Thank you. This has been an awesome Friday. And welcome to the next session, P3005, MARSOC Human Factors Council: Sealing Slip-Through Cracks in Special Operations Forces, Warriors, and Families. It's my pleasure to introduce Lieutenant Commander Emily Crossman, Lieutenant Colonel Brian Rideout, and Dr. Thomas Stein.

Lieutenant Commander Crossman is a board-certified family medicine physician and also a trained sports medicine physician. She currently serves as the Marine wider support group surgeon. Lieutenant Colonel Rideout is currently completing his Naval postgraduate education at the Naval War College. Dr. Stein currently serves as the senior clinical psychologist for the United States Marine Corps Forces Special Operations Command, and has developed a training colloquium focused on treating special operations forces personnel.

This session will cover the Marines Special Operations Forces Human Factors Program, attracting mechanisms and incorporate weekly updates on battalion leadership, medical, and support providers. Please join me in welcoming Lieutenant Commander Crossman, Lieutenant Colonel Rideout, and Dr. Stein.

Thank you, Major Pittman. I'm going to go ahead and kick this off. I'm Brian Rideout. And right up front I just want to levy the disclaimer that we're not here to sell anything, nor are any of us seeking grants for research funding or any further research. I know that's in a subsequent slide, but we're just here to talk to you about two key tenets that we fed into an approach, and those tenets were trust and collaboration. And from a foundation of trust and collaboration, that contributed to building a comprehensive approach toward caring for the men and women at Marines Special Operations Command as well as their families. It's our hope that you might be able to apply a similar approach within your own organizations if you see something in here that's possibly repeatable within your own spheres of influence.

Just by way of background, Marine Special Operations Command is a component to U.S. Special Operations Command headquartered in Tampa, Florida. If you've ever served or supported Special Operations you're probably familiar with what we refer to as the "SOF truths," the Special Operations Forces truths. There are five. And these are more or less a philosophy that governs the way Special Operations men train, equip, and prepare forces for the arduous missions they accomplish across the globe.

I'll give you a quick refresher of those tenets, those five truths. The first one is humans are more important than hardware. The second one is quality over quantity. The third one is Special Operations Forces cannot be mass produced. The fourth one is competent special operators cannot be produced after an emergency -- cannot be created after emergencies. And the fifth one is most Special Operations Forces missions require non-SOF support. And, again, this core philosophy sort of governs how SOCOM approaches manning, training, equipping and preparing these forces.

And one of SOCOM's top priorities, as a former commander, when I first came into Marines Special Operations, Admiral McRaven, and now the current commander General Votel, both kept as a top priority Preservation of the Force and Families, or, we love acronyms in our business, POTFF. So each one of the SOF components, MARSOC included nests under that prioritization. And so at Marine Special Operations Command, one of our core priorities there is the "M" part of "MARSOC" Preservation of the Force and Families. And "MPOTFF" has six pillars; okay. We're going to talk about a few of those today in terms of how they integrate and relate to our particular approach. Those six pillars are human performance, spirituality, family, medicine, safety, and transition. And the whole purpose behind MARSCO setting up this Preservation of the Force and Family entity was to integrate and synchronize as well as provide resources from all six of these pillars. So it sounds a lot easier in words than it is in practice.

Another reason why we set up that MPOTFF structure within MARSOC is to educate and develop our leaders as well as the operators within the command, with the ends to achieving a sort of balance between the mental, spiritual, and family sort of approach to caring for our individuals. That's a really
important tenet. So, just by way of background, right, SOCOM, philosophies, truths, MARSOC, that component of SOCOM, and then that priority scheme in POTFF and how MARSOC sees that "MPOTFF" through its six pillars and how we try to integrate and synchronize those pillars together. That's sort of what we want to talk about today. And I'm going to turn it over to -- I'm going to skip through a couple of the more administrative slides and turn it over to Dr. Stein on my left.

We're skipping over the usual disclosure statements. We don't have really much a dog in this fight other than trying to share something that we think has worked really well with our command. The learning objectives are pretty clearly outlined. We're going to try to share a program, talk a little bit about protected health information and some of the tension that arises with sharing of that with command and the task that they have versus the task that provider has, and how there's really more in common than they are disparate tasks.

We all know that there's all kind of threats out there that can adversely impact on individuals. The stress that exists across the military is certainly every bit, if not more so, in a special operations force community, not just for the personnel in the community for their families as well. And it can -- threats can arise from injuries and diseases and problems in the unit or problems, you know, within the family. And recognizing that all these threat were out there gave rise to the MARSOC developing this Human Factors order and was redone in July of last year.

And the whole purpose of this is to assist the leaders to try to mitigate the stressors so that we can preserve force and family and maintain combat readiness for the individuals as well as family readiness. This occurs by a quarterly screening that everyone in the command receives, a great deal of emphasis is initiated from the command to mid-level management for an engaged type of leadership, and then monthly human factor council meetings.

All of this is done in the hopes that we're going to prevent casualties, mitigate the effects of stressors, improve health, help people develop problem-solving skills better able to handle things on their own. We believe that it enhances unit cohesion, and certainly enhances combat readiness. And the principal three-legged chair that we rely on is early recognition, use of holistic solutions, and what we call engage small leadership. We want to support but also provide accountability for that small unit leadership. We want to enable the commanders and leaders, as well as the subject matter experts that are on the Factors Council, to know what to look for, better help identify indicators when adverse impacts of various life conditions or behaviors or interpersonal issues within units, whatever, begins to arise. And we also want to teach and allow people to develop these skills so that they are better able to resolve things on their own without having to turn to subject matter experts in a way of medical and behavioral health providers.

Key part of this is that this whole engage small leadership involvement has to be done in a non-punitive manner. The whole thing is recognizing that knowing your Marine and having the overall best interest of that Marine at heart is the foundation upon which the whole program rests. And, in fact, we think that also is reducing the stigma of accessing help for medical, but primarily for behavioral health resources in as much as everybody is getting screened. You pretty much come into MARSOC and are viewed in our color-coding four levels, green, yellow, orange, red. Everybody is kind of like yellow. You really got to make a substantial case to get down to a green if you don't have any issues that warrant us keeping an eye on you and you being aware of it.

So that led to the development of program, and this is a permanent organization, this Human Factors Council. It meets monthly. It's chaired by the battalion and the units or commanding officers. And it includes the commanding officer, an executive officer, the sergeant major, and special subject matter experts who have been identified in writing as being able to receive protected health information and other information as well, for the whole purpose of determining what's going on in this individual's life, is it going to have an adverse impact on the command's readiness and the command's military mission.

There are very strict guidelines as to how these monthly meetings are conducted. There's a privacy and confidentiality statement read before not just every meeting but for each -- as we bring in logistics or we
bring in communications or we bring in intelligence within a battalion. Each time a new group of people is brought into the room that trust and confidentiality statement is read. There's a comprehensive review of what's going on. And then this obviously, for the behavioral health providers out there, this is going to make everybody's, you know, hair kind of stand up a little bit about, "Geez, confidentiality is the whole corner and foundational stone of everything we do and what's going to happen here, you know, if our patients and everything think that what we're telling is getting communicated to our commanding officers and the like, like that, you know."

Well, the other side of that coin is, you know, this commanding officers, you know, they've got a hell of a need or a very important need, you know, for communication as to what is actually going on and whether or not these people are actually, you know, ready for, you know, mission, are they mission-ready. So there has to be a balance between these two. And that whole balance, the focal for that whole balance is [inaudible] of trust that Colonel Rideout referenced in his initial remarks. The provider's got to trust that the commanders are going to use this information appropriately and certainly in a non-punitive manner, an alternative to the commander's trust that the providers understand what the mission is and communicate the information and only the information that is being required. So, in a nutshell, that's kind of an overview of this big program that we think has worked really well. Now we're going to go to a slide and show you a tool that we utilized.

So one of the things they tell you when you go to command officer school -- there isn't a commanding officer school, by the way -- 20 years of learning vicariously through others, having rich mentors is just one of the attractive components of the United States Marine Corps from my opinion. But one of the things that you learn very quickly as a commanding officer is that you are responsible for everything that your unit does or fails to do. That includes the conduct of your Marines and sailors. And so establishing this culture and command climate is a very important aspect from a commanding officer's tool bag.

As Dr. Stein described a little bit of what the MARSOC Human Factors Council is and how it came about, I bet some of you, either physically or in virtual land, are wondering what exactly does that look like. So imaging a windowless room in a highly secure facility, a conference room, with cables sort of situated in a square where everyone can see everybody else. And I'm sitting in the middle of one of these tables, surrounded by 15 or so of my closest trusted agents, field grade officer, company grade officers, and senior enlisted personnel. The aggregate number of years of military experience in the room exceeds hundreds of years. Some of you are probably doing the math on that now. So maybe when we invite these folks in it gets over the hundreds, but imagine a room like that with those folks in it; okay.

And projected on a wall, on one of the screens is this spreadsheet, a tracking pool being assembled. It's just a means to display a lot of information, relatively condensed, in order to catch everybody up, accelerate, and under a universal understanding in the room about each particular case we're discussing. All right, and that's a very important facet because when you have a tool like this that can amass 50, 60, 70 names in one unit, you can imagine trying to keep the number of details straight can be a little mind-boggling.

So you have this tool projected, and, again, as I said, it's a means to sort of accelerate understanding and bring those subject matter experts into center of who we're discussing, what we're discussing about that individual, and, more importantly, reviewing sort of the care that's been received, and projecting recommendations on the care ahead. So, from that, as we sort of go from case to case throughout this two- or three-, or sometimes three-and-a-half-hour process every month, again, depending on the number of cases and the complexity of each case, we start to develop some trends. And we sort of log those trends and use that as indications and warnings in looking across our unit and other units for when we see those types of trends pop up, we sort of have a foundation or a base from which to start a discussion as to opposed to starting it from ground zero.

The way in which this sheet gets filled out, it's done by those trusted agents I mentioned. So my company commanders are all majors in this particular special operations battalion. It's a very senior organization, sergeants and above. So just think age-wise, maturity-wise, senior folks. Every month we meet as a
council with all our credentialed health personnel. Every week I required the first line of defense, those middle layer managers, if you will, to populate this tool. And we looked at it every week and we hung it encrypted, password-protected, so that only those folks with HPI could get on and look at it.

Again, part of the stipulations that are spelled out in the order are to keep the confidentiality aspects of this program intact. And so when we compile a lot of potentially sensitive information in a file like this, we take -- we guard its content very closely. So every week my guys would go in and essentially consolidate their notes, if you will. And if you look in the lower right corner, it's color-coded, and that's merely to facilitate, again, a rapid understanding, from week to week, how each case is evolving. And so that color was just meant to sort of cue folks in, here's the delta from the previous week, here's what's transpired in the last seven days.

That's just the requirement, but here's the reason why I levied it on a weekly basis as opposed to just filling it out monthly. It ensured that those middle layer managers, those leaders at the small unit level were engaging with their people day in and day out, and they were finding out, you know, what was going on in their individual lives, in the lives of their families, to the extent -- and it varies, depending on the nature and relationship and the complexity of the case. But it was a very important piece.

I wanted this to become part of the culture that we're going to check on you, not in an intrusive way but in a caring way. And that required a significant foundation of trust to get folks to open up, both on my side of the fence as well as when they -- if they found themselves in the care of one of our prevention medical providers. If they knew they were coming from a culture and environment of trust, they were more apt to reveal information earlier on in their care. And that really helped us quite a bit. So all in a simple tool, it was the manner in which we employed it, I think, that brought us some success.

So, as providers, we all have the patient's best interest as number one, and that's just inherent in what we do. What is sometimes more challenging is figuring out who to share additional information with, what to share with them, how to share it with them. And there's actually a DoD instruction on it, you see it listed there. And it actually really lines -- it tells you who is privy to this information, when you need to be giving this information, and some guidelines on the level of detail of information that you give. Certainly, when it's obviously in the red, that's easy. When it's obviously in the green, that's easy. When it's in the middle, it's a little bit more difficult, and that's when developing the trust and knowing that the information you're sharing not only is in the best interest of the patient but is going to help the commanders assist them in their healing, whatever type of healing that is.

So the other thing that we're doing is, really, your job is to provide information and guidance to the commanding officer in regard to that service member and what they have going on, whether it's mental or physical or emotional. You're informing them of the risk that they have, the injury, the challenges that they're undergoing. You're giving them guidance on the symptoms and signs that they can expect to see, and that they should be helping watch for. You're getting -- and you're helping give them the information on how to move that service member in the right direction, what things would be helpful at the unit level to assist this person, whether it's knowing about the types of appointments or what kind of position would be helpful for them in their small unit.

Part of when you look at the provider roles, it's all input to the commanders. And what we have found as this program has developed and our collegiality has developed, that the providers are receiving a lot of information as well. And sitting on these Human Factor Councils, we're learning a lot more about the patients, a part that we don't see and we would have no access to. And it makes a huge difference in how we move them forward in their healing.

So when we first started it seemed like a lot of output. And we quickly realized how much it helped us as well. We say "provider roles," "provider" is a pretty broad term when it comes to our Human Factors Council. We're not just talking, you know, the medical officer and the psychologist. That's expanded to our social workers, our family readiness officers, our physical therapists often give us input because they're
Some of the roles of the provider that supports the council, things that we are doing over in the clinic amongst ourselves is what most people are doing already. You know, they're having multidisciplinary meetings just in the medical field, a lot of internal communication. And we, over in our clinic, would do it on a daily basis, you know, between the mental health providers and the social worker, so all of that background stuff we are doing outside of the Human Factors meetings. The other part that I think is really helpful for the commanding officers is anticipating and explaining to them the impacts of the treatments that they're going through, and how that could impact their readiness for whatever mission is coming up.

And, for example, it may be that someone is -- something as simple as having shoulder surgery, and in discussion with the physical therapist they're anticipating it's going to be a pretty invasive procedure. Well that's an important thing to be communicating to the commanding officer because -- and understanding what the service member's next mission is, because they might be thinking, "Oh, he'll be good in three months." But, truthfully, we're talking about a six- to nine-month plan. And if you aren't integrated in these meetings where you are learning about, "Well where's this person going next," and you don't understand, "Well, wow, we're setting them up for trouble or we're going to leave the command short," and those little things we have been able to keep from falling through the cracks by having these kind of meetings and being really integrated on all levels, command and support personnel.

I mentioned part of my responsibility in the capacity as a commanding officer is you're responsible for everything your unit does or fails to do. It's worth repeating. It's a heavy burden to bear. While I might do it, it's one that's exceedingly worth it. Something that -- going through the bullets on these slides -- this next slide, if any one of my leaders were to improperly handle PHI, it's my job to drop the hammer. So I've got to know these duty instructions that Dr. Crossman spoke about, or people like me are responsible for knowing all those kinds of things.

As I alluded to, I was fortunate to lead a very mature organization, so we didn't have these kinds of problems. Again, a confidentiality statement is read ahead of time. I had some extremely cunning operators, a lot of intelligence personnel, systems and communication personnel. They understand information technology. They understand how to protect classified information. So I think that really carried over nicely into PHI, that that confidentiality, it made implicit sense to them. So didn't really have too many issues with that.

That third bullet, dispelling stigma, is probably one of the most difficult things that I would speak to, and this isn't a leadership-centered conference, but, again, from the perspective of a command's role, I would put a big bold underlined enlarged font, "establish and maintain trust." And how you do that really varies on the approach of the individual and the team with which he or she has to work with. I can tell you when I arrived at the Marine Special Operations Command, the commander of U.S. SOCOM spoke with his component commanders. Mine at the time was Major General Mark Clark. And then Admiral McCraven was keen on a book called "Speed of Trust" by Steven Covey Jr., and so General Clark had all the officers and senior enlisted read this book. And of course as a commander, I turned around and had all my guys read it, and we discussed it one day.

And so at the core sort of base level he sort of goes through this strata of trust, and it starts with personal trust, and personal trust is built around competence and character, and there's several other sort of satellite attributes that surround each one of those key words. But I invested a lot of time talking with my folks about confidence and character to build that trust, not only inside the battalion, but across other lanes, in constructing bridges with folks in the medical arena and/or care provider arena as Dr. Crossman referred to it. So that's a key point that's missing on the slide, but I wanted to make sure it wasn't missed, that that's an important tenet or foundation from which to build.

Once you have it you've got to remain engaged and you've got to let folks -- with that trust, they'll believe you when you tell them that if you follow up with these folks, if you protect the HPI and ensure you're
staying engaged with your people, it's a non-punitive; right, just like that last bullet says, a sure leadership follow up is not punitive and fosters a cultural support. And so those are the three things I would leave you with on this slide; trust, engage leadership, and non-punitive.

I'd like to go into a case study now. The first one involves a Special Operation Force critical skills operator who'd been in for 16 years, had five highly kinetic combat deployments, and then after a tragic training accident, where seven of his former team members were killed, became over-reliant on alcohol as a self-coping mechanism. His command kind of recognized -- not kind of -- his command recognized what was going on, approached him, but he said, "No, I got a handle on it," and, :No, don't worry about the alcohol, and I'm handling it pretty good."

Well weeks later, while out at another training event, he gets intoxicated, runs afoul of the law, gets arrested, and then is brought back to the command, and whereupon he sees Dr. Crossman and myself at our medical clinic. And, to me, fesses up, well the reality is I've been drinking a fifth a day here now for six weeks, and in terms of scratching the surface, he fesses up to three years of real significant PTSD symptom endorsement. So his alcohol use was such that we determined that he needs to go get detoxed in residential treatment. And while we have a lot of resources within the SOF and within MARSOC inpatient, residential treatment's not one of them. So we have to send him away. Remember, one of the fifth truths is how SOF has to rely on non-SOF support, you know. Well that was clearly an instance of that.

So he goes away, spends four weeks, comes back, and then is engaged in three-times a week, intensive outpatient services with myself for the PTSD, and also over on main side at Camp Lejeune for our substance rehab program, SRP, where they're doing after care for the alcohol three or four times a week. And that goes on for months and months. And meanwhile, we are ratcheting down every month. You know, we elevate it up and then ratchet it down as he starts to go and be fully engaged in the treatment and everything.

He's there as he gains more and more trust with us, so we know what we're doing, we're not going to betray, we try to get him out of SOF or off the team or something like that, and that we truly have his best interest at heart. He starts doping about other things that are going on, including all these orthopedic issues. So now he's done the hallway seeing Dr. Crossman again, you know, and scraped his shoulder injury, he used his knee injuries, you know, his neck injuries his back injuries, you know, and then next thing you know, well physical therapy ain't going to treat that, so we've got to call our surgeons over at Naval Hospital Camp Lejeune, and they're in there doing arthroscopic on this shoulder and that knee and the like, like that, and all the while, the command's going, okay, you mean he's got to go to this therapy? Yeah, you know, okay.

And so the command gives (inaudible) and cooperation, and he starts to recognize, you know, wow, everybody truly does have my interest at heart. They're even calling up and checking on my wife and everything else like that too. So he continues to get better and better and better, and the long story short, he's now 128 days out or something like that, you know, no alcohol, backend, doing regular duties. Not back on a team yet, but he will be back up on a team probably by February. So that's the first case study. Dr. Crossman's got another.

And I if I can dovetail just a tiny bit on that. One of the things that you have mentioned that he has actually since been referring other folks to our services.

He has street credibility among this operator community that none of the three of us has, you know. And I'll bet he's sent eight other operators to me since he initially engaged. So we got a deepening path from their shops to our clinic door. And, again, it's about trust and competence, you know, and emotion.

So the second case, actually, for time, if we want to skip ahead to the figure.

Yeah.
So we have another way of training this, and we actually -- this is a single slide that we presented to our commanding general about just the program, an example of how it works. And it's just another way of looking at it. For those of you who aren't -- I think you'll recognize most of the acronyms of the support people surrounding the service member maybe. F-R-O is the FRO, the Family Readiness Officer, and MFLC is the Military Family Life Counselor. But this is kind of a visual representation of what a human factors council would look like, all trying to -- when there's support to the service member.

This particular one is a 29-year-old SOF enabler, so a support person who, upon return from his third deployment, showed up at the clinic just complaining of some sleep difficulties. We got him engaged in care there. And during his treatment, of course there was more than just sleep, had significant PTSD symptoms and depression, at which point, you know, we added some care, added some other treatment. And over the course of a couple months he continued to trend in the wrong direction.

There was a point where in one of our clinics, multidisciplinary meetings, we said we're started to get concerned about his ability to carry out the mission, to potentially deploy, and that's the point where we reach out to the command and we say here's what we have going on. And that brought this service member sort of onto the tracker as high risk. So there will just represent that that kind of pulled him in to where he was getting a really deep discussion, which is extremely helpful. It increased the command's awareness of what was going on so their visualization of how he was doing and signs of symptoms was raised. And that actually led to a lot better understanding of how he really was struggling.

At one point, probably a month after he got put on the tracker, he revealed some suicidal ideations to one of the members of the care team. The very next day the CO was sort of notified and we called an impromptu meeting of the Hu.

So he completed in-patient treatment for severe depression. While he was there, there was a lot of communication between medical command and the service member, so he felt very supportive. In fact, the chaplain escorted him down there. We were preparing, even before he came back to say, well what's a good place for him to be. You know, where could you put him in the command where you can really use him skills and make him feel worthwhile and a place where we can keep an eye on him and make sure that he continues to move in the right direction.

So when he came back he was reengaged in care at the clinic. He was shifted to a different spot in the command, which he found very fulfilling. He slowly but surely continued to trend from that red extreme down to orange and has gotten better, and this is now probably about over nine to ten months.

The combination of care is really what has kept him trending positively, and there's been a number of times where, okay, now he's having this surgery and we all have to be on the same page to coordinate. Well he'll be on leave, okay, the command is going to check in, you need to be cautious about this and that. And that has kept him from having any dips back, and he has become very appreciative of the care and has just blossomed into who he really was right before our eyes over the course of this time. So a really, really rewarding case and illustrating, you know, how that team work can help somebody.

I kind of wanted to -- I think Dr. Crossman, perhaps either in the interest of time or her own humility, is underscoring the level of attention and effort that she and her team and Dr. Stein, and, really, I could put a name on every one of these blue bubbles who participated. And let me just be clear, this individual marine was on the brink of death. He was standing, metaphorically speaking, at the edge of the cliff with
is toes dangling over the abyss. In two years of leading over 300 special operators, I had never seen a case this severe. And it was truly a collective effort.

She mentioned an impromptu meeting, the MARSOC or Human Factors Order has a portion in it that accounts for an extremis HFC, Human Factors Council. And I actually called that one that afternoon upon receiving information from our Military Family Life counselor who is a PhD psychologist with her own practice, just happens to be also in support of us; the Dr. Grossman, Dr. Stein, and the chaplain, who I kept very close to me through my two years of command. Extremely valuable people, all seeing a different -- all given about ten pieces of a 500-piece jigsaw puzzle. And so when you bring folks together, you really start to get more of a complete picture in that framework and mechanism for forcing the collegial collaboration didn't previously exist. Sure, we had orders and directives. Sure, we had plenty of resources, but there was no forcing mechanism to bring everybody together, and we did it very rapidly in the case of this particular case study. But what's remarkable about it is we sustained it over almost a year period.

That individual, when he came back from the in-patient treatment facility, was actually moved out of the section, and he wasn't working in a toxic section. We just wanted him to be near -- we wanted to empower him, give him some more responsibility, make him feel more of a valued member of the team, which is part of the input from his therapy that we utilized on the work or marine side of the house, and we very strategically placed him in a workspace in between a highly exuberant young lady, our family readiness officer, just an absolutely social butterfly, who exudes positively, and a couple other those other trusted agents of mine, key leaders. And so that sort of -- whether that wore off on him or whether he, through those interactions in that side of the environment is what helped him or just contributed to the care he was already -- the sustained care he was already receiving. I think the point I just wanted to make that it was a collaborative effort, and it required a lot of behind the scenes phone calls and convincing to do each one of those wickets along the way to start him getting in the outpatient facility -- or in-patient, excuse me, facility.

Anything you want to add on that, Dr. Stein.

Well, no. But I think the next slide we get into, we subjectively, you know, believe wholeheartedly this is really a good program and really works, and that's why we've driven up here to kind of share that. But more than our subjective insurgency to that, you should know that the United States Special Operation Command conducts annual surveys of the health command and they do that across all of the SOF communities, Air Force, Navy, the Army, and, of course, Air Force, Marine Corp.. And they've done it three years in a row now. This last year I believe 11,000 people responded to the survey, you know. In MARSOC it was about 1,100. Didn't you tell me, MARSOC makes up what percent of SOCOM?.

Yeah, there's a couple so what about the numbers, the "so what" guys. So right now the end strength of special operations command is about 69,700. I think that's what the general defense 14 authorized. So you can do the math on 11,600 and what slice of SOCOM responded. From our perspective, our contribution to the special operations effort is 2,742 members. We're the smallest of the components. We comprise 4% of that 69,700 number, 4%, but we had about 1,170 respondents to this survey, and that's one of a dozen surveys marines are asked or required to an annually. So this idea of "surveyitis" come into play.

That aside, about 10% of the SOF respondents came out of Marine Special Operations Command, again, a component that comprises only 4% of SOCOM's total strength. So I thought that was a significant point raised on that.

A couple of survey results -- charts here they go through, and each one has a corresponding graph. It's interesting to note, again, Dr. Stein mentioned this is wave three or the third year they've done the survey, so 2012, '13, and '14, and the next one should be coming out shortly. From 2013 to '14 there's significant, at least from our stock, significant investment on that human performance facet of the MPOTFF of the MARSOC preservation of force and family, high utilization rate of sports medicine resources. Again, this is
sort of promoting the notion that our operators are combat athletes and they require, you know, just they carry a lot of gear, they go through a lot of arduous training, and the subsequent deployments and operations they conduct are physically demanding to say the least. So we invest a lot of money in their training. We want to be able to ensure their physiological resiliency so that they can continue to operate for the duration or good portion of their careers; however long that might be. But if you were to pour a bunch of resources into training and preparing an individual, send them down range and break them, that's kind of a significant loss. Okay?

So, again, so just wanted to highlight, and I think the graph really tells the story a little better. Just a reminder this is Special Operations Command. This is the higher command survey. This is there data, not Marine Special Operations Command. But just looking at the bottom center of the legend in that color corresponding to the top bar, this is the human performance sort of program, HPP as part of that MPOTFF, and you see it's significantly higher than the other components within SOCOM. And I can talk a little bit behind why I think that is, but I'm going to save that for the next chart. I do want you to take note of a slight dip between wave two and three, so that's the 2013 and '14 data in the human performance rung, and just to kind of caveat that with the next chart, this is the behavioral health-care slice of that survey. Notice the delta between wave two and three, an 11% increase in marines exercising the psychological resources that we have within Marine Special Operations command.

So, again, really high participation in the human performance, as one might expect, but a 4% dip from two to three, that corresponds with an 11% increase in the psychology. And I'll let you draw some of your own conclusions, and perhaps while you're thinking, I'll share an opinion as to what might have transpired there. Our operators started trusting the system to help them in a field or an area that notoriously has sort of had a stigma surrounding it. Marines don't want to go see guys like Tom. So occasionally about maybe twice a month I would go see him. That's a whole other panel and conference, and we can get into in another room. But upon occasion, exiting Dr. Stein's office I would run into one of my operators on their way in, and so this happened more than once. So, again, I'm not suggesting that those infrequent intersections contributed to 11% increase. More, I would attribute that to the overall climate and the trust embedded within the culture. The marines understand that it's okay to exercise that.

Again, I said that we're 2,742 strong at Marine Special Operations, and Dr. Stein alluded to the street credibility of that first case in particular subsequently sending eight of his friends, his peers who might have previously said heck, that's a load. I'm not going to go in there. I'm afraid of what he might ask me, what test I cheated on in first grade or, you know, my relationship with my mother. Whatever it might have been. But none the less, eight folks by word of mouth. And, again, if you've ever served with or supported special operations teams, these are folks at the smallest level who go into some very politically sensitive extremely complex mission sets, often in, you know, the worst places you can imagine, so they trust each other implicitly. And if you can extend that, expand that beyond the boundary of their team into a unit and then connect that unit to some of the rich resources we're already investing in based on those core SOF truths, that humans are more important than hardware, quality is valued over quantity, then you're really putting your money in the right place and you're really spending your time on the right things, building that trust, because it truly has an effect. And in this case, again, you can draw your own conclusions from looking at that data, but an 11% increase in behavioral health care with a corresponding dip.

So this brings us to our last slide, and we narrow down the intended time to speak to you and sort of open up and invite your questions or comments. This is just an example of the previously blank chart just to show you some generic data for about how flushed out these fields are, and, again, you see the corresponding color on the far left, red, green, yellow, or orange. That was the tool.

There was a few other things worth talking about, I think, amplified in the cases that for perhaps how we use this tool but something that simple built on a foundation of trust and collaborative efforts to make our folks hyper aware a at the leadership level but all the way down to the independent operator level to ensure their combat readiness and to maintain a resilient special operations force. So that was our intent, and we thank you very much for your time and attention.
Thank you so much. That was a wonderful presentation. We're going to take questions right now. We have one from our live audience.

So thank you. It was a very nice presentation. Colonel, I'm going to start with you. I guess what you describe is really, I think, good care; right, overall, and good multidisciplinary work. And I'm going to, I guess challenge you a little bit to say the structure you described I think is necessary but not sufficient, because in the narrative you gave us, in the stories you gave us what you describe are people who really take their job seriously and do it well. I think that's the part I want to know how do you replicate that.

Right.

Because I know you can give that tracker to every, you know, special forces, you know, section across the military. My question really is is will they really know how to use it if they don't have the people like you there?

No, it's an absolutely great question, and thank you for asking it. You know, my peers, I've spent some time on the conventional side of the house. I've spent half my career on the operational side of the house, another half in sort of supporting establishment. So I've bumped into all walks and types of people across the joint community, but I'll stick with just the Marine Corps for now. And, you know, when I went to the Marine Special Operation Command there were a few of my peers who were slightly jealous. That's probably an understatement.

And I recently had a conversation with a former infantry battalion commander, a friend of mine, and he asked me, "Brian, hey, how many article 15 nontraditional punishments did you exercise or execute during your tenure?" And I can count them on just over one hand in two years. I said "Seven." And he said, "Wow, I had about 20 a month." And I said, "Okay, well it's two different populations; all right." His a lit bit younger, and so I don't know if you could generalizable that statistic across all marine infantry battalions.

But one of the points that we subsequently discussed is, you know, because naturally he said, "Well you're in SOCOM, you know, of course your guys are hand selected and screened, and they're put through, you know, these arduous pipelines, training pipelines, and you guys pay a lot of attention to that," and I just get what I get after the recruiter and drill instructors, and those guys are done with them. And those guys do a fantastic job I might add. So, I said, "Well what are the similarities between my boys and your boys?" And at the fire team level and in an infantry battalion you ask a lance corporal rifleman, you know what he'll tell you? The guy on my left and the guy on my right, the guy that's in front of me and the guy that's behind me. And so I don't think that that core tenet differs too much from a special operations team. There might be disparity in age, maturity, amount and type of training, but that's an incredibly powerful element that you can build trust from.

And it doesn't matter if you're an 0302 infantry commander or an 0370 specialty operations officer. If you recognize those core things first and build a program from that and developed on that kind of trust, I think you can find success with. I don't know that my infantry -- now I should probably caveat, I started out, I'm a ground intelligence officer by trade and training, so I went through the infantry officer course as one of my first MOS schools. So a lot of these infantry guys out there I can poke fun at, because I was one of them once upon a time. And so this -- we share that in common.

And, you know, if I put a spreadsheet in front of them, some of my friends would probably pick the computer up and throw it at something, because, hey, this is a great aerodynamic projectile, I can probably hurt someone or some thing. But I say that half tongue and cheek. There's a whole slew of them out there that would absolutely knock your socks off with their intellect, their creativity, their ability to innovate. It is unbelievable what these young men and women can do. So I would trust them with it.
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I would send them the spreadsheet. I'd give them a few instructions and I would say this is how we did it. See if you can pull a piece or component of it and apply it, and it works for you great, and if you find a better way to do it, please call me and tell and I'll adjust mine on my end. It's a great question. Thanks.

I'm an Army psychiatrist and it's wonderful to see the work that you're doing to save lives. And obviously, you know, the complexity of the cases is very, very, you know, apparent in some of the cases that you've talked about. This is my own curiosity. I've treated marines and sailors in my time. If you were to seek treatment self-referred, without somebody else, you know, the command telling you to go, how much of that information is shared with the command verbally or through records?

Go ahead. Go for it.

Well there are many folks that are seeking care in our clinic that none of the information is relayed to the commanding officers. It is only when it gets to the point of obviously risk to self or others or mission. So if we're thinking, wow, I know this guy is supposed to deploy next summer a month, I see where he's going, that's the trigger.

[Inaudible].

If we had time for a case three, I'd elaborate and relate it to your question, sir. I had an individual, fairly seasoned, well-trained individual that came from an intelligence organization, and I was putting him through a multi-disciplinary operator course, or that was the intent. He was about to go through it. And there were some alarms, if you will, at that middle layer manager level that went off. He was exhibiting, you know, the kind of behavior that appeared depressive and toward suicidal.

When I went to talk with Dr. Stein about it, I then learned that this individual had already received care for upwards of four years. Now because I'm a commanding officer, I have access to, you know, read some of that information, and we came up with an approach to allow this guy the leeway to go through the same course at a later time. And eventually it just wasn't a good match. I called a good friend on the marine conventional side but within the community, and we replanted the lad. And about a year later I saw him and I spoke with that lieutenant colonel, and so he was doing remarkably well.

Thank you. We have time for one more quick question. This is one from the virtual audience. On the tracker there was a mentor column. How do you feel like the mentors?

You take that.

Yeah, so great point. In this windowless room that's in a highly secure facility there are several whiteboards along the walls. Much to the display of my staff, they would hide the markers from me whenever I was in the room, because I had a tendency to get up and draw pictures on the wall. And during one of the sessions I drew a stick figure in the middle and I started drawing concentric circles around the stick figure, and I was labeling each line, you know, the individual, his roommate, peer, chain of command, health-care provider, [indiscernible], FRO, family, spouse, parent, you know, and then myself somewhere on a really far out orbit. And then I asked my people, where's the line that cuts across all these layers and why don't we have one?

And so we added a mentor, somebody who doesn't necessarily have to be in the individual's chain of command but someone who knows that individual well enough who that individual trusts, and it was sort of that mentor's job to maintain that daily contact and watch the case progress. So that's where the mentor column came from.
Oh, awesome. Well that's all the time we have for questions. I know there's plenty of other questions out there in the room and online. I think your contact information is available, so if people do want to contact the speakers to ask any more in-depth questions, feel free. If you will all just join me in thanking our speakers today.