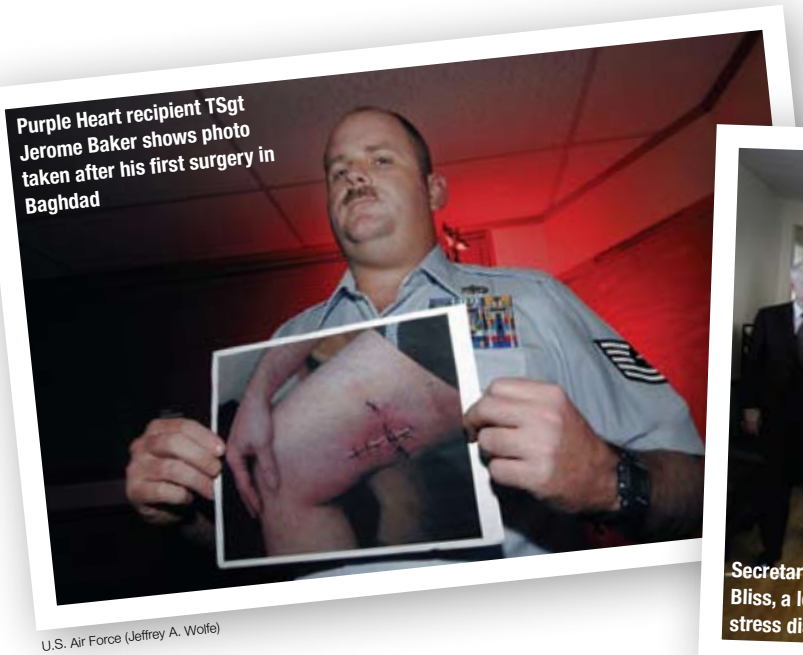


U.S. Air Force (Jeffrey A. Wolfe)


DOD (Cherie Cullen)

# Healing Hidden Wounds

## The Mental Health Crisis of America's Veterans

*By* DREW T. DOOLIN

From August 2004 to January 2005, and from January to September 2006, I commanded a Marine Corps logistics battalion of more than 1,100 Marines and Sailors in Iraq whose mission was to provide support for a Marine infantry regiment in combat. My men and women drove over a million miles through the worst of Iraq's "bad guy country"—western Anbar Province. During both deployments, battalion convoys were attacked with improvised explosive devices (IEDs) that resulted in loss of limbs, hearing damage, concussions, and other injuries—and on one occasion members of the battalion were victims of a suicide vehicle-borne IED that caused shattered limbs and permanent disfigurement from severe burns. Just as tragic, we lost Marines and Sailors to vehicular accidents in the line of duty. Even life in the base camp was not free of danger, as we frequently received rocket fire from a nearby town. This was life in our area of operations during the height of the insurgency.

After our return from the first deployment, I held roundtable discussions with my Marines and Sailors to talk about what we had seen, how each of us would characterize the deployment, what it was like being home, and how those feelings manifested themselves. Many of the participants in these discussions commented that the operational tempo of the deployment was incredibly demanding—and they liked it; that being back in garrison was slow, boring, and meaningless; that those who did not deploy with us "just didn't get it"; and that everyone missed those they served with. Although only a few admitted they had experienced symptoms of combat stress (for example, sleeplessness, anxiety, anger, and intrusive thoughts), most everyone's alcohol consumption had gone up exponentially, suggesting there were some issues my Marines and Sailors were not dealing with.

After these informal discussions, I realized how much my battalion would have benefitted from a formal combat operational stress control (COSC) program that could have provided some training and education before deployment. An established program also would have given me some tools as a commander to assist my personnel through the transition from war back to "normal" life. During my time in battalion command, I was not aware that such a program existed and wondered what was available to commanders in the other Services. With this in mind, as a Federal Executive Fellow this past year at the Brookings Institution, I have researched what psychological wellness programs are available for today's commanders. I talked with other commanders, psychologists, psychiatrists, licensed counselors, chaplains, and returning war veterans to gain insight on the topic of effective stress control and returning to optimal emotional health following combat. I also reviewed program briefings from each of the Service programs, interviewed people directly involved with these programs, surveyed Servicemembers who were about to deploy or had recently returned from a combat zone, and examined studies on combat stress.

**Colonel Drew T. Doolin, USMC, is a Federal Executive Fellow at the Brookings Institution.**

During my research, I found that until recently there was a lack of investment in mental health care to prepare Servicemembers for combat and to help them reintegrate into life at home. I also found significant barriers to receiving mental health care, which include a lack of sufficient mental health care providers and the cultural stigma attached to self-reporting symptoms of combat stress response. A stigma can come from military culture itself, society in general, or the terminology used to describe and treat combat stress reactions. Thus, this article discusses barriers to care, provides a current model for mental health care, and examines each of the Services' programs to explain the progress made since my time in command and to highlight where improvements are needed. In addition, the article suggests recommendations for further program development.

## Background

America's returning veterans of Operations *Iraqi Freedom* and *Enduring Freedom* are in the midst of the largest mental health crisis since the Vietnam War. The Department of Defense (DOD) is undergoing a "full court press" to address this problem. A review of recent studies reveals that hundreds of thousands of war veterans manifest combat stress responses that require identification and treatment as early as possible to reduce more serious and long-lasting effects of combat deployments.[1] These studies suggest that the *length* of combat tours, *number* of repeated tours, and *time* between deployments have a significant impact on the psychological health of the military force.[2] Moreover, the direct combatants are not the only ones who are suffering from these hidden wounds.

These wars have reshaped the combat construct. Logisticians in supply convoys, engineers repairing road networks, explosive ordnance disposal teams, those who handle remains, and those working in base camps also feel the effects of war and are often the target of enemy activities. Furthermore, military members who serve stateside in a variety of roles and missions are affected by combat-related stress, as are their families.

Post-traumatic stress disorder (PTSD) receives the most media attention and is therefore more widely known, but other serious conditions, such as major depression, anxiety, substance abuse, impairment in social functioning, and inability to work, can be stress-related illnesses that may require professional intervention. From a commander's perspective, far more common are veterans who experience stress responses, such as feelings of guilt, anger, decreased energy, social isolation, and the need to replicate the "rush" of combat. While these symptoms are not definite indicators of psychiatric illness, Servicemembers who exhibit these symptoms would greatly benefit from education and treatment.

The leadership at the highest levels of each Service is fully aware of the scope of this crisis, but a knowledge gap exists at the battalion level and with midcareer officers and enlisted leaders. Not only are these individuals unaware of the magnitude of the psychological health problems of returning combat veterans, but they also are unfamiliar with their own Services' formal combat operational stress control programs.

*returning veterans of Operations* Iraqi Freedom *and* Enduring Freedom *are in the midst of the largest mental health crisis since the Vietnam War*

The Army and Marine Corps have the highest reported numbers of combat-related mental health problems. However, the four Service programs—the Army Battlemind program, the Marine Corps COSC program, the Navy Operational Stress Control program, and the Air Force Landing Gear program—remain separate and distinct initiatives whose differences do not stop with their titles. Understandably, each Service reserves the right to modify its program to fit its own cultural needs and to institutionalize the program as the Service deems appropriate.

## Mandate for Action

The National Defense Authorization Act for Fiscal Year 2006 directed the Secretary of Defense to establish a task force to examine mental health matters within the Armed Forces and to provide a report that would assess the efficacy of mental health services provided by DOD.[3] This was an important step to address the problem, but this effort is 30 years too late. Unfortunately, following the Vietnam War, the Nation was not interested in tackling veterans' mental health problems. The result is a generation of veterans who still struggle with mental health issues, many of whom are homeless and live over steam vents. The herculean effort currently applied to this enormous and complex problem was needed in the years between the end of the Vietnam War and today. The current national response must be evaluated because it is unrealistic to expect in mere months a perfect solution that should have been developed decades ago. Fortunately, the interest and resources to fund program development are now in place and must be capitalized upon.

The mandate for DOD-wide strategy development, plans, policy, and compliance lies within the Office of the Assistant Secretary of Defense for Health Affairs (OASD[HA]). This office develops the overall plan for addressing psychological health and traumatic brain injuries. A subunit of OASD(HA) is the Defense Centers of Excellence (DCoE) for Psychological Health and Traumatic Brain Injury, whose mission is to "maximize opportunities for Warriors and families to thrive by leading a collaborative global network promoting resilience, recovery, and reintegration for psychological health and traumatic brain injury."[4] According to its director, Brigadier General Loree Sutton, USA, the goal of the DCoE is to help the individual Services and their programs to "build resilience, mitigate injury, intervene early, and treat when needed."[5] The DCoE has developed a "resiliency model" (see page 76) to illustrate its program development of these four concepts.

## Barriers to Care

Building the "perfect" program is difficult. Even the best-designed program will face personal or professional opposition. In addition, widely known barriers to care need to be overcome to make programs accessible to veterans and their families. The stigma attached to seeking mental health treatment is the most significant barrier to receiving psychological care.[6] The most common reason military members cite for not fully reporting operational stress injuries with the Post Deployment Health Assessment or Re-Assessment or for not seeking professional help is the fear that their careers will be negatively affected.[7]

Access to care is the second most significant barrier to seeking help. Simply stated, there are not enough mental health care providers.[8] Furthermore, professionals who can treat patients are not forward deployed. This is where I believe their assistance would be most effective. Mental health care providers should give

support at the battalion level and deploy with their unit. Chaplains I have interviewed stated that being forward deployed is the most effective place to provide spiritual care. Moreover, sharing the hardships of a deployment with troops gives chaplains instant credibility. Troops know the chaplain "gets it." This method should work for mental health care providers as well.

Procedural barriers, policies, programs, or language can also inhibit individuals from seeking care. The most noted procedural barrier was the infamous "Question 21" on the security clearance questionnaire. Previously, anyone who applied for a security clearance and answered "yes," indicating he or she had received mental health counseling, could be denied a security clearance. Now, personnel who have undergone or are undergoing mental health counseling are excluded from reporting counseling related to marital, family, or grief issues and only need to report violence by the member.

Still, cultural barriers may be the most difficult to overcome. The military in general and the individual Services in particular go to great lengths to develop their respective cultures. This modern "warrior class" is rightfully inculcated with an unofficial code, or Service-specific ethos—core values that bind professional soldiers together. These beliefs and the warrior culture itself, however, can deter Servicemembers from seeking help. As an Army captain commented, "Seeking mental health care means that you are not 'Army Strong.'"

Another cultural barrier revolves around ownership and responsibility in the chain of command for the mental wellness of one's subordinates. A mental wellness program that is in the domain of the clinician (the "psych" doctor) has inherent barriers in its design and execution before it begins. The same can be said if the unit chaplain owns the program, although possibly to a lesser negative degree. Successful programs are built on a team concept, whereby the commander leads the effort, assisted by professionals who are fully integrated into the unit.

*the stigma attached to seeking mental health treatment is the most significant barrier to receiving psychological care*

Likewise, language used in advertising, diagnosing, treating, or discussing a stress injury is a cultural barrier to care. Many people incorrectly refer to a variety of symptoms as PTSD, which creates a false belief that PTSD is an "all or nothing" proposition—one either has no symptoms or one has PTSD.[9] However, many troops experience stress reactions that fall short of a PTSD clinical diagnosis yet do not seek help because of the false belief.

Rear Admiral Richard Jeffers, the Medical Officer of the Marine Corps, believes DOD needs a 50-year approach to program design to overcome the stigma barrier to care and to institutionalize help-seeking behavior.[10] It may be, however, that stigma toward mental health care is generational. In general, Generation Y (individuals born between 1980–2005) views the world differently than previous generations and is more accepting of "hot button" issues, such as homosexuality, women in combat, and diversity. In particular, members of Generation Y may not be as inhibited to seek mental health care if that is the norm in the military culture of their time. Anecdotal evidence suggests that if a trusting environment about seeking mental health care is established at the battalion level, young warriors will be more likely to self-report mental health issues. If future studies support this evidence, it may not take as long as predicted to eliminate the stigma of seeking mental health treatment. Thus, there is hope the younger generation may more readily accept the vital role of mental health care in force and family readiness.

### DCoE Resiliency Model

The resiliency model depicts the continuum of an individual's psychological health, with the goal to keep or return individuals to the resilient and optimal level of performance and well-being (see left side of model). The model helps individuals, families, units, professional care providers, and educators identify and initiate the appropriate response during a particular stage in one's psychological health in order to provide appropriate training, education, or treatment and to intervene early. The objective is to return individuals to their optimal status and continue to be mission ready, both at home and at work.

With the resiliency model in mind, an optimal combat operational stress control program should include tenets that address each zone of the model from "optimal" to "ill," and should provide training and education throughout an individual's career. This training

**Building a Culture of Resilience**

must include families and focus on the most demanding circumstances, which are the three phases of the deployment process. Building on the elements of the DCoE model and my research, I have developed new criteria that mental health care personnel should include in an ideal military program.

The table below depicts 11 elements necessary to design an optimal military mental health program. It also grades the respective Service programs against these criteria. These elements were derived from discussions with commanders, mental health care professionals, chaplains, and several developers of the Service programs. They can be used by psychiatrists or social workers to evaluate programs. For example, using the first element, an evaluator could ask whether the mental wellness program includes stress control training throughout an individual's career. If it does, the evaluator might assign a score (using a Likert-type scale) that determines to what degree the essential element is performed. These 11 optimal design elements will be applied to each formal Service program.

Using the proposed criteria, I evaluated the four existing COSC programs to determine whether they include all the necessary components for a quality program and what elements the programs are missing and whether any elements need improvement.

## The Service Programs

Given that the Army and Marine Corps have the greatest number of members who report psychological health–related symptoms, Battlemind and the Marine Corps COSC program are examined first. In addition to the formal programs offered by each Service, several of the disparate features are mentioned.

***Army Battlemind Program.*** This program design calls for training and education materials throughout one's career continuum and is meant to be "leader-owned" (although it appears to be a medical program forced on the leadership). Battlemind provides standardized training and education materials at most of the critical points in the deployment cycle, includes training and education materials for families, uses an excellent Web site and a variety of training materials to present topics, and is designed to be culturally accepted by Soldiers, though the program may benefit from improvement in three areas. Specifically, it should:

- include continued training and education materials during deployments as well as in-theater treatment
- adopt a holistic approach to wellness by integrating the mind, body, and spirit aspects of health into one program
- ensure that the entire Army population receives this training instead of being infantry-centric.

*the objective is to return individuals to their optimal status and continue to be mission ready, both at home and at work*

However, a new Army initiative, the Comprehensive Soldier Fitness Program, may cover these specific deficiencies in Battlemind. If this happens, Battlemind may need to be rolled into the new program.

In execution, Battlemind can be improved by getting the word out that the program exists and is beneficial. In an interview with an Army captain who recently returned from a 15-month tour in Iraq with the 407th Brigade Support Battalion of the 2d Brigade Combat Team, 82d Airborne Division, he noted that he had not heard of Battlemind; prior to deployment, the battalion received some information provided by their family services organization that was helpful but did not cover combat stress; and the only redeployment training the battalion received was a short, informal, chaplain-led roundtable held in-theater, during which some reintegration topics were discussed.

As part of my research, I conducted an informal, anonymous, and admittedly unscientific survey that supports the captain's comments. Of those who responded, 88 percent were aware of Battlemind, but only 66 percent were required to attend predeployment training. Merely 44 percent were required to attend postdeployment training. Of those surveyed, 44 percent self-reported stress symptoms, but only 25 percent sought help, with the remainder believing they could handle their symptoms without professional help.

**Eleven Elements for an Optimal Military Mental Health Program and Service Ratings for Respective Programs**

| Service | Career education | Leadership-owned | Predeployment | During deployment | Post-deployment |
|---|---|---|---|---|---|
| Army | ★ | ★ | ★ | ★ | ★ |
| Marine Corps | ★ | ★ | ★ | ★ | ★ |
| Navy | ★ | ★ | ★ | ★ | ★ |
| Air Force | ★ | ★ | ★ | ★ | ★ |

| Service | Families included | Multiple methods for access | Treats mind, body, spirit | Credible facilitators | Widely known and used | Combats stigma |
|---|---|---|---|---|---|---|
| Army | ★ | ★ | ★ | ★ | ★ | ★ |
| Marine Corps | ★ | ★ | ★ | ★ | ★ | ★ |
| Navy | ★ | ★ | ★ | ★ | ★ | ★ |
| Air Force | ★ | ★ | ★ | ★ | ★ | ★ |

*Key*: ★ Good in current Service program; ★ Passing but needs improvement in current Service program; ★ Failing or nonexistent in current Service program.

As the table illustrates, the Battlemind design also calls for training and education throughout a Soldier's career. Yet when the captain from the 407th attended a career level course following his deployment, neither Battlemind nor general stress control were mentioned in the curriculum. Therefore, at this time, the program design may fall short in the career education category. Battlemind may be the most polished of the four programs, but as with all of the Service programs, success or failure depends on execution.

The Army has an additional program at the Fort Bliss Restoration and Resiliency Center that should be rolled into Battlemind or the new Comprehensive Soldier Fitness Program. This center provides holistic treatment in both Western- and Eastern-style treatment for Soldiers with PTSD. Although this center and its methods are one of a kind, it is one example of the many disparate efforts taking place that, if deemed valuable, need to be duplicated and better coordinated inside the larger Service programs.

Lt Col Mike Jaffee, director, Defense Veterans Brain Injury Center, and then-COL Loree K. Sutton, director, Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury, hold media roundtable

DOD (Robert D. Ward)

***Marine Corps COSC Program.*** The Marine Corps has taken a comprehensive approach to addressing the mental health of returning war veterans. The COSC program was first chartered in 2005 and differs from the programs of the other Services in that it places the ownership, responsibility, and accountability squarely on commanders. This program design successfully covers a majority of the elements of an optimal program, although, like the Army program, it needs improvement in several key areas. Like Battlemind, the Marine Corps COSC does not currently include enough continued training and education while the unit is deployed. Indeed, there are debriefs conducted by commanders after particular events, but nothing that addresses the day-to-day stresses all deployed personnel feel. While it may be unreasonable to hold training while actively on the march to Baghdad, during "steady state" operations such as those in Iraq in recent years, a commander should find time to continue stress training and education, focus on optimal physical and mental functioning, and further seek to identify the resources that are available.

The Marine Corps seems to agree with the idea of continuing training and education while deployed. Marine Corps Bulletin 6490 directs a commander to conduct an "operational pause" for some reintegration preparation immediately prior to a unit's return to the United States. This same idea can be integrated mid-deployment, or at varying times during deployment, to allow for continued training and education. Similarly, commanders at all levels have used "stand downs" when an adjustment is needed in unit tactics, techniques, procedures, and equipment. Stand downs are important because they allow for adjustments necessary to accomplish the mission. Therefore, logic dictates that the same could be said for a personnel stand down.

A deficiency as detrimental as the lack of continued training and education while deployed is the absence of a useful Web site that can carry all of the available training materials and resource points of contact. Currently, the standardized training materials are buried in the Marine Corps Manpower Web site and are difficult to locate.

Additionally, an area the program can quickly and easily improve is in the integration of the mind, body, and spirit aspects of personal health. The Marine Corps has an excellent fitness program called Semper Fit that, along with the Chaplains Religious Enrichment Development Operation, can be better integrated into the Marine Corps COSC program. This integration will improve the effectiveness of the "body, spirit" aspects of the program.

In execution, the Marine Corps COSC program fails in the "widely known and used" category. Interviews with two battalion commanders (one returning from Afghanistan and one deploying to Iraq) highlighted the same reality. Although both had seen Marine Corps Bulletin 6490 on the COSC program, neither was fully aware of his responsibility as commander, nor was he aware of the standardized materials available for use. A strategic communication plan led by the commandant and sergeant major of the Marine Corps must be developed to gain a broad familiarity and improve cultural acceptance of the program. A congressional staffer commented during a recent interview that "when the average Marine knows as much about the USMC COSC program as he does the new combat fitness tests and body fat standards, then you'll have something."

*Battlemind may be the most polished of the four programs, but as with all of the Service programs, success or failure depends on execution*

The Theater of War Project, which was introduced to the Marine Corps by a non-DOD entity, is a series of dramatic readings from translations of Sophocles' *Ajax* and *Philoctetes*. These readings have become a catalyst for discussion among audiences such as first responders, college students, and military personnel about heath care, chronic illness, and veterans returning from war. This inspirational piece of theater may be a key to helping vet-

erans return to optimal health. It is, however, presented by one theater company and can only reach a limited number of audiences. This initiative was first presented at the Marine Corps Combat Operational Stress Conference in San Diego in August 2008, and was repeated at the DCoE Resiliency Conference in November 2008. Unfortunately, both performances were presented to care providers and leaders, as opposed to the sufferers of operational stress injury who would have benefitted most.

Using Samurai techniques to cope with combat and PTSD is the focus of the Warrior Mind Training classes at two major Marine Corps bases. Here again, this type of treatment is interesting but limited in availability, and evidence of efficacy is only anecdotal so far. If these classes prove effective, Warrior Mind Training, like similar programs, could be rolled into the larger Marine Corps COSC program and expanded. This may help to integrate mental and physical wellness within the program.

***Navy Operational Stress Control Program.*** This program is the newest, having been signed into being November 21, 2008. As it is being institutionalized, the curriculum and training are being developed jointly with the Marine Corps. The Navy program differs from the Marine Corps COSC program in that it takes a broader view of operational stress, as Sailors more often have stress-related symptoms that are associated with deployments other than combat. Both the Navy and Marine Corps programs use the same resiliency model that was the precursor to the DCoE model. Given the fledgling state of the Navy program, the jury is still out on how it will be executed. In design, the program benefits from the lessons learned from both the Army and Marine Corps programs. The Navy program will attempt to cover all 11 proposed elements of an optimal program.

The Navy Reserve Returning Warrior Weekend program is an adjunct initiative in addition to the formal operational stress control program. These Returning Warrior workshops bring together guest speakers, clinical health care providers, chaplains, the Department of Veterans Affairs, family services, and other combat veterans to introduce available resources and care to aid in the reintegration process. These retreats get high praise because facilitators are often warriors themselves, and therefore they have instant credibility. But these retreats are limited in size and reach only a small portion of those who could benefit. The workshops should be reassigned to the regional or base and station Family Service Centers, which can provide more retreat opportunities targeting both Active-duty and Reserve units instead of regions and can thus be offered to many more veterans.

***Air Force Landing Gear Program.*** Statistically, the Air Force has the smallest problem in terms of combat stress and PTSD, with 1 percent of Airmen being diagnosed with PTSD and 4.7 percent showing one or more symptoms of combat stress injury. However, Air Force discharges from PTSD jumped from 10 in 2001 to 110 in 2007. The Air Force program is more clinician-focused than the other programs and expends significantly fewer resources on the career training continuum as well as predeployment and postdeployment training, with just 30 to 60 minutes allotted to each of the pre- and postdeployment phase training packages. The program relies on leaders to identify Airmen at risk and weighs heavily on the usefulness of the Post-Deployment Health Assessment (PDHA) survey to identify those who need mental health care. The weakness is that the PDHA is only as accurate as the answers given in the survey. It is widely recognized by commanders and clinicians alike that PDHA data are highly suspect due to minimization of stress reaction symptoms in self-reporting because of stigma issues. Furthermore, the approach of focusing on a small population at risk does nothing to reduce the stigma of help-seeking behavior, potentially reducing the value of the PDHA further.

With the seemingly small number of Airmen in need, the Service believes that the Landing Gear program is the best approach. Due to this dramatically different view of program design, comparing Landing Gear to my suggested 11 optimal program elements results in unflattering marks in 10 of the 11 elements. This begs the question of which approach is correct. Clearly, I believe a more comprehensive approach is better than the Air Force method.

DOD (Chad J. McNeeley)

**ADM Mullen visits patients of Traumatic Brain Injury Warrior Resiliency and Recovery Center, Fort Campbell**

*the fledgling Navy program benefits from the lessons learned from both the Army and Marine Corps programs*

Despite the above, the Air Force currently has an innovative program that is perhaps the best example of building an initiative from the ground up with the specific culture of its designated audience in mind. The program, designed by an Air Force psychologist, is called One Shot, One Kill. This pilot program is a performance enhancement tool that provides predeployment information about how to maintain mental wellness for line leaders and supervisors. It was created to operate to the left side of the DCoE resiliency model. This program uses common language and takes out

words and phrases that Airmen would consider "clinician-speak." Therefore, the program is culturally accepted. Each offering of the training has achieved maximum attendance.

**Recommendations**

Based on the information above, there are seven major deficiencies in the DOD response to the ongoing mental health crisis facing returning veterans:

- insufficient number of mental health care providers
- lack of leader buy-in and responsibility for COSC programs
- lack of comprehensive and culturally acceptable approaches to building and maintaining resilience
- poor synchronization inside each program as evidenced by the adjunct and disparate activities taking place outside the formal programs
- lack of programs to combat stigma
- barriers to care
- inadequate efforts to get the word out on each program.

The military mental health care situation is bigger than any one Service. It requires inter-Service, DOD, and interagency involvement. To achieve the best outcomes for our returning veterans and their families, the Chairman of the Joint Chiefs of Staff, Service chiefs, leaders at all command levels, and individual Servicemembers must play a part in improving the DOD mental health care system.

The Chairman should appoint the Vice Chairman as the uniformed advocate for all Service combat operational stress control programs and establish an oversight council for comprehensive Servicemember fitness. This body would be chaired by the Vice Chairman and attended by the vice chiefs of Service, the DCoE director, and each Services' representative for comprehensive fitness. The role of this council would be to review, validate, integrate, synchronize, and standardize each Service's program.

DCoE should develop measures of effectiveness to evaluate program successes and failures. As DOD's executive agent for coordination, it should review all disparate activities and recommend what should be integrated into individual Service programs and what should be eliminated. In essence, DCoE should be the clearinghouse for good ideas. It should also examine best practices for inoculation used by first responders, emergency room personnel, and other professionals who may provide valuable insight into DOD training deficiencies.

The Services should:

- ensure that respective programs are leader-driven wellness programs that reach everyone
- institutionalize combat operational stress control programs so they become an enduring part of Service culture
- ensure that respective programs appeal to and are relevant for their populations
- develop a population-based (everyone receives training, education, and treatment), integrated, holistic approach to wellness
- develop an aggressive strategic communication plan to get the word out about programs
- ensure that all training and education are standardized across programs
- hold leaders accountable for conducting the required training and education modules
- develop a peer-to-peer counseling program whereby former troops who have deployed, experienced operational stress injuries, and benefitted from counseling or treatment are contracted to serve as peer counselors
- select, train, and certify credible instructors
- increase the number of mental health care professionals and assign them down to the battalion level
- identify to DCoE any adjunct initiatives that fall under the realm of their particular Service to allow DCoE to review these initiatives.

Leaders should get on board and support their respective Service programs to aggressively eliminate stigma and also develop an atmosphere of trust. They should emphasize that seeking mental health care will not negatively affect a Servicemember's career.

Individuals should understand that stress injuries can happen to even the strongest, best trained, and most prepared warrior. Calling in "supporting fires" is an admirable and responsible way to take charge of overall fitness.

There is a significant mental health crisis in the military that will only become greater as the wars in Iraq and Afghanistan continue. While a great deal has been accomplished to support the returning veterans since my time in command, there is an opportunity to improve and institutionalize the current programs, make them more relevant and widely accepted, and take a different approach to mental health care DOD-wide. The Department of Defense must shift from a clinician-owned and -operated, treatment-centered, facility-based effort to a comprehensive, leader-driven wellness program that reaches everyone. The formal programs initiated by each Service and the disparate initiatives in use are well intentioned but need some revision. Even if the wars in Afghanistan and Iraq ended today, the Nation would face a need for mental health care services for years to come. Addressing this challenge is the moral obligation of the Services, the Department of Defense, and the Nation itself. **JFQ**

## NOTES

[1] A 2007 study by the RAND Corporation estimated that nearly 20 percent (approximately 300,000) veterans have been affected by combat experiences. This estimate focuses only on those whose combat stress reactions fall into the "illness" category where stress injuries do not heal without intervention. Data collection methods for this study have been noted by clinical professionals as less than optimal, but the point remains that the number of veterans who have been affected by their experiences is significant.

[2] See Mental Health Advisory Team V, "Operation Iraqi Freedom 06–08: Iraq; Operation Enduring Freedom 8: Afghanistan," February 14, 2008, available at <www.armymedicine.army.mil/reports/mhat/mhat_v/Redacted1-MHATV-4-FEB-2008-Overview.pdf>.

[3] Department of Defense Task Force on Mental Health, *An Achievable Vision: Report of the Department of Defense Task Force on Mental Health* (Falls Church, VA: Defense Health Board, 2007), 1.

[4] See <www.dcoe.health.mil/about.htm>.

[5] Brigadier General Loree K. Sutton, USA, opening remarks at Defense Centers of Excellence Warrior Resilience Conference: Partnership with the Line, Fairfax, VA, November 18, 2008.

[6] Department of Defense Task Force on Mental Health.

[7] See "Invisible Wounds: Mental Health and Cognitive Care Needs of America's Returning Veterans," RAND Center for Military Health Policy Research, 2008, available at <http://rand.org/pubs/research_briefs/2008/RAND_RB9336.pdf>.

[8] Ibid.

[9] Dr. Thomas Gaskin, director, Marine Corps Combat Operational Stress Control Program, interview with author, February 23, 2009.

[10] Rear Admiral Richard Jeffers, USN, interview with author, November 18, 2008.