



**The Emergent<sup>1</sup> Psychological Health System at Marine Corps, Base Camp  
Lejeune 2012-2015: Analysis and Recommendations**

**January 12, 2016**

Dr. Amy Glasmeier PhD  
Mr. Eric Schultheis JD  
Dr. Annette Sassi PhD  
Dr. Christa Lee Chuvala PhD  
Mr. Andrew Bell  
Mr. John Fay

Sociotechnical Systems Research Center  
Massachusetts Institute of Technology  
77 Massachusetts Avenue, E38-632  
Cambridge, MA 02139

This material is based on research sponsored by the USAMRMC (under the cooperative agreement number W81 XWH 12-2-0016) and a consortium of other government and industry members. The U.S. Government is authorized to reproduce and distribute reprints for Governmental purposes notwithstanding any copyright notation thereon. The views and conclusions contained herein are those of the authors and should not be interpreted as necessarily representing the official policies or endorsements, either expressed or implied, of the USAMRMC, the U.S. Government, or other consortium members.

---

<sup>1</sup> Definition of the term “emergent” is discussed in the preface of the report.

# **The Emergent Psychological Health System at Marine Corps, Base Camp Lejeune 2012-2015: Analysis and Recommendations**

**January 2016  
Executive Summary**

## **Overview:**

This report represents a synthesis of research conducted at the Marine Corps Base Camp Lejeune over the period 2012-Fall 2015.

## **Objectives:**

Recognizing its large scale and history of battlefield innovation, in 2013 General Joseph Dunford offered Marine Corps Base Camp Lejeune as an interesting case to examine the system of care in its then current form and its ability to evolve. MCB Camp Lejeune offers interesting system level insights into the Marine Corps—insights that inform MIT’s research on the Memorandum of Understanding MOU signed in November 2013 by BUMED, MFP and Marine Corps Health Services.

At the start of the project, Marine Corps senior leaders, especially General Dunford, asked MIT to analyze the system with a focus on the following questions:

- Are there psychological health system problems?
- How big are the problems?
- What are the problems’ key system variables?
- How are we currently trying to solve the problems?
- How do we measure the psychological health system?
- Is there stigma associated with seeking psychological health care?
- What should we be doing to solve the problems?

The goals of the initial study were to apply a systems perspective while leveraging existing change initiatives:

- Identify clear improvement opportunities.
- Highlight potential solutions for the short and longer term.
- Study the psychological health system along the care delivery continuum.

In this study we focused on the experiences and perceptions of active-duty Marines and Sailors: line leaders, uniformed providers, and civilian providers working with service members.

## **Analytical Perspectives**

We have drawn our analytical focus from a perspective in organizational research that considers the *dynamics* between organizational structures and individual actions within those structures. Our scale of focus on Marine Corps Base Camp Lejeune allowed us to consider how different elements of a complex system with emergent properties came together over a three-year period of time.

As referenced regularly in the literature, there is growing support for understanding health systems and mental health systems in particular from a complex systems perspective, where unintended consequences are the norm in the implementation of health policy and that such consequences often constitute the realization of the policy. Recognizing this tendency, theories of implementation point toward design practices that can circumvent some of the more likely manifestations of unintended consequences by engaging the “small scale”-- the actors and agents that will inhabit the system itself. Our report considers a select set of elements of a system that affects the process by which Marines seek care and the factors that influence the paths they take and the care they receive. We propose recommendations to support the system’s stability while enabling flexibility of the system in its formative state.

Our work has focused on a system that is being built in real time. It is a system of intersecting, overlapping and orthogonal elements that ultimately come together into momentary states of operational equilibrium. We began our work with two overarching observations. First a system of care had to consider the Marine and his or her family and/or its social support system as a unit. Wellness of individual Marines is incumbent upon the safety and security of the constituents surrounding them. Second, the situation under study was local, evolutionary and composed of elements of a learning system demonstrating the ability to accumulate and utilize “know how” (the skills and practices to accomplish a task) and “know why” (the comprehension of why a task is being done) to continue to develop and transform the system over time.

## **Research Methodology**

**Data Collection:** The initial research framework of 2013 was formulated to provide answers to questions posed by Marine Corps Headquarters leadership concerning the effectiveness of the then emergent Marine Corps-Navy psychological health system. Fieldwork began in June 2013. We conducted surveys of 280 respondents and held

83 individual and group open-ended interviews. These interviews form the foundation of the research reported here. We conducted follow-up interviews with select leadership in June of 2015 and December 2015.

We conducted an exploratory study of out-in-town providers near both Camp Lejeune and Camp Pendleton in fall of 2014. Using a "purposive" sampling technique, we developed a cross-section sample of providers located within a 40-mile driving radius from Camp Lejeune and Camp Pendleton respectively. We developed an open-ended interview protocol designed to probe how these mental health professionals provide care to Marines and their families. A total of 28 providers were interviewed.

**Data Analysis:** All interviews were transcribed. We developed a rigorous coding process based on principles from grounded theory. This process entailed multiple readings of the interviews through which the codes were increasingly refined. This process produced a final code dictionary, with which we coded both the on-base and out-in-town interviews. We then wrote a series of code memos for the on-base interviews. After the code memos were completed, we then wrote four analytic memos that synthesized and further analyzed the information presented in the code memos to address the broader research questions initially posed. The out-in-town analysis followed the same framework as the on-base analysis.

## Findings

The research report represents the overall Marine Corps Base Camp Lejeune project findings presented in chronological order.

**Initial 2013 Findings:** Using Marine Corps Base Camp Lejeune as a demonstrator, the initial study reflected a current state analysis of the system of care. The study examined the respondents' knowledge of the care system, the pathways to care and the reasons Marine chose a particular pathway when seeking care. Respondents included care providers, members of the chain of command, civilian professionals and junior leaders who were asked about their perceptions of the psychological health care system.

By examining factors that shaped the care-seeking process, we were able to discern influences that govern the choice: a) to seek care; b) from whom; c) under what circumstances; and d) the expectation of anonymity. Also evident was a reciprocal influence of leadership's effect on a Marine's disposition to seek care and from whom. Regardless of the availability of care, concerns about perceptions of self and about self and others directly affect the actions of Marines with expressed need for care. The initial analysis indicated the following findings:

- Real and perceived stigma has impacts on care seeking, most likely limiting care-seeking.
- Line Leaders showed a definite preference for medical mental health care pathways over non-medical options.
- MTF providers were not clear about the roles and responsibilities of OSCAR Providers. Questions focused on what the OSCAR providers' responsibility to care for Marines their regiments were and when (and if) they should refer Marines to the Naval Hospital.
- The siloed nature of provider groups -- institutional stakeholders with different cultures, resource streams and accountability structures -- resulted in limited communication and collaboration opportunities, which constrained overall care coordination.
- Challenges with sharing medical information were evident. Two contributing factors were the lack of a comprehensive medical information system and differences in providers' and commands' understanding about rules governing HIPAA and privacy.
- Demand for medical mental health care exceeded the supply of providers.
- Hiring qualified professionals was challenging. Contributing factors were the isolated nature of MCB Camp Lejeune, uncertainty about long-term employment, and bureaucratic time lags associated with the hiring process.
- The General Counseling Services within Marine and Family Programs (MF) was underused.
- Unease between on-base and TRICARE providers resulted from a lack of effective communication channels.

**2015 Reanalysis of 2013 Findings:** Through a systematic reanalysis of the original qualitative findings, the 2015 reanalysis identified six main themes: (1) care initiation (2) stigma (3) beliefs and knowledge about mental health; (4) operational pressures (5) institutional factors, and (6) informational flow factors. This reanalysis clarified fundamental relationships governing the process of care-seeking, in light of the roles of individuals, leadership, stigma, and confidentiality. Our key findings from this reanalysis include:

- **Care Initiation:** Care initiation is not always through the chain of command. Rather it is contingent on a number of situational factors such as command climate. Care initiation through the chain of command is more likely to occur when a commander identifies issues. Marines who seek care on their own may seek more anonymous routes or many may not seek care at all. By not seeking care on their own, Marines put the burden of identification on their commander, peers, and family members.
- **Stigma:** Stigma and the fear of being stigmatized may keep Marines from seeking mental health care. That stigma is a critical factor is reflected in the

- frequency with which respondents mentioned it throughout the interviews, independent of rank or position.
- **Beliefs and Knowledge:** Leaders' knowledge of mental health care itself, their perception of provider qualifications, and their deep-seated beliefs and attitudes about psychological health problems can influence their assessment of Marines' issues and appropriate care pathways. These factors also contribute to the persistence of stigma and to situational and causal factors affecting Marines' access to care and ultimately their care trajectory.
  - **Operational Pressures:** The requirement to balance operational readiness with individual wellness can contribute to commanders' doubts about the validity of mental health issues, expectations for quick diagnoses, and impatience with the pacing of long-term treatments. Institutional and temporal pressures to ensure troops are "ready to deploy" can favor the desire for "black and white" assessments and outcomes.
  - **Institutional Factors:** Many of the elements of the Navy/USMC care system had been operating in an uncoordinated fashion across the range of care providers. Factors that affect coordination occur at three organizational levels:
    - a. Operational capacity. Factors affecting operational capacity across organizations include: 1) autonomous accountability structures; 2) separate resource streams; and 3) technical limits of the medical information system.
    - b. Professional relationships. Ongoing tensions between medical and non-medical providers over individual competencies and program efficacy exist. MTF providers in particular expressed concerns about non-medical providers and the overall models of some programs such as OSCAR and MFLC programs.
    - c. Individual competencies. Individuals at different points in the system lacked competencies to engage in effective collaborative efforts including medical records keeping skills, communication skills, and trust building skills.
  - **Information Flow Issues:** In addition to ongoing technical limits to effective information flow, communication among providers and between providers and commanders is affected by the HIPAA regulatory environment and privacy concerns.
    - a. Commanders and providers often have different ethical norms and expectations about what information should be shared and how to communicate with each other.
    - b. Providers and commanders rely on informal communication networks to help manage the constraints imposed by the limits of the formal medical information system and the HIPAA regulatory environment.

**Role of Out-in-Town Providers:** Building on a geospatial analysis that identifies the potential supply constraints of out-in-town providers, we developed an exploratory study to examine non-spatial factors that influence out-in-town provider use.

We report on findings from only our non-spatial study. Our analysis identified a number of significant ways in which the out-in-town providers not only *augment* available services by providing additional resources, but also *supplement* those services by providing care options not available to Marines and their families on base.

Our open-ended interview design allowed us to probe how out-in-town civilian mental health professionals provide care to Marines and their families. We focused on three main topic areas: 1) Why Marines and family members use these providers; 2) How they access them; and 3) What the experience of using them entails.

Why Marines and Family Members Use Out-in-Town Providers:

- **Provider shortages and quality of care:** Out-in-town providers said that Marines can be both frustrated with delays in care and dissatisfied with the quality of care received.
- **Privacy and the avoidance of stigma:** Out-in-town providers also reiterated the concerns about privacy and stigma, which could draw Marines off-base.
- **The Need to Seek Family Care Off Base:** Family members in need of behavioral health services were required to seek care off-base because on-base services were not available for them.
- **Family as a Source of Individual Marine Care:** Family care can be a source of some form of support for a Marine who may have personal issues but, for concerns about privacy or pride, is not willing to seek care. A recurrent pattern described by out-in-town providers is that a family member will seek care and then the Marine may ultimately get involved.

*How Marines and Their Families Access Care:* Marines and their families get a referral to use out-in-town providers in two ways:

- **Military OneSource:** Marines are given the name of a provider to call within 30 days. Several providers noted that they did not know how a provider was assigned.
- **TRICARE referrals:** For both Marines, who need a referral from an on-base provider and their family members who do not, finding a TRICARE provider usually requires looking on the website to identify a provider and contacting that provider directly to make an appointment.

Several providers indicated that they occasionally see Marines who self-pay. Such Marines would need no referral. Providers also indicated that they saw more Marines through Military OneSource than through TRICARE.

We asked all of the out-in-town providers why a Marine or family member might choose them. They offered five factors:

- **Location:** the providers said that their location would matter, particularly if they were located within easy access of the base. Easy access could include physical proximity or it could be easy driving distance (e.g. right off the highway).
- **Specialty:** Providers also cited specialty as a reason someone would choose them.
- **Responsiveness:** Several providers commented that some clients might come to them because they actually answered the person's call. They noted that some providers do not answer the phone or return calls in a timely manner.
- **Hours:** Several providers commented that clients chose them because they offered more convenient hours, particularly evening and weekend hours.
- **Reputation and word of mouth:** A number of the providers cited their reputation as a key factor in people choosing them. Providers in both locations mentioned that clients had said that someone in their network of friends recommended them.

Selecting an out-in-town provider appeared to be somewhat arbitrary or opportunistic. Those seeking a provider may choose someone from the website based on hours or location. Or, they might go to someone because a friend or acquaintance recommended him or her.

*Professional Practices and Norms of Out-in-town Providers:* Based on descriptions, we identified five qualities that characterize out-in-town providers' approach to care:

- They rely on little input or involvement from either on-base providers or commanders.
- They treat the whole family.
- They focus on alleviating the most severe symptoms.
- They stress the possibility of returning to a "normal" state.
- They begin a course of treatment by trying to build a sense of "hope".

While these qualities likely did not differ much from those of any individual on-base provider, the actual experience with an out-in-town provider may differ because of the absence of operational pressures. Consequently, Marines who use out-in-town providers may feel they receive more personal attention from them.



Also, our data suggest that the providers in our sample abide by the rules governing their professional practice and follow established professional norms.

- They abide by treatment rules and guidelines, treating only conditions for which they are qualified.
- They adapt to Marines' daily and deployment schedules.
- They respect HIPAA and professional norms of privacy.
- They say they recommend medication only as a last resort.

In considering, then, what kind of supplemental care the out-in-town providers offer, we identified three potential draws for Marines. Out-in-town providers: 1) offer more confidential care; 2) create a safer and less judgmental context; 3) can be accessed through informal and potentially more discreet networks.

**June 2015 On-base Changes:** In the span of two years, the organizations involved in psychological health care at Camp Lejeune have experienced significant and rapid changes, from the addition of new services to leadership turnover. The most influential changes identified in a June 2015 site visit were:

- The standing up of the Community Counseling Center (CCC) and the Community Counseling Program (CCP).
- Geographic separation of CCP services from the Family Advocacy Program (FAP).
- Expansion of CCP staff from four to 15 counselors with different backgrounds including individual and family therapy.
- Coordination of the SACC and Substance Abuse Rehabilitation Program (SARP) into a system of care of tiered substance abuse prevention and early intervention programs, counseling, and non-medical outpatient and intensive out-patient treatment, which used to be fully handled by the Blue-side program that provides medical care to treat substance abuse issues.

These changes have enhanced the capacity of mental health organizations to establish critical practices that enable them to work together more effectively.

*SACC and SARP coordination:* The working relationship between SACC and SARP showed the most progression in June 2015. Three main developments now had allowed them to work together as a continuum of care rather than as separate or duplicative programs:

- The current department head (DH) of SARP was hired as Deputy Director of Mental Health and was attending a multidisciplinary team meeting each week, with the SACC manager, clinical supervisors, and SACC counselors.
- SARP had hired a PhD Psychologist in the position of admissions coordinator.

- The two programs and the SACOs had developed a method of email encryption to allow them to share key documents such as treatment and discharge letters as well as other critical information across the Navy-Marine Corps network divide.

*MF and the MH Clinic collaboration:* Leadership from MF and the MH Clinic met in May 2015 to discuss possible modes of collaboration. They agreed to collocate a counselor from the CCP in the MH Clinic for several mornings per week. The CCP counselor would be able to educate providers about the MF's behavioral health programs and assist in channeling Marines to the type of provider most appropriate for their needs.

*MF Behavioral Health and II MEF coordination:* As of June 2015, leadership at MF and II MEF had begun discussions about collocating a behavioral health counselor at the II MEF commands at Lejeune, Cherry Point, and Beaufort.

*MARSOC and CCP collaboration:* MARSOC leadership had arranged with CCP to have a clinician assigned specifically to their units.

*CCP Outreach:* CCP leadership has begun to informally give prevention-oriented trainings that focused more on interaction among Marines and less on transfer of information.

**Remaining Challenges as of June 2015:** As of June 2015, we identified a number of on-going issues that could constrain efforts to improve effective collaboration and coordination among behavioral health providers and stakeholders.

- Geographic isolation and the lengthy distance of the Ground Combat Element (GCE) and associated green mental health providers from other psychological health resources limited coordination.
- As of June 2015, neither MF behavioral health leadership nor OSCAR leaders had initiated efforts to bring MF behavioral health personnel and OSCAR providers together for introductions or explorations of possible coordination practices.
- Roles and responsibilities for Division mental health professionals continued to be poorly understood across the spectrum of on-base providers.
- Significant cultural distance and a lack of understanding existed among psychological care providers in the MH and Division Psychiatry.
- Demand for medical mental health care and its pressure on providers at the MH Clinic remained high. The MH Clinic was booked four to six weeks out for appointments and the clinic was sending approximately 20% of Active Duty clients out to the TRICARE network to receive care.
- Time constraints and a heavy workload limited communication between MH care providers and the Division Psychiatrist.

- Certain technological hindrances to effective information exchange evident in 2013 remained including separate electronic records systems at the MF and the MTF.
- No infrastructure to enhance communication and information sharing between MCB Camp Lejeune and off-base mental health professionals existed or was in development.

### **December 2015 Current Status**

More defined and regular communication and collaboration with the MTF, commanders, and Division Psychiatry representing the GCE, ACE and the MLG exists. Four structural features represent enhanced collaboration as of December 2015:

- Cross installation communication between leadership at the Naval Hospitals at Marine Corps Bases Camp Lejeune and Camp Pendleton.
- Full implementation of the Marine Intercept Program.
- Maturation of the Community Counseling Program.
- Colocation of CCP assets in several sites across the installation.
- Enhanced collaborative relationships as measured by invitations to attend Force. Preservation Councils and the Human Factors meetings at two regiments and MARSOC.
- Cross installation outreach and collaboration between the CCP and Military Chaplainry enhancing Marines access to information about and physical contact with psychological health services and providers.
- Division Psychiatry instruction to Marines on the installation-based, tiered system of care including points of entry to psychological health resources.

### **Recommendations for Improving the Psychological Health Care System at Marine Corps Base Camp Lejeune**

The following recommendations are based on the synthesis of findings from the 2013 analysis, the 2015 reanalysis, the out-in-town provider study, and the 2015 follow-up visits.

- *Recommendation 1:* The Marine and Family Programs Division of the MCCS and the CCP is growing in importance and should be further integrated and utilized for behavioral health care.
- *Recommendation 2:* Camp Lejeune should establish a three tiered system of intake for screening and referrals and train all Level One providers with the same sets of skills and knowledge of pathways to conduct first level assessments. This is modeled after the Marine Centered Medical Home.

## Executive Summary

---

- *Recommendation 3:* Build a records system or improve the current system to allow integrated information sharing among all mental health care providers in the Navy- Marine medical, non-medical care system.
- *Recommendation 4:* To reduce stigma, better orient marines to resources and to normalize care seeking processes, develop and distribute psychological health training opportunities to include “learning in context,” role playing, and protective practices.
- *Recommendation 5:* To shift the modalities and outcomes of this type of training create and implement a FM/TM (Field/Training Manual) oriented toward making mental health and observation/reporting of key symptoms integral to the role of a individual Marine.
- *Recommendation 6:* To enhance local level observation of Marine psychological health while normalizing the practice of mental health self-care and facilitating care-seeking when needed, establish a new Corpsman billet that integrates identification and maintenance of psychological health with the role of the SACO.

## Table Of Contents

---

### Table of Contents

Preface.....	1
Part One, Section One: The Original Charge: Examine the Psychological Health System at Marine Corps Base Camp Lejeune .....	3
Overview.....	3
Introduction.....	5
Outline of the Report .....	7
Part One: Section Two: Care seeking and Care Receipt: The Emergent Marine-Navy Psychological Health System at Marine Corp Base Camp Lejeune .....	10
Challenges to Efficient Provision of Mental Health Care at Camp Lejeune 2013 .....	10
Real and Perceived Stigma and the Effectiveness of Prevention Efforts .....	11
Line Leaders’ Preference for Medical Mental Health Care Pathways.....	12
Ambiguity About the Roles and Responsibilities of OSCAR Providers .....	13
The Siloed Nature of Provider Groups .....	14
Sharing Medical Information.....	16
Demand for Medical Mental Health Care Exceeds Supply of Providers .....	17
Difficulty Hiring Qualified Professionals.....	17
Underutilization of General Counseling Services within Marine and Family Programs (MF) ...	18
Unease between On-base and TRICARE Providers .....	18
Summary: .....	19
Part Two: Section One: Utilizing Hypotheses Derived from Literature About Access to Care and Care Seeking: Reanalysis of the 2013 Data .....	21
Care Initiation .....	21
Stigma .....	22
Stigmatized for Seeking Care.....	23
Malingerers as a Source of Stigma .....	23
Fear of Stigma Affects Care-Seeking .....	24
Consequences of Seeking Mental Health Care are Real .....	24
Beliefs and Knowledge .....	24
Beliefs about Mental Health Issues.....	24

## Table Of Contents

---

The "Tough it Out" Mentality and the Doubting of Self-identification .....	25
The Fear of Malingering .....	26
The "Lazy" Generation.....	26
Knowledge of Mental Health Care and Providers .....	27
Operational Pressures .....	28
Commanders' Expectations for Unambiguous Diagnoses and Efficient Treatments.....	29
Seeing Issues Through the Lens of Readiness .....	29
Creating Pressure for Marines with Issues to Stay "Under-the-Radar" .....	30
Institutional Factors.....	30
Professional Relationships.....	32
Gaps in Individual Competencies Needed for Effective Coordination .....	38
Summary.....	39
Part Two, Section Two 2015: Research Findings of Civilian Out-in-Town Behavioral Health Providers and How They Serve Marines and their Families.....	41
Introduction.....	41
Research Approach for the Out-in-Town Spatial Social Analysis .....	42
Why Marines and Family Members Use Out-in-Town Providers.....	45
Why Marines Seek Individual Care Off Base .....	46
The Need to Seek Family Care Off Base .....	49
Family as a Source of Individual Marine Care .....	49
Typical Issues Treated .....	50
How Marines and Their Families Access Care .....	51
Professional Practices and Norms of Out-in-town Providers.....	52
Professional Protocols and Rule Abidance .....	56
Summary: Commitment to Accessible Psychological Health Care for Marines, Sailors, and Their Families.....	58
Part Two Section Three: Changes in Mental Health Care Provision at Marine Corps Base Camp Lejeune from 2013 to 2015 .....	61
Advances since 2013 Cross-organizational Coordination .....	62
Behavioral Health at MF and the MH Clinic .....	63
Behavioral Health at MF and II MEF.....	64
Remaining Challenges .....	65

## Table Of Contents

---

Coordination of Care and Information Exchange.....	68
Part Two Section Four: December 2015 Evidence of Cooperation and Collaboration Buttressed by Shared Experiences and Added Resources Represent New Developments at MCB Camp Lejeune .....	71
Coordination of Care and Information Exchange.....	72
Outreach and Prevention .....	73
Division Psychiatry and the Ground Force Element Reaching Out and Providing Guidance ....	74
Part Two Section Five: Evolving Toward a Psychological Health System Marines Will Use.....	76
Part Two Section Six: Recommendations for Improving the Psychological Health Care System at Marine Corps Base Camp Lejeune.....	78
Part Two Section Seven: Level II Recommendations: 2013 Recommendations to the MCB Camp Lejeune Commanding General and the ACMC.....	80
Appendix A: 2015 Research Methodology .....	85
Design of the Reanalysis Scheme .....	85
Appendix B: Marine Corps Base Camp Lejeune Psychological Health Care System Map .....	88
Appendix C: List of Acronyms.....	89
Appendix D: Original TRICARE Analysis .....	94

## Preface

In 2012 MIT researchers in the Sociotechnical Systems Research Center (SSRC) under the leadership of Dr. Deborah Nightingale were asked to analyze the psychological health care system of the U.S. Military using an approach drawing from the field of sociotechnical systems analysis.

This report reflects one of two major elements of the Navy-Marine Corps project: the study of the Marines psychological health care system at Marine Corps Base Camp Lejeune. The second element is an investigation by Dr. Anne Quaadgras of the Memorandum of Understanding signed between Navy Medicine and Marine and Family Programs for the protocols defining the responsibilities for medical and non-medical psychological health services for Marines and Sailors.

Our scale of focus on Marine Corps Base Camp Lejeune allowed us to consider how different elements of a complex system with emergent properties came together over a three-year period of time. As referenced regularly in the literature, there is growing support for understanding health systems and mental health systems in particular from a complex systems perspective, where unintended consequences are the norm in the implementation of health policy and that such consequences often constitute the realization of the policy. Recognizing this tendency, theories of implementation point toward design practices that can circumvent some of the more likely manifestations of unintended consequences by engaging the “small scale”-- the actors and agents that will inhabit the system itself. Our report considers a select set of elements of a system that affects the process by which Marines seek care and the factors that influence the paths they take and the care they receive. We propose recommendations to support the system’s stability while enabling flexibility of the system in its formative state.

The title of our report is purposeful. Our title is meant to imply that our work has focused on a system that is being built in real time. The current system is comprised of intersecting, overlapping and orthogonal elements that come together into momentary states of operational equilibrium. Over time, problem solving institutional practices lead to standardization of performance. We began our work with two overarching observations. First a system of care had to consider the Marine and his or her family and/or its social support system as a unit. Wellness of individual Marines is incumbent upon the safety and security of the constituents surrounding them. Second, the situation under study was local, evolutionary and composed of elements of a learning system demonstrating the ability to accumulate and utilize “know how” (the skills and practices to accomplish a task) and “know why” (the



comprehension of why a task is being done) to continue to develop and transform the system over time.

Guiding our thinking was the recognition that complex systems are characterized by three properties. These are: 1) Emergence. The system, as a whole, would have properties that only ‘emerged’ once it had been created from its components; 2) Non-determinism: The system would not always produce the same output when presented with the same input neither within a single location nor across locations of an overarching system; and 3) Subjectivity. Subjective behavior has a big influence on outcomes. The success or failure of a system in supporting organizational and user objectives depends on the interpretation of system stakeholders. Hence, superimposition of an externally determined value system, unfamiliar with local norms and practices can yield suboptimal outcomes.

By selecting a single site in a larger constellation of psychological health resources, in a period of resource accumulation, we were prepared to see change: adjustments in practice, reversals in direction, and workarounds created to bridge gaps among elements not yet developed. The present bundle of resources has solidified and now has the markings of a system of care that presents important opportunities to provide the best possible care for the Lejeune community and individual Marines. Key to next steps is to recognize that the system of care operates at two levels: the small-scale care provider and user level and the large-scale policy and decision making level. A basic organizing principle focused on the small scale, such as “designing a system of care Marines, Sailors and their families will use” is central to establishing system accountability.

According to practitioner-academics Joachim Sturmberg and Holly J. Lanham of the University of Newcastle<sup>2</sup>, “abiding by *simple rules* as a strategy has been shown to produce the best possible health outcomes for individuals and communities. Our effort in the study of Camp Lejeune has been to dig in deeply at the small scale and to understand some, but not all, of the basic elements of the emergent system of psychological health care for Marines, Sailors and families. Over the three-year study, the one “unflinching goal” we were exposed to in each engagement we had, was to “build the best system of care possible.” As we observed, the greatest challenge was not a problem of will, but more a matter of concretely specifying the terms of how to achieve that goal, which proved to be the greatest challenge.<sup>3</sup>

---

<sup>2</sup> Sturmberg, Joachim<sup>1</sup> and Holly J. Lanham 2014. “Understanding health care delivery as a complex system: Achieving best possible health outcomes for individuals and communities by focusing on interdependencies.” *Journal of Evaluation in Clinical Practice* **20** 1005–1009.

<sup>3</sup> We acknowledge the help and assistance of many people: professionals at MCB Camp Lejeune, The Office of the Medical Officer of the Marines, professionals at MCB Camp Pendleton, professionals at the University of Arizona Student Veterans Center, OEF-OIF veterans of the Army and Marines; noteworthy were the Marines who provided insight into the lived experience of being a Marine

---

## Part One, Section One: The Original Charge: Examine the Psychological Health System at Marine Corps Base Camp Lejeune

### Overview

#### The First Encounter with the Marines

In January 2012, the Post Traumatic Stress Innovations (PTSI) team from the Massachusetts Institute of Technology Socio-Technical Systems Research Center (SSRC), conducted an investigation of a Marine installation as a part of its early reconnaissance work regarding the United States Marine Corps/Navy care delivery enterprise for Post-Traumatic Stress and related conditions. The team conducted interviews with members of key stakeholder groups from Marine Corps and the Navy, focusing on how they participated in care delivery services for post-traumatic stress and related conditions affecting Marines and their families.<sup>4</sup>

In this first encounter with the Marines we focused on two levels of analysis: factors that impinged on receipt of care and factors that improved access to care. This analysis was not intended to be comprehensive, and instead formed a considered observation of the extant services available based on open-ended discussions with members across a spectrum of care providers, Commanders, program managers, and specific care units within the Marines and Navy context.

The key issues identified in 2012 were: a Military Treatment Facility (MTF) centric routing system with insufficient capacity to effectively direct Marines to care; a cluster of services not yet congealed into a system of care that was overwhelmed by demand despite receipt of a significant increase in provider resources over the previous three years<sup>5</sup>; difficulties faced by embedded providers in routing Marines into the MTF for care; and an inability to achieve prescribed dwell times and the dispersal of members of returning units.

Mitigating circumstances identified during the investigation were intended to address challenging issues related to communication among Commanders and care providers and the availability of care convenient to returning Marines. MTF Mental

---

professionals at the Naval Hospital Balboa, San Diego and Dr. Jayakanth Srinivasan who has been a faithful colleague willing to share just about anything.

<sup>4</sup> Jayakanth Srinivasan, MAJ Shane Scott, and Andrea Ippolito. 2012. *Case Study of the Behavioral Health Delivery System at Site D.* Contact the author for the complete report.

<sup>5</sup> According to interviews with behavioral health professionals of the Navy Hospital Camp Lejeune, the growth in treatment professionals expanded from 4 in 2004 to 7 in 2007 to 55 in 2010 to 65 in 2016.

Health leadership made a strong push to align care with the “Marine Centered Medical Home (MCMH) model. The implementation of the model was showing signs of engendering trust between Commanders and providers in places like the Deployment Wellness Center by providing commanders with a single point of contact within a clinic. Access was enhanced through the operation of a mobile unit of the Deployment Wellness Clinic for executing post deployment screenings proximate to returning units. Emphasis was being placed on tiered oversight of Marines reflecting multiple modalities of psychological health training focused on prevention and early intervention.

### The Selection of Lejeune as a Demonstration Site

With the original case investigation as a backdrop, in summer 2012, General Joseph Dunford (then ACMC) recommended that MIT study the Psychological Health System at Marine Corps Base (MCB) Camp Lejeune, headquarters of the 2nd Marine Expeditionary Force (II MEF). Recognizing its large scale and history of battlefield innovation, General Dunford offered Marine Corps Base Camp Lejeune as an interesting case to examine the system of care in its then current form and its ability to evolve MCB Camp Lejeune could offer interesting system level insights into the Marine Corps—insights that could inform MIT’s research on the Memorandum of Understanding MOU signed in November 2013 by BUMED, MFP and Marine Corps Health Services.

The installation is a 246-square-mile (640 km<sup>2</sup>) military training facility located in Jacksonville, North Carolina. The facility includes six support locations including: Marine Corps Air Station New River, Camp Geiger, Stone Bay, Courthouse Bay Camp Johnson, and Greater Sandy Run Training Area. Conversations with key stakeholders led us also to include Marine Corps Air Station (MCAS) Cherry Point and MCAS New River, for a full II MEF perspective. We collected data at Camp Geiger to include the School of Infantry (SOI) perspective on training, resilience, and the psychological health system. The II MEF area in North Carolina is home to over 53,000 enlisted Marines and Sailors, about 4,500 Navy and Marine Corps officers, and approximately 50,000 active-duty family members.

At the start of the project, Marine Corps senior leaders, especially General Dunford, asked MIT to analyze the system with a focus on the following questions:

- Are there psychological health system problems?
- How big are the problems?
- What are the problems’ key system variables?
- How are we currently trying to solve the problems?
- How do we measure the psychological health system?
- Is there stigma associated with seeking psychological health care?
- What should we be doing to solve the problems?

The goals of the initial study were to apply a systems perspective while leveraging existing change initiatives; identify clear improvement opportunities; highlight potential solutions for the short and longer term; and study the psychological health system along the care delivery continuum. In this study we focused on the experiences and perceptions of active-duty Marines and Sailors: line leaders, uniformed providers, and civilian providers working with service members. We did not study processes of clinical care provision nor did we interview Marines of ranks E1-E2.

### Introduction

In 2013 the psychological health care system at Camp Lejeune was in a formative state. There was a shortage of psychological health professionals nationally and at Naval Hospital Camp Lejeune. Demand for psychological health care easily outstripped the supply of human resources available, thus hampering the delivery of effective, timely, and appropriate levels of care.

Our fieldwork began in June 2013. We conducted surveys of 280 respondents and held 83 (of 90 planned) individual and group interviews. At that time, the investigation highlighted significant issues associated with access to care, concerns about privacy, and organization. Respondents told us there was a lack of cooperation among Navy Medicine, civilian, and embedded providers. Inadequate coordination across programs and a dizzying array of pathways existed, making access to care cumbersome and inexact. According to system users, the quality of care was uneven and wait times were intolerable. The shortage of providers meant family members and Marines were sent off base in order to receive timely care. Our early interviews suggested that on-base care was insensitive to the needs of Marines and their families. Prescription medication was often the recommended solution when talk therapy was what was desired.

Key system variables were out of sync: information systems lacked interoperability; pathways to care were inconsistent and haphazard in approach; there was documented disagreement about the severity of the psychological health problems of Marines and family members; and commanders expressed considerable skepticism about the value of and need for psychological health services unless provided by psychiatrists. There was an absence of trust across ranks, roles were blurred and locations of care exhibited variation in the approach and practice of documentation. Marine psychological health care professionals and leaders distrusted civilian providers both on base and out-in-town. Commanders were frustrated by the lack of communication from MCCA headquarters about the rollout of new programs. The psychological health care system was insufficiently resourced, appearing fragmented to Marines and their families.

These structural limitations began to diminish in the fall of 2013. The Community Counseling Program was stood up and the needed professionals were hired. The Naval Hospital had increased by a factor of 10, the number of professionals providing mental health related care and services (Staff numbers in 2004 were four; 2007 seven; 2010 the figure increased to 55; 2016 gained ten to 65 2016). Infrastructure for this undertaking was built from the ground up and protocols were emplaced, albeit initially in somewhat ad hoc fashion. MTF staff were calling MFP counselors and coordinating care. Experiments were initiated at the base and at Marine Headquarters; not all of them worked according to plan.

In 2013, the Office of the Chief of the Marine Corps Headquarters Behavioral Health Branch initiated a push to consolidate resources and functions, including a new evaluation capacity at Headquarters. Leadership of the Marine Corps made public commitments to the need for psychological health services to combat the prevalence and persistence of stigma and articulated the importance of psychological health as an integral aspect of a Marine's fitness for duty.

Evident in the fall of 2013, Navy Medicine was initiating efforts to formalize and codify the relationship between mental health services delivered by Navy providers and the counseling element of the Marine Corps Community Services, Marine and Families Program (MFP). A Memorandum of Understanding (MOU) was in development to establish operational guidelines in support of a continuum of medical and non-medical counseling services available to Marines and their families to be delivered by Navy medicine and MFP.

At the beginning of 2014, nascent elements of a system of care were beginning to coalesce and needed resources were aligning to form a system of care. The IIMEF Surgeon's recommendations at the end of 2013 highlighted actionable steps to significantly enhance and improve the system of care at Marine Corp Base Camp Lejeune.

Appointed in the fall of 2014, the new Medical Officer of the Marine Corps reinforced the emerging transparency among resources, providers and practitioners, fostered trust among members of the Marines and Navy medicine, and encouraged and empowered system participants to increase the accountability of the care system.

While the MOU specified system wide relationships and procedures, at the local level, central to the development of improved coordination was the Marine Intercept Program (MIP), a precipitant of cross installation interactions. This multilevel initiative spawned new communication pathways and protocols to track, intervene, and support Marines experiencing suicidal ideation and other life-threatening actions. The formulation of the program encouraged collective learning; built new relationships across functional lines based on familiarity and ultimately trust; and

reinforced the importance of tracking metrics to document “ learning by doing,” enabling real time system adjustment.

Redefining and relocating important service assets such as the Family Advocacy and Substance Abuse Rehabilitation Programs contributed to improving care provision by disrupting the stigmatizing effects of co-location of such services with those of psychological health care. Division psychiatry proposed a tiered approach to providing psychological health services that guided Marines and family members to all non-medical points of entry—this approach connected need for care with case management resources.

These new developments stand alongside constraints related to infrastructure limitations and the continued effects of stigma. Measurement of outcomes remains a continuing challenge. Data exist, but local level human resources required to implement and analyze these data are still lacking. Outcome metrics are proposed for implementation at Marine Corps Base Camp Pendleton; plans include piloting these metrics at MCB Camp Lejeune in 2016.

Fear of career consequences in seeking psychological health care remains a serious problem at Marine Corps Base Camp Lejeune. Throughout our analysis starting in 2013, health care providers frequently mention fear of stigma as a deterrent to care-seeking. Out-in-town providers also raised concerns that stigma inhibits Marines from seeking care on base. The fear that care-seeking can have career impacts discourages Marines from utilizing non-confidential care services. As our recommendations at the end of this report suggest, the impediment to seeking care requires careful examination to identify means that provide Marines with a sense of privacy while enabling them to receive services required to ensure fitness for duty.

### **Outline of the Report**

This report represents a synthesis of research conducted at the Marine Corps Base Camp Lejeune over the period 2012-Fall 2015. Preparation for the fieldwork underlying this study began in late Fall 2012. The second data collection effort occurred in June 2013 and was designed, executed and supervised by Dr. Jorge Fradinho. Supporting researchers included Steven Moga, Clayton Mealer and Andrew Bell. A Current State Report, authored by Dr. Fradinho, was edited as a final document by Dr. Anne Quaadgras with contributions from the authors of this report. The final document stands as the “The Marine Corps II MEF Psychological Health System: Overview, Findings and Recommendations 2015.”

The following document represents the overall Marine Corps Base Camp Lejeune project findings. This document is divided into two parts, each part contains several sections, and within sections are subsections of analysis. Part One Section One

summarizes the original charge given to the researchers while Part One Section Two describes the Marine Corps Base Camp Lejeune care provision system circa 2013 as described in “The Marine Corps II MEF Psychological Health System: Overview, Findings and Recommendations 2015”.

Part Two Section One focuses on the care-seeking practices of Marines. Here we examine what Marines do in searching for care both on their own and from the referrals of others. This discussion reexamines the original interview data and identifies causal forces shaping the care-seeking practices of Marines at Marine Corps Base Camp Lejeune.

As part of the care-seeking experience, Marines and their family members seek care utilizing off-base providers. Part Two Section Two reports the analysis of interviews conducted with “out-in-town” psychological health care providers surrounding MCB Camp Lejeune, North Carolina and MCB Camp Pendleton, California. This investigation is the second of two studies of off-base care provision and availability.<sup>6</sup> Our findings indicate Marines and their families use off-base care to supplement services available on base. These services are key components of the overall system of care available to Marines and their families.

Part Two Section Three reports findings from a return to Camp Lejeune in June 2015 to examine advances in the development of cross-organizational coordination. This investigation occurred in conjunction with an assessment of progress made toward the implementation of the NAVY-MCCS MOU, which defines roles and responsibilities of the medical and non-medical components of the psychological care provision system.

Part Two Section Four presents an update of psychological care practices at Marine Corps Base Camp Lejeune as of December 2015. This update documents strengthening relationships and the development of shared practices in the provision of psychological health care on Marine Corps Base Camp Lejeune.

Based on the total project findings, Part Two Section Five synthesizes our findings and suggests the features of a care system that Marines willingly use in seeking care.

Part Two Section Six presents our recommendations in support of the evolving system of care. Part Two Section Seven directs the Marines to revisit the 2013 II MEF

---

<sup>6</sup> In December 2013 the Assistant Commandant of the Marine Corps requested examination of the care practices of out-in-town providers serving Marines and their family members. The analysis highlights the important role of these care providers in supplementing the existing care services available on Marine Corps Base Camp Lejeune, noting treatment practices, approach to care of active-duty Marines and their family members, evidence of mechanisms utilized to secure medications and their experience with the psychological care system both on MCB Camp Lejeune and Pendleton.

## Analysis and Recommendations

---

Surgeon recommendations to improve the operation, cooperation, collaboration and coordination of elements of a psychological health care system at MCB Camp Lejeune.



## **Part One: Section Two: Care seeking and Care Receipt: The Emergent Marine-Navy Psychological Health System at Marine Corp Base Camp Lejeune**

The initial research framework of 2013 was formulated to provide answers to questions posed by Marine Corps Headquarters leadership concerning the effectiveness of the then emergent Marine Corps-Navy psychological health system. Using Marine Corps Base Camp Lejeune as a demonstrator, the initial study reflected a current state analysis of the system of care. Care providers, members of the chain of command, civilian professionals and junior leaders were asked about their perceptions of the psychological health care system. The study examined the respondents' knowledge of the care system, the pathways to care and the reasons Marine chose a particular pathway when seeking care, including the use of off-base providers.

While individual perceptions revealed preferences for certain attributes of a care system, also evident were patterns of behavior that reflected the care-seeking process itself. By examining factors that shaped the care-seeking process, we were able to discern influences that govern the choice: a) to seek care; b) from whom; c) under what circumstances; and d) the expectation of anonymity. We also documented the reciprocal influence of leadership's effect on a Marine's disposition to seek care and from whom. Regardless of the availability of care, concerns about perceptions of self and about self and others directly affect the actions of Marines with expressed need for care.

### **Challenges to Efficient Provision of Mental Health Care at Camp Lejeune 2013**

Next we provide an analysis of the 2013 research findings conducted at Marine Corps Base Camp Lejeune. Our data revealed a system of disparate elements operating in a largely autonomous fashion across the range of care providers. Most participants recognized the need for coordination, but each individually lacked the authority, time or resources to collaborate in a concerted fashion. Overall, however, we observed a deep recognition of the value of working together to produce the highest quality system of care possible.

In this section we examine a number of issues associated with a Marine's understanding and selection of care pathways. We posit that care-seeking is a negotiated process contingent on the alignment of Marines' worldview of subordination of self to the well-being of others and contextual factors governing

referral processes.<sup>7</sup> In the specific case of the care referral process, we found: 1) differences in knowledge and understanding of mental health and treatments; 2) interpersonal working relationships (matters of communication, trust, and cooperation; and 3) inefficient systems and processes privileged specific pathways and not others.

In this section, we examine the nature of referral processes as seen through a deep analysis of the 2013 current state findings that identified the influence of preferences and knowledge of intermediaries and interpersonal relationships that predisposed and constrained providers to recommend certain pathways and not others. Here we make causal connections between the referral process and care receipt, which we believe, should inform the design of psychological health services for Marines and family members.

### **Real and Perceived Stigma and the Effectiveness of Prevention Efforts**

Findings from our 2013 interviews showed that strong cultural attitudes still shape Marines' perceptions of the validity of mental health claims and care.<sup>8</sup> In particular, the common belief that seeking psychological help indicates weakness remained prevalent. With the value Marines place on mental and physical toughness comes a bias against self-identification of mental health symptoms. In the minds of some Marine leaders, mental health issues are only "real" when someone else points them out, and by extension Marines with "real" psychological distress should not *want* to pursue treatment because it would keep them from fulfilling their responsibilities. A pervasive belief in the value of "toughing out" psychological distress is at odds with self-motivated care-seeking for mental health issues and likely fuels poor treatment of Marines with mental health issues in units where the leadership holds to these views.<sup>9</sup>

The potential career consequences of seeking mental health care are a more complicated barrier. The fact is that certain psychological disorders and the medical treatment for those conditions *can* have legitimate repercussions for employment that relate to the ability to accomplish specific missions. However, some Marines perceive that care-seeking for *any* mental or behavioral health issue will have similar negative career consequences if those above them in their chain of command become aware of it and believe it reflects poorly on those Marines' performance.

---

<sup>7</sup> Rikke Sand Andersen and Peter Vedsted. 2015. Juggling efficiency. An ethnographic study exploring health care seeking practices and institutional logics in Danish primary care settings. *Social Science and Medicine*. Volume 128, March. Pg. 239-245.

<sup>8</sup> Eugenia Weiss, Jose E. Coll and Michael Metal. 2011. "The Influence of Military Culture and Veteran Worldviews on Mental Health Treatment: Practice Implications for Combat Veteran Help-seeking and Wellness." *The International Journal of Health, Wellness and Society*. Volume 1, Number 2.

<sup>9</sup> Providers confirmed that this type of mistreatment continued to occur in certain units in 2015.

Over the last ten years, the USMC has introduced numerous prevention-oriented initiatives and programs to reduce these barriers to seeking psychological health care and to help Marines identify symptoms of psychological distress exhibited by their peers. To some extent, this emphasis on mental health care and understanding mental health issues has helped Marines at all levels become more aware of the signs and impacts of psychological distress and has potentially contributed to shifting the negative associations held by some Marines of mental health treatment.

However, in general, we saw evidence that two factors combine to produce a disjuncture between the *dissemination* and *absorption* of prevention-related information. First was the sheer number of program offerings and a perceived lack of coordination among them, both in terms of the way they are promoted and their content. Some interviewees suggested that it was difficult for Marines to keep track of the range of options and that they would benefit from a consolidated summary, like a booklet or a binder, on the available programs. The second element inhibiting the absorption of information concerned the predominant mode of formal information transfer around prevention and early intervention—lecture style PowerPoint presentations. Regardless of the importance of the topic, Marines—particularly those of lower ranks—reported ineffective uptake of information presented in lecture form. This disjuncture may occur for several reasons – the Marines may be overwhelmed, they may not have immediate need, they may not be paying attention, or they may be responding to perceived or actual stigma associated with the idea of mental health care. Reliance on past practices of information-sharing combined with an inability to grasp the emergent state of the system of care, inhibited system usage and sense-making by Marines of the importance of psychological health.

### **Line Leaders’ Preference for Medical Mental Health Care Pathways**

When a Marine is identified by a member of his/her chain of command as displaying symptoms of psychological distress, the easiest and most direct route to discerning the problem (if it requires handling outside of the chain of command) is for that leader to send the Marine to a Corpsman or the Medical Officer (MO). The benefits are evident: probability of trust between the leader and the MO, close proximity so the appointment does not take too much time, and the likelihood that the information about that Marine’s diagnosis and treatment will be communicated back to the leader. Some commanders also showed a strong bias for the medical care pathway. That is, when they were unsure about the levels of psychological distress in their Marines, they would rather send subordinates to a medical rather than a non-medical provider.

Similarly, MOs are likely to default to referring to the medical side of mental health care due to issues of familiarity, trust, training, duty and easier information exchange through the medical records system. Within Division the next person in line would be the OSCAR provider or the Division Psychiatrist, again providing proximity and in-

unit information-sharing.<sup>10</sup> Further care or lack of personnel might require the OSCAR provider to refer once again, and the relative ease of sharing information through AHLTA makes it more likely that the referral would go to the medical side of Mental Health.<sup>11</sup> MOs or surgeons outside the infantry division would be more likely, due to presenting conditions or sometimes under pressure from a leader, to refer Marines directly to the MTF. In the end, Division and the MH Department may be understaffed to accept the flow of referrals originating from MOs as a result of recommendations from leaders.

### **Ambiguity About the Roles and Responsibilities of OSCAR Providers**

According to Nash (2006), one of the primary intentions of embedding psychologists, psychiatrists, and psychiatric technicians at the regimental level through the OSCAR program was to establish a forward presence of mental health professionals in operational units in order to provide the earliest possible intervention and treatment as well as provide preventative services within units in order to maximize unit readiness. A 2011 MARADMIN stated that “Unit-support [meaning non-clinical interaction and education] is the primary duty for OSCAR mental health professionals along with providing direct clinical services.”<sup>12</sup> In 2013 Marine Corps Order (MCO) 5351.1 established clear goals for the OSCAR (COSC) program:

*Maximize force preservation and readiness through prevention, identification, and early intervention of combat and operational stress issues, deployed or in garrison; promote psychological resilience and the long-term health of Marines and their families; promote the five core leader functions of Strengthen, Mitigate, Identify, Treat, and Reintegrate; and establish a climate where Marines can seek assistance for stress reactions without fear of reprisal.*

Despite the clear language of the order, it appears as though contingency has diminished the program’s efficacy. As a result of deployment pressures and demand for mental health treatment in garrison, OSCAR providers have been unable to fulfill their role as a preventative asset. Insufficient MH resources across the Marine Corps

---

<sup>10</sup> At Camp Lejeune, OSCAR providers only serve infantry units.

<sup>11</sup> Although there is evidence that mental health providers at MTFs sometimes push back against referrals from unit providers. For example, one provider said: “That stuff happens. And then you’ll have staff at the hospital saying why they hell are you bothering me? You should know how to do this. Because they can be very rude and mean. Nobody wants to deal with that.”

<sup>12</sup> William Nash. 2006. .Operational Stress Control and Readiness (OSCAR): The United States Marine Corps Initiative to Deliver Mental Health Services to Operating Forces. In *Human Dimensions in Military Operations – Military Leaders’ Strategies for Addressing Stress and Psychological Support* (pp. 25-1 – 25-10). Meeting Proceedings RTO-MP-HFM-134, Paper 25. Neuilly-sur-Seine, France: RTO. Available from: <http://www.rto.nato.int/abstracts.asp>; MARADMIN 597/11, Operational Stress Control and Readiness Training Guidance, October 7, 2011. <http://www.marines.mil/News/Messages/MessagesDisplay/tabid/13286/Article/110997/operational-stress-control-and-readiness-training-guidance.aspx>

have not allowed the system to scale with rising demand, forcing OSCAR providers to use the majority of their time treating acute issues within the unit rather than providing education, building unit resiliency, and prevention.

However, Division mental health care providers reported that significant numbers of requests for clinical treatment were limiting the educational and support services they could provide to the units. We also identified tensions between Division providers and mental health professionals at the Naval Hospital over the extent of treatment that should be given at the unit level.<sup>13</sup> These tensions centered on questions of responsibility: are OSCAR providers and the Division Psychiatrist/Psychologist ultimately responsible for all aspects of care for Marines in their regiments? When should they refer Marines to the providers at the Naval Hospital, if at all? On some occasions, OSCAR mental health professionals would prefer to remove Marines needing care from the Division environment, while already overscheduled MTF providers expressed frustration over treating patients at Division who already had access to fully qualified psychiatrists and psychologists through the OSCAR program.

### The Siloed Nature of Provider Groups

In the Marine Corps, four distinct institutional stakeholders with different structures, cultures, and priorities provide mental health care. These are:

1. *Navy medical personnel in medical treatment facilities (MTFs)*. “Blue” medical staff works in Naval Hospitals and clinics. Battalion Aid Stations are Marine “Green” assets with Green providers/corpsmen on base. Distinguishing features of the two over-arching systems--Navy and Marine-- are referred here as Navy Blue and Marine Green. At Marine Corps Base Camp Lejeune, Blue mental health providers, and Marine assets serve in different settings. Navy assets include the Mental Health Clinic at the Naval Hospital and the Substance Abuse Rehabilitation Program (SARP); Marine assets represent Marine and Family Programs and the Community Counseling Program and the Substance Abuse Counseling Center services.
2. *Embedded providers*. “Green” medical providers are Navy personnel embedded in Marine Corps units, including medical officers, Corpsmen, and OSCAR providers. Other embedded providers include Chaplains and Military Family Life Counselors (MFLCs).<sup>14</sup>

---

<sup>13</sup> Interviews with Navy psychiatrists and medical professionals underscore this issue, referring to the problem as “market encroachment.” Similar references were made in reference to the early strained relationship between the expanded non-medical counseling function of the CCC operated by MFP and medical professionals of the MTF.

<sup>14</sup> MFLCs are not associated with the Navy or the Marine Corps, they are funded directly by the DoD. Not all MFLCs are embedded.

3. *Marine and Family Programs (MFP)*. Non-medical licensed counseling opportunities are available through the behavioral health programs of MF, and run by the Marine Corps.
4. *The off-base civilian network* of mental health professionals, including TRICARE and Military OneSource providers.

The diversity of medical and non-medical responses to psychological health concerns is potentially beneficial for a large, at-risk population. The range of options can allow a wide variety of issues to be effectively addressed at different levels, with varying degrees of confidentiality. Interaction and communication among all of these quasi-independent provider groups is essential for reasons of diagnosis and risk assessment, efficient directing of Marines to appropriate care pathways, and coordination of care for Marines already receiving treatment. However, divisions created by separate accountability structures and institutional cultures (e.g. Marine Corps or Navy, on-base or off-base, embedded or non-embedded), geographic separation even among on-base providers, incompatible technologies such as records systems, and differing perceptions of what information should be shared with commanders inhibited connections among provider groups in the absence of specific collaboration protocols. Moreover, in 2013 each of these types of divisions contributed to tensions at the organizational and interpersonal levels that further separated providers into siloed program areas.

As a result, we found in 2013 that providers from one group were often not informed about the courses of action and types of activities performed by providers in other groups, sometimes regarding the same patient. In a number of cases, there was little interaction required or formalized between different kinds of providers, and little institutionalized in-person communication across organizational boundaries —e.g., regular meetings between MF and Division providers, or MTF and MF mental health professionals—was limited.

The critical element for the most efficient mental health care was relationship building among providers and commanders. When individuals took the time to establish connections, learn names and obtain contact information, and initiate informal phone or in-person conversations, information flow improved, tensions were reduced, and levels of trust increased. Capacities and skills needed to develop these types of relationships differed by individual, but opportunities for valuable interpersonal interactions were also hampered by structural factors such as lack of geographical proximity, insufficient forums for cross-organizational communication, and the frequent turnover due to Permanent Changes of Station (PCS) for active-duty service members.

### Sharing Medical Information

Efficient communication and information exchange are central elements in the functioning of any large, multi-entity organization. The challenge of creating appropriate and effective channels of information is particularly sticky within complex systems of military mental health care, when communication of patient information is constrained by privacy considerations but also necessary to ensuring unit operational readiness. In 2013, three key issues hampered the smooth flow of information among the mental health care provider groups at Camp Lejeune.

First were the *technical* challenges of multiple records systems. AHLTA, the system for medical records, is compatible with the Navy “Blue” Internet network but will not run on the Marine Corps “Green” network. Although embedded medical providers were expected to use AHLTA, not all Green-side health facilities were equipped with access to the Blue network, limiting timely access to and input of patient data. On a different level, medical and non-medical providers have deliberately separate records systems; in 2013, MF programs were largely using paper records that had no connection to AHLTA. This disjuncture was noted as a source of frustration for mental health professionals in both provider groups.

Second, issues with *usage* of records systems impeded information flow. Medical providers (both on and off base) at times had different standards for the type and extent of patient information that should be entered into AHLTA, and there were some complaints related to a lack of detail or thoroughness in note-taking. The transfer of diagnosis and treatment reports to AHLTA from TRICARE network providers off base was the main usage challenge, however. In some cases, network mental health professionals were not submitting reports within the required timeframe, creating problems for on-base providers trying to track a patient’s treatment. In other situations, off-base providers sent in their reports in a timely manner, but the processing of the information—scanning into AHLTA—was delayed or even botched.

Third, in the military information-sharing under *HIPAA and privacy restrictions* is a distinctly negotiated process that shapes communications between providers and those in the chain of command, as well as communications among providers in different institutional spheres. Mental health professionals are allowed by law to share with Marine leaders the “minimum necessary” patient information to enable leaders to evaluate their subordinates’ “fitness for duty.” However, the nature of “minimum necessary” information is relatively subjective. Some types of providers, such as Chaplains or MFLCs, have even more restrictive ethical constraints regarding what they are permitted to share, but must make communication decisions in the unit environment sometimes under pressure from leaders. In relation to providers, interpretation of HIPAA and privacy regulations was cited as a reason for the separation of AHLTA and the MF records system, constraining the channels of



information exchange even among mental health professionals with medical and non-medical orientations.

Care coordination and information exchange are intricately connected, so similar to processes described in previous sections, providers and Marine leaders at Camp Lejeune created informal, relationally-based modes of communication to overcome technical, user-based, and privacy challenges. Phone calls, face-to-face interactions, and warm hand-offs of patients among medical and non-medical providers all offer opportunities for unwritten and non-verbal interactions. However, these communication channels are strongly dependent on the strength of individual relationships and can lead to compromises in confidentiality at one end of the spectrum or failures to notify key parties of critical information at the other end.

### **Demand for Medical Mental Health Care Exceeds Supply of Providers**

In 2013, we frequently heard from both line leaders and on-base providers that the medical side of the mental health care system at Marine Corps Base Camp Lejeune (including Blueside personnel at the Naval Hospital and Greenside embedded providers) was overtaxed. More specifically, professionals in the Department of Mental Health at the Naval Hospital were scheduling appointments one to two months out and Marines often had long wait times before they could be treated. Even when they did receive treatment (particularly therapy) it was not possible to schedule them for the most beneficial course of appointments (e.g. a Marine should be seen weekly for therapy, but instead he or she has a session every three to four weeks). Similarly, personnel serving Division, including the Division Psychiatrist and OSCAR providers, were struggling to manage the demand for psychological health care from Marines in their units to the exclusion of preventive care, the original purpose behind the OSCAR resource.

The main question of interest was whether this issue of wait times and provider overwork was a problem of supply and demand (a growing number of Marines seeking care and too few providers), a problem of allocation (inefficiencies in the mental health care system that fail to channel Marines to the appropriate treatment pathway), or some of both. We discuss four potential contributors below.

### **Difficulty Hiring Qualified Professionals**

Apart from issues of patient allocation among different on-base provider types, another contributor to the misalignment between the supply of providers and the demand for care is the struggle to hire mental health professionals, even when billets are available for specific positions. Providers cited Marine Corps Base Camp Lejeune's isolated location, length of personnel processing time from interview execution to hire, uncertainty over job security in some contract positions, and lower government salaries as possible reasons for the lack of qualified candidates.



### **Underutilization of General Counseling Services within Marine and Family Programs (MF)**

In 2013, non-medical General Counseling (GC) was housed within the Family Advocacy Program (FAP) under Marine and Family Programs (MF) in MCCS. However, GC did not appear to have the same staffing and demand issues as were evident among providers at the Naval Hospital or in Division. Medical providers were handling many patients who could have been equally well or even better served by the mental health professionals at GC. As discussed above, Marines within the Ground Combat Element (GCE) identified by members of command as needing care were more likely to be referred to the Division Psychiatrist/OSCAR Providers or the Hospital. Some Marine leaders expressed confusion about the qualifications (or lack thereof) of GC counselors and the types of services they offered. For Marines seeking psychological health care on their own, the fact that GC was connected to FAP could be off-putting. The fact that FAP mainly handles issues of domestic violence and abuse led providers to indicate that some Marines felt that they were being associated with domestic violence simply by entering the building.<sup>15</sup> In general, our 2013 data suggested that the services offered by General Counseling were not well understood by line leaders or by other types of mental health care providers on base.

### **Unease between On-base and TRICARE Providers**

If certain types of medical mental health care are not provided at the Naval Hospital or if wait times for appointments are excessive, Marines will be directed to civilian providers outside of the base through the TRICARE insurance network (with authorization from on-base personnel). Marines can also self-refer through the DoD-funded confidential care referral system, OneSource. In 2013, according to M2 data estimates, mental health care providers at Camp Lejeune referred 12 percent of active-duty patients to the TRICARE network, indicating that professionals out-in-town were significant players in serving Marines with psychological health needs.<sup>16</sup>

In addition, off-base professionals almost always treat family members requiring medical mental health care. Since family relationships can have a substantial effect on the mental health of service members, even if TRICARE providers were seeing no active-duty patients they would still be a key stakeholder group due to their connection to dependents. In fact, we found that some out-in-town mental health professionals, particularly marriage and family therapists, would treat active-duty service members they identified as needing psychological health care without on-base providers' knowledge while providing therapy to a couple or a family, though the spouse would be the primary patient.

---

<sup>15</sup> We heard this statement about FAP and General Counseling numerous times during our interviews at Camp Lejeune in 2013.

<sup>16</sup> This figure stands at 20% today.

It seems likely, with the staffing difficulties and demands for care outlined in previous sections that off-base civilian providers will continue to play some role in caring for the mental health needs of Marines at Camp Lejeune in years to come even with efforts to recapture all treatment of active-duty service members. Furthermore, TRICARE professionals are a resource and may potentially offer Marines increased access to medical mental health care. However, our data indicated a considerable amount of distrust of civilian mental health professionals on the part of line leaders and on-base providers. These doubts centered on three perceptions: 1) civilian providers do not understand the nuances of military life and work; and 2) civilian providers are unwilling to share necessary information; 3) out-in-town providers were the source of polypharmacy.

The challenges of information exchange among on- and off-base providers were reported to be one source of the misgivings. As noted, reports on out-in-town TRICARE-oriented sessions and treatment can be lost or delayed in the transmission process, resulting in an information gap for on-base providers. On the base, some of these types of communication challenges are addressed through informal in-person conversations that are a natural result of geographical proximity and ease of interaction. The lack of these informal connections between on-base and out-in-town mental health professionals may raise the level of suspicion and hesitation in these relationships.

Some off-base providers shared this sense of disconnection, with one calling the base a “black box” and others noting how little they spoke to anyone at the Naval Hospital. For those who did communicate by phone to some extent with medical providers on base, for the most part these calls were not regular or particularly emblematic of a strong networking relationship. Philosophical differences may be at the heart of the lack of engagement. All on-base mental health professionals must consider to some extent the readiness needs of the operational units and the information needed by commanders. Out-in-town providers generally do not share this objective, in the sense that it does not guide their practice. On the whole then, they may be uncertain about the ethics of sending patient information back to the base, which may influence the level of detail they add to the required diagnosis and treatment reports. Even among those working on the medical side through TRICARE, the extent of information sharing is a negotiated process and there are few on-base/off-base channels that facilitate those negotiations.

### Summary:

The 2013 system of psychological health care at Marine Corps Base Camp Lejeune comprised a range of resources, functions, and provider types that developed over a number of years, and in the last decade evolved under the pressure and intensity of active military conflicts. The care system was an outgrowth of a medical model of mental health care provision, operated by Navy Medicine in conjunction with the

MTF. In 2013 the psychological health services represented a medical treatment system that was both centralized in alignment with the Navy Hospital and decentralized in proximity to the Marines Ground Combat Element (GCE), including the Logistics Combat Element (LCE) and Aviation Combat Element (ACE) operations. Assets of Navy Medicine flowed from the MTF to specialized clinics and Battalion Aid Stations, and were collocated in proximity to elements of the LCE and ACE. Assets allocated to the GCE provided care to Marines while in Garrison and during Deployment in conjunction with the expeditionary force. The configuration of overlapping and yet largely autonomous systems of care operated in tandem across the range of care providers and locations across the base. A single telecommunications and record management capability linking the constituent elements of the care provision system was non-existent. Overall, however, we observed a deep recognition of the value of working together to produce the highest quality system of care possible.

Recognizing that the original interview data had the potential to reveal a more nuanced and subtle interpretation of the Marines and Navy psychological health system and the understanding of underlying motives for and experiences with care-seeking, in the next section we utilize Grounded Theory methodology to reanalyze the nearly 100 group interviews; our objective was to move beyond descriptive inquiry to causal interpretation of the essential motivations enabling, guiding and restricting the care-seeking process of Marines. Understanding the underlying motivation of care-seeking is fundamental to the design of a system of care responsive to the desires and needs of Marines. In other words, factors governing the process of care-seeking must be understood if the objective is to design a system of care Marines would choose to use. This approach requires identifying and then explaining the norms and practices governing the processes and procedures that form system usage on Marine Corps Base Camp Lejeune.

The literature provides substantiating hypotheses about access to care and care-seeking behavior. The reinvestigation allowed us to construct theoretically grounded interpretations of care-seeking practices shaped by the actions of care seekers, care providers, and individuals advising about care-seeking pathways. The actions and practices of key actors influence the predictability of care-seeking behavior. Our reinterpreted findings are presented below.

## Part Two: Section One: Utilizing Hypotheses Derived from Literature About Access to Care and Care Seeking: Reanalysis of the 2013 Data

This section of the report considers the reanalysis of the original qualitative findings, clarifying fundamental relationships governing the process of care-seeking, in light of the roles of individuals, leadership, stigma, and confidentiality.<sup>17</sup>

### Care Initiation

Our original analysis of the interview data in 2013 identified the perception among commanders and providers that Marines entered the mental health care system primarily through their chain of command. Our reanalysis indicates care initiation is not always through the chain of command and is contingent on a number of situational factors. For any given Marine in need of care, the pathway is not direct and the best path may not always be the one chosen.

There is definitely a *normative* stance—that is, Marines seeking care should do so through their chain of command, as illustrated by a comment from a high ranking officer:

*The Marines . . . are most likely to talk to family and friends. That would be the first level of identification. Then it is usually with their Corpsman, which is the first line of medical defense. Either the Corpsman is going to recognize something or [the Marine] must have trust in the system to go to the Corpsman or to the battalion surgeon. That is how most Marines, a lot of Marines, seek attention. Now if the command climate is positive such that there is reduced stigma and all those kinds of things, that is how I would like it. You would hope that they would all go to their Surgeon and that is the way it would be addressed.*

Yet, lower-level leaders in particular emphasized that the chain of command was not always followed. These qualified responses came more often from those who work closely with the lower rank Marines. They were more likely to mention "work-

---

<sup>17</sup> In early 2015 the research team first engaged in an exhaustive investigation of the literature on access to care and care-seeking behavior reported in the scholarly and technical literatures. This led to hypotheses generation and key word development to be utilized in the recoding of the on base interviews. After an initial round of unfettered coding of the interviews with on-base personnel, this analysis used a preliminary coding scheme focused on the content of what was said. Based on this scheme, 30 memos were written from selected 2013 transcripts, identifying themes and the various concepts within each theme based on a holistic reading of entire interviews. Through this process, we uncovered five main themes: (1) care initiation (2) stigma (3) beliefs and knowledge about mental health; (4) operational pressures (5) institutional factors, (6) informational flow factors. Recoding the 2013 findings. After the completion of recoding the on-base interviews, the coding dictionary was used to develop an interview protocol to guide the interviews with off-base civilian providers. This step facilitated the comparison of on and off-base data.

arounds" or "side-steps". Two illustrative comments, the first from a platoon sergeant and the second from a Non Commissioned Officer (NCO), make this point:

*I would say that it's more they try to find someone least inside their chain of command, because they are afraid that it's going to affect their career. I would say they try to go maybe more to the Corpsman and say, hey let's keep this silent. On the down level, I would not say that they go to anybody above them because there is a persona that it's going to ruin your career.*

*If you don't want the whole chain of command really knowing about your personal issues and being brought up in meetings, I say you can go to uh... you go to a mental health [provider] on your own or go to uh, call the hotline to do all that on your own and then come to your chain of command and uh, "I got a meeting I got to get to."*

While respondents at all ranks -- commanders and providers alike -- acknowledged that Marines are reluctant to seek treatment at all, the lower ranked leaders provided more candid responses that suggest that those seeking care through the chain of command protocols represent only a subset of individuals who need services. As one Lance Corporal bluntly said in response to the question of how Marines seek care: "We don't." In another instance, an NCO commented, "I haven't seen somebody that actually seeks out help." Respondents at this level say Marines are more likely to go to their Chaplains, talk with their peers, or stay silent entirely.

A key way in which Marines do go through the chain of command for care is when their issues are commander-identified. Commander identification is complex and can be fraught with imprecision. Commanders at all levels acknowledge that they often are challenged to discern "normal" from "not normal" and often rely on their own beliefs and lay knowledge about mental illness to recognize a Marine in need of care.

### Stigma

The 2013 findings identified "stigma" as a central factor shaping care-seeking practices. Both commanders and providers reported believing that stigma still existed but thought that the degree of stigma was a function of command climate and leadership support.

Our 2015 reanalysis reaffirmed that stigma and the fear of being stigmatized play a central role in a Marine's decision to seek mental health care. That stigma is a critical factor is reflected in the frequency with which respondents mentioned it. At least one use of the word "stigma" appears in 37% of the interviews. Additionally there are

references to stigma both directly and indirectly in 66% of the interviews, and more common among Marines than providers.<sup>18</sup>

### Stigmatized for Seeking Care

Respondents typically associate seeking or receiving mental health care as a sign of "weakness".<sup>19</sup> One person called this type of stigma "*the 'individual, internal, everybody is afraid to be criticized or judged or perceived as weak'*" stigma." Weakness results from admitting one needs help. Another respondent elaborated:

*There's this sort of stigma that's attached to reaching out and saying that I need help. . . People think that "I'm going to be looked at as a broken person" or something. . . The stigma is still there. People still think that they're going to be viewed as less than good-to-go or something.*

The origin of assigning "weak" to those who seek care lies largely in the Marine ethos of perfection and high performance (Tortorello 2014)<sup>20</sup>

*Probably the single most corrosive thing in the country today, especially in the military, is the zero-defects mentality. You're either perfect, and nothing's wrong with you and you're a high performance machine, or you are unreliable and broken. . . Really the issue is stigma . . . especially for mental health care. You're either perfect or you're not. And especially when you have people who are very driven and their entire self-esteem is built on how they think others perceive them.*

### Malingers as a Source of Stigma

We found that there is a recurrent concern among leadership about malingerers. The suspicion that any Marine claiming to have mental health problems could be feigning them can contribute to the persistence of stigma. For instance, in a moment of self-revelation, one higher level leader admitted to reacting to a Marine's issues with doubt:

*[Psychological problems] come with a stigma and sometimes I catch myself. I'm like, "Hey, these freakin' guys need to just suck it up and keep marching." I think*

---

<sup>18</sup> 78% of Marines (49 total), 88% of Green providers (16 total), 56% of Blue providers (12 total), and 50% of MCCS providers (6 total) referred to stigma directly or indirectly when interviewed.

<sup>19</sup> William M. Marcellino, and Frank Tortorello. 2014. "I Don't Think I Would Have Recovered: A Personal and Sociocultural Study of Resilience among US Marines." *Armed Forces & Society* 1-23.

<sup>20</sup> Frank Tortorello. 2014. "Stress and Resilience in the U.S Marine Corps: The Corps is missing an opportunity." *Marine Gazette*. June 2014. Pg. 30.

*sometimes when we're in positions like that we have to remind ourselves that some of them are legit and some are the gamers.*

### **Fear of Stigma Affects Care-Seeking**

Respondents acknowledged that the fear of being stigmatized can keep Marines from seeking care. By not seeking care on their own, Marines put the burden of identification on their commander, peers, and family members.

### **Consequences of Seeking Mental Health Care are Real**

Our respondents reported that once Marines are identified as having sought mental health care, they could experience a number of concrete consequences of the stigma associated with it. These include:

- Being marginalized and mistreated by fellow Marines.
- Being perceived as not responsible or not competent as a result of a limited duty status.
- Having one's long-term career options compromised.

Our analysis of stigma parallels findings in the literature that indicate that the stigma associated with mental health issues has real effects on a Marine's experience and can affect his/her willingness to seek care even if he or she needs it.

### **Beliefs and Knowledge**

The 2013 analysis identified differences among leadership regarding both their knowledge of available mental health programs and their perceptions about the quality of these programs. It reported that lower ranking officers were aware of basic programs, but lacked more comprehensive knowledge of all available services.

Our 2015 reanalysis took into account the fact that leadership's knowledge of mental health care itself, their perception of provider qualifications, and their deep-seated beliefs and attitudes about psychological health problems affects their awareness and assessment of available programs. By taking a closer look at these issues, we identified ways in which they contribute to the persistence of stigma and to the situational and causal factors affecting Marines' access to care and ultimately their care trajectory.

### **Beliefs about Mental Health Issues**

We identified three persistent attitudes or beliefs about mental illness that can color a commander's perception of the issues. Specifically, their perceptions do not follow strict diagnostic definitions but are grounded in a mixture of some training, individual experience, and personal beliefs. A persistent theme across these attitudes is doubt about the veracity of any behavioral health claim.



### The "Tough it Out" Mentality and the Doubting of Self-identification

Although the Marine Corps has instituted policies and programs designed to normalize the existence of mental health conditions and encourage Marines with issues to come forward, Marine culture still venerates personal strength and willpower as the primary avenues to success. Some Marines perceive seeking mental health care as a character flaw:

*As he's been saying this entire time, it's just we're, as marines, we just, we tend not to want to lean towards counseling, any mental health of any kind because in our mind it shows weakness. Even though it takes you to be a stronger person to go and actually seek out that help.*

With the value placed on mental and physical toughness comes a bias against self-identification. For some Marine leaders, mental health issues are "real" only when someone else points them out. Not only that, but there is a belief among some leaders that Marines with "real" psychological distress should not *want* to pursue treatment because it would take them away from their responsibilities:

*I would think the legitimate medical, the ones that have issues, they don't want to be separate, they don't want go to appointments, they don't want to be separate from the guys, they want be with their platoons and be with their guys, they don't want to be singled out and looked at differently. They want to keep doing what they are doing and some of them need help and they may have to go to appointments, but they don't want to.*

Along with a distrust of self-identification, leaders sometimes conflate the legitimacy of symptoms with Marines' levels of performance: a solid worker with mental health issues would be viewed with less suspicion than a Marine whose conduct was less than stellar. In the same vein, a Marine who is or wants to be viewed as high-performing may be reluctant to pursue any pathway of care for fear of letting someone down, as noted by a company commander:

*I know he's not going to want to go to the doctor – I had to almost force him to go get help because they don't want it to affect their career or get that label as being somebody who is trying to get out of something even though they've done everything that has been asked of them ... a solid performer.*

A pervasive belief in the value of "toughing out" psychological distress is at odds with self-motivated care-seeking for mental health issues. In addition, if leaders believe that their Marines are demonstrating behavioral health symptoms because they are weak, they are far less likely to be empathetic, potentially resulting in delayed care.



### The Fear of Malingering

Related to the mistrust of self-identification is the perception that care-seeking is a form of "malingering." The perception of substantial malingering among Marines may present a barrier to seeking treatment for mental health conditions.

Although some malingerers are likely to exist within the system, the perception of their prevalence or equating all or most mental health claims with malingering can have a negative effect on the understanding of mental health issues within the Marine Corps. A number of leaders stated that they believed large numbers of Marines seeking mental health care were doing so for two reasons: to separate from the Marine Corps altogether, or to avoid undesirable duties or field exercises. Compounding this skepticism, leaders may also test Marines' mental health claims against what they know of their prior combat experience:

*But I think a lot of people that are claiming PTSD and whatnot never went through such traumatic events that they'd actually have it. Maybe that's why I'm jaded a little bit, because I might be totally wrong.*

One higher-level leader went so far as to say, "I'm convinced everybody is faking it. And I know they're not."

This sentiment is present at lower levels too, where leaders admit they believe that the Marines asking for help are not those who need it because those who need it would not do so.

### The "Lazy" Generation

Commanders also raised concerns about the resiliency of younger Marines, suggesting that new recruits seem less capable of coping with stressful situations. This is perhaps a common viewpoint among older generations in both military and civilian life:

*I think this younger generation has coping skills issues, older generations we were taught how if you fell in life, you picked yourself up, keep going. I call them the silver spoon generation – chuckles – this 25 and under where everything is handed to them with the whole thing, CPS (Child Protective Services), DSS (Department of Social Services) these days, their parents are afraid.*

The perception of a weaker generation can influence leadership's views on the legitimacy of mental health issues. Leaders who generalize younger recruits as lacking endurance or toughness often also think that Marines are commonly using the claim of psychological stress to shirk responsibility. At times this negative view contributes to a sense that the Marine Corps itself is weakened as a result:

*Seriously, I think honestly we have weaker guys coming in now than what we did before. I mean guys coming in that can't handle stress to where "Oh, I got PTSD from SOI or Boot camp." And we get here, and people entertain that.*

### Knowledge of Mental Health Care and Providers

In addition to lack of basic knowledge of services, we found that leaders down the chain of command admitted to having limited capacity to assess the validity of an issue, but at times were also confused about the qualifications of the different providers.

In particular, they expressed confusion about the qualifications of non-medical providers such as mental health counselors and licensed clinical social workers working out of the 2013 MCCS programs, some even going so far as to indicate that they weren't sure these providers, were "certified" at all.

*I think Family Services is a pretty good program. They have a pretty good deal over there and I don't think they are actually certified, they are certified, but they can't like diagnose and give out meds and what not if they need it, but they got a pretty good program over there.*

A pragmatic consequence of this lack of knowledge is that commanders admitted to being more likely to refer Marines to the medical officer. They said that they are more likely to trust a medical provider to make accurate diagnoses or recommendation for care:

*[OSCAR training] points you in the right direction a little bit and I can speak a little more intelligently with the medical officer or someone like that. Still like, I'm not going to say you need to go to division psych or you need to go to so and so out in town. I'm still going to talk to the medical officer first because I'm not a doctor . . . I'm going to get his opinion about it.*

This reliance on medical opinions sets up a bias toward a medical trajectory. Just as commanders indicate that they are likely to refer a Marine to their medical officers, medical officers continue the medical trajectory by referring to an on-base psychologist. Further, while psychologists acknowledged that they might get too many low-level cases, they also indicated that experience in psychological practice could be necessary for making definitive decisions:

*. . . [I]t also requires an experienced person to take a look at the individual and assess whether or not the service member is just having a tough time waking up early and getting their head shaved and people yelling at them and you know, doing things they don't want to do and whether or not they are going to be successful in their career or whether or not they are just going to consume an enormous amount of resources and at the end, never conform and ultimately end*

*up being discharged based on patterns of misconduct or some sort of additional comorbidity challenges that are brought up along the way. So I think it is important to have the most experienced psychologist and leadership involved in that process as well as having a nurse who manages a lot of the ... is this a LIMDU situation, is this light duty, is this someone who is meeting the criteria for ADSEP – that's not an easy process.*

When these gaps in knowledge about diagnosis combine with doubt about the very authenticity of mental health issues, there is a distinct bias toward a medical pathway even when it might not be necessary. Utilizing an inappropriate pathway may lead to repetition of evaluation and put stress on resource allocation. For example, for Marines who may have more severe medically-based mental health issues, working their way through lower-level providers (e.g. mental health counselors) and then only eventually seeing a medical provider takes time and puts stress on the units and their own ability to maintain readiness. Conversely, a person who might benefit from non-medical counseling might be sent to a medical provider too soon and potentially could be unnecessarily medicated, thereby also compromising readiness. Furthermore, they would likely take up resources needed by those with more serious issues.

Our data indicates that, even as the Marine Corps has made substantial inroads toward helping leaders and their units be more informed about the nature of mental health and illness, leadership will still look to medical professionals to help make definitive decisions.

### **Operational Pressures**

The 2013 initial analysis identified negative repercussions associated by leaders with their need to monitor Marines and be accountable for their behavior. The finding emphasized the stress leadership experiences by having to be vigilant in order to avoid blame for any transgressions associated with both the disciplinary and mental health issues of the Marines in their units.

For our 2015 analysis, we identified this accountability pressure as part of the broader requirement to balance operational readiness with individual wellness. We examined how the need to maintain operational readiness can lead leadership to put the health of the "unit" ahead of the well-being of the individual Marine. This on-going pressure can contribute to commanders' doubts about the validity of mental health issues, expectations for quick diagnoses, and impatience with the pacing of long-term treatments. Institutional and temporal pressures to keep troops "ready to go" can favor the desire for "black and white" assessments and outcomes.

We identified three key ways in which the ever-present task of balancing operational readiness with individual wellness can affect both access and care coordination:

## Commanders' Expectations for Unambiguous Diagnoses and Efficient Treatments

The drive to maintain readiness can influence the expectations leadership can have of mental health services. Maintaining readiness, for instance, creates less patience for ambiguous diagnoses or time-intensive therapy, characteristics with which the civilian mental health care system is accustomed. Commanders expect to have definitive diagnoses and are less likely to tolerate gray areas. A high-ranking commander elaborated:

*There are several occasions where we've had to push our way in on a little more of an aggressive stance to get some of the healthcare providers to make a determination on what's going on with this Marine. And sometimes that's difficult because we might think on a certain side, but it's hard for them to come down and say black is black or white is white. And that puts us in a difficult position sometimes.*

Providers also find themselves under pressure to treat efficiently in order to get Marines either back to their units or separated as quickly as possible. Such pressure may contribute to less discernment and less careful identification of issues. Medical providers can feel pressure to prescribe medications when not needed or vice versa.

## Seeing Issues Through the Lens of Readiness

A second important way leadership and providers alike face balancing readiness and wellness in their day-to-day work is actually identifying individuals with issues and getting them into care. As noted earlier, commanders especially harbor doubts about the validity of mental and behavioral health issues. Military personnel who interact with Marines acknowledge the difficulty of discerning behavior that is "normal" and behavior that is of concern (i.e. "not normal.")

Because operational demands require commanders to keep the unit ready to deploy, they may seek to have someone removed from their unit or, conversely, may seek to keep the numbers up and therefore not identify or refer Marines who might need services. It is in making such judgments about Marines that commanders and providers can find themselves making implicit trade-offs between supporting a Marine's wellness or the unit's readiness requirements.

The possibility that "readiness" can override wellness, is reflected in a comment by a Marine Family Life Counselor (MFLC):

*The overriding issue in every military base is the ability to commit to your mission and be able to complete it. And so, they're not going to allow anything, unless it's not going to interfere with the completion of that mission. So even if*

*the services [are] provided to them on base, they're still going to be aimed at activating their resilience and their ability to complete their mission.*

### **Creating Pressure for Marines with Issues to Stay "Under-the-Radar"**

A third way that the challenge of balancing wellness and readiness is evident relates to a Marine's reluctance to initiate care. Marines themselves experience organizational pressures *not* to be identified with mental health issues and their willingness to come forward rests not necessarily on seeking the "right" care for themselves but on finding a safe route to receive *some kind* of care, sometimes under the radar.

Our analysis suggests that addressing wellness and readiness demands together is not a straightforward task. The two aims are not always aligned. Personnel at different points in the system may have incentives to focus on either wellness or readiness at the expense of the other. Marines who seek care on their own may have to make choices that can compromise their own readiness (e.g. seeking medication or hospitalization) or wellness (e.g. seeking under-the-radar options or not seeking care at all.)

### **Institutional Factors**

The 2013 analysis identified a number of institutional level factors that constrain effective access and care coordination. It highlighted the proliferation of mental health services across jurisdictions, some of which overlap or duplicate already existing programs. It also pointed to a general shortage of providers in key services such as the Military Treatment Facility (MTF). Both were considered indicative of the lack of coordination across services. The information systems in place were deemed inadequate to support comprehensive information sharing across medical and non-medical boundaries. Finally, the 2013 analysis identified the disconnected nature of decision-making and accountability across organizational entities.

Our 2015 analysis subsumed the 2013 findings under the umbrella of inter-organizational relationships. A uniting theme is that many of the elements of the Navy/USMC care system operate in an uncoordinated and largely autonomous fashion across the range of care providers. Our analysis identified factors that affect coordination at three organizational levels: 1) Operational capacity; 2) Professional relationships; and 3) Individual competencies.

*Operational Capacity:* Operational capacity refers to the availability of resources to support the organization's goals and missions. We identified three key operational capacity limits that can affect coordination efforts.

*Autonomous Accountability structures:*

The Marine Corps psychological health system has evolved in a fragmented manner in response to new needs of the population that have arisen over time. As a result, each of the four main stakeholder groups of providers— Blue medical, Marine and Family Programs, embedded providers, and the off-base civilian network, both documented and undocumented—have separate accountability structures with distinct procedures and expectations. These separate structures create one of the layers of separation between the entities that can impede collaboration. In the past they have effectively operated as somewhat independent units without formalized cooperative or collaborative procedures, although this is starting to change by necessity. The MOU between the MCCS MFP and Navy Medicine is an example of current efforts to generate routing protocols to enable Marines to reach the correct location for needed care.

Several other layers of separation contribute to the siloed nature of these four groups. The first is the lack of geographic proximity. Second, providers in different spheres of influence are also divided by technology. Third, and perhaps most importantly, these provider groups and the entities within them are divided by their allegiances.

*Resource distribution issues:* Because three separate resource streams administer the different on-base Marine Corps behavioral health programs, it can be challenging for personnel across institutions to provide seamless care trajectories for Marines. We identified four main concerns about uneven distribution of resources, particularly in terms of how they affect getting the "right" care to Marines:

- A program or agency might not receive enough resources to accomplish its mandate. An example given was the OSCAR program, which some thought did not have enough resources to do both education/prevention and treatment and would therefore refer too many people to the MTF.
- There was a perception of duplication of services.
- There was a perception that some resource decisions were misguided. For example, some individuals expressed resentment toward the established MFLC program when their organization had limited resources.
- There was a perception that resources were not being used effectively within a given organization. For example, a provider at the MTF felt that additional nurses would be more cost effective than having psychiatrists do intake.

Because resource distribution decisions for the different mental health service organizations are made largely independently of each other, both real and perceived inefficiencies and inequities arise. One provider captured the sense of frustration associated with working across these different resource streams and not being able to effectively share the resources:

*Nope. Sorry. Just, I'm going to take my toys and go home. I'm not going to play well with others because I can't get exactly what I want. That's the kind of crap. And I'm sure you're going to hear Blue side say that Green side is not playing along. . . . [Y]ou've got other people kind of promising things to other people, but they didn't have any business promising it to them in the first place. So now you've got hurt feelings and ... it's unfortunate that really ... we're supposed to be taking care of patients and ... I don't get why people can't get along and share resources.*

Whether or not the inequities are real or perceived, the effect they can have on inter-organizational relations can be very real. There was evidence in the data that both leadership and providers experienced confusion, resentment, and anxiety over having to deal with these resource issues.

*Information flow challenges:*

Our 2015 analysis also identified the same technical issues with the medical information system. The technical ability to share information across organizations is challenging because incompatible information systems limit the development of a comprehensive tracking system and hence a complete record of care of Marines.

The medical records system—AHLTA—has difficulty running on the Marine Corps Internet. Overcoming limitations requires that computer capacity to both systems be deployed in facilities where Blue serving Green assets provide care. By 2014 most locations supporting "Green" providers' had dual communication systems enabling green providers to input and access data at Division Psychiatry about individual Marines. Respondents have suggested that the dual system is cumbersome, but workable but that there are still limits to the separate systems potentially leading to time delays and lost data. From an organizational standpoint, such technical challenges may contribute to a level of frustration among some providers or other personnel (e.g. nurses, case managers) and result in individuals not making efforts to share relevant information.

The separate system also is a source of frustration for providers on the medical side. The records for Marines receiving non-medical treatment on base through the MF programs—anger management, marriage therapy, financial support, counseling for adjustment issues—are held in a separate system controlled by MCCA and are deliberately *not* in AHLTA. For medical providers, often tasked with making difficult recommendations about the capacity of Marines to serve, not having access to additional information can limit their understanding of a Marine's full situation.

### **Professional Relationships**

The technical limitations to communication were often compounded by the interpersonal connections. The ways in which the different stakeholders work with



each other and the relationships that they establish can affect the quality of care that Marines can receive. We identified two main factors that can have an impact on care coordination: how stakeholders manage the Health Insurance Portability and Accountability Act (HIPAA) regulatory environment and how they manage the division between medical and non-medical care.

*Managing the HIPAA regulatory environment:*

HIPAA and other privacy rules -- as well as how people understand them -- affect what information is shared or logged into medical records. Commanders and providers often have different ethical norms and expectations about what information should be shared and how to communicate with each other. We identified two central ongoing tensions that exist between providers, whose obligation is to protect a Marine's privacy and commanders, who are required to maintain operational readiness: 1) What counts as the "minimum necessary" information; and 2) Who are the "appropriate military command authorities."

*What information:*

The type and amount of information that commanders would want to have access to varies. Most said they want just the information that would allow them to make clear decisions for their unit: who can do what, who is deployable, who is on limited duty, and so forth. One leader very directly stated this point of view: "*I want somebody at the psychiatric level to tell me this Marine's mental state.*" Such information would provide a "definitive" diagnosis to allow a commander to make decisions about the unit. Many leaders accept a straightforward interpretation of "minimum necessary": the diagnosis, the treatment plan, medications, and the duty status. Knowing more or having access to more would be, in fact, having too much information.

Yet, we also found that commanders can be accustomed to having access to many aspects of a Marine's personal life and indeed feel that they should have control over them. This culture can clash with the HIPAA "minimum necessary" clause. As one provider noted:

*Marine Corps involved leadership is becoming a pillar of the Marine Corps -- meaning get involved deeply with the very close and personal lives of your Marines. Whether or not that might not want to make a Marine to kill himself more remains to be seen. HIPAA privacy, HIPAA law, Marine Corps involved leadership are in drastic divergence. Drastic divergence; not convergence -- divergence. The way to meet both of those is to have a paper trail in writing and keep it ethical.*

Consequently, HIPAA adds to tensions that can arise around the need for information to track Marines being seen for mental health issues. But the question of what



information is also complicated by ambiguities around who actually has access to information in a Marine's medical record.

*Who has access?*

Apart from what constitutes “minimum necessary” information to assess the fitness of a Marine, confusions can arise around what *level* of the command should be permitted knowledge of private information. In the HIPAA documentation, “appropriate military command authorities” include “all commanders who exercise authority over an individual who is a member of the Armed Forces.” But the chain of command includes lower and higher ranks, and there is some disagreement among providers and leaders as to where the cutoff falls. One provider said that commanders often may try to use their rank just to find out about individuals -- where their *desire* to know may in fact trump their *need* to know:

*A Corporal does not need to know medical record information on a LCPL. But I'm cool with company commanders and I'm cool with company first sergeants. That's a debatable level and that's where some people will and won't agree. But it's all legal, if you have the documented paper trail . . . Sometimes once they get the appointment letter from the CO they'll say they want to look at this Marine's medical record . . . you have to . . . say, "Hey look, I understand you have the appointment letter, but it's diagnosis, treatment plan, and duty status – duty limitations. It doesn't mean you can pour through his medical record wholesale."*

Thus, HIPAA rules can complicate already strained information flow patterns by imposing constraints that challenge cultural and professional expectations. These rules require ongoing negotiation among the relevant parties to ensure that information transfer requests are fair and ethical -- that is, that they protect a Marine's privacy while ensuring effective care coordination. Deciding the correct balance of information sharing on the psychological health conditions of Marines in care is more of an art than a science for military providers.

**Balancing privacy with disclosure in mental health care: Creating relational networks for informal information exchange**

In any organization, there are formal systems and informal interactions. Organizational analysts understand well that informal relationships matter, that they are the means by which formal systems are implemented and maintained. Understanding the *informal* organization is just as crucial as understanding the formal one. Our analysis indicates that informal connections are central to identifying mental health symptoms and negotiating diagnoses. These informal networks play a key part in the flow of information particularly within the constraints imposed by the formal medical information system and the HIPAA regulatory environment.

**The role of relationships and informal checking-in.** We found that medical providers indicate a preference for face-to-face meetings with each other rather than phone calls when feasible, especially when referring to a behavioral specialist. Such in-person connections allow providers to give a “warm hand-off,” personally introducing the Marine to the psychologist or counselor and laying the groundwork for trust between patient and provider. This introduction seems to be particularly important with more severe mental health issues perhaps because it ensures that the Marine makes at least an initial contact with the specialist, which may help with further compliance.

Geographical proximity of providers either within a unit, health care facility or hospital facilitates these encounters, which can allow for similar or better information exchange in less time than a standard referral. Working together in the same building or unit also makes it easier to build relationships. The interview data demonstrated that many providers take advantage of physical nearness, dropping in on other providers to discuss cases or directly refer patients, as two surgeons noted:

*I think right now if I had to pick proximity or privacy, I'd pick proximity – as the least evil. Having been at the concussion center in Afghanistan . . . right across the hall from us we had a psychologist. If I had a guy that was just having a tough time, I'd say I want to introduce you to someone across ...*

*Especially with these two guys here is when they do send a patient to OSCAR, oftentimes it is more urgent – they'll just come over and talk to either [one] and tell them this is what I have and that way you give a verbal brief so that you don't have to write a 10-page referral and then they'll understand the urgency and they'll see them that day – it's so much easier and then follow up ... they'll know follow-up must be very close.*

That providers would prefer informal, face-to-face encounters in order to manage referrals and obtain more thorough information about patients is not surprising. Yet, how such informal interactions are managed can have implications for privacy and confidentiality.

*Informal communications between commanding officers and providers:* To manage commanders' needs for psychological health information and the seriousness of HIPAA and confidentiality violations, some leaders and providers have developed their own *informal* patterns of information sharing also based largely on face-to-face interactions. HIPAA and MEF policy allow for a somewhat more liberal exchange between medical providers and commanders, but even under those circumstances providers have developed workarounds that allow them to discern and convey necessary information, sometimes by taking advantage of the relative freedom on-base providers have to discuss cases with each other, as illustrated by these comments from two different division psychiatrists:

*If there is something that is ... something is going wrong with the patient or something that I think needs to happen with the patient ... I don't ... a lot of times I'll funnel that information through the MOs because there's a lot of HIPAA stuff involved, so the way I get around it is I'll talk directly to the MOs and they are very good about passing that information forward to the line leaders because again, I can't go directly to the line leaders because I can't get out of my office to do that.*

*And then because he's the company commander I can talk to him about certain aspects of the case and I talked to him about risk for violence and weapons in the house – that sort of thing. They made their decision based off of the information I provided.*

Providers and commanders have developed an interdependence in which providers indeed rely on the informal knowledge they get from commanders and the commanders depends on providers to make a definitive judgment about the Marine's condition. One surgeon described how the diagnostic process can have a back-and-forth quality that includes input from the Marine's chain of command:

*Their whole chain of command gets involved when it comes to mental health. . . [S]o you get the story from the patient, but then you have to balance that story sometimes with what is actually going on. Their story, the company's story, and then there is the truth in the middle somewhere. . . You go talk to the first sergeant or their immediate corporal and it's like yep, they're 100% on, or it is nope, this is the real story. We find out that maybe some of the family issues are going on and feeding into mental health problems. Hey they deployed X amount of times and they were blown up 3 times and it has never made it to their medical record or whatever the case may be. So some of the history may not be in their medical record or the patient isn't giving you – a lot of times [it] comes out of the company.*

Our data suggests that similar informal interactions occur between leaders and MFLCs or Chaplains. These face-to-face exchanges can involve more negotiation and a certain amount of verbal and nonverbal coding to navigate both confidentiality restrictions and the presence of internal and external stigma. They are effective largely because they happen within a unit where regular contact is the norm. In some situations, commanders and Chaplains or MFLCs will make informal and sometimes covert arrangements to create connections with particular Marines who would perhaps not have sought care on their own, as one commanding officer noted:

*I'll tell you what – and we'll sit there and war game – without making it obvious...I'll tell you what this is where she works – just poke your head into this room and just see and let's just pull her out without isolating her and offer her ... those are the things, those are the opportunities. Or, it goes the other way. We're*

*talking about a Marine, just again, another great example: the MFLC spoke to him last week and although he's saying this, these are really the issues. Ah, okay; Doc what do you think? I'll tell you what, he needs to go see somebody. Because there's a negative connotation with psychological health, let's be candid here. I'll tell you what doc, let's just set up a physical and then during the physical we all know what's going on and we can pull some strings – offer him an option and see if he goes with it. Those are the things that we have...And that's where we like the MFLCs, because now they're embedded – and I'm fortunate I have 2 of them – now they're kind of embedded into our battle scheme. We have our duties. Well if we need to, we can have small meetings where they whisper in our ears; hey doc get over here or SgtMaj get your ass in here we need to talk about so and so. We come up with what we think is the best guidance.*

Ultimately, this type of informal, negotiated information exchange that guides care decisions is dependent on the strategic development of relationships, a point that was clear to some respondents, both leaders and care providers. Knowing people by name, having their phone numbers, keeping in fairly regular contact, and creating goodwill facilitates the transfer of information in an environment dealing with the tension between maintaining confidentiality and fitness for duty. But establishing and maintaining these relationships requires time and skill. Not all participants in the system are willing to put in the time, and not all have the necessary interpersonal abilities. Furthermore the frequent turnover in the Marine Corps setting means this relational work must be done over and over. This process is summarized by one commanding officer:

*It's a people business. Some are literally don't tell me what to do, I'm the doctor and shut the hell up. And some are ... matter of fact, the 3 people we deal with, literally you would think they are part of our staff. They'll call us up and hey we just had an appointment or hey... I just had a follow-up with CPL so-and-so and call if you want to discuss or let me know. And you can go both ways...Everyone has different ways of terming it, I call it the underground. I mean you can call it whatever you want to call it, but it's literally ... you work behind the scenes ... now here's the difference, how much time do you have in the day depending on other crises, things – is going to dictate how much time you can put into these things that we think are good.*

#### *Managing the Medical/non-medical division:*

While the historical division between the Navy and Marine Corps behavioral health services has emerged along "medical" and "non-medical" lines, the distinction between medical and non-medical *care* can blur in practice. The clinical distinctions between medical and non-medical diagnoses and their respective treatment approaches are continually in flux and are always being negotiated and re-negotiated. This blurring can raise professional "turf wars" where different providers claim

greater expertise and authority for treating conditions. This issue was particularly evident among some medical providers who were dubious that some programs outside of the medical purview would succeed.

For example, some MTF providers took issue with the MFLC program and the OSCAR program. In both cases, they were unsure that the *fundamental model of intervention* on which the programs were based would be effective in identifying, treating, or appropriately referring serious problems. A main point of contention for both was the localized -- and isolated - nature of the interventions. Regarding the MFLC program, providers thought the MFLC approach undermined good professional norms:

*They [MFLCs] don't even do notes. You know, it's this casual thing, and I'm sorry I'm a board certified psychiatrist. I feel that there are certain ways that people will benefit from treatment and I just don't think meeting them for coffee at Starbucks is going to help.*

Also, Navy Medicine's reservations about the then newly emerging OSCAR program echo their critique of MFLC. A main concern was that, while commanders might welcome the practice of embedding providers, it would really not allow the time and the space to substantively address serious issues, which could then go untreated.

### **Gaps in Individual Competencies Needed for Effective Coordination**

Finally, our 2015 analysis identified the need for individuals working day-to-day across different mental health programs and organizations to develop the necessary skills and competencies to support improved coordination efforts.

#### Medical record-keeping skills:

When providers brought up limits to care coordination, they often mentioned that medical record keeping was fraught with gaps. They cited two main issues:

- **Slowness in processing:** A number of providers expressed frustration with the way the reports were being processed once they were submitted. Even after off-base providers submitted reports, respondents noted that there is often a time lag for when the reports are actually entered into AHLTA.
- **Limited or abbreviated data entry:** Some respondents indicated that the notes of both on-base and out-in-town providers are not always very thorough or well-written. Some mental health providers may not enter detailed notes due to time constraints, while others may deliberately choose to provide as little information as they are required so as to leave open the diagnosis.

#### Communication skills:

We also identified ongoing frustration with interpersonal communication among key stakeholders, particularly between commanders and providers as well as between

medical and non-medical providers. Issues were evident at multiple levels, from managing individual cases to designing improved program coordination. At the case level, for instance, providers complained of not always being able to reach other providers or not always getting callbacks.

At a program level, individuals complained of not being informed of programs or being included in planning processes. One provider on the non-medical side noted, for instance:

*I don't think we communicate enough. We've made a lot of efforts this last year with the hospital. My supervisor does a lot to try to integrate us in and make sure we are aware of each other but, because of turnover and all those kinds of things, collaboration is a continual challenge and it really has to be a continual effort. . . . Definitely not enough green-side and MCCS communication. There is a big resistance there. We do get invited to things like the II MEF suicide prevention council but we sit along the wall and aren't really told to speak.*

### Collaboration and trust building skills

As evident throughout our findings, access and coordination of care can be compromised by a lack of trust. Commanders did not always trust the veracity of a Marine's mental health issues. Medical providers were dubious of non-medical providers' skills or the embedded providers' model of care. Non-medical providers worried about over-medicalizing an issue. In a system marked by autonomous and semi-autonomous accountability structures, improved coordination is constrained when relevant parties lack trust in each other.

### **Summary**

We began our 2015 re-analysis with a close examination of the non-physical factors associated with gaining access to care. We were able to develop a rich description of the factors that can shape whether or not a Marine seeks care and the ways in which Marine culture can affect identification and care-seeking. We then were able to consider the factors that would constrain a Marine's care trajectory and shape the outcome of access at different points in the system. Marines may find their way to a particular "door" in the system but that door may not align well with their ultimate needs. The ongoing coordination issues we identified may limit the Marine's opportunities to find the most effective path.

As we come to a close of this section, our emphasis has been on understanding the actions of individuals and the systemic bases of care selection by Marines. From our 2013 interviews and other documentation, on-base services are only one avenue of care available to Marines. For families, off-base services through TRICARE and Military OneSource are the available avenues to care, unless an emergency prevails. Marines and Sailors can also utilize off-base resources; access varies according to

## Analysis and Recommendations

---

regulations governing these two sources of care. The next section of our report steps off base and examines care-seeking through the lens of private providers including those operating as sole practitioners in single person firms to individuals working within a group practice. By integrating these two analyses, we begin to offer something akin to a *wide-angle* view of care-seeking at and around MCB Camp Lejeune.

## Part Two, Section Two 2015: Research Findings of Civilian Out-in-Town Behavioral Health Providers and How They Serve Marines and their Families<sup>21</sup>

### Introduction

The out-in-town component of our research grew out of the recognition that these behavioral health providers make up an appreciable segment of the behavioral health services that Marines and their families use. As our on-base analysis proceeded, we increasingly identified ways in which the out-in-town providers not only *augment* available services by providing additional resources, but also *supplement* those services by providing care options not available to Marines and their families on base.

22

The resulting interviews in 2014-2015 with out-in-town psychological health care providers allowed us to explore the care-seeking practices of family members as individuals, as parents of children, as part of a family unit, and as active-duty Marines. Out-in-town providers include those professionals that are accessed utilizing Military OneSource, the anonymous referral service funded by the Department of Defense. In addition, the care of families is purchased almost entirely off base using TRICARE insurance. Active-duty members also can be referred off base either as a TRICARE referral, when circumstances on base such as appointment wait time is excessive or if some type of specialty care is unavailable on base. Late 2015 data indicate that upwards of 20% of active duty personnel are being referred off base for mental health care due to supply constraints at the MTF. Active-duty Marines can also avail themselves of off-base non-medical counseling with the protection of confidentiality through Military OneSource. Added together, a significant portion of all care needs of Marines is addressed beyond the oversight of Navy Medicine and non-medical Marine and Family counseling services. An unaccountable amount of care is received using the anonymous Military OneSource program. Hence the ability to determine the efficacy of the system requires understanding the motivation behind the desire to seek off-base care by Marines and their families. Care-seeking and care receipt, then, is an interactive and mediated process that offers Marines and their family members a number of pathways to care for psychological health needs.

---

<sup>21</sup> This section represents the final report of out-in-town provider study of psychological health resources surrounding Marine Corps Base Camp Lejeune (40 mile radius). The enclosed material expands significantly beyond the original project deliverable.

<sup>22</sup> Andrew Bell. 2014. *Moral Obligations and Fiscal Responsibility: Barrier to Tricare Reform*. Unpublished paper. Our work on TRICARE began with an historical analysis of the military health care system and the components providing access to care for active duty, retirees and family members. This study focused on the historical difficulties of reining in costs for the TRICARE health care insurance system.



Family care-seeking is circumscribed by numerous factors including the underlying problem motivating the need to seek care, constraints associated with the location of care, including the ability to travel, the availability of supply, the need for timeliness of care and the desire for privacy. At the start of the OIF conflict, research made clear there was an insufficient supply of care providers or medical corps to treat Marines in country. A similar paucity of care was evident in garrison as Marines returned experiencing “combat stress reactions (CSR)”<sup>23</sup>. Our initial 2012 and 2013 research on the supply of TRICARE providers around Camp Lejeune highlighted supply constraints. Subsequent statistical research in 2014 confirmed a continuing supply constraint in the communities surrounding MCB Camp Lejeune and MCB Pendleton.<sup>24</sup> Even as the supply of care built up over time in both theater and in garrison as well as in communities surrounding the installations, the use of off-base care by active-duty Marines was an important component of all care sought. Statistical evidence indicates the fraction of Marines returning from deployment with CSR symptoms was greater than the number of Marines seeking care for such indications. The growth in demand for off-base care was also fueled by family needs that were growing over time. That Marines and their family members made choices not only about where to seek care from, but also from whom and by what means made self-evident the need to study the care-seeking process itself.<sup>25</sup>

### Research Approach for the Out-in-Town Spatial Social Analysis

**Step One: Assessing the Potential Supply of Care Providers.** We undertook two separate analyses to study the off-base care environment around Camp Lejeune. Our first investigation of off-base care availability examined the relationship between the member density of the off-base, Civilian Behavioral Health Provider Network (Off-Base CBHPN) and the two sources of demand on the Off-Base CBHPN — the

---

<sup>23</sup> Nausheen Momen, LCDR MSC USN; Chris P. Strychacz, PhD; Erik Viirre, MD, PhD. 2012. “Perceived Stigma and Barriers to Mental Health Care in Marines Attending the Combat Operational Stress Control Program.” *Military Medicine*. 177, 10:1143.

<sup>24</sup> Eric Schultheis and Amy Glasmeier. 2015. “Spatial Typologies of Care: Understanding the Implications of the Spatial Distribution of Off-Base Civilian Behavioral Health Providers Who Accept TRICARE Prime to Service Persons and Their Dependents.” *Military Medicine*, Volume 180 Issue 9, pp. 979-985.

<sup>25</sup> Our findings from this section rest upon a few important front line facts. Marines in need of care seek information from each other and from those close by. Those who provide comfort, support and direction express a range of understandings of the care available and how access works. As in the previous section, stigma and fear of reprisal are overriding influences shaping both those seeking care and those directing others toward care. The single largest referred care source in our analysis was to Military OneSource, the confidential service funded by the DoD. The familiarity of this resource, the comfort and assurance with which interviewees mention this capability as an offering to others, more than any other evidence underscores the deep dedication of Marines to solve their own and the problems of their brothers and sisters without prejudice or jeopardy of their ability to be a Marine.

population enrolled in the military treatment facility (MTF) and the civilian population within the vicinity of the base. Behavioral health providers consist of a range of health care professionals including, but not limited to, psychiatric nurse specialists, counselors, psychologists, psychiatrists, therapists, and social workers. We studied a subset of the total universe of provider types.

There are two sources of demand on the Off-Base CBHPN. One demand source comes from beneficiaries enrolled in TRICARE Prime at the MTF. This population consists primarily of (1) service persons, (2) TRICARE-eligible guard members who are stationed at the base, and (3) the dependents of service persons and TRICARE-eligible guard members. The second source of demand for the services of Off-Base CBHPN is the civilian market, or more specifically, the universe of civilians who are enrolled in health insurance networks to which providers belong. We estimate the magnitude of this second demand source with the total number of persons who live in the vicinity of a base.

A comparison of the rate of off-base civilian providers (1) per 1,000 persons enrolled in the MTF and (2) per 1,000 persons in a base's vicinity allowed us to understand the likely demand on the Off-Base CBHPN. Using this dual approach we were able to determine the effect of the density of the surrounding population on the geography of potential care. Our findings indicate that the bigger the surrounding population of potential users the lower the likelihood of available care providers to service Marines and their families.

We used two administrative boundaries (40 miles and a 30-minute drive) to define the study areas around each of the bases examined. We settled on the 40-mile boundary when analysis showed no discernable difference between the two boundaries. Using this boundary selection, our results demonstrated that population density was a significant influence on the likely availability of off-base care providers for Marines and their families. The provider networks around installations like Camp Lejeune may experience less civilian demand and thus potentially be more responsive to the needs of Marines and their families compared with a base such as Pendleton, which is situated in an area of higher population density.

**Step Two: Assessing Characteristics of Providers and Their Cultures of Practice.** With the first analysis serving as a local baseline of system of supply, to gain a deeper understanding of the aforementioned social factors, we designed an exploratory investigation to gain insight into why Marines use out-in-town behavioral health providers, how they access them, and what their experience of using them entails. Using a grounded theory approach (Corbin and Strauss, 2015<sup>26</sup>), we employed a "purposive" sampling technique to establish a cross-section sample of providers

---

<sup>26</sup> Juliet Corbin and Anselm Strauss. 2015. *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory*, 4<sup>th</sup> edition. Thousand Oaks, CA: Sage Publications.

---

---

## Analysis and Recommendations

---

located within a 40-mile driving radius from Camp Lejeune and Camp Pendleton respectively. The table below lists the number of each provider type that we interviewed in each location:

Type of Provider	Lejeune	Pendleton	Total
Licensed Clinical Social Workers	2	1	3
Psychologists	2	8	10
Mental Health Counselors	5	1	6
Marriage & Family Therapists	4	4	8
Psychiatrists	0	1	1
Total	13	15	28

We developed an open-ended interview protocol designed to probe how out-in-town civilian mental health professionals provide care to Marines and their families. It was structured to allow us to probe the following key areas:

- Who they treat and what the nature and type of mental health issues they generally encounter are.
- How Marines and families are referred to them.
- What their professional approach is toward treating Marines and their families.
- What their information sharing practices are.
- What connections they have with on-base providers and other providers in the community.

We coded the interviews using the same coding scheme developed for the 2015 re-analysis of the on-base interviews.

The exploratory out-in-town provider study was intended to give insight into the experience of accessing and using out-in-town providers. Our findings are delineated into three main topic areas: 1) Why Marines and family members use these providers; 2) How they access them; and 3) What the experience of using them is like. Our premise is that understanding some of the experiential factors that shape out-in-town provider care-seeking and usage can inform the development of policy recommendations sensitive to the needs of those using these services.

### Why Marines and Family Members Use Out-in-Town Providers

In examining why Marines and families use these providers, we focus on the client base of the providers interviewed, reasons for using an out-in-town provider, and the typical issues treated.

#### Who is served?

To appreciate why Marines or family members use out-in-town providers, we begin with a brief account of who is actually served by these providers.

Because our initial focus of the study was on TRICARE providers, sample selection included only providers who accept TRICARE insurance. Marines and family members can also access out-in-town providers through Military OneSource and by choosing to pay privately, which some do. Our data indicates the following breakdown in payment method/program affiliation:

- All 28 providers interviewed accepted TRICARE insurance.
- Twelve providers definitely participated in OneSource and one other probably accepted it; nine did participate in OneSource. It was unclear whether or not the remaining six providers accepted it.
- Five providers mentioned having had multiple Marines who paid out-of-pocket.<sup>27</sup>

We asked all providers to describe their client base: who they treated and for what. Because any provider's client base is fluid and changes week-to-week, the telephone interview format allowed us to obtain only a general snapshot of their practice. We were not able to obtain firm statistics of client numbers but were able to obtain the general configurations of clients served. We identified the following:

- Five providers indicated they were seeing Marines alone through TRICARE
- Nine providers indicated they were seeing Marines alone through OneSource.
- One provider indicated seeing Marine couples through OneSource.
- Twenty-six providers indicated they were seeing various configurations of Marine families: Family members (spouse or children) without the Marine or together with the Marine.

---

<sup>27</sup>It is important to note that we cannot speak for the other providers because we did not explicitly ask if they had ever had self-paying Marines. This data point is included only to support the perception on base that some Marines do pay out of pocket for care.

---

- One provider did not have any military-related clients at the time of the interview.

We had begun the out-in-town study with the assumption that we could not limit an inquiry into the military's behavioral health care system to MTFs and other on-base behavioral health resources or only individual Marines. A focus on the service person's behavioral health divorced from the family may miss critical factors that affect the overall well-being and operational readiness of Marines.

Our initial assessment of the out-in-town providers' client mix indeed points to the importance of including family members in assessing behavioral health services for Marines. While almost half of the providers did see individual Marines, almost all of them treated family members, sometimes including Marines as part of marriage or family therapy. The role of these providers as a means of ensuring care for these Marines and their families cannot be underestimated.

We also note that Marines are using Military OneSource to access care with out-in-town providers. More of the providers were seeing Marines individually through OneSource than through TRICARE. This is not surprising because OneSource does not require a referral whereas TRICARE does. But it does raise questions about why they seek care from these providers and whether or not the care is perceived as different from (or preferable to) on-base care.

This brief accounting of who out-in-town providers see then sets the stage for considering the more experiential components of out-in-town providers' contributions to care for Marines and their families. We now turn to some of these factors.

### **Why Marines Seek Individual Care Off Base**

Our respondents were clear on several key reasons why Marines as individuals will seek care off base. Some apply more directly to Marines being referred off base through TRICARE and some apply more directly to Marines using Military OneSource to obtain short-term non-medical counseling.

#### Provider shortages and quality of care:

One of the intended purposes of TRICARE is to provide a means for Marines to get timely care when it is not available on base. Our on-base analysis confirmed that MOs or behavioral health specialists at the MTF would at times make these referrals when necessary for Marines.

From the perspective of the out-in-town providers, the Marines they see who have already sought care on base have concerns not only about the availability but also the quality of the care. They have issues not only about seeing a provider in a timely

manner but also about the actual experience of seeing the provider. One provider captured these different sentiments:

*All I can do is take their word for it. But all I get is the negative feedback from people who have tried things on base and they don't appreciate it. They are not getting what they want or getting what they need. What they tell me is usually they end up talking to a social worker as opposed to either a counselor or a therapist. They tell me that they see them for fifteen or twenty minutes and that's about it. They tell me that they only see them on a very irregular basis, once every two weeks, once every three weeks. The other complaint that I get from people is that if they are lucky enough to see a psychiatrist, at the Navy hospital, for example. That person usually wants to just give them medication and doesn't have time to really talk about the issues that brought them in. They just want to do what psychiatrists do, I guess, which is prescribe medication. It's very rare that they have the opportunity to actually speak with someone about their issues. That's what most of these people really need and want, that talk therapy. They want to be connected with and be able to express their feelings about whatever is going on.*

Based on experience working with these Marines, this provider had the perception that Marines did not always have the opportunity to engage with a counselor about their issues, which is what they may have needed. Concurring with this view, another provider noted that sometimes Marines will say, "*I tried to get help on base and I could not and I insisted that I come out.*" Consequently, some of the referrals are at the request or insistence of the Marines themselves.

Privacy and the avoidance of stigma:

As we found with our on-base analysis, fear of stigma is a key factor driving some Marines to seek care off base. This is particularly the case for Marines who seek care through Military OneSource. Without exception, all of the out-in-town providers interviewed mentioned that active-duty members will resist seeking care because of how it could affect their career and how others might see them. They had the sense that, even if more providers could be hired on base, some Marines still would seek care off base because they would want to ensure their privacy. A provider whose son was a Lieutenant Colonel in the Marines expressed concern that some commanders could access more information about a Marine's medical history than is appropriate:

*But then the people are inclined not to go, because all of their information goes directly back into their file. Their superior officers have it available to them. I don't like that. I don't like that for a human being . . . .*

While not all commanders can access information as freely as this provider suggests, the comment points to the very real concerns of Marines seeking care off base and

about who has access to their medical records. And, given our findings on the ways informal communication can work, the concern may have some legitimacy.

As with our on-base respondents, the out-in-town providers identified stigma as a risk associated with a loss of privacy regarding behavioral health services:

*Even though the military says time and time again, "Don't worry, this will have no effect on you or on your career." Or whatever, that's not the reality. The reality is that individuals make these decisions and some individuals feel that way. I have actually had some good feedback about officers who have said, "Yes, go get the help you need." I've had a lot of other feedback with people saying, "If my gunnery sergeant or if my captain finds out I'm here, I'm done."*

A number of providers acknowledged that Marines specifically fear the effect of seeking mental health care on their career and are particularly concerned about their commanders finding out that they are getting help. These providers expressed awareness that Marines are especially worried about promotions. As one noted:

*I've had some cases that have given me examples of how they've been a stellar Marine, then the Command finds out that they're having some adjustment problems being back from deployment and everything and they feel like they're, kind of, treated differently, so, how accurate that is I don't know, but, to me, the main reason that they would seek help off the base is, is for that reason.*

While the out-in-town providers cautiously acknowledge that they were basing their perceptions on stories they hear from the Marines themselves, project data indicate that these accounts are consistent across our respondents.

It is important to note that the need for confidentiality to avoid stigma carries over to those who pay out-of-pocket. Several providers commented on serving Marines who were able to pay on their own for care, citing privacy concerns as the main motivation. One provider explained the rationale for choosing to pay out-of-pocket:

*[A]ctive military has to [go through their referring physician] unless they pay cash. . . [A] lot of pilots, stuff like that [will pay cash.] Yea it happens more frequently than you would think. . . Then only they would have access to their records. . . I have had a few active duties in the past that just paid cash and didn't want any TRICARE, Military OneSource or anything. I've only had that happen a couple times. . . But there seems to be a stigma, they don't want to see a therapist on base. They're more apt to pay out of pocket to see a therapist. You know, I don't want to say 'more apt to' but several are seeing a therapist off base because they don't want their commanders to know that they're suffering from PTSD or getting therapy.*

Another provider indicated that the confidentiality afforded by seeing an out-in-town provider unencumbered by connections to commanders results in better quality care: *"My care is more confidential so I think they're willing to disclose more and therefore can get more effective treatment."*

### **The Need to Seek Family Care Off Base**

As we note above, a significant percentage of the out-in-town providers' military clientele involve some configuration of family members. Sometimes it may just be a child or a spouse, at other times it is the whole family. The Marine may or may not be part of the group, depending on his or her availability or willingness to come.

The main reason that family members seek care from out-in-town providers is that care is not available for them on base. While there are support programs for families on base, out-in-town providers indicated their clients lacked familiarity with the programs available to them at Marine Corps Base Camp Lejeune.<sup>28</sup> Because spouses and family members can access a certain number of visits and thus do not need referrals to initially use TRICARE to see out-in-town providers, they are able to get appointments without seeing a primary care provider.

Families may seek care off base because they lack information about the services available on base. In considering how the Marine mental health system could be improved, one out-in-town provider commented that it sometimes seemed like some of the Marine and family clients were unaware that family support programs existed on base. Other evidence suggests that family members seek care off base in order to protect the confidentiality of their active-duty member.

### **Family as a Source of Individual Marine Care**

An important aspect of family care is that it can be a source of some form of support for a Marine who may have issues but, for concerns about privacy or pride, is not willing to seek care on his or her own.

A recurrent pattern described by out-in-town providers is that a family member will seek care and then the Marine may ultimately get involved. TRICARE covers family therapy and Military OneSource allows for 12 visits not only for the Marine but also for the spouse or for couples counseling. Consequently, a spouse may initiate care utilizing TRICARE resources and the Marine may be included at some point in the care. As one provider noted:

---

<sup>28</sup> Out-in-town providers commented that their clients demonstrated limited knowledge about available care on base.



*Often times, I'm contacted by the spouse but then when I get to know what's going on and get to see the family, then it really involves both of them -- sometimes, much more significantly with the active-duty person.*

The provider then explained that the spouse would be identified as the TRICARE beneficiary with some specific diagnosis. It would therefore not be on the Marine's record. But, within the context of marriage and family therapy, it would be acceptable to include the Marine. As the provider noted "*because most of what I do eventually involves a larger system than just the individual, it's okay to bring in the other person.*"

Importantly, the Marine may in fact have an opportunity to talk privately with the provider if the provider deems it to be necessary or valuable. As the provider above noted, "*Even when they're having a relational problem, sometimes they're just a little more open and a little bit more honest when they're talking to me privately.*"

For Marines reluctant to seek care on their own, marriage and family counseling may indeed serve as a "side door" into behavioral health care.

### Typical Issues Treated

We asked providers to describe the typical issues that they treated. The issues that they mentioned fall into two broad categories: Individual issues and relational issues.

Individual issues: Many of the respondents described treating a range of individual issues commonly associated with Marine mental health. These included anxiety disorders, panic attacks, depression, and PTSD. Included also were more specific symptoms such as irritability, sleep disturbances, and memory impairment. A few providers commented that they also treated more serious issues such as symptoms of traumatic brain injury.

A few providers commented that Marines might seek counseling to address issues they are having with their work or talk through some personal issues.

Relational issues: The relational issues mentioned likely encompass more individual issues and reflect the stress of balancing Marine and family obligations particularly when the Marine and the family are not prepared to deal with them.

One important theme across a number of interviews is those Marines and their families seeking care can have long-standing issues and that the stress of military life brings them to the fore. One provider elaborated:

*I think a lot of the family members even the spouses present with their own post-traumatic stress, often childhood issues, adjustment disorders, depression . . . We see a lot of childhood trauma [and] dysfunctional family systems. So they didn't develop healthy coping skills. So then we get the military personnel that are*

*dealing with trauma from the war. Some of these young military are getting married at 17, 18, 19 years old and not having the tools to know how to manage a marriage and the responsibilities and maturity that comes with that.*

This provider highlights the interconnectedness of many of the issues with which these Marines and their families are coping. The latent issues such as childhood trauma can intersect with limited coping skills for managing a marriage in the demanding and stressful Marine Corps environment. Issues that can arise may include physical or verbal spouse abuse, alcohol abuse, and anger management issues.

Several providers commented that challenges with adjusting to family life when returning from deployment often bring Marines and families in for care. One provider described a typical scenario:

*Often when Marines come to me, they're having a problem with their wives or significant others. There's a sense that they're not being understood, demands are being made on them that they can't meet, and that what they've been through just isn't something they can explain to someone who has not been through it, especially a significant other that doesn't understand why these guys often don't want to talk about their experiences.*

### **How Marines and Their Families Access Care**

Accessing care with out-in-town providers happens in several ways depending on whether or not the Marine or a family member is seeking care.

Military OneSource: For Marines seeking to use the Military OneSource option, they are usually given the name of a provider that they need to call within 30 days. Several providers commented that they did not understand the process or rationale associated with assigning a provider to someone seeking a Military OneSource referral.

TRICARE referrals: For both Marines, who need a referral from an on-base provider and their family members who do not, finding a TRICARE provider usually requires looking on the website to identify a provider and contacting that provider directly to make an appointment.

We asked all of the out-in-town providers why a Marine or family member might choose to see them. The responses tended to fall into several categories.

Location: Because many of the people seeking care were using a website to find a provider, the providers said that their location would matter, particularly if they were located within easy access of the base. Easy access could include physical proximity or it could be easy driving distance (e.g. right off the highway).

Specialty: Providers also cited specialty as a reason someone would choose them.

Responsiveness: Several providers commented that some clients might come to them because they actually answered the person's call. They noted that some providers do not answer the phone or return calls in a timely manner.

Hours: Several providers commented that clients chose them because they offered more convenient hours, particularly evening and weekend hours.

Reputation and word of mouth: A number of the providers cited their reputation as a key factor in people choosing them. Providers in both locations mentioned that clients had said that someone in their network of friends recommended them.

Finding an out-in-town provider has a certain arbitrary or opportunistic quality to it. Those seeking a provider may choose someone from the website based on hours or location. Or, they might go to someone because a friend or acquaintance recommended him or her.

### **Professional Practices and Norms of Out-in-town Providers**

In considering effective ways to improve the care for individual family members as well as for the integrated family unit, it is important to include the *experience* of the care itself. It was not unusual for us to hear concerns from on-base respondents (commanders and providers alike) that the out-in-town providers represented something of a "black hole;" that is, it was difficult to track what care Marines might be receiving and for what issues. Communication with providers was limited and written medical records were slow to appear and often cursory and uninformative. Fears were evident that Marines were using these providers to acquire off-the-record medications.

But, in order to improve care coordination, we need to understand these practices from the perspective of the providers. We turn attention here to their descriptions of their care approaches and the intersection of their professional norms with military norms and expectations.

Care approaches and characteristics: While our on-base analysis highlighted the challenges of balancing individual wellness with operational readiness, the out-in-town providers appear largely insulated from these different and sometimes conflicting institutional demands. As a result, when they described their treatment approaches they emphasized the well-being of their clients but did not raise the same concerns about readiness that we heard from on-base providers.

While this singular focus may feel incomplete, it is important to look more closely at it to understand better why some Marines and their families might prefer seeing out-in-town providers.<sup>29</sup>

First, it is important to note that the out-in-town providers we interviewed all expressed sensitivity to the realities of Marine Corps life. More than one-third of them, in fact, had some connection to the military. Two respondents had been in the military (Navy and Marine Corps respectively); one additional respondent had been in the Navy and had had a family member in the Marines. Three others also had family members in the military (Marine Corps and Air Force.) Two respondents were working on base as MFLCs and one was working at a Navy Hospital at the time of the interviews. One respondent had worked on a Navy and Marine base in the past. The providers without military connections expressed the same awareness of the stresses of military life as those who had current or past connections.

The providers were very cogently able to describe concerns with stigma and the affects that stigma could have on Marine's career trajectories. They brought up career concerns a number of times. They also clearly described issues associated with deployment stress and the challenges that families face with both long deployments and then the subsequent reintegration of the Marine into the family's life and routine.

Yet, when we asked whether or not they treated Marines or their families any differently, they generally responded that they did not. They used the same therapeutic approaches and practices as they did with their civilian clients. We identified a consistent care model across all respondents that had a slightly different tone and sense of urgency than that evident with on-base personnel.

Most of the out-in-town providers worked as solo practitioners. Their views of care reflect their professional roles as part of a provider-client relationship: to help their clients and families. They spoke with us primarily about their use of therapeutic approaches to help their clients gain control of their issues. Their priority was on the people or persons they are treating. Their descriptions contrast with the range of viewpoints we heard from on-base providers, which often involved balancing conflicting objectives. We identify five characteristics:

They start with a blank slate. Unlike on-base providers who may engage with each other or commanders to develop an understanding of a Marine's situation, out-in-town providers generally begin with little such information. Most civilian providers talked about the importance of their own clinical assessment, which they do during

---

<sup>29</sup> We feel that these issues are important especially when considering the expansion of CCP's role in addressing more holistic family care.

the first session. While they may get some information about the person as part of the referral, they say they need to take time to make their own diagnosis:

*I assess the concerns; the presenting problem and I make recommendations as to what [modalities] I'm going to use, whether I'm going to treat the family or the individual.*

Most of the providers say they use the first meeting to develop a treatment plan as they get to know their clients. The purpose of the intake interview is to both develop a treatment plan and establish buy-in from the patient or family.

*I just listen at first to their whole history and then I'll tell them what I think would help. If that sounds like something they want to do – because I always want to try to get them to work together like we're a team, and we're going to work together in solving this – and then we proceed from there.*

They are aware that issues may involve the whole family unit: As mentioned above in the discussion of typical issues, many of the providers are intimately aware that issues affect the whole family. They recognize, for example, that many mental health and substance abuse issues have a family basis, that many Marines and their spouses are ill-prepared for marriage and the stresses that come with military life, and that the consequences of dysfunctional family dynamics can spill over into the Marine's professional life, affecting work and career potential as well.

Because many of the out-in-town providers are trained as family therapists, they understand that the family needs to be involved in addressing many of these issues.

A focus on alleviating symptoms: As the quote above notes, the notion of “normalcy” at an individual level entails reducing or alleviating the symptoms the person has. Symptom monitoring is a key function of their mental health approach and guides their treatment plan.

*I want to assess the severity of the symptoms, the functional impairment that they are reporting to me in their lives. If what we're talking about (in terms of treatment) is not moving them to higher levels of functioning, or decreasing symptom frequency, intensity, or duration, then I would consider referring them to a psychiatrist for a medication evaluation.*

A focus on helping clients and families return to their "normal" state. Out-in-town providers spoke generally about helping their clients return to some level of normal functioning, where normal is generally thought of as a state before the onset of symptoms:

*[My typical treatment goal] is to get them so they can function properly where you're back to a normal status or to alleviate a lot of the symptoms.*

“Normalcy” also means improving the family/couple dynamics and family functioning, especially given that many of the providers we interviewed often saw active-duty personnel as part of a family or in couples counseling. As one person noted,

*If I see them individually then I see the individual but if they come to me at a marriage counseling then my client is marriage.*

Improving the marriage or the family might include improving communication patterns and styles, helping the family establish “safety nets” for when the person deployed, and helping the active-duty person reintegrate into the family when returning from deployment.

The aim is to build “hope”: A fourth goal that providers articulated was more general – that of building a sense of “hope” for clients, especially those who were depressed and/or suicidal:

*I'm almost more interested in building a rapport and some hope for the future than a long series of goals the first session. They're very depressed and I'm trying to work through depression and then give them some hope.*

Their desire to build a sense of “hope” as an immediate goal of treatment tacitly assumes that individuals coming in for care are treatable and deserve the opportunity to get better.

These five characteristics highlight a primarily individual or individual/family unit focus that includes little input or involvement from on-base personnel. Consequently, the experience of seeing an out-in-town provider may differ from an on-base experience where commanders may view a Marine's issues with some degree of skepticism and doubt and providers find themselves mediating between this skepticism and the Marine's personal needs.

Although the out-in-town providers were quite familiar with the rigors of life in the Marine Corps, their approach to treating Marines and their families is predicated on the belief that their clients need care and generally give priority to the personal well-being of their clients. They did not seem directly influenced by military imperatives. As one provider noted, *“The military is not my patient, it is the individual.”* They did not describe any difficulties associated with addressing concerns from commanders skeptical of the validity of issues. Nor did they express any judgmental views about the Marines or communicate feeling pressure to treat Marines any differently than their civilian clients.

### Professional Protocols and Rule Abidance

One of the concerns we heard from on-base respondents was that out-in-town providers were not always following rules and guidelines for appropriate treatment, especially in the case of medication and information sharing. Our data suggest that the providers in our sample abide by the rules governing their professional practice and follow established professional norms.

They abide by treatment rules and guidelines: Our sample included a range of primarily non-medical provider types with different credentials. They expressed awareness of the conditions they could and could not treat, and communicated that they did abide by the rules related to severity of illness:

*Because you have to deal with what the limitations are. What kinds of therapy you can actually do with these people. And when it becomes more than a V Code, which is more than a parent relationship problem or a parent child problem then they have to be referred back to the military. They have their own psych services there.*

They also were clear that Military OneSource was for non-medical counseling. For instance, one provider noted:

*Military OneSource actually provides extremely clear guidelines and restrictions under what conditions you can see active-duty service members in the program. They are typically restricted to V-code issues. So if I have an active-duty member who is having a re-adjustment issue or who's having a family issue or an occupational stress issue, those are all acceptable. But as soon as I determine that there is an active mental health or substance abuse disorder problem that's a new treatment. I then have to refer them back to the base for a treatment.*

They adapt to Marines' schedules: The out-in-town providers also communicated a willingness to work around arduous schedules that include pre- and post-deployment commitments of Marines:

*Well with active-duty you have to work with their command and their schedules and the command's, what their actual job entails them to do, as far as, their schedule. They'll be on field ops where they're not accessible for two or three weeks or they're getting set for deployment and you have to assess if they can go on deployment, if this is a serious enough issue that it prevents them from going on deployment and they need to stay working on it. But you have to work with commands and the commands ultimately have the final say. We recommend and the command has the final call.*

*And if they have a diagnosable condition, you're not to treat them, you're to send them back to the base. And then the base, and then the base doesn't have, does*

*not have enough people to handle them and they don't have a rapport with those people and they can't see them often enough and so on and so forth.*

They respect HIPAA and professional norms of privacy: From the perspective of on-base personnel, out-in-town providers can be a source of frustration when wanting to obtain information from them about Marines in their care. While maintaining a Marine's privacy, they acknowledge their responsibility to report imminent threat of danger to self and others. Many offered that before discussing matters of treatment, clients were asked to sign a release regarding information sharing.

Yet, from the perspective of the out-in-town providers, they generally follow professional protocols in managing information flow about their clients. Many of them still kept written notes and submitted only the necessary information required and for billing purposes. When asked about who should get information about a Marine's care, one provider commented, "*I don't feel like it's needed for most of the people that we see to have their mental health information given to non-health care people.*" This sentiment carried through virtually all of the out-in-town providers.

Yet, they were very clear that if there were some dangerous concern, they would act on it appropriately:

*I just fall back on the standard, ethical procedures. If I feel someone is in danger of harming himself or herself or harming other people, I will certainly take action in a case like that. Absent that, I tell them, "You have every right to pay for a service that I'm offering. Your employer does not need to know unless it falls under one of those categories.*

They appear more likely to recommend medication as a last resort: Contrary to the perceptions of some on-base personnel, we found little evidence in our sample that out-in-town providers substantially contribute to over-medication. When asked about recommending medications, most responded that they would do so only if it seemed like their therapeutic approach was not working effectively. Several indicated that, according to their training, medication was counter-indicated for PTS.

Importantly, psychiatrists make up only a small percentage of out-in-town providers near both Camp Pendleton and Camp Lejeune and they are the only providers licensed to prescribe medication. They are also more apt to charge for appointments and one respondent provided knowledge of a price quote of \$400 per visit. For the other providers, if medication were deemed necessary they would need to recommend that the clients see their primary care provider.<sup>30</sup>

---

<sup>30</sup> We were not able to interview anyone from one large behavioral health care group comprised of different levels of providers including psychiatrists. Consequently we have no data on whether or not



### **Summary: Commitment to Accessible Psychological Health Care for Marines, Sailors, and Their Families**

Our interest in understanding better how out-in-town providers serve Marines and their families grew out of our awareness that these providers make up a significant component of the psychological health care that Marines together with their families receive.<sup>31</sup> Knowing how and why Marines access this care, what the experience of using it entails and how it intersects with on-base services can help inform policy decisions regarding the development of care options for Marines and family members.

While our initial focus was on the referral component of the TRICARE mental health care provision program, we soon realized that that was only a portion of the out-in-town care. Marines being referred as individuals through TRICARE to out-in-town providers appeared to make up only a small percentage of the clients that were seen by out-in-town providers. Notably, providers indicated that they saw more Marines through Military OneSource than through TRICARE. TRICARE was utilized more for family care than for overflow of Marine care. The Military OneSource program appeared to have some draw. Marines were making use of it.

It made sense to shift from considering the out-in-town providers simply as a resource to augment services when the providers on base were over-extended or in short supply. It made more sense to view them as supplementing services by providing care options that were not readily available on base. In other words, Marines have access to several levels of care on base and off base. Selecting to use the different services is motivated as much by the experience of the underlying characteristics of the care available as it is purely a question of access itself. Marines want privacy and they also want access to different modes of treatment. Thus having available options for care is a critical component of the Marine and Family psychological health system. Removing parts of the system or engaging in efforts to dial back their availability may have serious unintended consequences for the intended recipients of care.

In connecting the out-in-town study with our on-base analysis, a recurrent theme was that individuals were not always satisfied with the care received through official MTF channels. It was not always private or confidential, it could tend toward over-medication, and it could be intermittent or perfunctory. That is not surprising, given that our on-base analysis highlighted ways in which the on-base providers are under constant pressure to balance individual wellness with operational readiness: having

---

this group, located near Camp Lejeune, had a different approach to recommending or prescribing medication.

<sup>31</sup> Earlier mention was made of the percent of active duty personnel sent off base for lack of care at the MTF. In 2013 the use of off-base care for Marines was between 12-17 percent. In late 2015 the same figure was 20%.

to assess if a Marine was a malingerer or a "faker", feeling pressure from commanders to get a Marine "back in the fight" as soon as possible, or assessing a Marine's suitability to serve at all. These kinds of pressures were largely absent from the out-in-town providers' accounts. While they were aware of the realities of military life, their attention was on individual wellness -- improving both the individual's mental health and the overall "mental health" of the family unit.

In considering, then, what kind of supplemental care the out-in-town providers offer, we identified three potential draws for Marines. Specifically, some Marines and their families may feel that out-in-town providers: 1) offer more confidential care; 2) create a safer and less judgmental context; 3) can be accessed through informal and potentially more discreet networks. It will be important to take these qualities into account when considering more holistic and comprehensive services on base not only for the Marines but for their families as well.

Out-town-providers acknowledged the possibility that the problems presented to them could impede a Marine's ability to do his or her job during deployment. At the same time these providers offered that their care is designed to contribute to a Marine's readiness to complete their job by ensuring that family mental health is cared for. Several references speak to the conditions presented by family members, individuals who often seek care off base as a last resort. According to our interviews, by the time family members make an appointment with off-base providers, they are usually debilitated and require considerable support to return to something akin to normalcy. Out-in-town providers saw themselves as part of the support system required by the Marine Corps to allow Marines to deploy.

Consequently, in comparing the findings from our 2013 on-base analysis with our out-in-town provider study, we recognized that an overarching question to address when developing policy interventions is, "What would a Marine Corps behavioral health system *that Marines would want to use* look like?" The on-base analysis drew attention to the ways in which Marine Corps culture and operational demands can contribute to an institutional environment that can make care-seeking feel burdensome.

We identified factors at multiple levels that make both care-seeking and care coordination challenging. At the time of the interviews, there were certainly mixed feelings and opinions about the validity and nature of mental health issues, challenges at the local level with identifying legitimate needs, and continuing concerns with the existence and consequences of stigma. At the systemic level, there were information flow issues, technology incompatibility across institutional boundaries, and limits on comprehensive care coordination for individual Marines. Intersecting these two levels were evident gaps in the collaborative capacity across stakeholders. Key issues identified included limited informal communication opportunities, professional

mistrust among provider types, and ongoing tensions between commanders and providers.

We identified coordination of services and improving the capacity of the system as a key leverage point to improve overall cohesive care for Marines. Yet, while improving coordination is crucial, our findings further suggested that such coordination efforts might be best implemented when aligned with efforts that improve the overall collaborative environment.

We recognized that coordination efforts are more likely to take hold when collaborative relationships are built first. Collaborative relationships depend on a number of factors such as:

- The establishment of mutual respect for each stakeholder's contribution to a shared goal;
- The development of trust across institutions through practice and shared experiences;
- The existence of informal communication channels.

At bottom we recognize that the Marines and Navy Medicine inhabit a world in which change at the operational level is a daily occurrence. Patients flow in, emergencies arise, unanticipated threats materialize, infrastructure fails and key change agents and leaders move on to new locations, retire or are taken out of the fight. The current system of care is evolving in real time. Solutions to the consequences of misaligned resources, the role of history in setting seemingly intractable constraints, the uncertain world we live in today, and modern day threats to the safety and security of the nation set forth the task to build a system of care marines will choose to use.

The next section of our report focuses on changes evident in the emergent psychological health care system of Marine Corps Base Camp Lejeune. Interviews during a site visit in June 2015 reveal noteworthy improvements in the practice of care on the installation. There are still significant challenges ahead. We begin this section by revisiting a number of major issues originally identified in 2013 and record their evolution as of June 2015. An end of year update in December 2015 describes important examples of enhanced communication, increased cooperation and improved collaboration. Recommendations comprise the penultimate section with an endorsement to revisit the 2013 II MEF Surgeon recommendations in 2016.

## **Part Two Section Three: Changes in Mental Health Care Provision at Marine Corps Base Camp Lejeune from 2013 to 2015**

In the summer of 2015 we returned to Marine Corps Base Camp Lejeune to examine the psychological health care system as it has evolved. In the span of two years, the organizations involved in psychological health care at Camp Lejeune have experienced significant and rapid changes, from the addition of new services to leadership turnover. Some of the most influential were the standing up of the Community Counseling Center (CCC) and the Community Counseling Program (CCP) and establishing the Substance Abuse Counseling Center (SACC) within Marine and Family Programs (MF) at MCCS. MF stood up the CCP in early 2014 under the current branch manager, and SACC in January of 2015 with its own manager. As noted earlier, the type of counseling offered by CCP used to be given through General Counseling as a part of the Family Advocacy Program (FAP). Since separating from FAP, CCP has grown from four to 15 counselors with different backgrounds including individual and family therapy. The services that SACC offers—substance abuse prevention and early intervention programs, counseling, and non-medical outpatient and intensive out-patient treatment—used to be fully handled by the Substance Abuse Rehabilitation Program (SARP), the Blue-side program that provides medical care to treat substance abuse issues.

As CCP and SACC have improved their visibility on the installation through communication and outreach, Marines from all ranks are increasingly taking advantage of the services. CCP counselors went from seeing 400 clients in CCP's first fiscal year (which was not a full 12 month period) to 890 in the second, a significant difference from the number they counseled as part of FAP, to 1250 in the first 11 months of 2015. SARP personnel noted that because of SACC's presence they are better able to treat Marines with more complex substance abuse problems. Both managers are working to create a visible presence at Camp Lejeune, and a substantial part of the efforts in SACC is toward prevention, whether through outreach or very early intervention. In fact, the head of the CCP feels the dedication of one hour per week for four to five weeks to learn coping and other behavioral skills, may prevent more serious issues that interfere with a Marine's readiness and may lead to fewer separations.

In addition, for years prior to standing up the CCC and fully staffing the CCP and SACC, the MH Clinic experienced leadership turnover that was reported to be an impediment to effective operations. The lack of continuity and major physical renovations to the space in the MTF in 2013 made it difficult to focus on both internal and inter-organizational collaborative strategies. During construction in-patient services were provided in an off-site facility near the base. As of June 2015, the base retained a contract for a number of beds at the facility for use by Marines' (Brynn Marr).

With the development of two new programs at MF and stable leadership at the MH Clinic, providers of mental health care across Marine Corps Base Camp Lejeune have had the opportunity to put in place critical practices that enable them to work together more effectively and to develop new modes of outreach that will strengthen relationships with members of command and persuasively battle the continued real and perceived stigmatization of mental health care and treatment. We first outline the coordination and outreach efforts undertaken since 2013, and then discuss remaining challenges to be addressed.

### **Advances since 2013 Cross-organizational Coordination**

**SARP and SACC.** The most well developed inter-organizational relationship we observed at Camp Lejeune in June 2015 was that between SACC and SARP. Before the current manager was hired to manage the SACC centers at both Lejeune and New River, there was a leadership gap of about six months during which substance abuse treatment was limited. Now the SACC has five counselors, two supervisors and a manager at Lejeune, and the manager hopes to add five more counselors over the next two years to match the number at the SACC at Camp Pendleton. As it expands, SACC is supposed to change facilities from the temporary quarters it has now to Building 14 on the other side of the base. After this shift SACC will be closer to where most Marines are located as well as to SARP, giving Marines easier access to services.

As part of standing up SACC at Camp Lejeune in early 2015, the manager and department head (DH) of SARP, began to establish practices to bring SACC's and SARP's services together as a continuum of care rather than as separate and perhaps duplicative offerings. Central to their discussions were the division of responsibilities and codification of referral practices. Substance Abuse Counseling Officers (SACOs) had for years been embedded in operational units to monitor Marines' alcohol and drug use. SACOs had little training and were not professional counselors. These officers now needed to be trained in selecting the appropriate programs for Marines struggling with substance abuse. The two programs have separate SOPs with a division of labor and referral guidelines. In general, SACC has taken on much of the initial screening work and also as a matter of course handles cases that do not require diagnoses—for example, isolated incidences of underage drinking. SACC also treats Marines assessed as having a mild substance abuse disorder, demonstrating one to three criteria out of a set of eleven. SARP is assigned those cases deemed to be severe, meeting eight to eleven of the same criteria. The moderate cases are less straightforward because the outpatient and intensive outpatient programs at SACC and SARP are structured differently. With the evolution of the two programs, SARP serves Marines with any substance abuse issues that have previously been treated at SARP to maintain continuity, as well as any Marine who has received a DWI.

Three main coordination processes between the two programs allow leaders to discuss all the cases, including those in the moderate range, and negotiate placement.

First, the current department head (DH) of SARP was hired as Deputy Director of Mental Health and attends a multidisciplinary team meeting each week, with the SACC manager, clinical supervisors, and SACC counselors. If a Marine self-refers or is sent to SACC, they receive a full bio-psycho-social assessment and his or her case is written up by a counselor. On the other side, if a service member comes to SARP, providers there do a preliminary assessment to quickly indicate the level of care needed. If the person screening believes the case should go to SARP, the Marine will receive a full screening. If not, SARP personnel will call SACC to let them know the Marine will be coming to their program and will then send the paperwork they have collected. At the interdisciplinary team meeting, participants discuss and staff each case, agreeing on the appropriate program for placement. The DH for SARP, who has access to AHLTA, shares patient information with the SACC staff if necessary. Participants in the team meeting then brief the SACOs responsible for ensuring those Marines show up for treatment. If it is decided that the Marine needs care at SARP, SACC makes a referral using a standardized form given by Headquarters. However, if SARP does not have appointments open for immediate treatment, SACC counselors will see that Marine weekly until the SARP treatment program begins.

Second, SARP has hired a PhD Psychologist in the position of admissions coordinator after that position had been empty for six to eight months. This member works with SACC and the SACOs from the individual units to assist in the process of placing Marines in treatment. Third, the two programs and the SACOs have worked out a method of email encryption allowing them to communicate key documents like treatment and discharge letters as well as other critical information across the Navy-Marine Corps network divide. Currently the DH and Manager are trying to streamline the screening and other paperwork necessary to admit a Marine into treatment because both programs now have different information requested but with significant overlaps. SARP and SACC staff and SACOs also communicate with each other and exchange paperwork through face-to-face and phone interactions rather than asking individual Marines in treatment to transmit forms among providers.

### **Behavioral Health at MF and the MH Clinic**

Since 2014, and particularly since the CCC and the CCP stood up and were fully staffed, and the current leadership of the MH Clinic began his tenure, the organizational relationship has been strengthened between the Department of Mental Health at the Naval Hospital and Marine and Family Programs. The Director of the MH Clinic and his Department Head and the Deputy Director from the Naval Hospital, and the Director of the behavioral health programs at MF and the Director of the CCP, along with several counselors met together in May 2015 to discuss possible modes of collaboration. Out of those meetings, the participants made the decision to collocate a counselor from the CCP in the MH Clinic for several hours a number of mornings per week. The CCP counselor in that position would be able to better educate providers

about the services of MF's behavioral health programs and assist in channeling Marines to the type of provider most appropriate for their needs.

### **Behavioral Health at MF and II MEF**

The head of MF, and, the Director of Behavioral Health Programs at MF, have also been working to develop connections to II MEF leadership. In particular, the head for MF had been meeting regularly and communicating by telephone almost daily with the II MEF prevention director (more about the prevention program below) before he was transferred to Marine Corps Headquarters. During their meetings, the idea of collocating a behavioral health counselor at the II MEF commands at Lejeune, Cherry Point, and Beaufort was conceived. When we met with the head of MF, she had just received a phone call from a II MEF analyst requesting a meeting to discuss putting that idea into action. At Camp Lejeune, the CCP counselor would potentially work in the II MEF headquarters several days a week, facilitating interactions with Marines, members of the chain of command, and other providers and offering opportunities for warm-handoffs to other behavioral health programs at MF. To handle the logistics of data, the collocated counselor would be equipped with a laptop containing assessment software and a spreadsheet for logging referrals and interactions in order to add the data to the main MF system upon returning to the office. In June it was difficult to discern whether going forward, the counselor would have the full/most pertinent data or whether IT problems would remain an impediment. Nor were we able to establish whether confidentiality problems/constraints would hinder this level of collaboration as it develops.

Possibly in response to the connections MF and II MEF were developing and perhaps because of CCP's and SACC's increasing visibility, in early June II MEF Commanding General Beydler requested a walk-through of the Behavioral Health programs. He spent 90 minutes visiting the SACC and CCC, discussing key issues affecting Marines and barriers to their care. MF leaders felt that the visit was successful.

Mental Health Care for MARSOC. The Marine Corps Special Operations Command, or MARSOC, has also been a testing ground for coordination efforts among various types of mental health care providers and members of the chain of command. MARSOC is geographically separate, and for that reason and for convenience to the commander and to accommodate the value of proximity for MARSOC families, the leadership approached CCP about having a clinician assigned specifically to their units. A tier three social worker with CCP, lives near the MARSOC units and spends most of her days there providing counseling for Marines and families. She also attends MARSOC Human Factors Council meetings (similar to Force Preservation Councils, but often characterized as more intensive) and engages with other providers and members of the chain of command there.



**Outreach and Prevention.** The need for a program to assist Marines and members of the chain of command in navigating the range of resources provided for behavioral and mental health on Marine Corps bases was identified in 2010-2011, but it was not until 2014 that the II MEF program was established with a director, analysts, and program specialists assigned to different elements of the base. The program was designed in part to support the standing up of the CCC and the CCP and SACC, keeping those in the chain of command apprised of these new resources and assisting in the logistics of connecting Marines to behavioral health options. As noted above, the first program director worked with the DH of MF and the Director of MF to brainstorm opportunities for coordination between Behavioral Health Programs and II MEF. Five prevention specialists were to serve different commanders and were expected to play a number of important roles to facilitate communication and effective information exchange. They were expected to collect data from the units to which they are assigned on suicide attempts and ideations, analyze trends in substance abuse and domestic violence data, and track incident reports to take early intervention measures. They were to attend Force Preservation Councils and act in an advisory capacity to higher-level leaders (O5-O6 and higher), not only serving as a “walking directory” of programs and services, but also educating Marine leaders on the types of incidents that must be reported and reminding them to follow up on the reporting process. Prevention specialists were also anticipated to make appointments for Marines for behavioral health services and try to the best of their ability under HIPAA regulations to facilitate communication among behavioral health providers and commanders.

The leadership of the CCP has also begun to informally give prevention-oriented trainings that focus more on interaction among Marines and less on transfer of information. The DH of the CCP ran a suicide prevention session for a large number of Marines utilizing the technique of role-playing to practice straightforward communication on the subject of suicide. The DH of the CCP found that even in the act of role playing, fearful of the potential consequences on their career, Marines were hesitant to say they were suicidal, and she used this reticence as an opportunity to talk about how to ask these questions without euphemisms and embarrassment, and what to do with the answers.

### **Remaining Challenges**

In the preceding section, we presented inroads that providers have made in moving toward a more cohesive system of mental health care at Camp Lejeune. However, considerable challenges remain that, if not addressed, may stymie current improvements. Some of these challenges are simply part of the time it takes to adapt to new programs and adjust to leadership changes. Others, though, require intentional interventions to shift existing functional and interactional patterns.

### **The Separation of the Ground Combat Element (GCE):**

---



One of the major challenges we observed at Camp Lejeune in the June 2015 interviews was the geographic isolation and lengthy distance of Marines in the infantry division and associated green mental health providers from other psychological health resources (Map Appendix II). The office of the Division psychiatrist, is located near the site of the Second Marine Division on the installation, and he and the OSCAR provider associated with the 8<sup>th</sup> Regiment currently work out of that building. At the time, the remaining OSCAR providers were connected to the 2<sup>nd</sup> and 6<sup>th</sup> regiments and worked out of Division Psychiatry. According to the Division Psychiatrist, there is need for a fourth OSCAR provider. Unlike the Division psychiatrist, OSCAR psychologists and psychiatrists are embedded with their assigned units, training and deploying with them. As a result they may often be out of their offices and difficult to contact.

On the side of the MH Clinic, although providers have occasional phone calls with the Division Psychiatrist, time constraints and a heavy workload limited communication between these care providers. At the time of our visit in June the head of the MH has had only one in-person meeting with the Division Psychiatrist to discuss changes in the process of writing up medical boards. BUMED would like medical boards to be handled mainly by Blueside providers out of a concern that Green providers would be too influenced by pressure from members of the chain of command. The Division Psychiatrist and OSCAR providers will refer to the MH Clinic, but there are no existing regular opportunities for interaction among mental health professionals at the Naval Hospital and Green mental health providers with Division. In early June, there were no specific plans discussed to establish coordination processes. MTF providers did not participate at all in Force Preservation Councils despite treating Marines discussed at these meetings. The one understood, but unwritten protocol is between the Division Psychiatrist's office and SARP: in general, if a Marine with a substance abuse issue is sent to the Division Psychiatrist, the Psychiatrist will refer that Marine to SARP and not SACC, under the assumption that the SACOs will catch less severe substance abuse cases.

Leaders and counselors with Behavioral Health at MF communicate to some extent with the Division Psychiatrist, but connections with OSCAR providers were limited. One individual referred to OSCAR psychologists and psychiatrists as "ghosts." MF personnel did not have names or contact information for OSCAR providers, nor were they certain that behavioral health programs even received referrals from Division mental health professionals apart from the Division Psychiatrist.<sup>32</sup> There appeared to be some confusion about the roles and credentials of OSCAR providers versus members of OSCAR teams. Thus far, during our visit in June there had been no attempt made to bring MF behavioral health personnel and OSCAR providers together for

---

<sup>32</sup> We heard from an OSCAR provider that he did make referrals to CCP. The Head of the CCP confirmed that referrals were coming from OSCAR providers.

---

introductions or coordination efforts. In addition, at the time MF leaders and counselors did not attend Force Preservation Councils in Division units, not, seemingly, from lack of time but from lack of an invitation. The disjuncture between behavioral health services at MF and the infantry units is particularly problematic in that Division Marines are an underrepresented population among the CCP's clients but represent the majority of Marines at Camp Lejeune. SACC is the only MF program that maintains a connection with Division through the SACOs working in operational units.

On the Division side, frustrations remain similar to those from 2013: roles and responsibilities for Division mental health professionals are not well understood across the spectrum of on-base providers. The Division Psychiatrist and the OSCAR psychologists and psychiatrists interpret their role under the original outlines of the OSCAR program as providing a certain level of mental health care to Marines in the Ground Combat Element, but not all levels of care. They can give therapy and prescribe, and the OSCAR providers are a consistent presence in the units to educate and to monitor Marines' behavior and unit climates with the goal of early identification of mental health issues. However, in acute cases the Greenside mental health providers we interviewed feel they needed to be able to move Marines from the infantry units to the Naval Hospital for three primary reasons: access to weapons, pressure to continue working from members of the chain of command, and mistreatment or abuse from other Marines. Each of these factors can exacerbate the conditions of Marines who are already exhibiting suicidal or psychotic behavior. These gaps in understanding and cooperation await resolution through formal channels.

The Greenside mental health providers in Division that we interviewed perceive that their counterparts in the MH Clinic, as well as some professionals in the behavioral health programs at MF, expect the Division Psychiatrist and the OSCAR providers to handle all tiers of care for Marines in the infantry units. This perception seems to be based on communications and actions from individuals within each provider group rather than on any kind of organizational statement to that effect. But Division providers have experienced some difficulties in moving Marines with acute psychological distress from the infantry environment to the Naval Hospital for treatment.

There remains significant cultural distance and a lack of understanding among psychological care providers in the MH and Division Psychiatry. One provider (outside of the infantry units) referred to the Division as "the toughest nut to crack," suggesting that the Marines in those units were strongly influenced by cultural attitudes associating seeking mental or behavioral health care with weakness and poor performance. At the same time, another observer suggested that there is a lack of awareness and understanding on the part of Navy Medicine of the operational

practices of the Marine Corps Ground Command Element. Rather than the Marines being difficult to figure out, there is a lack of situational and cultural awareness of the operations of the ground forces that reinforces isolation and fosters suspicion, both diminishing the likelihood of cooperation and collaboration in the provision of care. That view indicates that more outreach to Marines in the GCE is needed to both shift pervasive misconceptions related to attitudes toward mental health and to connect Marines to the available services. The II MEF prevention program is a step in that direction, but it is not yet a permanent initiative. Likewise, the creative and interactive suicide prevention sessions described earlier and offered by CCP are not yet an institutionalized part of the set of outreach and prevention resources.

For their part, Division providers indicated an interest in collaboration with other MF and MH Clinic mental health professionals, up to and including a separate Greenside mental health clinic with providers from all three groups in one location near the infantry units. The political and economic feasibility of this idea is under consideration, but at the very least Division providers must be included in coordination strategies engaging the MH Clinic and MF. At present, this lack of coordination leads to unscheduled patients queuing up to see the Division psychiatrist in lieu of being seen by a psychologist to schedule the requisite follow-up with the appropriate care provider. Although it is a small and distinct case, the successful collocation of a MH Clinic and CCP provider at MARSOC—which already has its own OSCAR provider—suggests that coordination among providers is possible and effective.

### **Coordination of Care and Information Exchange**

The extensive changes that have shifted the provider landscape for mental health care at Marine Corps Base Camp Lejeune over the last two years require time for adjustment and adaptation. The advent of the CCC and the repositioned SACC are essentially still new programs within MF, and the new leadership at the MH Clinic until the Head of the MH came in was an obstacle in establishing cross-organizational coordination practices. Many of the challenges from 2013 remain in terms of the demand for medical mental health care and the pressure this creates on providers at the MH Clinic. There are still significant wait times for follow up care. MOs still tend to send Marines to medical over non-medical providers, particularly as the CCP is still building its reputation. The MH Clinic continues to be booked four to six weeks out for appointments, and while the Clinic providers accept patients through the emergency room, they would like to provide better walk-in services for Marines who self-refer. Impacted, the MH is sending out approximately 20% of Active Duty clients out to the network to receive care.

Certain technological hindrances to effective information exchange evident in 2013 are still in place. MF has a separate electronic records system, DOD-CMS, used by all of its programs. The MTF now utilizes a patient medical record system Essentris. At

present, Division Psychiatry lacks access to the mental health portion of the record. When introduced, there was no technical assistance or support provided to ensure that psychological health providers had access to the record system. Access requires training, in a situation where time scarcity is a day-to-day hindrance to getting the job done. As with any major change in technology, providers are still adapting to the use of new products and are working out kinks in the system, such as the fact that staff from different programs cannot look at the same record at the same time. Workarounds are evident, but their consequence is an extra burden on the staff member who has dual access to both systems. There is no connection between DOD-CMS and AHLTA, so medical and non-medical personnel need to develop a work around to ensure access to required information, which they have. This separation may be intentional; providers indicated that the subject of connecting professionals at MF to AHLTA had been discussed, but as of June the outcome appeared to be negative. Selective privileging of CCP providers by the head of the MH in the MTF is a possible solution for to limitation.

Collocating a CCP counselor several mornings a week at the MH Clinic is a promising avenue for addressing some of these roadblocks to communication and coordination. The presence of the CCP counselor would provide the opportunities for face-to-face interactions and relationship building so important to the efficient functioning of organizational systems. It would strengthen the “no wrong door” approach and help to manage MOs’ (and line leaders’) bias toward medical mental health referrals as the counselor would be able to place Marines who would benefit from non-medical behavioral health care quickly into the appropriate program. Finally, under predetermined privacy agreements, the collocated CCP provider could bridge the records gap between AHLTA and DOD-CMS by exchanging information on individual patients with MH Clinic providers. However, the presence of a CCP counselor cannot serve the same function as key procedures that are not yet in place between MF and the MH Clinic: regular, institutionalized phone and in-person meetings among the leadership, and formalized understandings of and protocols for sharing of patient information among providers. Moreover, since the infantry units comprise such a large proportion of the Marines at Camp Lejeune, failure to integrate Division mental health providers into coordination schemes disables the efficient functioning of the care system.

The current leadership is actively working toward bringing medical mental health care for active-duty Marines completely under the purview of the MH Clinic to avoid referring Marines to TRICARE providers off base. This may be possible as CCP continues to increase its reach and the MH Clinic fills its billets for providers, but a certain number of Marines needing treatment for psychological issues are still referred to the network at this point (20%). CCP offers services for Marine dependents, but for medical mental health care families must generally use off-base providers. Yet despite this significant role, in our 2014-2015 interviews with mental

health professionals out-in-town, we found that there are few opportunities for off-base civilian providers who treat Marines and other military patients to connect relationally with each other or with mental health professionals on the base.

Evidence of communication with off-base providers comes from a reference to actions taken starting in 2012 by the II MEF Surgeon and the then head of the MTF through their participation in the North Carolina Health Care Council. Referenced in our interviews with off-base mental health care providers, is a need and desire for similar infrastructure to enhance communication and information sharing between MCB Camp Lejeune and off-base mental health professionals serving the region around the Camp Lejeune installation. Developing such a program would go a significant way toward fulfilling the desire of on-base care providers to have a better understanding of off-base care provision and vice versa.

Moreover, providers have to meet certain criteria to be accepted by TRICARE, but once designated they do not have to participate in any programs specific to treating military service-members. Nor is there a specific training program required to develop sensitivity to specific characteristics of life in the Military. One potential tool for improving on-/off-base relationships would be to create a TRICARE mental health providers association that would also have a partnership-oriented link to the base. Periodic formalized meetings between on-base providers and this association could provide a forum for relationship building and better mutual understanding of the roles of each type of provider. Adding a continuing education component with requirements related to military psychological health might help to increase on-base providers' perception of civilian professionals' credibility.

To further strengthen the program at Camp Lejeune, our 2015 visit identified the execution of regularly scheduled interactions among providers and mental health leadership at the Lejeune and Pendleton installations. The head of Mental Health at the Camp Pendleton Naval Hospital regularly communicates with the head of Mental Health at Naval Hospital Camp Lejeune and is sharing "state of care" practices developed at Pendleton and found in other locations within the system and beyond. CCP Bureau Chiefs of the two installations also are in limited communication. Cross fertilization and information sharing is vital to the effective implementation of the "no wrong door" concept, a practice predicated on trust, communication, and collaboration, and the often referenced framework that underpins strengthening coordination among units of the psychological health care system.

## **Part Two Section Four: December 2015 Evidence of Cooperation and Collaboration Buttressed by Shared Experiences and Added Resources Represent New Developments at MCB Camp Lejeune**

Communicating with psychological health providers at Marine Corps Base Camp Lejeune in December 2015 for corrections and updates to our June 2015 report, we see demonstrable progress made in the practice of care provision, cooperation and collaboration efforts. Four structural features represent enhanced collaboration as of December 2015. We note: full implementation of the Marine Intercept Program; maturation of the Community Counseling Program; colocation of CCP assets in several sites across the installation; and enhanced collaborative relationships as measured by invitations to attend Force Preservation Councils and the Human Factors meetings at two regiments and MARSOC. These developments have coalesced to produce a dynamic and synergistic context supporting and encouraging a growing awareness of and trust and engagement in psychological health programming at MCB Camp Lejeune. There is more defined and regular communication and collaboration with the MTF, commanders, and Division Psychiatry representing the GCE, ACE and the MLG. Procedural innovations built upon cross-organizational cooperation and collaboration are leading to coordination that is growing and becoming more robust. Leaders of programs reference the evident commitment of commanders to psychological health efforts.

### Cross-Organizational Implementation of the Marine Intercept Program (MIP).

Perhaps more than any other element beyond adoption of the MOU, the full implementation of the Marine Intercept Program has served as a forcing function in establishing recognition of, rapport with and inter-reliance among nearly the entire complement of psychological health assets at MCB Camp Lejeune. Almost two years into its implementation, the MIP was just beginning to gel in June 2015. The initiation of the program was originally hampered by a lack of detailed guidance from Marine Corps Headquarters, which was overcome through a MARADMIN and the experimentation and coaching made available and dispersed from MCCS Headquarters in Quantico to MCB Camp Lejeune.

The MIP implementation required establishing a communications chain triggered by a Critical Incident Report that traveled from the base to Marine Corps Headquarters in Quantico to MCCS Headquarters (similarly situated) back down to the base through HQ MCCS to CCP and then to a local level contact. When originally introduced, the head of the CCP was instructed to contact the presiding commander closest to the Marine involved. Initial hesitancy subsided as awareness spread, the MARADMIN was released and the communication chain solidified. Initial implementation required a new form of care provider-commander communication. The first response to this requirement was to hesitate. This past. Eventually the emergent protocol came into place and contacts across rank and role smoothed out with deliberate haste. While

seemingly elaborate and time intensive, the round trip from the initial filing of the Critical Incident Report to notification of Marine HQTRS and Headquarters MCCA to the return journey to MCB Camp Lejeune typically occurs in less than 24 hours. The level of involvement is intense and all encompassing, including ultimately the platoon level where the Marine's direct contact information (cell phone) is accessed; this regularly involves the Gunnery or the First Sergeant.<sup>33</sup> The extensive number of incidents occurring over the course of the past two years, meant tens of opportunities arose to communicate across rank, role, function and location among parties at MCB Camp Lejeune. The program has been honed for efficiency and effectiveness. A byproduct of the program is the extensive network of relationships and trust built up across the installation. Early on during the program implementation the DH of the CCP made a critical and strategic decision to assign the same professional counselor to be the point of contact (POC) with each battalion. Individuals serving as the primary contact were specifically selected for their knowledge of the Marines and that had an individual-comportment in line with previous experience engaging with commanders.

Bottom Up Coordination. The chain of contacts are further cemented as CCP has one day to get in contact with the presiding commander and then a little longer to get in contact with the service member. Operated as a phone chain, MIP relies upon someone at the local level already paying attention; usually the MO or the OSCARS are watching. The contact at the CCP checks to see that the Marine has services in place and is getting to his/her appointments. The CCP contact assesses whether there are any barriers to receipt of care, thereby ensuring a case management function is in place. Some MIP participants come back into counseling at the CCP, but this relationship is separate from the MIP program.

Cross Function Coordination. As a result of the MIP program, several new points of access and intermingling exist strengthening the ties among the parties in the psychological health system of MCB Camp Lejeune. It has led to invitations to the CCP leadership to have counselors participate at the Force Preservation Councils of two regimental units 1-8 and 1-10 and the Human Factors meetings of MARSOC.

### **Coordination of Care and Information Exchange**

#### Community Counseling Program.

The combination of maturing trust developed across the installation in conjunction with the MIP program and the collaboration of the CCP with the MTF and Division Psychiatry through the efforts of OSCAR providers, the CCP has grown in recognition as an effective care provider. Since 2014, the client numbers have increased by almost a third from 890 in FY 2014 to 1250 in the first eleven months of 2015.

---

<sup>33</sup> They have the cell phone number of the marine in their pocket.

Behavioral Health at MF and the MH Clinic: As anticipated as of June 2015, the CCP has placed licensed providers at several locations at MCB Camp Lejeune. Essential is the placement of a licensed counselor at the MH at Naval Hospital Camp Lejeune three afternoons a week. This allows staff in the MH to work alongside of members of the CCP. Borrowing an office, CCP personnel conduct referrals, complete assessments and importantly share information with NH MH providers about cases, referrals, and other matters. This information feeds into regular meetings between the second in command of the NH MH Clinic and the head of MFP and the CCP. Here issues are identified and bottlenecks addressed. Resulting outcomes are smoother working relationships between CCP and members of the Naval Hospital MH, heightened information sharing and case management, and familiarity with the practices of both organizations. This has resulted in greater collaboration between the providers as well as an improved understanding on both sides of the mission, scope, and role of each provider. CCP resources encompass a broad spectrum of CCC providers increasing relationship building across the two programs.

Behavior Health at MF and II MEF: As of June plans were to locate a CCP counselor at II MEF. The details of this outreach are still being developed. Both sides, II MEF and Behavioral Health, are eager to engage the opportunity of enhanced services. This outreach will be in place within the next few months. II MEF has a new Commanding General, General Miller, as well as a new Prevention Director, Rani Collins. These changes anticipate full implementation by the first of the year. Leadership of both Marine and Family Programs as well as II MEF are preparing for this collaboration.

### Outreach and Prevention

#### Cross Installation Event: Building the Warrior Within: Suicide Prevention Through Wellness” Events

Cooperation and collaboration evolving over the last nine months culminated in a cross installation program, planned and executed in September in recognition of Suicide Awareness month. The head Chaplain of New River and the head of the CCP organized a day long fair for members of the installation community of MCB Camp Lejeune and New River. Stimulated by the Chaplain at New River, planning with the CCP began in February 2015 and the event was held at the end of September, running across two separate days at New River and MCB Camp Lejeune. A MARADMIN was released and planning engaged all psychological health programs on the installation and several organizations outside the base. Private care providers in the community helped sponsor the events and made donations of resources to support the operation. The head of MFP was instrumental in bringing resources in from off-base care providers. The event included stations with various activities Marines were to complete.

Participants included:



*MCCS: CCP, FAP, SACC, New Parent Support, Exceptional Family Member Program, Personal and Professional Development, Marine Corps Family Team Building*

*Blue Serving Green: Chaplain Corps, II MEF Embedded Prevention Staff, Embedded and School based MFLC's, FOCUS, Intrepid Spirit TBI Clinic, Wounded Warrior BN*

*Other Resources: Eastern Carolina University, Brynn Marr Hospital, NCIS*

Attendees included staff from the Naval Hospital MH, members of the off-base community including staff of Onslow Co. Partnership for Children, the Jacksonville Police Dept. and the Onslow Co. Sheriff. 1200 Marines participated and members of the chain of command in attendance included Flag officers.

### **Division Psychiatry and the Ground Force Element Reaching Out and Providing Guidance**

Three developments highlight significant change occurring within Division Psychiatry and across the installation. First is the specification of a continuum of care by the Division Psychiatrist. Second is the augmentation of care providers to support regiments including the operational units and the Division Psychiatry Clinic. Third is the allocation of space within Building 318 to collocate Division Resources to enable closer coordination of the psychiatric resources for the GCE and ACE.

#### Specification of a Continuum of Care among Care Providers on Installation

The lack of clarity of the care pathways for Marines dating back to 2013 was evident in our visit in June 2015. The Division Psychiatrist and the OSCAR assigned to the 8<sup>th</sup> regiment sought to formalize a pathway toward psychological health resources at Marine Corps Base Camp Lejeune. The system is defined based on tiers of acuity. The first tier directs Marines and Sailors to first tier resources for assessment. Resources here include providers falling under the following organizations and individuals: BHIP, MFLC, CCC, Military OneSource, Prevention Specialists and Chaplains. This "first open door" will conduct assessments and provide direction for further assistance. Tier 2 includes OSCAR providers and Division Psychiatry resources. Tier 3 assets include the NHCL. The defined system is designed to provide measured direction by specifying the array of entry ways to care while clarifying the more extensive resources available at MCB Camp Lejeune.

#### New Resources Provide Capacity and Opportunities for Coordination

The second major development is the opening of several new Navy billets to support Division Psychiatry. As originally referenced in 2013 and currently planned for implementation, in the summer of 2016 Division Psychiatry is scheduled to receive as many as three new psychiatrists; one each for regiments 2, 6 and 8. Navy Medicine recognizes the need to put psychiatrists in operational units and Division Psychiatry is expecting to receive another psychiatrist for the Marine Logistics Group 2<sup>nd</sup>

## Analysis and Recommendations

---

Division. This will help support the East Coast Expeditionary Force allowing Division Psychiatry to focus on its current tasks. The resources allocated to the operational units are not expected to deploy. They will be Oscar-like, but they are not dedicated Oscars.

### Approval Received to Collocate 2nd Marine Division Psychological Services Assets

The third development is the agreement by the Marines to resource a physical home at BLDG 318 for the Division Psychiatry function, coalescing resources around OSCAR Mental Health providers, division psychologists, psychiatric technicians and supporting staff in the next several months. The Marines have agreed to allocate the downstairs spaces and provide needed telecommunications capabilities. The space was previously used as a medical clinic and will situate 2nd Marine Division mental health providers in one location. This force multiplication will allow the Division Psychiatrist to better manage the ebb and flow of deployments while securing high efficiency Garrison care.

## **Part Two Section Five: Evolving Toward a Psychological Health System Marines Will Use**

MIT's original charge in 2012 was to provide answers to questions posed by Marine Corps leadership concerning the efficacy of the then emergent Marine Corps-Navy psychological health system. A team was detailed to investigate the psychological health care system at Marine Corps Base (MCB) Camp Lejeune. 2014-2015 work examined factors that shape the care-seeking process. We discern influences that govern the choice: a) to seek care; b) from whom; c) under what conditions; and d) with expectations of varying degrees of quality and anonymity. Our recommendations highlight elements of a system of care Marines are willing to use based on their actions.

The 2013 system of psychological health care at MCB Camp Lejeune developed over a number of years, evolving under the pressure and intensity of active military conflicts. The range of options comprising the current system can allow a wide variety of issues to be effectively addressed at different levels, with varying degrees of confidentiality. Interaction and communication among all of these quasi-independent provider groups is essential for reasons of diagnosis and risk assessment and to efficiently direct Marines along appropriate care pathways while coordinating the care of Marines already receiving treatment. Prior divisions created by separate accountability structures and institutional cultures (e.g. Marine Corps or Navy, on-base or off-base, embedded or non-embedded), geographic separation even among on-base providers, incompatible technologies such as records systems, and differing perceptions of information sharing requirements not only are recognized, but are being surmounted as leadership at all levels support local level initiatives and innovations thereby boosting the potential of system formation through measurable increases in cooperation and collaboration. Still, much remains to be accomplished.

December 2015 unveils a future based on findings that major changes in cooperation and collaboration are capable of merging into a system of care signified by care provision available in a shorter amount of time and with a system of single provider case management. There is evidence of less friction across roles and functions while resources are being utilized as intended and at a level of performance indicative of system transformation. An emergent system is in place; outcome metrics at CCP are scheduled for implementation by early 2016; cross provider communication is being formalized through shared human resources effectively enhancing connectivity, and Command is reaching out to care providers to understand better how the system works and to pursue efforts to integrate Psychological health resources into current state operations. These features underlay essential elements of a fully coordinated system of care.

## Analysis and Recommendations

---

Explicit efforts toward enhanced coordination are required to maintain and secure progress made over the last three years. Progress during the last year is notable and yet there is significantly more that must be done. Cross installation communication is essential to ensure system evolution. Downscaling of embedded resources to the level of the Company and even the Platoon would significantly increase oversight and support of Marines in need of access to psychological health care resources. It is imperative that new approaches to combating stigma be developed. The next section lays out recommendations in support of findings evident in this report.

## **Part Two Section Six: Recommendations for Improving the Psychological Health Care System at Marine Corps Base Camp Lejeune**

*Recommendation 1:* The Marine and Family Programs Division of the MCCA and the CCP is growing in importance and should be further integrated and utilized for behavioral health care.

*Recommendation 2:* Camp Lejeune should establish a three tiered system of intake for screening and referrals and train all Level One providers with the same sets of skills and knowledge of pathways to conduct first level assessments. This is modeled after the Marine Centered Medical Home. Locations for these services should be located in buildings (Except FAP or SARP) with other non-prejudicial health services to avoid an immediate, potentially stigmatizing association with psychological health care. MF should serve as the coordinator of this function. The intake process would screen Marines for both medical and non-medical mental health issues. Within the Marine Centered Medical Home environment, the BHIP function should serve as the referring agent. These first tier providers will determine the appropriate care pathway for the Marine, whether through MF, embedded assets or the MTF.

A key element of an effective intake function is a case management practice where the first point of contact retains control to guide and track Marines through all aspects of the psychological health care system, whether medical or non-medical. The clinical case managers will be responsible for scheduling and following up on referrals both on and off base, tracking missing information, and communicating with commanders or embedded providers.

*Recommendation 3:* Build a records system or improve the current system to allow integrated information sharing among all mental health care providers in the Navy-Marine medical, non-medical care system. This includes: true interoperability including all required protocols, access approvals, mobility characteristics, and analytics. This information should be portable across all installations and related locations on land and at sea.

*Recommendation 4:* To reduce stigma, better orient marines to resources and to normalize care seeking processes, develop and distribute psychological health training opportunities to include “learning in context,” role playing, and protective practices. Two aspects of such training include: Identification of mental health issues (how to decide if someone is experiencing distress) and cultivation of judgment involved in taking action (how to decide what to do).

*Recommendation 5:* To shift the modalities and outcomes of this type of training create and implement a FM/TM (Field/Training Manual) oriented toward making mental health and observation/reporting of key symptoms integral to the role of an

## Analysis and Recommendations

---

individual Marine. Beginning training in boot camp would instill in new recruits the knowledge that they are in an occupation with a high mental health risk, and they should be vigilant with regard to their own and others' warning signs to ensure safety and security of Marines and mission.

*Recommendation 6:* To enhance local level observation of Marine psychological health while normalizing the practice of mental health self-care and facilitating care-seeking when needed, establish a new Corpsman billet that integrates identification and maintenance of psychological health with the role of the SACO. In effect create a local psychological health technician role at the Platoon level. Presently the SACO function is an add-on to a Marine's existing duties. Combining these two educational and oversight roles can provide early warning of Marines in distress and can help identify and direct Marines to seek treatment for stress.

## **Part Two Section Seven: Level II Recommendations: 2013 Recommendations to the MCB Camp Lejeune Commanding General and the ACMC**

In 2013, in collaboration with II MEF medical system, MIT recommended a series of broad actions designed to advance the psychological health system serving Marines and Sailors.

The recommendations made in 2013 by then II MEF Surgeon are restated here and should be reviewed and assessed for potential continuing implementation. Several of the original recommendations were the target of existing experimentation, but a significant number of the recommendations remain unattended and should be considered for implementation. The specificity of the II MEF Surgeon's recommendations represent a reasoned entry way into collaborative routes for enhanced communication and coordination across the psychological health resources on Marine Corps Base Camp Lejeune and in the surrounding community.

### **Bolster and Maintain Effective Cross-Organizational Relationships:**

#### *Cross-organizational relationships of on-base providers*

Implement regular cross-organizational meetings to discuss both system and patient related issues and successes [Ex. Mental Health Advisory Board (MHAB)]. This organization should include line leadership.

Curb the negative effects of personnel turnover by coordinating people and activities across programs. Focus on specific timelines (e.g. returning from deployment; PTSD awareness month) when stress and/or heightened awareness are evident.

Establish mechanisms for cross provider engagement wherein policy changes can be considered and built upon through better cross communication.

Include line leaders in all relevant facets of the system of care including established NHCL-II MEF-MCCS monthly Mental Health Boards.

Set expectations that each MHAB session's participants need to brief/inform their respective organizations (e.g. flight surgeons need awareness of MHAB discussion). Standardize reporting format, membership and practice of Force Preservation Council Meetings (FPCs). Mandate attendance at FPCs of selected MF and MH Clinic representatives. Include a member from the CCP. Identify and utilize "success case" modeling to increase buy-in from existing FPC stakeholders. Success case test FPC should be championed by battalion/squadron CO.

Continue plans for and the practice of labor borrowing and/or co-location of MCCS and MTF.

Request MF, MTF, and II MEF program directors / coordinators set a forcing function to drive collaboration within and across their organization. Strengthen collaboration practices by highlighting developments at monthly report of the mental health boards.

Assess value of and utilization by MCCS BH providers of a simplified questionnaire (e.g. screening moderate/severe conditions such as depression (PHQ-2), substance abuse, anxiety, and PTS) to quickly assess whether the needs of a Marine, Sailor, or Family Member require a referral or warrant involvement of unit or MTF primary care clinicians.

Define in detail the roles that Division providers (the Division Psychiatrist, OSCAR psychologists and psychiatrists, MOs and Surgeons) play in the psychological health system in relation to the MH Clinic and MF Behavioral Health. Division providers are well placed to manage patient flow between Division Psychiatry and the MH Clinic. Determine general practices for referrals, including when it is appropriate to remove a Marine from the unit environment.

Navy psychiatry has opened up more psychiatry billets for uniformed operating forces. Summer 2016, two new psychiatrists will be supporting regiments 6 and 8. A third psychiatrist will be allocated to the 2<sup>nd</sup> MLG regiment. Tripling the resources at the Division level affords an opportunity to comprehensively plan for the implementation of these assets.

Division psychiatry consists of an array of resources that are dispersed among regiments and physically housed in a number of locations. To utilize these resources effectively and to benefit from the principle of force multiplication, these resources should be aggregated in one location.

Assess the proposed practice of annual meetings between on-base and off-base providers. Annual meetings of on-base and off-base providers should be designed to build relationships (trust, understanding and communications).

Model and enhance reported regional coordination practices with organizations that can better inform and help build human resource planning capability in the region. Examples from Cherry Point suggest local Community College resources have been utilized in support of programs that serve region wide needs.7.2.1.0 Establish and maintain effective information sharing between stakeholders to Operationalize BUMED and II MEF HIPAA Policy

Conduct HIPAA operational workshops. Assess the practice of “train the trainer” for unit surgeons and MCCS BH leaders who train their subordinate teams.



Create clear guidelines with “What if” and “Do and don’t” examples relevant to each stakeholder.

**Evaluate and Enhance Existing IT System that Directs Marines and Sailors to Existing Programs:**

Utilize BUMED documentation of HIPAA and privacy regulations to design and implement standardized information sharing practices. Through training, establish consistent stakeholder awareness of patient information sharing limitations. Include II MEF HIPAA MEFO in provider orientation (“cheat sheet” signed / provided). Utilize role-playing exercises in trainings to enhance uptake and institutionalization of common practices. Include IIMEF.

Assess development and utilization of consent to inform (other than CO or CO designee) documentation in the clinical record. Expand use of consent to inform practice within II MEF, MCCS and MTFs. II MEF HSS, MCCS, and MTF leaders educate providers (provider orientation).

Establish practices allowing designated collocated providers (CCP at MH Clinic, or at Division) to share information with other designated providers from the two electronic reference systems (AHLTA and DOD-CMS).

Assess and adjust infrastructure enhancements scheduled for introduction in 2014. Ascertain progress toward implementation. II MEF was targeted as the first MEF with “hard fiber” connected electronic medical record access (AHLTA) in support of MCMH enhanced clinical care coordination and communications. Hardware installation and initial training was on track for 4-22 NOV 2013. II MEF HSS and G-6 lead NAVMISSA installation.

The MTF has implemented a new patient record system, Essentris. Access to the psychological health portion of the patient record is not automatically coupled with access to the medical record and requires a separate approval process. The process of system integration needs additional support to ensure effective implementation. Utilize models of information sharing currently applied II MEF HSS. Assess for ability to replicate of existing NHCL sports medicine practice of inserting this information into the record to allow analysis and targeted interventions.

**Dispel Stigma of Seeking Care:**

*Assess practices governing light duty and limited duty designations*

Assess practices governing light duty and limited duty designations to specify capabilities in addition to limitations: what Marines/Sailors CAN do. Document the practice.

II MEF HSS coordination with MTFs and unit clinicians and ascertain policy and change in forms / practice. II MEF HSS will coordinate with MTFs for MTF clinicians to provide “Can Do” information up front. Assess Unit surgeon to CO regular communication to determine implementation of intended practice.

As part of training around what Marines/Sailors CAN do, and to dispel stigma of seeking care build training around examples of Marines and Sailors who temporarily lost status while seeking care and eventually regained original status or were reassigned a desirable MOS change.

Develop a culture of practice that emphasizes a preventative rather than a reactive approach to the role and responsibility of the individual Marine for maintaining their psychological health. Consult the CAOCL-TECOM Resilience Research Project recommendations for training opportunities.<sup>34</sup>

Target small unit leadership to improve awareness and better guide Marines and Sailors through the system. Change the delivery of awareness and safety trainings to maximize content assimilation and reduce potential numbness. Develop field manual that inculcates a model of individual psychological health prevention and promotion as part of daily routine, with built in regular assessments of what constitutes good practice. Assess practice of incorporating behavioral health training into daily routine and common event briefs to provide small doses of programs and stigma reducing education.

**Redesign Training and Education:**

*Use the Marines School House to Transform Education About Psychological Health*

Educate critical leadership roles in order to develop awareness of relevant programs and their role toward supporting a preventative rather than reactive approach. Further emphasize non-punitive care-seeking environment while maintaining the quadruple aim despite concerns of malingering.

Assess extent that unit stakeholder BH teams (unit MOs, MTF BH team, FROs, and Chaplains) are coordinated with unit leaders to optimize NCO (and others) education regarding how to access programs.

Assess extent that unit leader training incorporates awareness that treated BH conditions are safer than untreated BH conditions.

---

<sup>34</sup> Foshier, Kerry, et al., final report, CAOCL-TECOM Resilience Research Project, Marine Corps Base Quantico, 21 August 2013, accessed at [www.tecom.usmc.mil/on](http://www.tecom.usmc.mil/on) 11 April 2014.

Assess implementation of training and documentation detailing positive practices from seeking care. Utilize successful examples of warfighters with top secret and PRP status that retain or reinstate their status when their BH condition is controlled.

**Develop Data Entry And Analysis Tools To Support MIPS Program:**

Bolster and extend ICM-RMS development. As of June 30, 2015 limited forward motion on development and dissemination of ICM-RMS. The long term implementation of the ICM-RMS tool seems in doubt at this point. During our 2015 visit, only limited mention was made of the tool's likely implementation plans.

**Implement and Track MCMH and Assess Appropriate Role for BHIP**

Cherry Point MCMH represents a well-functioning example of the MCMH and is utilizing the BHIP capacity to effective intent. One care provider commented that while the MCMH appeared to be successfully operating at Cherry Point, it was not clear how the MCMH was expected to operate when attached to the MTF.

## Appendix A: 2015 Research Methodology

After collecting the survey data of out-in-town providers, the research team integrated sets of findings from 2013 and 2015, and engaged in a lengthy coding process using Grounded Theory methodology (Corbin and Strauss (2015)). For each of these themes, we then developed (1) a set of preliminary hypotheses and questions and (2) theme-related codes that we grouped into sets of concepts (called “bundles”). The codes were meant to explore the various preliminary hypotheses and questions without assuming that the preliminary hypotheses and questions are the proper framing. Based on the synthesis of the transcript memos and these questions, we created a substantive coding scheme that fell under the five themes previously established. By substantive, we mean that the various codes (and how they are applied) shifted from categorizing the specific words used or topics discussed (formal codes) to how the interviewee statements expressed or related to the various themes and concepts.

The scope and number of codes was substantially reduced based on the results of three rounds of inter-coder reliability testing during which three members of the team coded 10 percent of the transcripts and compared their results for similarities and differences. Using the new scheme, we re-coded the interviews, further disaggregating interview segments under the substantive code heading. As with most empirical qualitative research methodologies and with grounded theory in particular, our (1) preliminary hypothesis and questions and (2) the themes, sub-themes, and codes were subject to review and revision during the coding and analysis processes.

Continuing the grounded theory approach, the team selected the most salient preliminary questions and identified the potential “constellations” of code memos that would provide information to answer the questions. We then collectively decided on ten substantive codes (ultimately reduced to nine during the writing process) for which to write detailed analytical **code memos** of about fifteen to thirty pages each. We selected these codes based on their perceived connection with other codes and our judgments about whether they would feed into possible “**constellation**” **memos**. In the code memos, team members distilled and interpreted the data under each substantive code, pointing out patterns and clarifying key processes. After several code memos were completed, we then wrote the constellation memos, synthesizing and further analyzing the information presented in the code memos to answer broader questions (Refer to Appendix 1 for a description of the memos and resulting analysis of the 2013 qualitative data).

### Design of the Reanalysis Scheme

Memos for the following codes are included:

1. What mental health care should/does accomplish and mediating factors
2. Distinction between medical and non-medical paths of care
3. Understanding of mental health issues: lay/folk

4. Understanding of mental health issues from training or mental health practice
5. Information transfer practices, results, and mediating factors
6. Why patients seek mental health care, who identifies, who initiates

The constellation memos cover the following questions:

*Constellation memo 1:*

- How do institutional or systemic factors influence the ways commanders and providers identify mental health care needs and initiate care?

*Constellation memo 2:*

- How do the goals of mental health care (as affected by cultural values) influence how actors perceive the value of types of care (and care providers) and the resulting types of care received?

*Constellation memo 3:*

- How does the method of information sharing impact the efficacy of the communication and/or the receiving party's perception of the importance of the communicator's role in the mental health care system?
- How do possible differences in communication standards for the on-base community and the civilian community inhibit interactions and/or effective information sharing?
- How do providers negotiate information sharing while maintaining patient privacy?

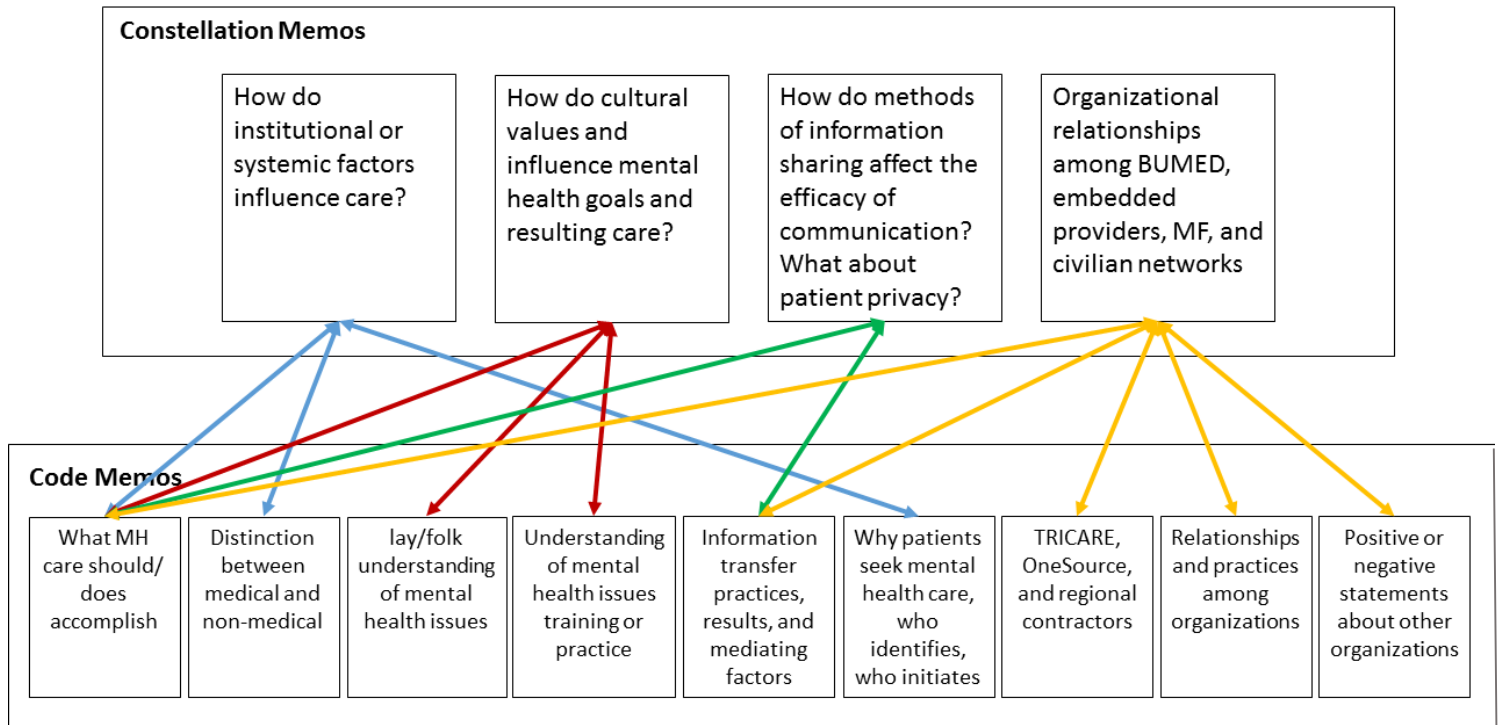
*Constellation memo 4:*

- How does the current organizational arrangement of mental health services and programs affect or shape interorganizational relationships?
- What types of tensions exist across institutional boundaries and how does the current organizational environment exacerbate or moderate them?
- What are the leverage points that might enhance interorganizational relationships in ways that improve service delivery?

The final code memos and constellation memo treat the subject of organizational relationships among BUMED, MF, a range of embedded medical and non-medical providers, and civilian mental health professionals off base.

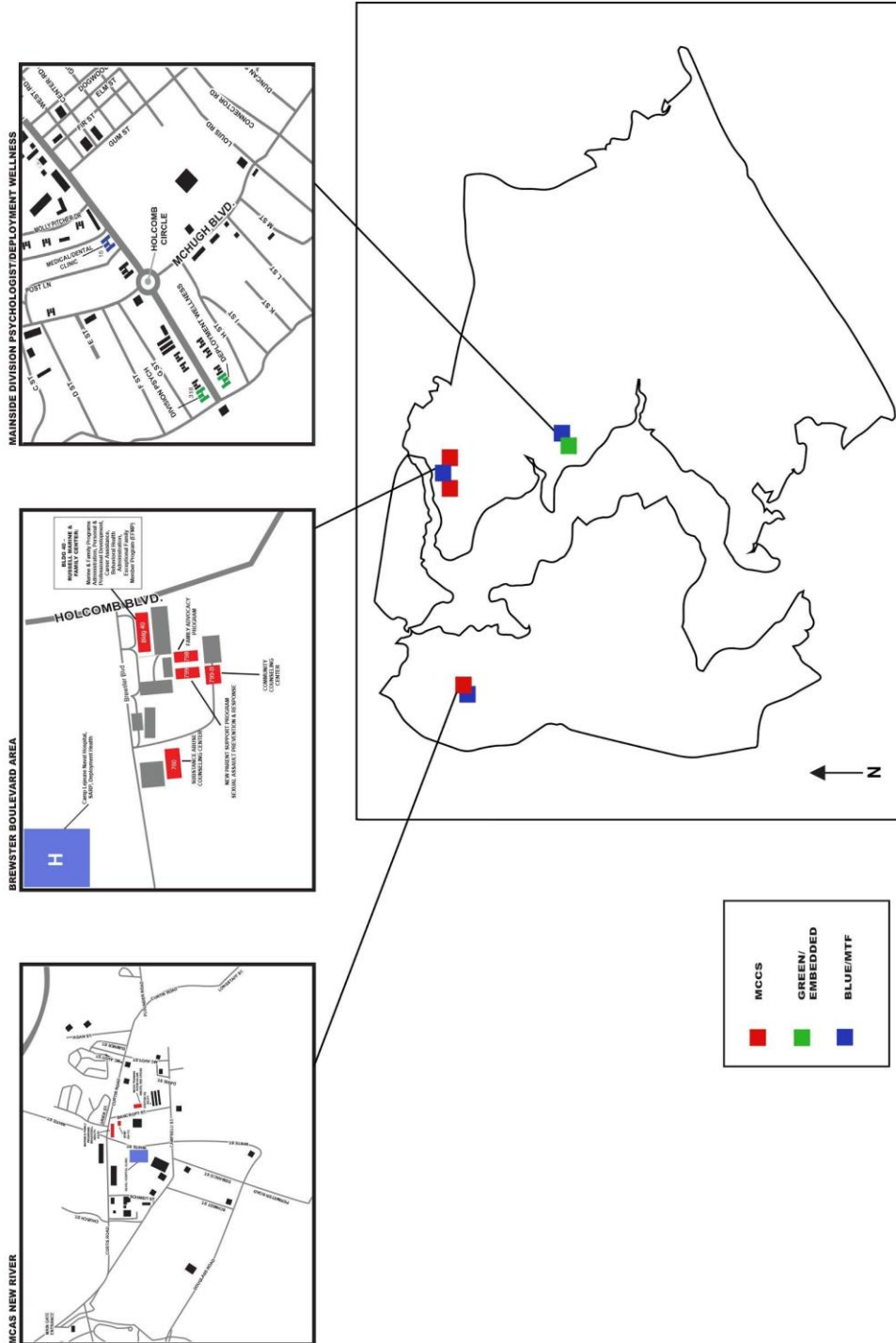
The following diagram represents the process:

## Analysis and Recommendations



## Appendix B: Marine Corps Base Camp Lejeune Psychological Health Care System Map

### CAMP LEJEUNE PH SYSTEM MAP



## Appendix C: List of Acronyms

ACA	Affordable Care Act
ACE	Aviation Combat Element
ACMC	Assistant Commandant of the Marine Corps
ACO	Accountable Care Organization
AHC	Accountable Health Community
AHLTA	Armed Forces Health Longitudinal Technology Application (electronic health record)
AHRQ	Agency for Healthcare Research and Quality
BH	Behavioral Health
Blue	Navy Health Care providers based in MTFs and Clinics
BUMED	Bureau of Medicine and Surgery, Dept. of the Navy
BUMEDINST	BUMED Instruction
CCC	Community Counseling Center (part of MFP Behavioral Health)
CDR	Commander
CMG	Case Management Group; installation; hears all unrestricted sexual assault cases
CMMI	Center for Medicare and Medicaid Innovation
CMS	Center for Medicare and Medicaid Services
COSC	Combat Operational Stress Control
DCHS	King County (WA) Dept. of Community and Health Services
DH	Department head
DHP	Defense Health Program
DIV	Division (Major Subordinate Command)



---

Analysis and Recommendations

---

DIV PSYCH	Division Psychiatrist (most senior OSCAR provider)
DOD	Department of Defense
DOD-CMS	DOD Case Management System (used by MFP BH)
DoDD	DOD Directive
DODI	DOD Instruction (policy document)
DPH	Director for Psychological Health
DSM	Diagnostic Statistical Manual of Mental Disorders
DWI	Driving while intoxicated
EHR	Electronic Health Record
ER	Emergency Room
FAP	Family Advocacy Program
FPC	Force Preservation Council
FRO	Family Readiness Officer
GAD-7	self-assessment for generalized anxiety disorder (7 questions)
GC	General Counseling (part of FAP within MFP BH before expanding into CCC in FY 14)
GCE	Ground Combat Element
GMO	General medical officer (primary care physician for active-duty personnel), also MO
Green	Navy health care providers embedded in Marine units (e.g. OSCAR providers, GMO)
HS	Health Services (Marine Corps)
HHS	Dept. of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HQ	Headquarters
IBHC	Integrated Behavioral Health Consultant (provides PH care in MCMH)

---

Analysis and Recommendations

---

ICM-RMS	Integrated Clinical Management and Risk Mitigation System (pronounced “ICM-Rams”)
I MEF	1st Marine Expeditionary Force (pronounced ‘one mef’)
II MEF	2 <sup>nd</sup> Marine Expeditionary Force (pronounced ‘two mef’)
IOM	Institute of Medicine
IOP	Intensive Outpatient Program
IT	Information Technology
MARADMIN	Marines Administrative (message)
MARSOC	United States Marine Corps Forces Special Operations Command
MC	Marine Corps
MCAS	Marine Corps Air Station
MCB	Marine Corps Base
MCCS	Marine Corps Community Services; MFP is part of MCCS
MCMH	Marine-Centered Medical Home
MCO	Marine Corps Order (policy document)
MEB disorders	Mental, Emotional, and Behavioral Disorders
MEF	Marine Expeditionary Force
MFLC	Military and Family Life Counselors (DOD non-medical program)
MFP	Marine and Family Programs (part of MCCS; sometimes written M&FP)
MH	Mental Health (directorate within Navy Medicine; department within MH Directorate)
MHS	Military Health System
MIP	Marine Intercept Program (MFP BH program in response to suicide ideation or attempt)
MIT	Massachusetts Institute of Technology
MLG	Marine Logistics Group

---

Analysis and Recommendations

---

MO	Medical Officer (Primary care physician for Active Duty personnel), also GMO
MOU	Memorandum of Understanding
MTF	Military Treatment Facility
NCIS	Naval Criminal Investigative Service
NHCL	Naval Hospital Camp Lejeune (NC)
NHCP	Naval Hospital Camp Pendleton (CA)
NMCS	Naval Medical Center San Diego (CA)
NPSP	New Parent Support Program (part of MFP BH)
OSCAR	Operational Stress Control and Readiness
PCL	PTSD Check List Self-assessment
PCMH	Patient-Centered Medical Home
PCP	Primary Care Physician
PCS	Permanent Change of Station
PH	Psychological Health
PHP	Psychological Health Pathways
PHQ-9	Patient Health Questionnaire's 9 question self-assessment for depression
POC	Point of Contact
Psych Tech	Psychiatric Technician
PTSD	Post-traumatic stress disorder
QA/PI	Quality Assurance/Process Improvement
RDML	Rear Admiral (lower half)
SACC	Substance Abuse Counseling Center (part of MFP)
SAMHSA	Substance Abuse and Mental Health Services Administration
SAPR	Sexual Assault Prevention and Response Program

---

Analysis and Recommendations

---

SARP	Substance Abuse and Rehabilitation Program (part of BUMED MH)
SECNAVINST	Secretary of the Navy Instruction
SIM	State Innovations Model (via CMMI)
SOI	School of Infantry
SOP	Standard Operating Procedure
SPRINT	Special Psychiatric Rapid Intervention Team (Navy)
SU	Substance Use
TMO	The Medical Officer (of the Marine Corps)
VA	Veterans Administration
VHA	Veterans Health Administration (part of the VA)
WHO	World Health Organization

## Appendix D: Original TRICARE Analysis

### **Moral Obligation and Fiscal Responsibility: A Barrier to TRICARE Reform**

**Andrew Bell**

#### Introduction

TRICARE is the Department of Defense (DOD) health insurance program that provides benefits to U.S. service-members, retirees, and dependents. The TRICARE program is the result of a multi-decade effort to provide healthcare to U.S. military personnel. Today, the TRICARE program's sustainability is threatened by rising healthcare costs. This raises the troubling fact that the objective the TRICARE program was designed to accomplish, ensuring the health and well-being of US service members and dependents, is now endangered by the TRICARE program itself. Policy interventions to address the rising cost must balance the normative issue that underlies the current fiscal crisis, namely, the moral obligation to provide healthcare to U.S. service members, retirees and their dependents, and system fiscal sustainability.

Present-day budgetary issues faced by the TRICARE program can, in part, be attributed to a half-century of legislation related to the provision of healthcare to U.S. service persons and their dependents. Left alone by 2016, the Military Health System (MHS) will represent nearly 60% of the standing military's (non-weapons) budget. Preventing continuous budgetary growth requires that the nation confront the extent of our moral obligation to our service members who choose to defend their nation's interests with their lives, and balance it against realistic fiscal constraints.

To date, MHS appears only to have expanded. For instance, in 2014, TRICARE consumer fees remain the same as they were 20 years ago despite inflation—a situation that has significantly contributed to growing budgetary demands. Ongoing attempts to raise TRICARE fees, in order to correct for inflation without restricting benefits, have been met with stark opposition by members of both parties in the U.S. House and Senate. Some members claim that this cost increase would violate the moral obligation to veterans for lifetime healthcare.<sup>35</sup>

---

<sup>35</sup> Webb, Jim. 2012. Senator Webb to DoD: You Cannot "Renegotiate" the Moral Obligation to Provide Health Care to Retired Service Members. March 28. Accessed 2014. <https://votesmart.org/public->

The moral obligation to provide care to U.S. service members and their dependents strongly influenced decisions to expand healthcare services provided while inhibiting any effort to offset rising cost with benefit contraction. Benefit expansion without a concomitant contraction of program elements is a constant in the DOD's provision of health insurance to active duty service members, retirees, and their dependents. We can now observe how this process is undermining the systems' ability to provide healthcare. In order to address the current crisis in the TRICARE program, and the MHS more generally, we must balance fiscal responsibility with the Nation's moral obligation to provide healthcare to service members, retirees, and their dependents. In order to understand how our collective interpretation of the moral obligation impedes fiscal change within the MHS, we begin by examining the historic balance between civic responsibility and resource allocation.

*The First Years of the Modern Military Health System*

TRICARE is the product of fifty years of MHS evolution. Its foundation has consistently been the principle of moral obligation. Its relevance in U.S. military history manifested clearly after the conclusion of the Second World War with the ratification of the Dependents Medical Care Act in 1956. These were the first clear expressions of the moral obligation to provide medical care for service members.

Pointing to the large population of U.S. military personnel who served during the Second World War and a growing need for a larger standing force to combat real or perceived Soviet aggression, Senator Leverett Saltonstall (R - MA) expressed the importance of providing U.S. service members with medical treatment regardless of location.<sup>36</sup> If service members were going to risk life and limb for U.S. sovereignty, Saltonstall contended, it was the country's obligation to provide for them in both peacetime and conflict.

In 1953, based on findings from the Citizens Advisory Commission (CAC), the DOD advocated for legislation to supplement military family care with civilian care. CAC members had emphasized a need for increased care for military dependents. Headed by Harold Moulton, a consultant from the Brookings Institution, the CAC had studied the need for dependent medical care and released a report, known as the Moulton

---

statement/682081/senator-webb-to-dod-you-cannot-renegotiate-the-moral-obligation-to-provide-health-care-to-retired-service-members#.U9LnR\_ldWM5

<sup>36</sup> Whipple, D. R., & Maassen, L. R. 1975. *A History of Military Dependent Medical Care Programs*. Monterey, CA: Naval Postgraduate School. pp18. August.

Report, outlining the extent and intent of an expanded dependent care system and suggesting the incorporation of civilian care providers.<sup>37</sup>

*Geographic Access Problems and the Need for Two Systems of Care*

Senator Saltonstall, sponsored a bill that outlined the U.S. government's obligation to provide consistent and effective health care regardless of geographic proximity to Military Treatment Facilities (MTFs). He argued that the U.S. Government had a moral obligation to construct and implement just such a system. The bill was named the *Dependents Medical Care Act* and outlined what would become the long-standing structure of the service member and dependent health care system.

Civilian-provided care for dependents would result in increased budgetary demands. Two years later, in the *Dependents Medical Care Act*, the House Appropriations Committee issued a directive limiting the provision of care by civilian providers. The perception within the House was that MTFs were being under-utilized. In an attempt to improve access to and use of these facilities, a bill was introduced in 1960 that placed a \$60 million cap (\$481 million in 2014) on civilian health care expenditures. The bill was adopted as an attempt at fiscal responsibility designed to reduce service members' and dependents' care in civilian treatment facilities and increase the use of MTFs.

The Senate disagreed and removed the cap, calling for a Joint Conference Committee.<sup>38</sup> The Senate prevailed in committee, though the House insisted on placing language in the bill suggesting that the military medical system needed to be used more efficiently. By 1961, in less than three years the eligible dependent population had risen to 3.74 million, an increase of 200,000 beneficiaries. This figure was projected to increase by an additional 80,000 by 1962, placing new pressure on the system, both in terms of need for more facilities and in increased costs.

*Rising Retiree Numbers Begin to Swamp the System*

Retirees and their dependents accounted for a large portion of the beneficiary population and the obligations to provide them with health care placed fiscal strain on the system. The pattern of usage by military retirees had shaped levels of demand, particularly around military bases as retirees frequently choose to reside near

---

<sup>37</sup> Major General M.C. Robinson, P. I. 1957. Medicare: Uniformed Services Program for Dependents. *Social Security Administration Bulletin*, pp. 1-8. July.

<sup>38</sup> Whipple & Maassen. 1975. p. 15. August.

military facilities, especially those in the South. This pattern was beginning to swamp military care providers.

In 1964, the DOD put forward a proposal to Congress arguing there was historical precedent for the provision of health care for retirees and their dependents.<sup>39</sup> The same year, the Special House Armed Services Subcommittee, chaired by Representative L. Mendel Rivers (D - SC), reported to the House of Representatives on a review of the utilization of military medical facilities. Senator Rivers was an adamant supporter of military preparedness regardless of cost.<sup>40</sup> The committee found that in the future, the number of beds would need to be programmed to reflect the breadth of care provided, taking into account the demand produced by retirees and dependents. Based upon the Rivers' subcommittee findings, three bills were introduced into Congress to amend the Dependents Medical Care Act (DMCA). These amendments put forth a number of changes to the breadth of eligibility and care provision.<sup>41</sup>

The Senate Armed Services Subcommittee convened hearings on amending the DMCA with Senator Robert F. Kennedy (D - NY) as the first witness to testify. He proposed an amendment to broaden benefits and coverage to disabled and handicapped dependents, and included psychiatric assistance for mentally ill dependents. Additionally, there was a provision for the immunization and physical examination of dependents stationed outside the U.S.

Despite witness testimony in support of the amendments, the bill was delayed for a year and had a number of benefits reduced or removed. In September 1966, two versions were introduced into the Joint Conference Committee (JCC). The final version was called the Military Medical Benefits Amendments of 1966 Codified title 24-10 section 1077 to 1086 of the U.S. Code and retitled as the *Civilian Health and Medical Benefits Program for Uniformed Services* (CHAMPUS).<sup>42</sup>

### *CHAMPUS Unleashes a Flood of Demand: In Less than a Decade Costs Rise 300%*

---

<sup>39</sup> Whipple & Maassen. 1975.p. 18. August.

<sup>40</sup> *About our Namesake*. 2013. Retrieved June 2013, from USS L. Mendel Rivers (SSN 686): [http://site.riversdelivers.org/About\\_our\\_Namesake.html](http://site.riversdelivers.org/About_our_Namesake.html)

<sup>41</sup> Whipple & Maassen. 1975. p. 20. August.

<sup>42</sup> Subcommittee on Supplemental Service Benefits. 1969. *Review of the Health Benefits Program of the Armed Forces*. Washington, D.C.: US Government Printing Office.



At the time, CHAMPUS was perceived as fulfilling the moral obligation to service members. Over the next decade, however, increasing budgetary pressure would begin to weigh on the system itself. CHAMPUS costs rose rapidly—in 1975 they were expected to increase to approximately \$551 million, more than a 300% increase since 1966.<sup>43</sup>

Congressional hearings on appropriations for the CHAMPUS program looked at ways to curb rising costs within the system, to little effect. Citing a review of the program in 1972, Lieutenant General John A. Kjellstrom testified that the primary driver of rising costs was the liberal implementation of benefits and an increasing number of dependents. In other words, limited attention had been given to fiscal constraint during the system's implementation.<sup>44</sup> <sup>45</sup> The review's authors noted that nearly any service or treatment recommended by a physician was considered covered, with only a few exceptions defined by law.

By 1975 a set of reforms had been outlined that were intended to reduce CHAMPUS costs. Although benefits were cited as issues, the real culprit draining the coffers of CHAMPUS was administrative inefficiency. Finding that the DOD was incapable of mitigating the increasing cost of the program, Congress implemented an initiative to lower CHAMPUS spending.

### *Costs Continue to Rise*

In 1986, CHAMPUS costs were still rising, reaching \$1.8 billion annually.<sup>46</sup> Cost escalation spurred Congress to address growing expenses related to CHAMPUS, and reform efforts to mitigate budgetary issues began. Public Law (PL) 99-661, the National Defense Authorization Act of 1987, would lay the institutional foundation for the formation of the modern TRICARE system. PL 99-661 introduced the CHAMPUS Reform Initiative (CRI), which was designed to reduce the cost of dependent care provided by civilian professionals.<sup>47</sup>

---

<sup>43</sup> Permanent Subcommittee on Investigations, Committee on Government Operations. Senate; Committee on Government Operations. Senate. 1976. p. 71.

<sup>44</sup> Hearing on Senate Committee on appropriations. 1972. 92<sup>nd</sup> Congress pp 278

<sup>45</sup> (Permanent Subcommittee on Investigations, Committee on Government Operations. Senate; Committee on Government Operations. Senate. 1976. pp. 70–73.

<sup>46</sup> Abramowitz, M. 1986. Pentagon Delays Private Health Plan. *Washington Post*, p. B1. September 12.

<sup>47</sup> Heinzelman, D. O. 1997. The Evolution of the Military Health Care Benefit (MHCB): the scope of the changes and the principle drivers behind them. Monterey, CA.: Naval Postgraduate School. pp. 31–32.

---

The proposed solution required the Pentagon to develop a managed care program similar in structure and scope to private sector HMOs, without reducing benefits. CHAMPUS was to be divided into a triple coverage option system: CHAMPUS standard was commensurate with the previous system and maintained its bureaucratic and benefits structure in order to minimize growing pains placed upon service members, retirees, and dependents. CHAMPUS Prime would operate like a civilian HMO and CHAMPUS Extra would act as a PPO.<sup>48</sup>

*Rising Numbers of Retirees, Equal Access Mandates, and the Need for Competitive Care to Ensure Access to Medical Professionals*

Throughout the 1980s retiree populations rose, the result of the large military personnel buildup during the Cold War and the early retirement age in the military.<sup>49</sup> This larger retiree population also meant a larger population of retiree dependents. This growth in the beneficiary population placed substantial stress, both personnel-related and economic, upon MTFs and MHS as a whole.

The broadening of the definition of dependents by Congress and the DOD further added to the beneficiary population. With the implementation of the Defense Officer Personnel Management Act, dependents were subject to gender equality, meaning that civilian men married to female service members were now dependents. Even as the system exhibited signs of unsustainability, the breadth and inexpensive nature of health benefits for service members was touted by policy makers as key to both personnel retention and to fulfilling the moral obligation to service persons and their families.

*Creating CRI: The Genesis of TRICARE*

In the late 1980s and early 1990s, the DOD and legislators created the CHAMPUS Reform Initiative (CRI). CRI was a pilot program to test the efficacy of the HMO newly envisioned by Congress and the DOD. This HMO would be called TRICARE.

The years 1987 and 1988 were marked by a legislative initiative to implement reforms touted by the CRI.<sup>50</sup> Congress held hearings on the Defense Department budget, eventually ratifying PL 100-180, *The National Defense Authorization Act of Fiscal Year 1988 and 1989*. During these hearings the future of the MHS and its efficacy

---

<sup>48</sup> Subcommittee on Military Installations and Facilities, Committee on Armed Services. House; Committee on Armed Services. House. 1993. pp. 319–320.

<sup>49</sup> Segal, David R., and Mady Wechsler Segal. 2004. *America's Military Population*. Vol. 59, No. 4, Washington, DC: Population Reference Bureau.

<sup>50</sup> Hosek, Susan D., Mary Anderson, Alan Hartford, George Olson, James Press, and Elizabeth Sloss. 1987. *Plan for CHAMPUS Reform Initiative*. RAND Note, Santa Monica, CA: RAND.

were estimated and serious deficiencies outlined. The DOD asserted that the rising costs of the CHAMPUS system would be exacerbated by base closures over the next decade. By 1997, with an estimated 35% of bases facing closure, the number of MTFs accessible to retirees and dependents were forecast to decrease dramatically. As a result, CHAMPUS costs would projected to increase as dependents and retirees were forced to use civilian facilities rather than seeking less expensive (for the DOD) treatment at an MTF.<sup>51</sup> This estimated increase in demand and decrease in supply led to pressure on the DOD to begin pilot studies of military managed care.

In 1988, the DOD implemented pilot programs to demonstrate the efficacy of the HMO TRICARE program. Three separate pilot studies were proposed in which groups of two states would implement the TRICARE delivery system in conjunction with private health care contractors. The goals of this new managed care system were to increase access to benefits and providers and to streamline the benefit delivery process-- two major failures of the CHAMPUS program.

Evaluations of the proposed program met with mixed success. Two of the studies, one in Florida and Georgia and the second in North and South Carolina, were cancelled due to cost and provider compensation issues. The third pilot program, conducted in California and Hawaii, was successful in contracting with private health care contractors associated with Foundation Health Services (federal division named Health Net Federal Services) and began the program demonstration at the end of 1988. The pilot study was to be conducted for five years and provide evidence of the cost-saving properties of managed care.

In theory, if private health care systems could operate economically with similar benefits packages, it was assumed a military managed care strategy would curb rising costs and reduce unnecessary compensation and treatment. Studies conducted on the MHS supported the proposition that an HMO-style system could be successful in reducing costs if accompanied by an effectively designed financing and delivery structure.<sup>52</sup>

---

<sup>51</sup> Subcommittee on National Security Appropriations, Committee on Appropriations. House; Committee on Appropriations. House. 1997. Department of Defense Appropriations for 1998, Part 3. HRG-1997-HAP-0088 (p. 471). Washington D.C.: U.S. Government Printing Office. PP162

<sup>52</sup> Subcommittee on Military Installations and Facilities, Committee on Armed Services. House; Committee on Armed Services. House. 1993. pp. 317-321.

---

In 1991, the DOD awarded a \$143 million contract to Foundation Health Corporation to run the California TRICARE pilot program.<sup>53</sup> Foundation Health claimed that the new HMO TRICARE system implemented by CRI would save the DOD more than \$100 million over the previous CHAMPUS system. However, the DOD had doubts about the efficacy of private managed care in reducing costs. By the early 1990s, the costs of CHAMPUS had nearly doubled rising to \$3.2 billion annually.<sup>54</sup> Despite inconclusive results from another cost-reduction pilot program, the Catchment Area Management (CAM) system, the DOD still believed the TRICARE system would be more effective at cost control than the CRI pilot program. This conclusion prevailed despite doubts by the first Bush Administration regarding the CRI's effectiveness on a national scale.

*Civilian Care Moves toward Managed Care; Military Attempts to Follow Suit*

The DOD hoped that the CRI reforms would constrain costs, increase beneficiary access and satisfaction within the system, and expand or improve the benefits provided to service persons, retirees, and dependents. Contrary to these goals, however, RAND showed that the CRI reforms increased costs for adults seeking treatment by 9%.<sup>55</sup> With greater benefit breadth and access, beneficiaries under CRI increased outpatient visits by more than 50%. In other words, a high number of beneficiaries who had previously sought care at MTFs were now being assigned civilian primary care physicians, raising the cost of the entire system. Further, the lack of a premium was causing many beneficiaries to drop civilian health care in favor of the significantly less expensive CRI option. However, while it failed to mitigate costs, CRI was viewed a resounding success in providing greater access to prompt medical care through CHAMPUS.<sup>56</sup> While the CRI pilot program showed that an altered CHAMPUS structure would not mitigate rising health care costs, Congress passed PL 103-160, *The National Defense Authorization Act of 1994*, which directed the DOD to implement and prepare for a transition from CHAMPUS to the new HMO TRICARE system.<sup>57</sup>

*Program Amalgamation Keeps the Old System of Care: Escalating Budget Liabilities Linked to Rising Health Care Costs*

---

<sup>53</sup> McAllister, B. 1991. Pentagon Cautious on Health Cost Management; Private Firm Boasts of Saving \$ 100 Million in CHAMPUS Program. *Washington Post*, p. A9. June 10.

<sup>54</sup> McAllister, 1991.

<sup>55</sup> Hosek, S. D. 1993. *The CHAMPUS Reform Initiative: Implications for Military Health Care Reform*. Washington, D.C.: Rand Corporation and National Defense Research Institute, pp. 4-5.

<sup>56</sup> Hosek S. D.. 1993., p. 6.

<sup>57</sup> Heinzelman. 1997. p. 44.

CRI concluded in 1995. During that same year, the HMO TRICARE system was implemented across MHS. CHAMPUS benefits became the TRICARE Standard Policy. Two other plans were added to provide a wider range of care under different cost parameters—TRICARE Prime was provided to all active-duty service members and would act as an HMO while TRICARE Extra allowed the use of a civilian PPO. The introduction of the triple option system had broad cost implications; an enrolled family of three only paid 27% of total costs—a significantly lower rate than comparable private plans.<sup>58</sup>

There were immediate difficulties with implementation of the TRICARE system. The unique demands of DOD care provisions as well as extensively customizable options made the system less than attractive to private health care providers. This difficulty in procuring private bids complicated the implementation process and led to initial difficulties within the system. By 1999 the average cost to the DOD of individual care had steadily risen from \$1,500 in 1984 to around \$2,700 in 2000 (\$3,422 – \$3,717 in 2014), while beneficiaries’ out-of-pocket costs had stagnated.<sup>59</sup>

A 2000 report by the Center for Naval Analysis (CNA) on the evolution of the benefits system concluded that:

*In terms of costs, beneficiary out-of-pocket payments have remained about the same over time and at low levels. The same has not been true for the Defense Department, which has experienced significant growth in payment levels for its military health care program.*

Adding:

*The military services in the year 2000 face the same dilemma as the civilian sector: covering the health care costs of an aging beneficiary population whose life expectancy has increased. During the 1980s and 1990s, the majority of the distribution of eligible beneficiaries shifted slowly from the younger and healthier active duty members and their families to favor the older retirees and their families.<sup>60</sup>*

---

<sup>58</sup> Lane, C. 2013. .TRICARE the Untouchable. *The Washington Post*, p. 1. March 25.

<sup>59</sup> Dolfini-Reed, M., & Jebo, J. (July, 2000). *The Evolution of the Military Health Care System: Changes in Public Law and DOD Regulations*. Alexandria, VA: Center for Naval Analyses. pp 45.

<sup>60</sup> (Dolfini-Reed & Jebo, July, 2000), pp. 51–52.

The contract bidding instituted a winner-take-all approach, making it difficult to maximize value on the contractor side while discouraging submission of competitive bids. In addition, the care provided and the terms of provision, both highly regulated by the U.S. Congress, presented a unique and difficult situation for contractors. The DOD struggled to maintain competitive pricing and bidding over the TRICARE regions.<sup>61</sup>

#### *Rising Demand and the OIF/OEF Conflicts*

The turn of the 21<sup>st</sup> century saw a continued decline in military medical personnel and a continued increase in the demands on the TRICARE system. Between 1999 and 2000 the legislative branch continued to push for extending benefits in order to fulfill the moral obligation even though there was a 15% decrease in medical personnel. During hearings on the Department of Defense Authorization for Appropriations for Fiscal Year 2000 and the Future Year's Defense Program, Senator Max Cleland (D - GA) and Senator Edward Kennedy (D - MA) asserted that Congress needed to direct the DOD to expand its coverage for retirees as a way of keeping its promise to service members and veterans.<sup>62</sup>

No one could predict the coming strain on the system due to 9/11. Seven years and two wars later, beneficiaries numbered upwards of 9.4 million.<sup>63</sup> Even prior to the enormous cultural change surrounding 9/11, the JCC was aware of the budget deficiencies within the MHS and created the Defense Medical Oversight Committee (DMOC) to assess the efficacy of MHS.

#### *The Moral Obligation in Jeopardy?*

The Distributed Missions Operations Center DMOC found that even with projected budget increases through 2007, funding would be deficient by at least \$3 billion. In response to these findings, the DMOC proposed substantial TRICARE fiscal reform.

---

<sup>61</sup> TRICARE Network News. (2004). TRICARE Newsletter Transition Edition. Retrieved July 2013, from Humana Military: [http://www.humana-military.com/South/provider/pdf/Trans\\_Newsltr.pdf](http://www.humana-military.com/South/provider/pdf/Trans_Newsltr.pdf)

<sup>62</sup> Subcommittee on Personnel, Committee on Armed Services. Senate; Committee on Armed Services. Senate. (1999). Department of Defense Authorization for Appropriations for Fiscal Year 2000 and the Future Years Defense Program. Part 6: Personnel. HRG-1999-SAS-0004 (p. 647). Washington, D.C.: U.S. Government Printing Office, pp. 265–278.

<sup>63</sup> Board on the Health of Select Populations, Committee on the Qualifications of Professionals Providing Mental Health Counseling Services under TRICARE, Institute of Medicine. 2010. "TRICARE Beneficiaries and Mental Health Issues in Military Families." In Provision of Mental Health Counseling Services Under TRICARE, 47- 54. Washington, DC: The National Academies Press.

These recommended reforms included a number of budget-taxing changes, such as a reduction in co-payments and the termination of annual enrollment fees.

Despite the focus on MHS budget reform, the promise of “free lifetime healthcare for U.S. veterans” prevented any attempts at the restructuring of TRICARE. In front of the Senate Armed Service Committee, the chairman of the Joint Chiefs of Staff (JCS) stated that the United States had “broken its health care promise to its veterans and beneficiaries.”<sup>64</sup> In addition to the aversion to reducing existing benefits, empty promises made by recruiters were added to the equation. For decades, free lifetime healthcare had been “offered” in exchange for service; despite the absence of evidence of a DOD policy to support such promises, legislators were loath to reduce benefits for current and former service members.<sup>65</sup>

In conjunction with Representatives Ronnie Shows (D – MS) and Charles Norwood (R – GA) Senators Tim Johnson (R – SD) and Paul Coverdell (R – Georgia) sponsored the *Keep Our Promise to America’s Military Retirees Act (Promise Act)*, which was intended to restore full access to the MHS for retirees and their beneficiaries by making them either eligible for lifetime TRICARE coverage or enrolling them in the Federal Employees Health Benefits Program.<sup>66</sup> By early 2001, 272 legislators co-sponsored the Promise Act despite the fact that it would result in a substantial cost increase. For instance, The Promise Act included permanent health care coverage for all retired military personnel (who had served at least 20 years) at an estimated total cost of \$60 billion over the next decade. Even retirees who were already on federal Medicare were included, with TRICARE operating as supplemental insurance and paying for most medical costs uncovered by Medicare. As noted by Norwood: “[The cost] absolutely means nothing to me. We gave our word.”<sup>67</sup>

#### *MHS Costs Continue to Rise*

Within a year Congress created the TRICARE for Life (TFL) option and instituted a pilot study to assess the costs associated with the program.<sup>68</sup> TFL was an insurance supplement for U.S. military retirees 65 and older. Previously, retirees who were receiving federal Medicare coverage were ineligible for TRICARE benefits. Billed as

---

<sup>64</sup> Congressional Record, V. 146, Pt. 1, January 24, 2000 to February 23, 2000 pp. 125

<sup>65</sup> Philpott, T. (2000, April). Its Showdown Time on TRICARE. *Air Force Magazine*, pp. 48–50.

<sup>66</sup> (Philpott, 2000).

<sup>67</sup> (Philpott, 2000).

<sup>68</sup> Korb, L. J., Conley, L., & Rothman, A. 2011. *Restoring TRICARE - Ensuring the Long Term Viability of the Military Health Care System*. Retrieved July 2013, from Center for American Progress, pp. 6–20. March.

the “Golden Supplement”<sup>69</sup>, TFL was significantly more generous than existing Medi-Gap plans, covering the nearly \$800 deductible, Medicare copayments, and pharmacy expenditures over the \$3,000 Medicare cap, all the while eliminating premium costs associated with private Medi-Gap plans.<sup>70</sup> TFL would reduce medical care costs for retirees by nearly \$1,500 annually. In addition, TFL reduced catastrophic liability levels from \$7,500 to \$3,000, a cost difference that would be directly incurred by the DOD. Possibly the most costly aspect of TFL was coverage of extended hospital stays. Under the TFL, retirees and dependents requiring long-term in-patient care over 150 days would be covered for 80% of costs incurred.

In addition to the implementation of TFL, Congress created the TRICARE Senior Pharmacy (TSRx). TSRx decreased the cost burden on beneficiaries at the expense of the MHS. Congress believed that TSRx was a necessary component of fulfilling the government’s obligation to service members, retirees, and dependents.

#### *A Decade of War*

2003 marked the beginning of Operation Iraqi Freedom (OIF) and a redoubled effort to recruit personnel for the additional conflict. By this time Operation Enduring Freedom (OEF) (the U.S. conflict in Afghanistan) had been in progress for nearly two years and fell from the public eye with the invasion of Iraq. After the initial appearance of success, OIF casualties began to rise. The U.S. found itself in a protracted conflict; at the same time, benefits for military retirees (those who had served in Korea and Vietnam) were again under discussion in Washington.

Despite their costs, existing TRICARE benefits were believed to be owed to those performing military service and a key factor in recruiting and retaining the service persons needed to wage the OIF/OEF conflict.<sup>71</sup> In the prior three decades, the DOD had been motivated to provide analogous health care coverage and flexibility to similar private-sector employers. By 2003 their care had reached or exceeded parity. Yet cost-sharing within the military system was radically lower than that of private employers. The sense of moral obligation to provide care inhibited efforts to put into place effective cost-control measures and served to exacerbate TRICARE’s unsustainable fiscal issues.

---

<sup>69</sup> Philpott, T. 2001a, April. Here Comes TRICARE for Life. *Air Force Magazine*, pp. 38–44. April.

<sup>70</sup> Philpott. 2001a.

<sup>71</sup>Hosek, S. D. (2005). Testimony: Initiatives to Control Military Health Costs. *Senate Committee on Armed Services, Subcommittee on Personnel* (pp. 1–9). RAND.

*“Today, TRICARE compares favorably with civilian health plans on many measures, and military members clearly consider it to be an important element of their compensation package and a visible marker of the support and appreciation for their service to the nation”*(p. 2).



*Cost Share Stagnates and DOD-Provided Care Becomes More Attractive Than Civilian Care*

In the late 1990s and early 2000s, private employers had responded to rising health care costs by decreasing coverage and increasing cost-sharing while the DOD and Congress had increased coverage and maintained cost-sharing ratios.<sup>72</sup> Due to this fact, DOD care was substantially more generous than employer-provided health care options. Whereas in the past the DOD had attempted to play catch-up with private insurance benefits, it now provided a substantially cheaper and broader range of benefits than the civilian sector.

Tricare's breadth and low cost compared with employer-based health care led many retirees to choose TFL or TRICARE as opposed to using their employer-provided plan. Cost-sharing for doctor visits was similar to civilian costs, but TRICARE had significantly lower premiums and pharmaceutical costs. Prescriptions under TFL and TRICARE were roughly half as expensive as similar civilian plans, and all prescriptions filled on base were, and continue to be, free. Premiums for civilian family plans in 2004 averaged \$2,661<sup>73</sup> per year. A similar plan using TRICARE cost \$461, a price that had not changed since it was implemented in 1995. Further, TRICARE required no premium and was similar in coverage to employer benefits making it more attractive to retirees and their dependents. Annually, choosing TRICARE over employer-provided benefits saved a consumer family an average of \$2,000 and their employer on average \$7,200, a cost for which the DOD would now be entirely responsible. As Susan Hosek, a MHS researcher working for the RAND Corporation stated in her testimony before Congress in 2005:

*To summarize, the TRICARE benefit is more attractive than the benefit offered by most civilian employers and, as a result, many retirees appear to be relying on TRICARE instead of their employer's plans.<sup>74</sup>*

By 2005, the TRICARE served more than 9 million people.<sup>75</sup> Nonetheless, Congress and the DOD further expanded TRICARE eligibility. National Guard and Reserve

---

<sup>72</sup> Hosek. 2005.

<sup>73</sup> Hosek. 2005.

<sup>74</sup> (Hosek, 2005), p. 7.

<sup>75</sup> Government Accountability Office. (2005, July). Defense Health Care: Implementation Issues for New TRICARE Contracts and Regional Structure. Retrieved July 2013, from Government Accountability Office: <http://www.gao.gov/assets/250/247234.html>

members now had access to TRICARE coverage for one to eight years depending upon the length of an individual's mobilization and retention commitment.<sup>76</sup> In addition, TRICARE now included seven services rather than four: the Army, Navy, Marine Corps, Air Force, Coast Guard, Public Health Services, and National Oceanographic and Atmospheric Administration (NOAA).<sup>77</sup> As a result, the cost of TRICARE doubled between 2001 and 2005.<sup>78</sup>

TFL had become the primary budget driver of the program, and was projected to cost more than \$100 billion between 2001 and 2010. By 2015 its cost was expected to reach \$150 billion. Although the rise in the retiree population had slowed due to a decline in World War Two and Korean War veterans, this group was still projected to total approximately 1.8 million by 2010. This increase in the covered population in conjunction with the overall rising cost of health care would strain the DOD budget over the next five years. Despite being engaged in two wars overseas, military spending was declining, and regardless of the conflicts' outcome, military health care would remain a serious long-term issue with which the DOD would continue to grapple. By 2006 the DOD budget had increased by \$7.1 billion, with growth directly related to TFL.<sup>79</sup>

#### *New Wounds of War and Fiscal Scrutiny*

In 2007, after nearly six years of war, casualty rates rose due to the protracted enemy insurgency. Faced with the possible failure of the U.S. mission in Iraq, military leaders implemented a strategy to curb the insurgency known colloquially as "The Surge." In order to implement this strategy the DOD expanded its recruiting. At the same time, the U.S. was on the cusp of its greatest economic recession since 1931. With new congressional interest in fiscal responsibility and budget cuts looming, the MHS came under fiscal scrutiny in an effort to curtail the rising costs associated with health care benefits. DOD estimates at the time placed the MHS budget between \$42 billion and \$52 billion in 2020 with a 2.3–3.9% annual spending increase.

DOD placed the blame for the cost increases on civilian care provided through the TRICARE. Median costs of seeking care were 25% lower when service members were treated at an MTF, with only 15% of MTFs having higher costs than civilian providers.

---

<sup>76</sup> Pentagon to Extend Health Coverage for Reserve Troops. *New York Times* (2005, March 25), p. A15.

<sup>77</sup> (TRICARE Network News, 2004), p. 8.

<sup>78</sup> Weiner, T. (2005, April 14). A New Call to Arms: Military Health Care. *New York Times*, p. C1.

<sup>79</sup> Hosek, Susan D. 2007. "Leveraging Other Federal health Systems." In *Restoring Fiscal Sanity*, 131-151. Brookings Institution.

Although the accuracy of these estimates is difficult to assess due to large variations in accounting, population served, and utilization rates, it is indicative of a historically consistent problem surrounding the MHS.<sup>80</sup> MTFs continued to be used for beneficiary care only on a space available basis; with active duty demands rising, the lack of feasibility of using existing MTF sites to treat the non-active-duty population led directly to an increase in overall system costs.

In an attempt to curb budget growth the Task Force for the Future of Military Health Care (TFMHC) was formed. Members called for MHS reform through executive and legislative action. Co-chaired by Air Force General John D.W. Corley, Commander of Air Combat Command, and economist Gail Wilensky, the task force suggested increasing cost-sharing for retirees. TRICARE fees had remained constant for more than a decade and had not been adjusted for inflation, which meant extremely inexpensive care for active duty and retired personnel. In addition to non-inflation-adjusted reimbursement rates, TRICARE Prime and TFL both lacked annual fees for service that were an aspect of similar civilian plans.

*The Moral Obligation Shapes the Response to Fiscal Crisis*

To close the cost gap the TFMHC proposed an annual enrollment fee for TRICARE Prime and TFL of \$120.00, which would be adjusted annually to reflect inflation. The TRICARE Prime enrollment fee was to be raised over four years from \$460 for a family and \$230 for individuals based upon retirement income. Any retirees earning less than \$20,000 would see their rates rise to \$900 by 2011, those earning between \$20,000 and \$40,000 would see their fees increase to \$1,190, and those retirees who exceeded the \$40,000 cut-off would see an increase to \$1,750 in 2011. On average, TRICARE Prime users faced a cost of \$1,100 for medical care, still significantly less than other federal health care premiums.<sup>81</sup> In addition to the proposed fee increases, a similar increase was to be applied to deductibles. Tiered to reflect retirement income, the deductible would be raised from \$300 for a family and \$150 for an individual to \$600 and \$300, respectively, and was to be reviewed at five-year intervals to maintain cost-sharing ratios.

The final proposal was an increase in co-pays to reflect nearly two decades of inflation. It would raise co-pays over two years from the abysmally low cost of \$3–\$15 to \$15–\$45 and would reflect the original cost-sharing ratios implemented in

---

<sup>80</sup> Hosek. 2007.

<sup>81</sup> Philpott, T. 2007.. Big Hike in TRICARE Fees is Endorsed. *The Herald*.

1996. All of these fee increases were proposed in an attempt to limit the growth in costs and bring the system better in sync with private cost-sharing. However, these proposals still did not correct the problem.

Even with fee increases, TRICARE still presented a generous benefits package. With the early age of military retirement combined with enticing coverage, TRICARE benefits kept working-age retirees from using employer-sponsored healthcare, passing the cost on to the DOD's already strained system. When cost-sharing ratios for other federal employees were compared to TRICARE, it was found that for those using federal civilian health care, nearly 25% of the total cost of care was shared with the consumer, while TRICARE shared at most 11% of the cost with the consumer. It's clear that when compared to similar federal systems, TRICARE's lack of cost sharing was unsustainable.<sup>82</sup>

Military Officers Association of America (MOAA) immediately objected to a tiered increase in cost-share rates. MOAA argued that retirees had already paid a premium up front when they joined the Armed Forces and risked their lives in service of their country. By making the sacrifices required by career service, military members had already paid higher premiums than any found in the civilian sector. Counter-intuitively, there was strong resistance to a tiered cost increase and an equal cost increase for all users was perceived to be a better solution; but even this was portrayed as breaking America's promise to its troops to provide free lifetime healthcare.<sup>83</sup>

Arguing fiscal necessity, TFMHC's recommendations for a TRICARE fee increase were a highly politicized and contested issue. The House Senate conference report on the 2008 Defense Authorization Bill blocked TRICARE increases in 2007 and 2008, and made it clear that reductions to TRICARE benefits would be negatively received. The stagnation in the system's fees had led to the over-utilization and under-appreciation of TRICARE benefits, in turn increasing system costs. Dr. S. Ward Casscells, Assistant Secretary of Defense for Health Affairs, stated the problem of over-utilization and under-appreciation clearly, "*TRICARE has gotten so popular that, if we subsidize it artificially, we will do so at the detriment to our military treatment facilities.*"<sup>84</sup>

---

<sup>82</sup> Philpott, T. 2007.

<sup>83</sup> Eisman, D. 2007. Military Retirees may Face Big Bump in Health Costs. *Virginian Pilot*.

<sup>84</sup> Kime, Patricia. 2014. "Proposed Tricare fee hikes dead for now." *Army Times*, April 30.

By 2008, DOD budget requests for the Defense Health Program rose from \$17.6 billion to nearly \$23.6 billion between 2005 and 2009. The DOD found that TRICARE was the primary reason for the budget increases. Between 2005 and 2009 the budget request would rise from \$9 billion to more than \$12 billion; by 2009 it represented 53% of the Defense Health Program budget request, rising by \$1.7 billion in just one year. This growth in cost was attributed to both an increase in the size of beneficiary populations and increases in system utilization, as well as substantial increases in administrative costs.<sup>85</sup>

Throughout the Obama Administration's tenure, MHS's circumstance state has remained the same.<sup>86</sup> High costs and a large, vocal, and politically powerful beneficiary population have prevented reform to ensure TRICARE's and MHS's sustainability.<sup>87</sup> One of the largest barriers to needed budgetary reform is the strength of the perception of moral obligation.<sup>88</sup> Due to the connection between TRICARE benefits and the moral obligation to care for service persons, retiree, and dependents, any attempt at TRICARE reform has failed. And yet, without effective administrative and economic controls, TRICARE will continue to be plagued by the growth in costs and diminishing returns.<sup>89</sup>

### *Conclusion*

Most legislators are reluctant to reduce or limiting service person, retiree, or dependent health benefits. This is true historically and today. Exacerbated by the growing public visibility of post-conflict mental health issues (PTSD/TBI) and post-conflict physical handicaps (prosthetics, serious ongoing injury treatment), the tension between the moral obligations to provide care and a fiscally sustainable system will persist.

In the last three years a number of attempts have been made by the Executive branch to increase fees and co-pays for non-active duty populations, all of which have been

---

<sup>85</sup> Inouye, Daniel, Ted Stevens, John P. Murtha, and C. W. Bill Young. 2008. Review of the President's Fiscal Year 2009 Budget Request for the Defense. Washington, DC: United States Government Accountability Office.

<sup>86</sup> "At \$460 a year for a family, TRICARE is too ..." *USA Today*, n.d., Academic Search Complete, EBSCOhost (accessed November 19, 2013). Section: News, Pg. 08a

<sup>87</sup> Lane, Charles. "TRICARE, bloated but untouchable." *The Washington Post*. March 26, 2013 Tuesday. Date Accessed: 2013/11/19. [www.lexisnexis.com/hottopics/lnacademic](http://www.lexisnexis.com/hottopics/lnacademic).

<sup>88</sup> The American Legion. 2014. "American Legion fights TRICARE increases." The American Legion. <http://www.legion.org/pressrelease/217883/american-legion-fights-tricare-increases>.

<sup>89</sup> Lane, 2013.

unsuccessful. Despite the demonstrated need for fiscal reform to ensure the sustainability of the MHS and TRICARE, reform remains politically unpopular. Recent speeches given by members of the Obama administration and Congress indicate that the strength of the moral obligation is if anything increasing, calling the nation's collective duty to service-members a 'sacred' rather than a moral obligation.<sup>90919293</sup>

The DOD and Congress face the difficult and seemingly insurmountable task of reducing costs while fulfilling the moral obligation to provide care to service persons, retirees, and dependents. The tension between the moral obligation to provide care and fiscal program sustainability and TRICARE's development helps to explain both the current fiscal situation and why it has occurred. Although the path forward is unclear, the DOD and Congress must find a way to balance the moral obligation to provide care in order to ensure system sustainability.

---

<sup>90</sup> Flaherty, Anne. 2011. "Gates Tries To Cut Military Health Care." The Huffington Post, January 7.

<sup>91</sup> Committee, The House Armed Services. 2012. Committee Overwhelmingly Passes the FY13 National Defense Authorization Act. May 10. [http://armedservices.house.gov/index.cfm/press-releases?ContentRecord\\_id=c1a26a15-9dd3-4658-abf2-e50d0852ba12&ContentType\\_id=e0c7b822-826f-493d-8cef-1e21aa53e12a](http://armedservices.house.gov/index.cfm/press-releases?ContentRecord_id=c1a26a15-9dd3-4658-abf2-e50d0852ba12&ContentType_id=e0c7b822-826f-493d-8cef-1e21aa53e12a).

<sup>92</sup> Miller, Jake. 2014. Facing VA scandal, Obama stresses "sacred obligation" to veterans. May 24. <http://www.cbsnews.com/news/amid-va-scandal-outcry-obama-stresses-sacred-obligation-to-veterans/>.

**Works Cited:**

*About Our Namesake*. 2013. Retrieved June 2013, from USS L. Mendel Rivers (SSN 686): [http://site.riversdelivers.org/About\\_our\\_Namesake.html](http://site.riversdelivers.org/About_our_Namesake.html)

Abramowitz, M. (1986, September 12). Pentagon Delays Private Health Plan. *Washington Post*, p. B1. "At \$460 a year for a family, TRICARE is too ..." *USA Today*, n.d., Academic Search Complete, EBSCOhost (accessed November 19, 2013). Section: News, Pg. 08a

Board on the Health of Select Populations, Committee on the Qualifications of Professionals Providing Mental Health Counseling Services under TRICARE, Institute of Medicine. 2010. "TRICARE Beneficiaries and Mental Health Issues in Military Families." In *Provision of Mental Health Counseling Services Under TRICARE*, 47- 54. Washington, DC: The National Academies Press.

Committee, The House Armed Services. 2012. *Committee Overwhelmingly Passes the FY13 National Defense Authorization Act*. May 10. [http://armedservices.house.gov/index.cfm/press-releases?ContentRecord\\_id=c1a26a15-9dd3-4658-abf2-e50d0852ba12&ContentType\\_id=e0c7b822-826f-493d-8cef-1e21aa53e12a](http://armedservices.house.gov/index.cfm/press-releases?ContentRecord_id=c1a26a15-9dd3-4658-abf2-e50d0852ba12&ContentType_id=e0c7b822-826f-493d-8cef-1e21aa53e12a).

Congress, Senate Committee on Appropriations 92nd. 1972. "Hearing on Senate Committee Appropriations." Washington D.C.: University of California. 278.

Congressional Record, V. 146, Pt. 1, (January 24, 2000 to February 23, 2000) pp 125

Dolfini-Reed, M., & Jebo, J. July, 2000. The Evolution of the Military Health Care System: Changes in Public Law and DOD Regulations. Alexandria, VA: Center for Naval Analyses. pp 45.

Eisman, D. 2007. Military Retirees may Face Big Bump in Health Costs. *Virginian Pilot*. December 21.

Flaherty, Anne. 2011. "Gates Tries To Cut Military Health Care." *The Huffington Post*, January 7.

Government Accountability Office. 2005. Defense Health Care: Implementation Issues for New TRICARE Contracts and Regional Structure. Retrieved July 2013, from Government Accountability Office: <http://www.gao.gov/assets/250/247234.html>. July.

Hearing on Senate Committee on appropriations. 1972. 92<sup>nd</sup> Congress pp 278

Heinzelman, D. O. 1997. The Evolution of the Military Health Care Benefit (MHCBS): the scope of the changes and the principle drivers behind them. Monterey, CA.: Naval Postgraduate School. pp. 31-32.

Hosek, Susan D. 2007. "Leveraging Other Federal health Systems." In *Restoring Fiscal Sanity*, 131-151. Brookings Institution.

Hosek, S. D. 2005. Testimony: Initiatives to Control Military Health Costs. *Senate Committee on Armed Services, Subcommittee on Personnel* (pp. 1-9). RAND.

Hosek, S. D. 1993. *The CHAMPUS Reform Initiative: Implications for Military Health Care Reform*. Washington, D.C.: Rand Corporation and National Defense Research Institute, pp. 4-5.

Hosek, Susan D., Mary Anderson, Alan Hartford, George Olson, James Press, and Elizabeth Sloss. 1987. *Plan for CHAMPUS Reform Initiative*. RAND Note, Santa Monica, CA: RAND.

---

## Analysis and Recommendations

---

Inouye, Daniel, Ted Stevens, John P. Murtha, and C. W. Bill Young. 2008. *Review of the President's Fiscal Year 2009 Budget Request for the Defense*. Washington, DC: United States Government Accountability Office.

Jim Webb Jr.. 2012. *Senator Webb to DoD: You Cannot "Renegotiate" the Moral Obligation to Provide Health Care to Retired Service Members*. March 28. Accessed 2014. [https://votesmart.org/public-statement/682081/senator-webb-to-dod-you-cannot-renegotiate-the-moral-obligation-to-provide-health-care-to-retired-service-members#.U9LnR\\_ldWM5](https://votesmart.org/public-statement/682081/senator-webb-to-dod-you-cannot-renegotiate-the-moral-obligation-to-provide-health-care-to-retired-service-members#.U9LnR_ldWM5).

Kime, Patricia. 2014. "Proposed Tricare fee hikes dead for now." *Army Times*, April 30.

Korb, L. J., Conley, L., & Rothman, A. 2011. *Restoring TRICARE - Ensuring the Long Term Viability of the Military Health Care System*. Retrieved July 2013, from Center for American Progress, pp. 6–20. March.

Lane, Charles. "TRICARE, bloated but untouchable." *The Washington Post*. 2013. Tuesday. Date Accessed: 2013/11/19. [www.lexisnexis.com/hottopics/lnacademic](http://www.lexisnexis.com/hottopics/lnacademic). March 16.

Major General M.C. Robinson, P. I. 1957. Medicare: Uniformed Services Program for Dependents. *Social Security Administration Bulletin*, pp. 1–8. July.

McAllister, B. 1991. Pentagon Cautious on Health Cost Management; Private Firm Boasts of Saving \$ 100 Million in CHAMPUS Program. *Washington Post*, p. A9. June 10.

Miller, Jake. 2014. *Facing VA scandal, Obama stresses "sacred obligation" to veterans*. May 24. <http://www.cbsnews.com/news/amid-va-scandal-outcry-obama-stresses-sacred-obligation-to-veterans/>.

Pentagon to Extend Health Coverage for Reserve Troops. *New York Times*. 2005. p. A15. Permanent Subcommittee on Investigations, Committee on Government Operations. Senate; Committee on Government Operations. Senate. 1976. p. 71. March 25.

Philpott, T. 2000. Its Showdown Time on TRICARE. *Air Force Magazine*, pp. 48–50. April 1.

Philpott, T. 2007. Big Hike in TRICARE Fees is Endorsed. *The Herald*. December 22.

Segal, David R., and Mady Wechsler Segal. 2004. *America's Military Population*. Vol. 59, No. 4, Washington, DC: Population Reference Bureau.

Subcommittee on Military Installations and Facilities, Committee on Armed Services. House; Committee on Armed Services. House. 1993. pp. 319–320.

Subcommittee on National Security Appropriations, Committee on Appropriations. House; Committee on Appropriations. House. 1997. Department of Defense Appropriations for 1998, Part 3. HRG-1997-HAP-0088 (p. 471). Washington D.C.: U.S. Government Printing Office. PP162

Subcommittee on Personnel, Committee on Armed Services. Senate; Committee on Armed Services. Senate. 1999. Department of Defense Authorization for Appropriations for Fiscal Year 2000 and the Future Years Defense Program. Part 6: Personnel. HRG-1999-SAS-0004 (p. 647). Washington, D.C.: U.S. Government Printing Office, pp. 265–278.

Subcommittee on Supplemental Service Benefits. 1969. *Review of the Health Benefits Program of the Armed Forces*. Washington, D.C.: US Government Printing Office.



## Analysis and Recommendations

---

The American Legion. 2014. "American Legion fights TRICARE increases." *The American Legion*. <http://www.legion.org/pressrelease/217883/american-legion-fights-tricare-increases>.

TRICARE Network News. 2004. TRICARE Newsletter Transition Edition. Retrieved July 2013, from Humana Military: [http://www.humana-military.com/South/provider/pdf/Trans\\_Newsltr.pdf](http://www.humana-military.com/South/provider/pdf/Trans_Newsltr.pdf)

Weiner, T. 2005.. A New Call to Arms: Military Health Care. *New York Times*, p. C1. April 14.

Whipple, D. R., & Maassen, L. R. 1975. A History of Military Dependent Medical Care Programs. Monterey, CA: Naval Postgraduate School. pp18. August.