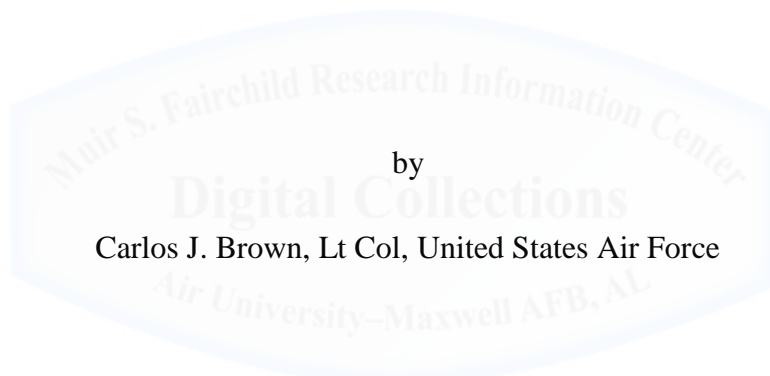AIR WAR COLLEGE

AIR UNIVERSITY

HEALING THE OPERATIONAL ENVIRONMENT:

ENCOURAGING MENTAL HEALTH HELP-SEEKING BEHAVIOR

by

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A Research Report Submitted to the Faculty

In Partial Fulfillment of the Graduation Requirements

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Biography

Lt Col Carlos J. Brown enlisted in the United States. Army in 1985 and received his commission in the Army Aviation Branch 1994 as a distinguished military graduate from the Arizona State University Army ROTC program. Since 2003 he has served as an Air Force HH-60G Rescue helicopter pilot. He served as a Capitol Hill Fellow for Texas Congressman Solomon P. Ortiz, as well as staff assignment as the Personnel Recovery/Special Operations Branch Chief on the Air Staff. His operational assignments include Director of Operations for the 66th Rescue Squadron, Nellis Air Force Base, Nevada and most recently commanded the 512th Rescue Squadron at Kirtland Air Force Base, New Mexico, responsible for all helicopter training in the United States Air Force. He is currently a student assigned to the Air War College, Air University, Maxwell AFB, AL.
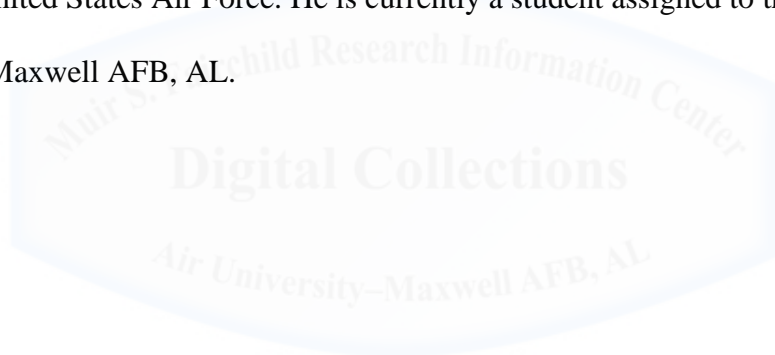
Abstract

The purpose of this professional studies paper is not to reinvent the multitude of existing mental health programs and tools available to squadron commanders. The intent is rather to refine the operating environment between the unit-level and base-level resources in an effort to debunk the stigma of help-seeking. The intent is also to increase awareness of the current mental health dilemma facing our post 9/11 force and to offer recommendations for commanders at multiple levels in order to create a climate that promotes greater mental health and wellness. I initially frame the problem by examining the percentage of overall Americans affected by mental illness. Then, I examine both the civilian and United States Air Force (USAF) suicide rates. I will demonstrate that suicide rates are a uniquely-useful indicator of problematic mental health issues – particularly at times when mental health concerns may remain masked in many individuals due to social stigmas. I next discuss causal factors that reinforce the stigma surrounding help-seeking within the military. Additionally, I utilize the Comprehensive Airman Fitness program's effectiveness as an example of an existing strategic framework within the USAF that promotes a healthy balance within the mental, physical, social, and spiritual health of Airman. Lastly, I provide examples of recommend changes to the current operating environment, also referred to as work place environment. When combined with the existing commander's mental health "toolkit" these changes will build increased rapport between squadron members and mental health personnel. Moreover, this will more fully integrate mental health personnel within operational units. While there is no panacea, the intent is to continue to debunk the stigma associated with help-seeking, allowing our Airmen to maintain both a personal and professional balance in order to achieve their full warfighting potential.

Both the DoD Task Force on Mental Health (2007) and the DoD Task Force on the Prevention of Suicide Among Members of the Armed Forces (2010) identified the stigma of mental illness as a significant issue preventing service members from seeking help for mental health symptoms or disorders.[1]

Introduction

The word stigma is defined as a mark of shame or discredit. When applied to social acceptance, specifically in the area of mental health, stigma serves as a distinguishing mark of social disgrace. Many Americans who suffer from mental illness and stigma are challenged on two fronts. On one front they struggle with the symptoms and disabilities that result from the mental illness. On the other front, they are challenged by the stereotypes and prejudice that result from misconceptions about mental illness. Just as in American society, stigma for help-seeking exists within military communities.

The Department of Defense (DoD) has long recognized the need for programs that address the mental health and wellness of our service members. These programs are even more critical as the current generation of Airmen, who have joined or served in the post 9/11 era, face mental health issues amplified by the effects of over a decade-and-a-half of continuous combat operations. The combined effects of repeated deployments, increased workload at home station, and the everyday stressors associated with being a military member all can affect a service member's mental well-being. Additional stressors such as reduction in the force, diminishing operating budgets, frequent family moves, changes brought on by the information age, and the escalating pace of military life have also taken a toll on the mental well-being of a large portion of the United States Air Force (USAF). Based on these factors, Congress, senior DoD officials, and Air Force leadership have recognized the criticality of mental health services and have

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1. Joie D. Acosta et al., *Mental Health Stigma in the Military,* RAND Report RR 426 (Santa Monica, CA: RAND, 2014), 1.

attempted to set appropriate policies and establish programs to improve the mental health of our warfighters. Despite these efforts, 2014 was recorded as having the highest suicide rate in the USAF since statistics have been recorded by the DoD. This data reflects the fact that the Air Force is challenged in meeting the mental health demands of our population. This poses a direct leadership challenge for squadron commanders, as Air Force Instruction (AFI) 1-2 *Commanders Responsibilities* states, "Commanders are charged with the codified authority and responsibility to promote and safeguard the morale, physical well-being, and the general welfare of Airmen in their charge."[2]

Thesis

Leaders at all levels have a continuous obligation and responsibility to change the stigma that surrounds mental health. I argue that squadron commanders are in the best position to debunk the stigma that surrounds mental health Squadron commanders have first-hand day-to-day interaction with Airmen and direct influence over their lives. This requires emphasis at all levels of command, to include increased personal interaction of mental health professionals in order to facilitate the cultural shift that will positively reinforce help-seeking behaviors.

Continuous process improvement and education is critical in order to fully support squadron commanders with meeting the command responsibilities that they are given. One precursor for removing stigma is for squadron commanders to be intimately familiar with the mental health resources available and offer opportunities for squadron members to build rapport with local mental health professionals. First, a review of the current literature will frame the magnitude of the problem by examining mental health challenges within the military compared to the civilian population. Next, I will examine the barriers for help-seeking within the military

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2. Air Force Instruction (AFI) 1-2, *Commander's Responsibilities,* 8 May 2014, 2.

and identify causal factors that reinforce stigma for Airmen. Then, I will examine command

climate and how work place environmental factors can also play a role in perpetuating stigma.

Additionally, I will review the USAF's Comprehensive Fitness program, in order to draw

knowledge from a historical perspective. Lastly, as a former squadron commander, I will offer

my own perspective and make intuitive recommendations based on that experience which can

serve as examples of ways to refine the operating environment.

This paper's objective is not to recommend an additional regulatory requirement or

another mandatory training event to compete with the multitude of other mandatory

requirements; more importantly, the objective is to generate thought. The goal is to generate

introspective thought and provide some simple concepts, that senior leaders, commanders at all

levels, and mental health professionals may utilize to increase focus on the interpersonal

dimension of the operating environment in order to finally dispel mental health stigma within our

service.

Defining and Framing the Stigma Challenge

Mental health is defined as a state of well-being in which every individual realizes his or

her own potential, can cope with the normal stresses of life, can work productively and fruitfully,

and is able to make a contribution to his or her community.[3] When a person's mental well-being

is challenged and not identified or if left untreated, mental illness may develop. Mental illness

affects a large percentage of Americans in the United States. The National Institute of Mental

Health estimates that, "One in four adults−approximately 61.5 million Americans−experiences

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3. World Health Organization, "Mental health: a state of well-being," accessed 02 October 2015, http://www.who.int/features/factfiles/mental_health/en/

mental illness in a given year."[4] While this statistic represents the aggregate for Americans,

military mental illness statistics are often presumed to be somewhat less, based on the fact that

military members are screened for mental health disorders upon entry. Therefore, the incidence

of some mental health disorders common among the civilian populace may not be as prevalent

amongst military populations. Conversely, mental health challenges such as post-traumatic stress

disorder (PTSD) may be more prevalent per capita in the military, than in the civilian population.

Comparisons between the overall American population and military samples can be made

for suicide rates, as well. This comparison is important, because a likely correlation between

suicide and mental health will be demonstrated later. A correlation between suicide and poor

mental health, while seemingly obvious, is especially important to the topic of help-seeking in

the military. The importance of this correlation is based on the fact that while suicides are easily

identifiable and can be tracked, one of the central problems with mental health is that instances

of it are often unknown until it is too late, based on the associated stigmas identified in this

paper. Department of Defense Suicide Event Report (DoDSER)[5] and the Armed Forces Medical

Examiner System (AFMES) data as of June 30, 2014, counted 259 suicides among Active

Component service members and 220 suicides among Reserve and National Guard service

members. The Active Component suicide rate was 18.7 percent per 100,000 service members.

The final numbers according to the DoD's 2014 (4th Quarter/Active Duty) Suicide Information

Report, reflected suicides by service to be 122 in the Army, 53 in the Navy, 34 in the Marine

Corps, with the Air Force losing a total of 59 Airmen. Air Force losses represented the highest

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4. National Institutes of Health. "National Institute of Mental Health. (n.d.). Statistics: Any Disorder Among Adults." accessed 02 October 2015, http://www.nimh.nih.gov/statistics/1ANYDIS_ADULT.shtml

5. Department of Defense Suicide Event Report, *Calendar year 2013 Annual Report*," (http://t2health.org/sites/default/files/dodser/DoDSER_2011_Annual_Report.pdf, 2013), 5.

incidence of suicide in the Air Force since tracking began in early 2000's.[6] Used as a frame of reference, comparisons can be made between the Centers for Disease Control suicide statistics for the civilian population and those of DoD military members. In 2013, the most recent year for which the Center for Disease Control data was available, 41,149 civilian suicides were reported. Statistically this resulted in 12.6 civilian deaths per 100,000 (making suicide the 10th leading cause of death for Americans).[7] Comparatively, the suicide rate for the Department of Defense Active Duty component was 22.7 per 100,000 service members. The collective statistics for the National Guard and Reserve component was 24.2, with the Reserve at 19.3 and the National Guard at 28.1 suicides per 100,000 service members.[8] Additionally, according to the National Alliance on Mental Illness, research has found that about 90% of individuals who die by suicide experience some form of mental illness.[9] The correlation between occurrences of suicide and mental illness likely suggests that the latter is also on the rise, despite the trend being masked based on an unwillingness to self-identify and seek help. This is a telling statistic, suggesting based on the significant increase in suicide that there is a large amount of mental illness currently within military populations. Additionally, if an appreciable number of applicants with mental health problems are screened out prior to entry into the military, then it can be deduced that a large portion of mental health problems began after the service member enlisted or was commissioned.

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6. Richard Sisk, "Air Force Must Do More to Curb Record Number of Suicides, Cody Says," Military.com, accessed 16 September 15, http://www.military.com/daily-news/2015/09/16/air-force-must-do-more-to-curb-record-number-of-suicides-cody-s.html
7. American Foundation for Suicide Prevention, "Facts and Figures," accessed 20 December 15, https://www.afsp.org/understanding-suicide/facts-and-figures.
8. Department of Defense Suicide Event Report, Calendar year 2012 Annual Report. http://www.dspo.mil/SuicideData/DoDSERAnnualReports.aspx, 2012, ix.
9. National Alliance on Mental Illness, "Risk Factors for Suicide," accessed 20 December 15, https://www.nami.org/Learn-More/Mental-Health-Conditions/Related-Conditions/Suicide

While the DoD and the Air Force have implemented policies and programs that have proven effective when utilized, something is causing an increase in the occurrence of mental illness in the military despite efforts to mitigate the challenge. Examination of the military culture may highlight contributing factors that inhibit Airmen from seeking assistance.

Causal Factors

The stigma of mental health is not a recent phenomenon in either the civilian or military population. This can be traced back to ancient times where beliefs about mental illness centered on the idea that those suffering were possessed by evil spirits.[10]

There are many reasons why Airmen do not seek help and avoid mental health services. Literature suggests that the most frequently noted causes of stigma are: the dissonance between self-image when asking for help and the military's cultural image of the "warrior ethos," concerns over impact to career, command climate, and the role of trust. Review of the literature also highlights that this phenomena continues today. Those suffering from mental illness are often stereotyped by society as being dangerous, unpredictable, responsible for their illness, or generally incompetent.[11] This type of stigma in the civilian population can lead to active discrimination, such as excluding people with these conditions from employment, social, or educational opportunities.

The stigma of mental health treatment in the military creates the same detrimental effect on military members based on the stereotype that members who seek treatment are weak. These perceptions of weakness derive from the belief that mental health treatment violates the

10. Museum of Health Care, "Mental Health: Tracing the History of Stigma," accessed 02 October 15, https://museumofhealthcare.wordpress.com/2014/07/15/mental-health-tracing-the-history-of-stigma.

11. Patrick W. Corrigan, Benjamin G. Druss, and Deborah A. Perlick, "The Impact of Mental Illness Stigma on Seeking and Participating in Mental Health Care," Association for Psychological Science, Vol 15 (2014): 42-43.

military norms of the warrior ethos of strength, group cohesion, and the individual's ability to cope in times of combat.[12] Stigma can also create another conundrum for military members known as self-stigma.

> People with mental illness may begin to believe the negative thoughts expressed by others and, in turn, think of themselves as unable to recover, undeserving of care, dangerous, or responsible for their illnesses. This can lead them to feel shame, low self-esteem, and inability to accomplish their goals. Self-stigma can also lead to the development of the "why try" effect, whereby people believe that they are unable to recover and live normally so "why try?" To avoid being discriminated against, some people may also try to avoid being labeled as "mentally ill" by denying or hiding their problems and refusing to seek out care.[13]

The self-stigma dilemma not only further inhibits a military member's willingness to seek mental health services, but may be a very difficult obstacle for a service member to overcome. This dilemma is created by the individual's perception that the image of a typical service member is characterized by the traits of toughness, resilience, and a warrior ethos. Unfortunately, seeking mental health treatment is stigmatized as a sign of an individual's weakness which violates the military cultural norm of toughness.[14] Therefore, even if the individual's command climate is supportive of help-seeking, the cultural norms of the military may play such a significant role that they may prevent the service member from seeking much needed mental health care. The quandary then becomes whether the service member should choose to seek help and risk professional and peer rejection or give-in to stigma and not seek help. Unfortunately, often times the latter option is the strongest often driving members to "suck-it up" as a sign of toughness in

12. Crosby Hipes, "The Stigma of Mental Health Treatment in the Military: an Experimental Approach," accessed 02 October 15 http://www.researchgate.net/publication/281065845.
13. Patrick W. Corrigan, Benjamin G. Druss, and Deborah A. Perlick, "The Impact of Mental Illness Stigma on Seeking and Participating in Mental Health Care," Association for Psychological Science, Vol 15 (2014), accessed 02 October 2015, http://www.psychologicalscience.org/index.php/publications/mental-illness-stigma.html
14. Crosby Hipes, "The Stigma of Mental Health Treatment in the Military: an Experimental Approach,"http://www.researchgate.net/publication/281065845_The_Stigma_of_Mental_Health_Treatment_in_the_Military_an_Experimental_Approach

lieu of seeking help. While stigma, self-image, and peer acceptance present strong barriers to help-seeking, confidentiality and career impacts are a significant concern for service members as well.

Confidentiality and career impacts are concerns for Airmen who may think that accessing mental health resources will automatically have a negative career impact. An example of such concerns was captured in a 2014 *Air Force Times* article where Lt. Col. Wendy Travis, the Chief of Mental Health Policy and Program Evaluation with the Air Force Medical Operations Agency (AFMOA), stated that, "Recent data from the Air Force Community Assessment Survey suggests that one in 10 active duty members reported untreated mental health problems and that 90 percent of these personnel had no intention of seeking mental health services."[15] Additionally, of this 90 percent, she discussed as one of the primary factors captured in the survey for not seeking help was concern about potential impact to one's military career and relationships. Unfortunately, this perception often plays a role in the decision for Airmen to defer seeking mental health assistance based on their special duty status. Service members assigned to positions related to the Personnel Reliability Program (PRP), personnel on flying status, or those who possess high-level security clearances unfortunately weigh the impacts of accessing mental health services over career goals and future aspirations. The fear of the unknown, that of being able to control the process once an individual takes the step of self-referral to the mental health facility for assistance, was listed as another one of the causal factors for not seeking help.[16] A 2014 RAND report titled, "Mental Health Stigma in the Military, a Department of Defense

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15. Larine Barr. "Air Force mental health programs encourage seeking help." Air Force Times, 28 May 2014, http://www.af.mil/News/ArticleDisplay/tabid/223/Article/485084/air-force-mental-health-programs-encourage-seeking-help.aspx.
16. Terri Tanielan and Lisa H. Jaycox., *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery,* RAND Report MG720 (Santa Monica, CA: RAND, 2008), 112.

Health Related Behaviors Survey," documented that 37.7 percent of those surveyed believed that seeking mental health assistance would harm their career.[17]

As highlighted in the introduction, commanders are charged with the codified authority and responsibility to promote and safeguard the morale, physical well-being, and the general welfare of Airmen in their charge.[18] Air Force Instruction 1-2 *Commanders Responsibilities* further directs that commanders will:

> …establish and maintain a healthy command climate which fosters good order and discipline, teamwork, cohesion and trust. A healthy climate ensures members are treated with dignity, respect, and inclusion, and does not tolerate harassment, assault, or unlawful discrimination of any kind.[19]

A consensus exists on the role of command climate throughout the military based on command regulations across DoD, leadership manuals, and applicable literature. Command climate constitutes a state or condition existing from shared feelings and perceptions among service members about their unit, about their leaders, and about their unit's programs and policies. This command climate condition is the environment created by the commander's vision, leadership style, and influenced and perpetuated by subordinate leaders within their chain of command. The goal of every commander is a healthy command climate and a cohesive unit capable of executing the unit's mission. As a foundational element of the proverbial art of command, command climate tends to be one of the most observed, but least understood concepts in the military. Another finding from the 2008 RAND study titled, "Mental Health Stigma in the Military," was that both service members and spouses who, when surveyed, stated that the level of support they received from the command and/or commander could contribute positively or negatively to their

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17. Joie D. Acosta et al., *Mental Health Stigma in the Military*, RAND Report RR 426 (Santa Monica, CA: RAND, 2014), 24.
18. Air Force Instruction (AFI) 1-2, *Commander's Responsibilities,* 8 May 2014, 2.
19. Ibid., 3.

mental health experience. The command climate was a key factor in help-seeking. When

commanders did not take mental health problems seriously, they contributed to stigma and

service members were less likely to seek help or complete treatment. Conversely, units who

displayed a healthy command climate were much more likely to have members successfully

complete treatment.[20] In summation, the state or environmental condition referred to as the

command climate is created based on the commander's character and interaction with the unit.

This interaction is critical to fostering a supportive environment for help-seeking as it conveys

the commander's credibility, intent, and willingness to do something that will benefit the health

and well-being of each individual and the unit as a whole.[21]

A positive command climate creates the sacred bond of trust between a commander and

his or her subordinates and leads to building trust. Trust can be defined as the feeling that another

person is reliable, caring, or effective. Additionally, rapport can be defined as, a friendly

relationship wherein trust is developed. Both of these definitions are required for a healthy

command climate to be possible and stigma to be broken. Unfortunately within the context of

the definitions, it is common that mental health providers and other mental health resources are

often viewed as outsiders, lacking the element of trust with those needing services. Dr. Craig

Bryan, an active duty U.S. Air Force psychologist, stated in his article on *Circumventing Mental*

Health Stigma by Embracing the Warrior Culture, that another significant factor that inhibits

building rapport is not only that mental health professionals are viewed as outsiders, but also that

rapport is also impacted by, "…the geographic separation of mental health services from the

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20. Terri Tanielan and Lisa H. Jaycox., *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery,* RAND Report MG720 (Santa Monica, CA: RAND, 2008), 279.
21. Lyman, Amy. *The Trustworthy Leader: leveraging the power of trust to transform your organization* (San Francisco, CA: Jossey-Bass, 2012), 4.

military unit, and it is very likely one of the most significant contributors to service members'

high level of distrust and skepticism of mental health professionals."[22] Dr. Bryan's research

further expressed that the conflict between the identity of the warrior culture that values

emotional toughness and the belief that discussing life or military related mental health stressors

with outsiders is not an acceptable norm and viewed as potentially jeopardizing the group's

identity as well.[23]

One way USAF leaders have attempted to combat stigma in the past is through Air Force

wide programs like Comprehensive Airman Fitness (CAF). The Air Force recognized the

imperative of maintaining a resilient and ready force and in doing so developed the CAF

program to incorporate a holistic approach for ensuring our Airmen are best prepared to execute

their mission. Examining the CAF provides the strategic framework and insight into the

operational resources available to facilitate resiliency and encourage help-seeking behavior

amongst our Airmen. The critical requirement is to create an operating environment that serves

as the integral link between the service member, resources available, and mental health

professionals. Building trust and rapport between Airmen and the collective mental health

community is vital to instilling the cultural shift required to debunk mental health stigma.

Comprehensive Airman Fitness

The Comprehensive Airman Fitness (CAF) program provides an example of an

established framework that emphasizes the importance of the inter-personal dynamic to maintain

a resilient force. At the individual Airman's level, CAF provides tools and skills to maintain a

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22. Bryan, Craig J. and Chad E. Morrow, "Circumventing Mental Health Stigma by Embracing the Warrior Culture: Lessons Learned From the Defender's Edge Program," American Psychological Association, Vol. 42/No. 1 (2011): 20.
23. Ibid., 17.

healthy balance in the mental, physical, social, and spiritual domains. CAF training requirements include a 4-hour, Individual Resilience Skills Training (IRST), mandatory for every active duty Airman to complete every calendar year. These tools and skills are intended to equip both commanders and Airmen with the ability to assess and adjust to a dynamic environment, as well as, develop mental well-being by encouraging help-seeking behaviors as one of the four pillars of wellness.[24] By design the IRST sessions focus on the delivery of information using a small group model of not more than 10 personnel for each training session. Resilience Training Assistants (RTA) facilitate the exchange and dialogue to build familiarity amongst fellow Airmen. Analysis of the CAF framework, and its success, provides the genesis for the recommendations below. These recommendations take into consideration a fiscally constrained environment, and make the effort to prevent added requirements to an already-taxed population. The provided recommendations are conceptual examples that could be implemented at the Air Force level, base level, and unit level and are provided in a cost conscious and least-impactful way to build trust and rapport between Airmen and mental health professionals.

Recommendations

Recommendation 1 (AF Level). Make in-person mental health screening in the mental health clinic mandatory during the annual physical health assessments (PHA). While the web based PHA and physical examination represent an effective cost saving screening tool for primary care, face to face mental health screening could also be used to reduce stigma by creating an environment in which all service members are required to be seen and speak with a mental health professional. While an increased investment of time, the benefits of this proactive approach should outweigh the cost. Building personal familiarity with mental health resources can begin

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24. Air Force Instruction (AFI) 90-506, *Comprehensive Airman Fitness (CAF),* 2 April 2014, 3-4.

the process of breaking the mental health stigma. For example, required visits to the clinic will provide all Airmen a common operating environment and foundational understanding of mental wellness. An Airman sitting in a mental health clinic's waiting room might be there for an annual checkup or for a self-referred visit. A distinction would not be apparent to anyone else in the clinic. Requiring at a minimum this yearly one-on-one interaction with a mental health professional also creates a baseline experience across the force. This further serves to diminish the curiosity, labeling, and the stereotyping elements of stigma. Additionally, the most positive outcome of these interactions is that as individuals build familiarity and rapport with mental health professionals (MHP) they will be seen more as part of the team. This creates a proactive approach to integration, which may facilitate more proactive self-referrals before a mental health problem becomes severe.[25]

Recommendation 2 (Base/Installation level). Co-locate mental health services within primary care clinics and flight medicine offices. The Air Force as early as late 1997 identified the benefits of mental health professionals working in a consultative role with primary care teams and implemented a Behavioral Health Optimization Project (BHOP) at Tinker Air Force Base. The BHOP has demonstrated the success of the integrated model over the last 14 years.[26] As a result of the project's success, in FY12 the BHOP transitioned from a project to the formally mandated program. To date the BHOP has been implemented on some scale across 90% of the Air Force.[27] While most medical support services are geographically co-located within the same facility, full integration within the same office space can serve to reduce stigma. This result is not

25. Bryan, Craig J. and Chad E. Morrow, "Circumventing Mental Health Stigma by Embracing the Warrior Culture: Lessons Learned From the Defender's Edge Program," American Psychological Association, Vol. 42/No. 1 (2011): 22.
26. Primary Care Behavioral Health Services. "Behavioral Health Optimization Program (BHOP), August 2014, 10.
27. Ibid., 15.

only based on Mental Health Providers being viewed by patients as another member of the primary care team. This provides additional anonymity, and also serves to reduce issues of confidentiality. Better face-to-face communication between providers can occur when mental health providers have offices co-located alongside family physicians, physician assistants, and medical support personnel in primary care clinics. This would also serve to alleviate the requirement for a separate appointment and the member would not have to visit the stereotyped mental health clinic with frosted windows on another floor. Under this arrangement barriers to seeking mental health may be reduced. In an interview with Maj Jack Reardon, Mental Health Flight Chief at Kirtland AFB, NM, where the BHOP has been implemented stated, "that although there is no quantitative data at this time to initiate a physically consolidated Primary Care Management –Mental Health office, based on a proactive approach of full integration, he would anticipate that mental health care prevention, intervention, and treatment may take place more often and the percentage of active-duty personnel that go undiagnosed or untreated may decline."[28] The physical integration of PCMs and MHPs would also produce a second order effect by creating additional synergy in care provided by developing a single health care team mentality, versus primary and specialty care providers.[29]

Recommendation 3 (Unit level). Assign/Integrate Mental Health Providers (MHP) to units identified as having a higher rate of mental health related incidents. This recommendation is provided based on an informal survey of eight Air Force Rescue Squadron commanders who stated that based on their experience MHPs are not integrated in any formal structure, and the majority commented that the only time a MHP physically comes to the unit is often by request

28. Major Jack Reardon (377th Medical Group Kirtland AFB, NM), interview with the author 22 December 2015.
29. Primary Care Behavioral Health Services. "Behavioral Health Optimization Program" (BHOP), August 2014, 89.

for support during designated Comprehensive Airman Fitness or Wingman training days, or often in reaction to a crisis that occurs when support is required. To ensure clarity, this recommendation does not have the unrealistic expectation of having MHPs permanently assigned at the unit level. It does recommend testing a prototype program where MHPs are assigned to monitor specific units. Therefore, I recommend that more MHPs be assigned to units with the responsibility to be engaged "boots on the ground" on a regular basis. By assigning MHPs specific units to be accountable for, they will be able to experience firsthand Airmen within their unique operational environment and identify potential mental health challenges created by the environment. This would also provide the added benefit of building rapport and trust based on proximity and familiarity between MHPs and the Airmen they serve. Additionally, when the MHP participates where applicable in the unit's mission, they too can more fully understand the effects of the unit's operational environment. Building this interpersonal relationship reinforces rapport and trust as the MHP is seen as part of the team, versus being viewed as an outsider. This type of imbedded relationship would also serve to further reduce the stigma of mental health by providing a proactive opportunity for commanders and unit members to enhance their knowledge of mental health impacts created by their operating environment. The biggest benefit will be the interpersonal dialogue that will serve to facilitate and encourage help seeking behaviors.

Conclusion

Statistics reflect that mental health challenges and suicide have become a significant problem for our Air Force. In 2015 we recorded the highest incidence of suicide with the loss of 59 Airmen. As the statistics in this paper reflect there is a correlation between mental health issues and those who commit suicide.

While our most senior civilian and military leaders have identified this epidemic and have implemented policies and programs in an attempt to change the service culture towards help seeking behaviors, we are still falling short. Both the DoD Task Force on Mental Health (2007) and the DoD Task Force on the Prevention of Suicide Among Members of the Armed Forces (2010) identified the stigma of mental illness as a significant issue preventing service members from seeking help for mental health symptoms or disorders.[30] Undoubtedly, more research will be conducted, but rather than waiting for more empirical data that points to stigma as barrier to seeking mental health treatment help solve this epidemic, I propose we can take some intuitive measures to build rapport between squadron members and mental health professionals. I argue that the critical point of intercept is creating a more interpersonal environment that facilitates the rapport required to establish the element of trust. Increased integration of mental health professionals with operational units can create this environment. Once we establish the bond of trust between Airmen and the mental health community, over time we can hope to change attitudes about mental health care and continue to cultivate the cultural shift that will reduce the stigma that acts as a barrier to seeking mental health treatment.

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30. Joie D. Acosta et al., Mental Health Stigma in the Military, RAND Report RR 426 (Santa Monica, CA: RAND, 2014), 1.

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