Behavioral Health in the Marine Corps

Looking back and moving ahead

by Marta Garrett

Behavioral health (BH) services in the Marine Corps leave behind unique sets of unique footprints. Despite the fact that many BH programs are mandated at the DOD level, there are still distinct differences in how BH services are implemented within the Marine Corps. First and foremost, the distinctive mission of the Marine Corps dictates the need for different BH services and dictates how these services should be implemented. Secondly, there are no uniformed BH providers within the Marine Corps. This creates a need to work closely with "Blue Side" services in all aspects, including setting BH policies, staffing, and implementing services. Finally, the Marine Corps is the only Service to offer community-based BH services that are not recorded in the servicemember's medical record.

Nearly a decade ago, the 35th Commandant, Gen James F. Amos, rededicated Marines to the core value of taking care of their own. In his *Commandant's Planning Guidance,* Gen Amos stated that the Corps must "keep faith" with Marines, Sailors, and their families. The Commandant's guidance gave voice to an evolution of new policies and programs aimed at altering the culture of the Marine Corps and move "left of bang" to focus on prevention.

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We have the means to get Marines from the field to the hospital. We must also be prepared to deal with follow-on health issues. *(Photo by LCpl Angel Traus.)*

BH Needs in the Marine Corps

As an expeditionary Service, the Marine Corps requires BH support services that are easily accessible, solution-focused, and expedient to support the warfighter and increase the operational readiness of the total force. Today more than at any time in the history of the Marine Corps, there is a plethora of BH services available to Marines, their families, and commanders. The challenge facing commanders today is navigating this complex web of BH services.

BH and Marine Corps Commanders

In the Marine Corps, all BH treatment decisions must be made while balancing the BH needs of the individual with the larger needs of the command. Many BH issues can be managed with prevention—never rising to the level that a Commander might need to be notified or involved. However, because commanders are responsible for unit readiness, they must have an understanding of all issues that could negatively impact the unit's readiness. This critical balance of information evolved into a more transparent BH system in the military community than in the civilian sector.

When commanders are not aware of Marines' BH needs, commanders are forced to make critical readiness decisions without key information. Commanders must constantly assess the safety and readiness of all Marines

in the unit: Is this Marine safe to carry a weapon? Is this Marine a security risk? Is this Marine deployable? When a Marine is deemed not mission capable for a protracted length of time, guidance from the Secretary of Defense now directs commanders to ensure the burden of deployment is equitably distributed across the force.

In the short-term, the readiness of any given Marine struggling with BH issues varies from day-to-day. High operational stress further exacerbates on-going BH issues and causes more stress as a Marine trains and prepares to deploy. The decision to remove a Marine from his duties affects the command and has a possible impact on readiness, especially for Marines in critical occupational specialties (also known as the MOSFL rating). Additionally, a decision to remove a Marine impacts other unit Marines who will need to cover additional duties. Finally, the Marine who is removed from his normal duties and peers may experience feelings of worthlessness and an increased risk of suicidal behaviors.

Because of the potential magnitude of decisions made by commanders, they must be aware of all BH issues that have the potential impact of safety and readiness. Behavioral health providers must balance the need to keep the commander informed with the need to protect patient confidentiality as much as possible. This unique balance requires responsive and close collaboration between the commander and BH providers. During times of peace, commanders and BH practitioners have the ability to meet regularly and resolve issues as they arise. However, during war or in operational units with demanding deployment schedules, complex BH situations that require day-to-day monitoring quickly become problematic for commanders who are not available or for BH practitioners who are carrying too large of a caseload.

BH prevention in the Marine Corps

In an environment that demands ready and deployable Marines at all times, the key is to catch BH issues as early as possible *before* they require demanding treatment and management. Consequently, in recent years the Marine Corps implemented a variety of BH policies, programs, and services to move the Marine Corps BH efforts toward prevention. As in all Marine Corps programs, safety is paramount. BH prevention programming is no different. Loss of life and potential for injury is a central theme of all Marine Corps BH prevention programming. Any discussion of BH prevention must first consider the *target* of prevention efforts. What are the BH-related issues that the Marine Corps is trying to prevent? The answer to this question relates back to the foundational concept of readiness. In other words, how can BH resources be used to improve individual, family, and unit readiness? Or, how can BH *prevention* resources be used to help commanders ensure that all individuals are ready when needed? How can the Marine Corps be sure it is effectively managing this risk?

In a dynamic and fast-paced environment such as the Marine Corps, BH program evaluation data is critical. The Center for Disease Control has long been recognized as the gold standard for BH program evaluation and offers the following framework for considering prevention and BH related programming:

Utility. Does this program serve the information needs of intended users? This is critical in a population that turns over as quickly as the Marine Corps where BH programming is quickly serving new cohorts or generations with differing needs every few years. In the Marine Corps community, this concept of program "users" not only includes the needs of the individual Marines, but also the needs of the commanders. Unfortunately, BH program decisions in the Marine Corps are made at the headquarters level with little or no input from commanders.

Feasibility. Are the goals of the program(s) realistic, prudent, diplomatic, and frugal? A zero-defect mentality in BH programming is neither realistic nor prudent, yet most Marine Corps BH programs operate on this principle. The Marine Corps community has a higher than average risk for many BH issues; thus, there is inherent risk that Marines will not always make healthy or rational decisions. Furthermore, the military lifestyle (relocations, operational demands, etc.), even during times of peace, increases some types of BH risk.

Propriety. Do programs behave legally, ethically, and with regard for the welfare of those affected? This question is often overlooked within government BH programs. While there are specific operational needs for less privacy than may be afforded in the civilian sector, BH providers in the military community must still be held accountable to the *spirit* of the regulations, laws, and guidelines that govern the delivery of BH services across the U.S. This is especially pertinent in the Marine Corps where the average Marine is young and often lacks formal education about BH treatment options. Marines deserve the same quality standards in BH care that would be afforded to them as ordinary U.S. citizens.

Accuracy. Do these programs actually help? This final program evaluation criteria speaks to the need to truthfully inform decision makers by providing them with correct and precise data and formally evaluate all programming. Data is only as good as the system in which it is collected and reported.

Unfortunately, despite the emphasis on evidence-based BH initiatives and outcome measures across the larger field of BH, little to no formalized evaluation has been published about the processes or outcomes of Marine Corps' prevention and BH initiatives to date. Additionally, there has been minimal effort to formally evaluate the effectiveness of long-standing BH-related DOD mandated programs in the Marine Corps (FAP, SAC, and SAPR). This lack of formalized evaluation data makes it impossible for commanders and the Marine Corps to determine which programs are most effective or how they might be improved.

What is the way ahead?

Based on this discussion, the following recommendations are offered to better support the needs of both Marines and commanders today and into the future:

Implement and standardize BH program data collection across the Marine Corps. First and foremost, all BH-related terms must be defined uniformly across the Marine Corps: what constitutes an "alcohol-related incident" in Camp Lejeune should be the same as in Camp Hansen, Okinawa. All BH definitions must be clear and consistent.

Secondly, standardize the collection of BH-related data across all Marine Corps programs and units. Data collected entirely within a unit may be under-reported while data reported by installation-level providers may be over-reported to ensure program manning. Currently, BH-related data in the Marine Corps is gathered from multiple sources at multiple levels but with little collaboration or standardization. Defining a data collection process and mandating what data is critical for each unit to track will help commanders determine where their unique unit risks are and focus on specific prevention needs at the unit level.

Mandate BH program evaluation across the Marine Corps. A comprehensive review of all Marine Corps BH programs and initiatives should be conducted toward the goal of increasing effectiveness, better understanding gaps in efficiency, and identification of duplicative services. This evaluation might be best completed by an outside source to minimize influencing attempts or program gerrymandering by stakeholders. All BH programs and new BH initiatives in the Marine Corps should include a multi-faceted built-in evaluation plan. Finally, these program evaluations should include feedback from commanders, Marines, families, and BH providers—not just headquarters elements.

Expand the measurement of personnel readiness to include additional measures of personal readiness. Maintaining "high quality people" is one of the three pillars of the Defense Readiness Reporting System. However, aside from calculating the number of deployable Marines on-hand and the MOS fill percentage (MOSFL) rating, the Marine Corps does not currently utilize any formal process to measure other intangibles that influence individual readiness (e.g., mental preparedness). Without such measures of individual readiness, it is impossible for commanders to make informed decisions about overall unit readiness.

Consider the need to reset current BH programming to reduce duplication of services, streamline access to BH services, and increase commander input. While some of the need to reset BH programming will be further informed by comprehensive program evaluation data over time, it is also critical to move forward with some initiatives in this area to ensure current needs are being addressed and resources not wasted.

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First, it is essential to add capacity and commander access to embedded BH-related practitioners at all colonel-level commands. Embedded BH assets tend to be more utilized, more efficient at meeting local or unit-specific needs, and more accessible to commander input. Embedded BH services should be the model of BH services moving forward.

Second, The Marine Intervention Program (MIP) should be housed with and administered from the uniformed BH providers rather than the Community Counseling Program (CCP) at Marine Corps Community Services (MCCS). This move will simplify data collection and record-keeping processes, ensure continuity of care (thus decreasing risk of suicide completion), and simplify the referral process and communications with commands. This will create a one-stop shop for all suicide-related evaluations and services to simplify appointment issues for Marines who access MIP services and commanders who need quick information about a Marine who is potentially self-destructive or suicidal.

Third, consolidate short-term, non-medical counseling programs to eliminate waste and to minimize confusion about where to send Marines who need these services. Currently, the CCP program and the Military and Family Life Counselors (MFCL) program both offer short-term, non-medical counseling by licensed professionals. This level of excess capacity is not needed during peacetime. The CCP program could be eliminated as it is the most expensive to run and least responsive to a commander's needs. The MFLC program is more cost effective and can be quickly expanded or contracted to meet location or crisis needs. Additionally, because MFLC services are embedded, they are responsive to commanders needs and more likely to be used by young Marines who are most at-risk. This discussion of the MFLC program does not suggest that the MFLC program is without faults. Minimally, the MFLC contract should be re-written to include the requirement to provide commanders with more prevention-related statistics and the contracts should be lengthened from six months to one year to provide continuity of care.

Finally, regardless of serious consideration of any or all of the suggestions above, it is time to consider the removal of all BH services from under the MCCS umbrella. This suggestion is made based on two critical problems with the current structure of housing BH under the Marine & Family Programs branch of MCCS. First, there is a significant conflict of interest in housing BH services under MCCS whose primary mission was derived from morale and welfare programs and emphasizes selling goods and services to make a profit. Second, there is a distinct lack of content expertise in MCCS human resources to address the selection, hiring, and credentialing needs of BH personnel. This is evidenced by the high turnover rates of these specially qualified BH professionals and the extensive gaps in hiring new BH personnel. There are potentially multiple options for where these BH positions could be housed or how they could be more effectively managed dependent on whether CCP and MIP were reconfigured or relocated.

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