioral health providers are likely not adequately trained in the assessment, management, and treatment of suicidality.¹ This is important to know because commanders typically have to take the psychologist's word at face value because this is not their area of specialty and it was not covered at the school house.

In speaking with a psychologist, a commander will likely notice that he or she may be long winded in providing feedback and fail to answer concerns about a Soldier in a brief and succinct manner; if at all. This is where your ability to provide immediate and direct feedback will help the psychologist develop the capacity to provide effective feedback in the future. For example, you can teach this person about the acronym BLUF and the phrase "the way forward" to improve the feedback that you receive.

EBH Clinic Versus Brigade Psychologist

Each maneuver BCT is supposed to have an EBH clinic inside their footprint by 2016. This clinic is filled with civilian behavioral health providers (social worker, psychologist, nurse practitioner), and one of these providers is assigned to each battalion in the brigade. This is done so that the providers can provide leaders with information on Soldiers who are receiving treatment, typically during the battalion health-of-the-force meeting. There is a good chance that the provider assigned to your battalion will not be treating the Soldiers whom you need information on and will likely present limited, secondhand information. Another limitation is that EBH providers are given minimal training on Army culture and regulations by the hospital prior to starting work at the clinic. This is important to know because you may have a Soldier who needs to be separated from the Army and the provider does not know that he/she can initiate the separation.

The ideal brigade psychologist is able to balance the needs of the Army and the Soldier without sacrificing the greater Army mission. You will find the brigade psychologist in either the EBH clinic or in the troop medical clinic (TMC). Whether they work in the EBH clinic or TMC depends on the chief of Behavioral Health. It should be known that the brigade commander can influence that situation. Being in the TMC versus the EBH clinic is much more conducive to treatment as it promotes a multi-disciplinary approach. This is beneficial because most behavioral health cases also present with physical issues. Many behavioral health problems (e.g. suicidality) are monitored and/or caught by physician's assistants (PAs), who can then do a drive-by consult with the brigade psychologist. The prototypical psychologist is likely not aware that information is time sensitive, and the brigade psychologist working in the TMC is more conducive for information flow.

The brigade psychologist and EBH clinic provide the following services: command-directed mental health evaluations (CDMHEs), administrative separations for behavioral health issues (Army Regulation [AR] 40-501, Standards of Medical Fitness, Chapter 5-13/17), drill sergeant and recruiter evaluations, sniper school evaluations, mental health evaluations as part of the chapter process for Uniformed Code of Military Justice (UCMJ) (Form 3822), psychological testing to determine symptom validity (i.e. is the Soldier exaggerating their symptoms), security clearance evaluations (request comes from Special Security Office via central clearance), determining

suitability for deployment from a behavioral health standpoint, and consults with inpatient psychiatry to get a Soldier admitted.

The difference between these two entities is that the brigade psychologist is 24/7 and should respond to your calls no matter the day or time. A second difference is that Army psychologists have gone through an Army internship and residency program and are trained on how to conduct school evaluations and other Army regulation-based evaluations. Civilian providers may receive minimal training, if any, in Army regulations related to behavioral health prior to taking their position and are expected to function at the level of the brigade psychologist. Third, the brigade psychologist will deploy with you while the EBH stays in place and continues to treat.

Recommendations

As a starting point, leaders need to be aware of the following health-related regulations in order to develop a baseline understanding: AR 40-501; AR 635-200, Active Duty Enlisted Administrative Separations; AR 600-85, The Army Substance Abuse Program (ASAP); Department of Defense Instruction (DoDI) 6490.04, and DoDI 6490.07. Chapter 7 of AR 40-501 discusses the difference between temporary and permanent profiles and the medical readiness determination point (MRDP). Chapter 5 outlines what is required for a behavioral health separation. Knowing when a Soldier reaches MRDP will help you monitor when a Soldier will meet criteria for initiating a medical examination board (MEB) and will impact your report of troop strength/readiness to deploy. Chapters 13 and 14 of AR 635-200 discuss these administrative separation avenues which require a mental health evaluation in the separation packet. AR 600-85 (paragraph 10-11 and table 10-1) discusses the Army's limited use policy, and knowledge gained from this AR will help you determine whether information received from a behavioral health provider can or cannot be used for an administrative separation (AR 635-300, Chapter 9) or simply falls under the commander's need-to-know policy. DoDI 6490.04 discusses what is entailed in a CDMHE, and DoDI 6490.07 discusses deployment-limiting medical conditions.

Prior to taking command, you should speak with the existing commander to get his or her take on the brigade psychologist and the EBH clinic. What you want to figure out is whether the psychologist and/or clinic is a force multiplier or a force detractor. If either or both entities are force detractors, how has the commander worked around this issue? You want to get the counseling forms for CDMHE, probable cause urinalysis, and Chapter 14 for a positive urinalysis. Second, have the psychologist brief you on his or her role, the roll of the EBH clinic, how or when to do a CDMHE, HIPPA and commander's need to know, and how to handle the return of a Soldier from the inpatient psychiatric ward.

In regards to CDMHEs, DoDI 6490.04 removed behavioral health providers as "gatekeepers" for approval of CDMHE. The change appears to be in line with how the Army has historically functioned with providers only being able to make recommendations to commanders, as leaders are ultimately held responsible for a Soldier's health, welfare, and morale. For example, hospital leadership does not make the ASAP counselor explain why a patient received a DUI while in treatment and they do not make the provider deal with the family or plan the memorial for a patient that completed suicide. Doing the chapter separation for a DUI and dealing with the fallout of a suicide falls squarely on your shoulders. DoDI 6490.04 also expanded those allowed to initiate CDMHEs to include those in supervisory positions over the Soldier. Prior to this policy, only commanders could initiate CDMHEs. There is a good chance that the brigade psychologist and/or EBH providers do not know this and having this directive at the ready will educate them. It is not your job to educate them, but educating providers will likely improve future interactions with them.

In speaking with the behavioral health provider that conducts your CMHDEs, you want to know the BLUF, the way forward, and what you can do reduce risk. The last step of the troop leading procedures is essential when dealing with a behavioral health provider following a CDMHE. You want to know the Soldier's initial treatment plan and when you will follow up to check on the Soldier's progress. At that second meeting, you want to get an estimate on whether the Soldier will likely be an MEB, a Chapter 5 separation, or be fully mission capable. During this meeting, you want to discuss how the Soldier's emotions/behavior have impacted his or her occupational functioning. Many providers fail to do collateral interviews and solely base their judgment on what the Soldier tells them. Sometimes the Soldier will paint a highly unfavorable picture of the chain of command and your input can clarify things. If you do not stay on top of the provider, there is a chance your Soldier will be treated indefinitely (missing a lot of

work for treatment). Behavioral health profiles are tracked on the unit status report (USR) as non-available or medically non-available, and your commander will want to have a sense of the way forward for the Soldier when you scrub the non-availables roster. In regards to risk reduction, it is a team effort and you can do something to reduce risk. For example, if it is discovered during the CDMHE that a Soldier has debt, you can command-direct the Soldier to participate in financial planning or you can look into whether the Soldier is eligible for an AER loan/grant.

In regards to a commander's need to know, you should meet with the brigade legal officer prior to taking command to have them brief you on HIPPA and how/when your need-to-know supersedes HIPPA. This will be useful information when interacting with behavioral health providers. For example, a provider may not want to tell you that a Soldier had a positive urinalysis while they were admitted to the inpatient psychiatric ward because it is against HIPPA. This isn't true in most cases (Army's Limited Use Policy) as it likely falls within the commander's need to know. Behavioral health providers commonly fail to think about these type of issues from your perspective and are overly focused on protecting the patient. When they do this, they fail to protect the Army. These providers need to balance the needs of the Army and the needs of the Soldier.

Notes

¹Ryan D. Graham, "Suicide Risk Assessment Accuracy Across Levels of Training, Experience and Confidence for Psychologists-in-Training" (Unpublished doctoral dissertation, Texas Tech University, 2014); David A. Jobes, Rene Lento, and Katherine Brazaitis, "An Evidenced-Based Clinical Approach to Suicide Prevention in the Department of Defense: The Collaborative Assessment and Management of Suicidality (CAMS)," *Military Psychology* 24 (2012): 604-623; David A. Jobes, M. David Rudd, James C. Overholser, and Thomas E. Joiner Jr., "Ethical and Competent Care of Suicidal Patients: Contemporary Challenges, New Developments, and Considerations for Clinical Practice," *Professional Psychology* 39 (2008): 405-413.

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