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14. ABSTRACT: Despite policies that aim to reduce stigma and access to mental health care within the military, almost half of Service members who may be in need do not seek mental health support. The current study builds on past research on barriers to seeking help for mental health concerns, particularly for suicidal ideation or suicide attempt, by examining factors that promote or prevent help-seeking from the perspective of Service members and suicide prevention gatekeepers. Data from the *2016 Status of Forces Survey of Active Duty Members* were analyzed to estimate the prevalence of non-help-seeking, and individual, occupational, and barrier factors associated with non-help-seeking. Focus group interviews with military suicide prevention gatekeepers provided context and further insight into the findings from the survey. In addition, gatekeepers discussed strategies for promoting help-seeking for mental health concerns. Findings from this study indicate that non-help-seeking Service members tend to be male, officers, less knowledgeable about suicide prevention skills, and more concerned about the impact of seeking mental health care on their career. Recommendations include: (1) conducting effective suicide prevention training and mental health awareness campaigns, and evaluating their implementation, (2) establishing programs to encourage Officers to seek help for mental health concerns, and (3) addressing Service members' concerns that seeking help will have an adverse impact on their careers. Ultimately, this study does not suggest changing the policies impacting career-progression and help-seeking behavior, as many of them have been put into place for reasons such as safety, but instead encourages decision-makers to address the perception of these repercussions.			
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PREFACE

In 2013, the Defense Suicide Prevention Office was designated as the DoD policy office for suicide prevention, intervention, and postvention. In 2016, the Defense Suicide Prevention Office funded the Defense Personnel and Security Research Center, a division of Office of People Analytics, to conduct research on factors associated with non-help-seeking behavior among Service members. The present study uses data from the *February 2016 Status of Forces Survey of Active Duty Members*, as well as information gathered from focus groups conducted with military suicide prevention gatekeepers, to estimate the prevalence of non-help-seeking among Service members who have experienced suicidal ideation or suicide attempts, and to explore factors related to non-help-seeking within military populations.

The findings from this study highlight the barriers to mental health care utilization that Service members face. Strategies for addressing these barriers are offered, as well as ideas for future research in this domain.

Eric L. Lang
Director, PERSEREC

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EXECUTIVE SUMMARY

INTRODUCTION

A large number of DoD and Service-level policies and procedures aim to reduce mental health stigma and enhance access to mental and behavioral health services. Despite these efforts, many Service members with mental health needs choose not to seek care. Some previously studied barriers to mental health service utilization include stigma and practical concerns (e.g., finding time to take off work). Service members also report concerns about their careers, being accused of malingering, or burdening their peers by taking time away from their duties to attend to mental health issues. This study, sponsored by the Defense Suicide Prevention Office, and conducted by the Defense Personnel and Security Research Center/Office of People Analytics, used survey and focus group methodology to advance the current understanding of non-help-seeking among active duty Service members.

METHOD

This study employed a mixed-methods design. In Phase I, data from 14,088 active duty Service members who responded to the *February 2016 Status of Forces Survey of Active Duty Members* were used to examine characteristics of Service members who had suicidal ideation or suicide attempt(s), estimate the prevalence of non-help-seeking behaviors among Service members who experienced suicidal ideations or attempt(s), and assess these Service members' beliefs about various barriers to care. Next, in order to gain a better understanding of factors associated with non-help-seeking, analyses were conducted comparing Service members who spoke to someone about their suicidal ideation or suicide attempt(s) with those who did not speak to anyone on individual characteristics, occupational factors, and perceived barriers.

In Phase II, Defense Personnel and Security Research Center researchers conducted focus groups with four types of suicide prevention gatekeepers to elucidate further how barriers arise and how to encourage Service members to seek mental health care and support when needed. Focus groups were conducted with Navy gatekeepers at Naval Station Norfolk, Virginia, and Joint Base Pearl Harbor-Hickam, Hawaii; Air Force gatekeepers at Keesler Air Force Base, Mississippi, and Joint Base Pearl Harbor-Hickam, Hawaii; and Army gatekeepers at Fort Bragg, North Carolina, and Fort Campbell, Kentucky[1]. Gatekeepers included: chaplains and religious program specialists; law enforcement and security managers; medical, mental, and behavioral health personnel; and unit leadership. The focus group questions covered topics related to non-help-seeking, barriers to mental health care, and the positive and negative impact of existing policies. An additional question at the end asked whether the issues discussed differed for the Reserve and

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[1] The Marine Corps was not able to support the focus groups due to competing requirements.

National Guard components. A qualitative data analysis was conducted in order to identify key themes present in gatekeepers' insights. Due to administrative delays, data from the Army installations were not available in time for the main analysis and are therefore not addressed in the main results section of this report. Data from these installations were analyzed separately and can be found in Appendix B, along with Army-specific recommendations. Data and recommendations concerning the Reserve and Guard-specific issues can be found in Appendix F.

FINDINGS

Among active duty Service members who had experienced suicidal ideation or suicide attempt(s) since joining the military, 43.3% reported that they had not sought help for their concerns. Among non-help-seekers, most never consider talking to someone about their suicidal ideation (70.2%), but a small proportion do consider talking to someone (29.8%). Factors associated with non-help-seeking included being an officer and male, not being able to identify suicide risk factors nor knowing how to take appropriate action to help, and being more concerned about the career impact of seeking mental health treatment.

Focus group discussions identified reasons why Service members experience mental health issues, why most Service members do not seek help for these issues, and why some Service members do choose to seek mental health support. Gatekeepers reported that mental health issues experienced by Service members include stress, anger, anxiety, depression, suicidal ideation and suicide, and post-traumatic stress. Participants also highlighted the relationship between behavioral health concerns, such as relationship conflict and financial distress, and mental health issues. Focus group discussions contextualized the *Status of Forces Survey of Active Duty Members* findings and indicated that mental health stigma and career concerns are two barriers that may impede help-seeking behavior. Unfortunately, these barriers often arise from policies that are in place to protect the safety of Service members. Gatekeepers also provided several examples for how to encourage help-seeking among Service members. These suggestions were translated into a set of stakeholder recommendations that are provided in the final section of this report.

CONCLUSION

This study found that a large portion of Service members who have had suicidal ideation or made a suicide attempt have never sought mental health support. Officers, men, and those who had greater concerns about mental health care impacting their career progression were less likely to talk to anyone about suicidal ideation or a suicide attempt. These survey results were consistent with focus group findings from interviews with military suicide prevention gatekeepers. Gatekeepers identified ways in which some current policies in place for the safety of Service members contributed to discouraging help-seeking for mental health concerns. This study found that perceived career concerns are the most significant

barrier to seeking mental health support, and that these concerns are often a result of real career implications of seeking mental health care within the military.

RECOMMENDATIONS

Several recommendations are provided in this report in order to assist the Office of the Undersecretary of Defense for Personnel and Readiness and Service-level stakeholders with combatting this difficult problem: (1) conduct effective suicide prevention training and mental health awareness campaigns targeted towards both military and community gatekeepers, and evaluate their implementation, (2) establish effective programs to encourage Officers to seek help for mental health concerns, and (3) address Service members' concerns that seeking help will have an adverse impact on their careers. Ultimately, this study does not suggest changing the policies impacting career-progression and help-seeking behavior, as many of them have been put into place for reasons such as safety, but instead encourages decision-makers to address the perception of these repercussions.

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INTRODUCTION

Due to growing concerns about the number of suicide deaths among military Service members in recent years, DoD and each branch of the military have implemented policies and procedures aimed at reducing mental health stigma and enhancing access to mental and behavioral health services. These efforts include multidimensional and multidisciplinary approaches to suicide prevention such as training for all military members, mental health treatment referral guidelines, post-suicide intervention, life skills training, and increased staffing of mental health providers (Bagley, Munjas, & Shekelle, 2010; James & Kowalski, 1996; Jones et al., 2001; Knox et al., 2003; McDaniel, Rock, & Grigg, 1990). However, despite these efforts, research indicates that some Service members in need do not utilize available services (Hoge, Castro, Messer, et al., 2004; Milliken, Auchterlonie, & Hoge, 2007; Quartana et al., 2014). While these studies were limited in that they either only included Army personnel, or focused only on deployment-related mental health concerns, the findings underscore the persistence of barriers to help-seeking for mental and behavioral health care. A number of studies have examined these barriers in the general population; however, a smaller number of studies have explored help-seeking and service utilization among military personnel (Bagley, Munjas, & Shekelle, 2010) and even fewer have studied how DoD and Service-level policies and procedures may encourage or hinder service utilization. The overall purpose of this study is to build on previous research by studying non-help-seeking across all DoD active duty military components.

The present study is sponsored by the Defense Suicide Prevention Office (DSPO) and conducted by the Defense Personnel and Security Research Center (PERSEREC), a division of the Office of People Analytics (OPA). Using data from the *February 2016 Status of Forces Survey of Active Duty Members* and focus group interviews with military gatekeepers, this study (1) identifies the characteristics and reasons why Service members need mental-health support, (2) estimates the prevalence of non-help-seeking among active duty Service members, (3) identifies the barriers to seeking mental health care, and (4) identifies the factors that promote help-seeking behavior.

BACKGROUND

Numerous policies within DoD address suicide prevention and mental health care among Service members (see Appendix A). These policies establish suicide prevention and stigma reduction efforts within DoD and require that the Services foster a command climate that encourages help-seeking, builds resilience, increases awareness of mental and behavioral health, reduces stigma, and protects the privacy of personnel who seek or receive mental health treatment. Despite these efforts, prior studies have found that around half of Soldiers who could benefit from mental health services do not seek them (Hoge et al., 2004, Milliken, Auchterlonie, & Hoge, 2007; Quartana et al., 2014). These studies did not estimate the prevalence

of non-help-seeking, particularly for suicide-related concerns, across the DoD Service components. Additionally, these studies did not examine the reasons behind non-help-seeking behavior, or what the literature terms as "barriers."

Barriers to Mental Health Service Utilization

Previous research has identified a variety of barriers to mental health service utilization including: stigma, lack of a perceived need for care, mistrust of health care services, and practical factors such as time restraints. The Behavioral Model of Healthcare Utilization (Andersen, Davidson & Baumeister, 2013) provides a theoretical framework of factors related to utilization of mental health care. Figure 1 shows a conceptual adaptation of this model to the military population. The model outlines individual, occupational, and barrier factors that may be associated with help-seeking behaviors, such as engaging in mental health care or seeking support from family and peers. Individual factors are characteristics of the Service member that may predispose him or her to service utilization, including the individual's age, gender, rank, level of reported resiliency, and their financial condition. Occupational factors include operational tempo, level of stress, deployment exposure, and satisfaction with the military. Barrier factors, such as stigma, are examined more closely in the remaining portion of this section.
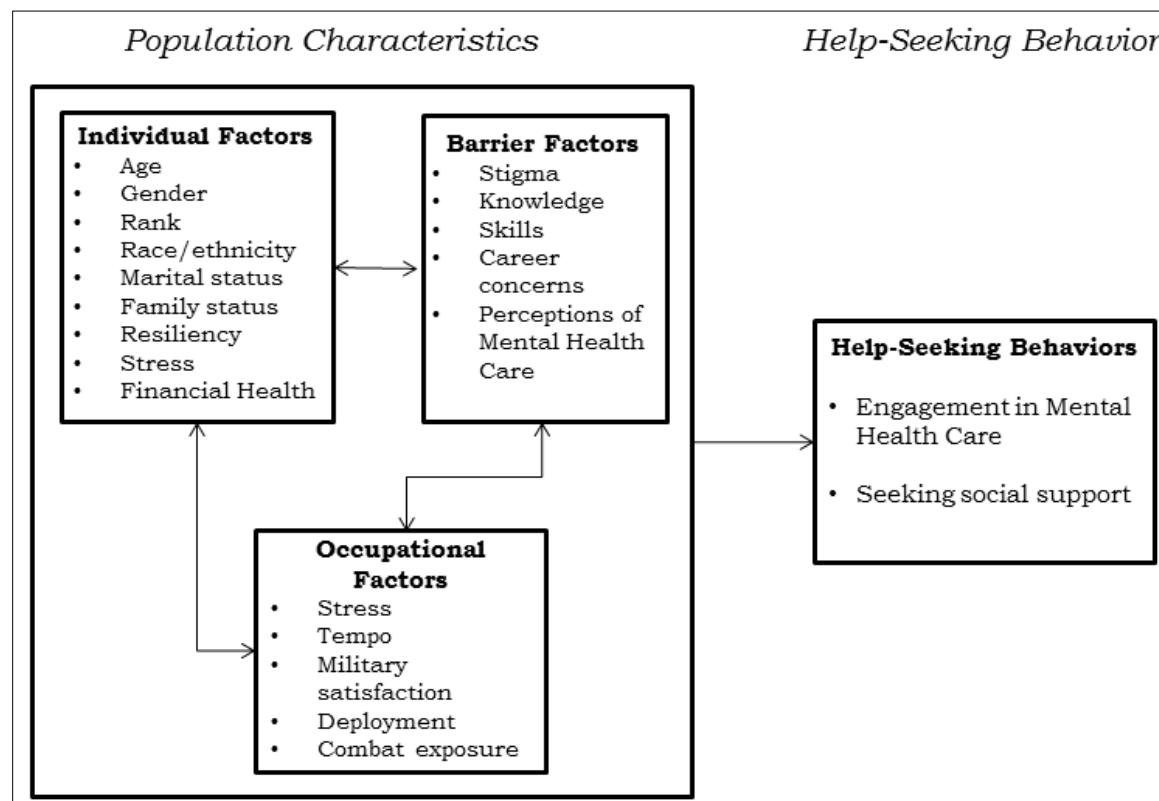
Figure 1 Conceptual Framework of Factors Associated with Mental Health Help-Seeking Behavior

One of the most cited barriers to service utilization in the general population is the stigma associated with mental health concerns and treatment (Hom, Stanley, & Joiner, 2015). People who experience mental and behavioral health symptoms may experience both public stigma and self-stigma (Corrigan & Watson, 2002). Public stigma consists of negative perceptions held by others about mental health service utilization and about the people experiencing mental health challenges, and can lead to stereotyping, prejudice, and discrimination. An example of public stigma related to mental illness is the belief that the individual is responsible for their illness because they have a weak character (Corrigan & Watson, 2002). Self-stigma consists of the individual's personal beliefs about mental health issues and service utilization; if an individual has internalized negative perceptions of mental health distress and treatment, it may lead to diminished self-esteem and create a barrier to seeking needed services (Corrigan, 2004; Corrigan & Watson, 2002; Pattyn, Verhaeghe, Sercu, & Bracke, 2014; Pietrzak, Johnson, Goldstein, Malley, & Southwick, 2009).

Concerns about stigmatization do not, however, fully account for whether or not an individual will seek mental and behavioral health services (e.g., Golberstein, Eisenberg, & Gollust, 2008; Jones, Twardzickim, Fertout, Jackson, & Greenberg, 2013). Practical barriers and structural factors have also been identified as a barrier to care. Practical barriers include geographical location, availability of resources, access to transportation, time constraints, financial limitations, and the general inconvenience of seeking out professional help (Hom et al., 2015; Mojtabai et al., 2011). These factors may present as non-trivial obstacles that decrease the likelihood of mental health service utilization.

In addition to the aforementioned barriers, there are certain mental health service utilization barriers that are more unique to military populations, including military beliefs and culture, concerns about leadership and chain of command, and concerns that service utilization will have a negative impact on career advancement or lead to the loss of security clearance (Vogt, 2011; Zinzow, Britt, Pury, Raymond, McFadden, & Burnette, 2013). Further, previous research suggests that the emphasis on values such as self-reliance and mental toughness within military culture can also hinder service utilization (Bryan, Jennings, Jobes & Bradley, 2012; Hom et al., 2015).

Military culture also values self-sacrifice, or enduring hardship for the greater good, which may exacerbate some of the identified barriers (Bryan et al., 2012). Individuals are encouraged to deny their natural instinct for self-preservation and instead to place their own well-being second to their mission. Therefore, mental health concerns may be viewed as a sign of weakness and a liability to others. Hoge at al. (2004) found that a majority of Service members reported being more concerned about how they would be viewed by their unit leader and fellow unit members for seeking out mental health services, than about logistical help-seeking barriers. Additionally, among Service members who met screening criteria for a mental health disorder, the majority reported concerns of being perceived as weak,

a "slacker," or of lying about their need for mental health care (i.e., malingering) (Hoge et al. 2004; Zinzow et al., 2013). As a result of this perception, Service members may not trust their leadership enough to discuss mental health concerns and may believe that the information that they share will not be kept confidential. Service members may also be reluctant to seek help because their leaders may not understand what treatment entails and may express disapproval of the amount of time needed away from work. Career concerns include beliefs that treatment seeking may hinder advancement or lead to discharge from the military (Zinzow et al., 2013).

Suicide Prevention Gatekeepers

Suicide prevention gatekeepers have an excellent vantage point for understanding the non-help-seeking population within the military. Given their role, they are able to observe how mental health care barriers in the military develop, and which strategies are most effective in compelling Service members to seek help. By definition, gatekeepers are individuals who have primary contact with those at risk for mental health concerns, including suicide, and are well positioned to encourage and facilitate help-seeking behavior (Isaac et al., 2009; Mann, et al., 2005). Chaplains; law enforcement and security personnel; military and family life counselors; medical, mental, and behavioral health providers; and unit leaders are some of the suicide prevention gatekeepers in the military. Previous research indicates that military gatekeepers have significant influence on both military culture and mental health care utilization (Britt, Wright, & Moore, 2012). For example, leaders who are in direct contact with Service members are more likely to influence the degree to which mental health service utilization is stigmatized (Clark-Hitt, Smith, & Broderick, 2012). DoD and its military installations issue policies that outline the duties of gatekeepers and military leaders who are in a position to provide support to Service members in need of assistance.

CURRENT STUDY

The main goal of this study is to advance the policy and research stakeholders' current understanding of non-help-seeking behavior for mental health concerns in the U.S. military, particularly for suicidal ideation and suicide attempt(s). In order to meet this objective, the current study focuses on answering the following research questions:

(1)   What are the reasons why Service members experience mental and behavioral health concerns?

(2)   What are the characteristics of Service members with a history of suicidal ideation or suicide attempt(s)?

(3)   What is the prevalence of non-help-seekers within the active components of the U.S. military?

(4)   What are the factors that contribute to non-help-seeking behavior?

(5)   What are the factors that promote help-seeking behavior?

The current study, conducted in two phases, employed a mixed-methods design to address the earlier questions from the perspective of: (a) Service members who may be in need of mental health support and (b) military suicide prevention gatekeepers who work with these Service members. Phase I consisted of analysis of data from 14,088 active duty Service members who responded to the *February 2016 Status of Forces Survey of Active Duty Members* (*SOFS-A*). Results from these quantitative data analyses addressed all of the earlier research questions from the perspective of Service members who may be in need of mental health support. Phase II consisted of a qualitative data analysis of 16 focus group interviews with Air Force and Navy gatekeepers (focus groups were also conducted at two Army installations; however, due to administrative delays, these data were not available in time for the main analysis, and are therefore not addressed in the body of this report. The findings from these installations were analyzed at later time and can be found in Appendix B). Phase II focused on exploring the research questions from the perspective of military suicide prevention gatekeepers who work closely with Service members.

This report will first review the methods and findings from the SOFS-A, next outline the methods and findings from the focus group interviews, and finally provide actionable recommendations for decision makers and recommendations for future research.

PHASE I: STATUS OF FORCES SURVEY OF ACTIVE DUTY MEMBERS

METHOD

This section outlines the process used to analyze data from the *Status of Forces Survey of Active Duty Members* in order to: (1) examine characteristics of Service members who have a history of suicidal ideation or suicide attempt(s), (2) estimate the prevalence of non-help-seeking behavior among Service members with a history of suicidal ideation or suicide attempt(s), (3) explore individual, occupational, and barrier factors associated with being a non-help-seeker compared to a help-seeker, and (4) examine the sources of preferred support and other barriers reported by Service members who have a history of suicidal ideation or suicide attempt.

Instrument

SOFS-A is a web-based survey administered annually to a non-proportional stratified random sample of active duty Service members. The goal of the survey is to assess the attitudes and opinions of active duty members on personnel issues that impact satisfaction, retention, and force readiness, as well as attitudes and opinions on key special interest topics, such as suicide prevention (Office of People Analytics, 2017). The *February 2016 SOFS-A* included, for the first time, a module on suicide and help-seeking behavior. The survey items included in this module were developed and written jointly by DSPO and OPA; see Appendix C for survey items).

Items Related to Barriers to Mental Health Care Utilization

Service members were asked to rate the degree to which they believed that career progression, loss of privacy and confidentiality, fear of being perceived as "broken," lack of confidence in the available resources, lack of confidence in the chain of command, and not knowing who to turn to were reasons individuals who need mental health care would not seek help. In addition, Service members were asked to rate how well they agreed that they had the necessary knowledge of suicide risk factors and behaviors to determine whether a person is in need of help. Service members also rated the degree to which they have the skills and abilities to help a person in need. All ratings were based on a five point Likert-type scale with responses ranging from 1 ("Strongly disagree") to 5 ("Strongly agree").

Assessment of Suicidal Ideation and Suicide Attempt

One survey question assessed whether Service members had ever experienced thoughts of suicide (i.e., suicidal ideation). A follow-up question established whether this suicidal ideation was experienced during military service.

Service members who indicated that they had experienced suicidal ideation were asked whether they had ever made a suicide attempt (i.e., purposely hurt themselves with at least some intention to die). One follow-up question established whether these Service members made the suicide attempt during military service.

Service members who indicated having suicidal ideation or a suicide attempt since joining the military (or during or following a deployment or other mission) were asked whether they had talked to anyone about their suicidal ideation or suicide attempt. Three response options were available: "Yes," "No, but I considered talking to someone," and "No, and I never considered talking to anyone." Based on these responses, Service members were divided into three groups: (1) help-seekers, (2) non-help-seekers (considered), and (3) non-help-seekers (never considered).

In a subsequent question, help-seekers were asked who they spoke with about their suicidal ideation or suicide attempt. Response options included family members (e.g., spouse or significant other, parents, or siblings), friends, fellow Service members, health care providers and counselors, and suicide helplines. Non-help-seekers (considered) reported to whom they *would talk* (with the same response options as previously mentioned). Non-help-seekers (never considered) were asked to identify the reasons they did not to talk to anyone. Possible response options fell into the categories of practical barriers, stigma, and previous negative experiences with care providers. See Figure 2 for a flowchart of survey item skip logic.

PHASE I: STATUS OF FORCES SURVEY OF ACTIVE DUTY MEMBERS
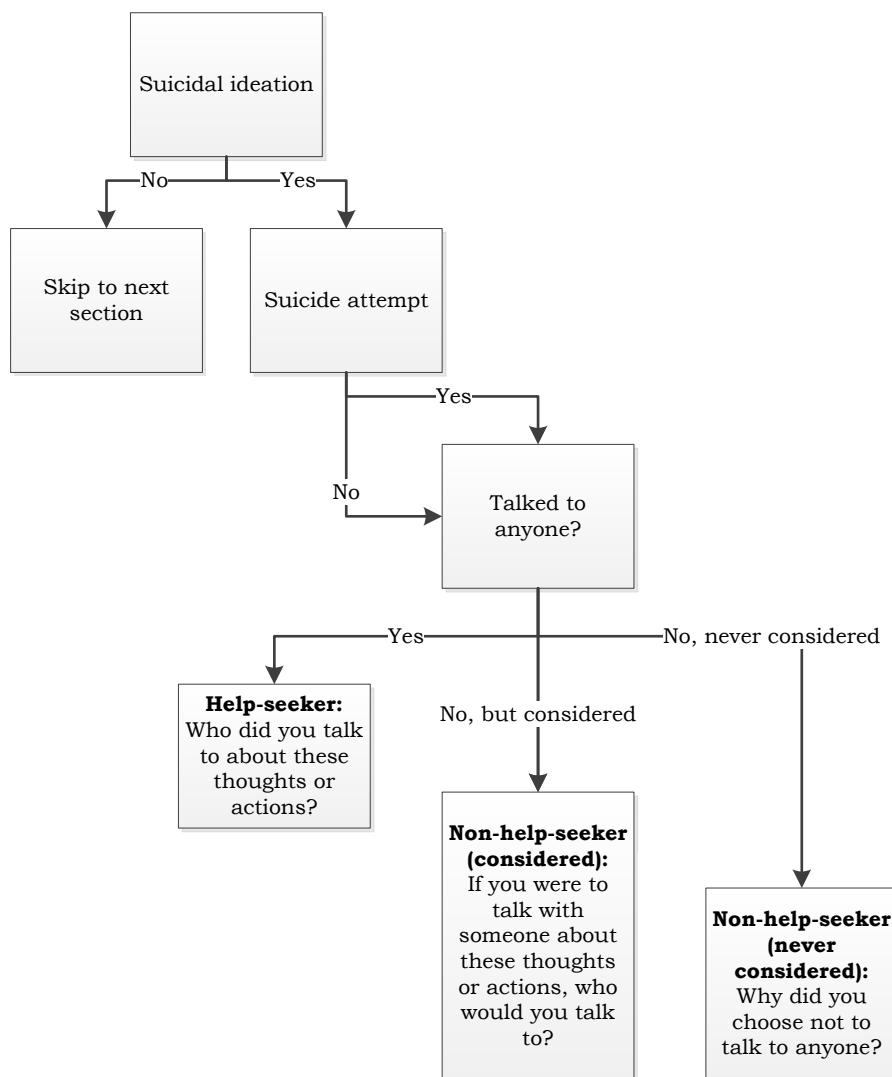
Figure 2 Flowchart of Survey Items Related to Suicidal Ideation, Suicide Attempt(s), and Help-seeking Behavior

Individual Factors and Occupational/Military Factors

Socio-demographic information such as age, sex, rank, race-ethnicity, highest level of education, Service branch, and years of service, was obtained from Defense Manpower Data Center administrative files. Other individual factors were reported by respondents on the survey. These individual factors were marital status, family status (i.e., number of dependents), number of deployments in the past 5 years, resiliency (Brief Resilience Scale; Smith et al., 2008), and financial health (i.e., perceived financial security). Occupational and military-specific factors assessed on the survey were combat zone exposure, combat operation exposure, satisfaction with the military, overall stress (adapted Perceived Stress Scale; Cohen, Kamarck & Mermelstein, 1983), and whether the Service member ever made a Permanent Change of Station (PCS).

Participants

A total of 66,280 active duty Service members were sampled for the *February 2016 SOFS-A*. Between January and April 2016, 14,088 active duty Service members completed the survey, resulting in a 23% weighted response rate (for survey sample design, see OPA, 2017). Demographic information for the unweighted and weighted samples is presented in Table 1.

Data Analysis

All analyses for this phase were conducted using SAS software, Version 9.3 (SAS Institute Inc., Cary, NC, USA) in order to correctly account for the complex sample design and apply the survey weighting scheme.

Sample Weighting

Ideally, a survey sample exactly mirrors the population from which it is drawn on all variables of interest, such as demographics. However, this rarely occurs in practice. Therefore, in order to draw conclusions from survey data that are applicable to the entire population of interest (in this case, the active duty military population), sample weights are used to align the sample to the population. In this process, an adjusted weight is assigned to each survey respondent.

Using an industry standard process, OPA developed the survey weights to account for survey selection probability, non-response, and known population values (for information on weighting process, see OPA, 2017). Both unweighted (raw) data and weighted (adjusted) data are presented in this report. SAS 9.3 is one statistical program that can correctly model parameter estimates for statistical significance testing with weighted data. In other words, the statistical significance testing is not influenced by the highly inflated weighted sample size.

Descriptive Analysis

Descriptive analyses were completed for the weighted and unweighted study sample (latter not shown, unless indicated) in order to assess: (1) overall demographic characteristics, (2) characteristics of Service members who experienced suicidal ideation, (3) characteristics of Service members who indicated that they had reported a suicide attempt since joining the military, and (4) the extent to which Service members experienced barriers to mental health care. Among respondents who reported suicidal ideation or suicide attempt(s) since joining the military, descriptive statistics were also calculated in order to estimate the prevalence of non-help-seeking and barriers to mental health care. Group comparisons for categorical data were conducted using a series of Rao-Scott chi-square tests (Rao & Scott, 1984). Group differences for continuous variables were assessed using Analysis of Variance.

Multinomial Logistic Regression

Bivariate analyses were conducted using Rao-Scott chi-square tests or Analysis of Variance to compare help-seekers, non-help-seekers (considered), and non-help-seekers (never considered) by individual, barrier, and occupational factors. These factors were selected based on the conceptual framework of help-seeking behavior shown in Figure 1. Factors that were associated with help-seeking behavior in the bivariate analyses were included in the regression analysis. Multinomial logistic regression was used to calculate the adjusted odds ratios (ORs) with 95-percent confidence intervals (CIs) for non-help-seeking (considered) and non-help-seeking (never considered) compared to help-seeking for suicidal ideation or suicide attempt during military service. The multinomial logistic regression is used when the outcome of interest, in this case help-seeking behavior, is a categorical variable with more than two levels (i.e., help-seeking, non-help-seeking (considered), non-help-seeking (never considered).

RESULTS

Weighted and Unweighted Sample Demographics

Table 1 displays weighted and unweighted sample demographic information. Both the weighted and unweighted demographic information is presented to demonstrate how the sample weights accounted for sample selection probability, non-response, and population characteristics. The sample of survey respondents were 30.2% Army, 21.2% Navy, 17.7% Marine Corps, and 30.8% Air Force personnel. The unweighted sample was predominantly male (81.5%), between 25 and 44 years of age (71.4%), with at least some college experience (89.0%), enlisted personnel (52.3%), married (67.7%), with dependents (55.1%), white (60.7%), and had deployed at least once in the past 5 years (55.9%). Nearly half of respondents had 10 or more years of military service (49.4%).

The weighted sample represented 37.3% Army, 25.0% Navy, 14.0% Marine Corps, and 23.8% Air Force active duty personnel. Overall, the weighted sample was predominantly male (83.6%), between 25 and 44 years of age (59.2%), with at least some college experience (76.9%), enlisted (81.9%), married (58.2%), and white (58%). One-third of the weighted sample (33.2%) had 10 years or more of military service, 51.3% had deployed at least once in the past 5 years, and nearly half had dependents (44.0%).

PHASE I: STATUS OF FORCES SURVEY OF ACTIVE DUTY MEMBERS

Table 1
Unweighted and Weighted Demographic Characteristics of the Active Duty Sample

	Unweighted %	Weighted %
Total	100.0	100.0
Army	30.2	37.3
Navy	21.2	25.0
Marine Corps	17.7	14.0
Air Force	30.8	23.8
Sex		
Male	81.5	83.6
Female	18.5	16.4
Age (years)		
17 – 24	19.4	36.7
25 – 34	41.4	40.6
35-44	30.0	18.6
>44	9.3	4.2
Military Pay Grade		
Enlisted	52.3	81.9
Officer	47.8	18.1
Race/Ethnicity		
White	60.7	58.0
Total Minority	39.3	42.0
Level of Education		
No college	11.0	23.1
Some college	35.8	50.1
4-year Degree	27.1	16.3
Graduate/Professional Degree	26.2	10.5
Marital Status		
Married	67.7	58.2
Never married	24.2	35.0
Separated, Divorced, or Widowed	8.2	6.8
Family Status		
Dependents	55.1	44.0
No dependents	45.0	56.0
Years of Service		
Less than 3 years	14.6	25.0
3 years to less than 6 years	20.1	25.2
6 year to less than 10 years	15.9	16.6
10 or more years	49.4	33.2
Number of Deployments in Past 5 Years		
Never deployed	44.1	49.7

	Unweighted %	Weighted %
1 time	30.0	27.6
2 times	16.6	14.7
3 times	5.7	4.7
4 times or more	3.6	3.4

Characteristics of Service Members with a History of Suicidal Ideation

Table 2 displays the characteristics of the weighted sample of active duty Service members who reported on the survey a history of suicidal ideation compared to those who did not have a history of suicidal ideation. Among active duty Service members, 14.5% reported a history of suicidal ideation. Those with a history of suicidal ideation differed significantly from those without a history of suicidal ideation on sex ($\chi^2[1]$ = 12.49, p < .001), level of education ($\chi^2[1.84]$ = 10.85, p < .01), marital status ($\chi^2[1.83]$ = 8.14, p < .05), military pay grade ($\chi^2[1]$ = 30.99, p < .001), branch of Service ($\chi^2[2.66]$ = 29.98, p < .001), overall satisfaction with the military lifestyle ($\chi^2[3.50]$ = 83.58, p < .001), and overall stress ($F[1]$ = 424.87, p < .001).

Female personnel were more likely to report suicidal ideation on the survey than were male personnel. Females made up 21.1% of the suicidal ideation group, but only 15.6% of the no suicidal ideation group.

Those who did not report suicidal ideation had somewhat more education than did those who reported suicidal ideation. Within the suicidal ideation group, 26.4% did not have a college degree, 51.9% had some college, 14.0% had a 4-year degree, and 7.7% had a graduate or professional degree. Within the group who reported no suicidal ideation, 22.3% had no college degree, 49.8% had some college, 16.8% had a 4-year degree, and 11.1% had a graduate or professional degree.

The group that reported suicidal ideation had a slightly lower proportion of married Service members (55.0%) than did the group that did not report suicidal ideation (59.1%). Service members that were divorced, separated, or widowed made up 9.1% of the group with suicidal ideation compared to just 6.4% of the group with no reported suicidal ideation.

Enlisted Service members were more likely than officers to report suicidal ideation. Enlisted Service members comprised 86.1% of the group that reported suicidal ideation compared to 81.0% of the group that reported no suicidal ideation.

Air Force personnel were less likely than those in the Army, Navy, or Marine Corps to report suicidal ideation. Air Force personnel comprised 25.3% of the group that did not report suicidal ideation and only 15.9% of the group that did report suicidal ideation.

Service members who reported suicidal ideation tended to be less satisfied with the military (17.6% dissatisfied, 10.9% very dissatisfied) compared to those who did not report suicidal ideation (12.6% dissatisfied, 3.2% very dissatisfied), and reported greater overall perceived stress (suicidal ideation group M=3.24, SD=0.98; no suicidal ideation M=2.43, SD=0.92).

PHASE I: STATUS OF FORCES SURVEY OF ACTIVE DUTY MEMBERS

Table 2
Characteristics of Service Members with a History of Suicidal Ideation

	Suicidal Ideation %	No Suicidal Ideation %	X^2/F
Total	14.5	85.5	
Age			
17-24	38.1	36.0	1.48
25-34	38.9	41.1	
35-44	18.7	18.8	
> 44	4.3	4.2	
Sex			
Male	78.9	84.4	12.49***
Female	21.1	15.6	
Race/Ethnicity			
White	60.4	57.7	1.90
Total minority	39.6	42.3	
Level of Education			
No college	26.4	22.3	10.85**
Some college	51.9	49.8	
4-year Degree	14.0	16.8	
Graduate/Professional Degree	7.7	11.1	
Marital Status			
Married	55.0	59.1	8.14*
Never married	36.0	34.4	
Divorced/Separated/Widowed	9.1	6.4	
Family Status			
Dependents	42.5	44.6	1.28
No dependents	57.5	55.4	
Military Pay Grade			
Enlisted	86.1	81.0	30.99***
Officer	13.9	19.0	
Branch of Service			
Army	39.8	36.8	29.98***
Navy	28.8	24.1	
Marine Corps	15.5	13.8	
Air Force	15.9	25.3	
Number of Deployments in Past 5 Years			
None	47.2	49.8	3.12
1	28.0	27.6	
2	16.5	14.6	
3	4.6	4.7	

	Suicidal Ideation %	No Suicidal Ideation %	X^2/F
4 or more	3.7	3.3	
Combat Zone Exposure			
Yes	73.0	73.1	0.002
No	27.0	26.9	
Combat Operation Exposure			
Yes	39.5	38.2	0.31
No	60.5	61.8	
Length of Service (Years)			
Less than 3	19.8	25.4	10.37
3 to less than 6	28.0	24.8	
6 to less than 10	18.4	16.4	
10 or more	33.9	33.3	
Overall Satisfaction with Military Way of Life			
Very satisfied	9.5	15.1	83.58***
Satisfied	40.1	49.9	
Neither satisfied nor dissatisfied	21.9	19.3	
Dissatisfied	17.6	12.6	
Very dissatisfied	10.9	3.2	
Perceived Stress Scale, M (SD)	3.24 (0.98)	2.43 (0.92)	424.87***
Brief Resilience Scale, M (SD)	3.73 (0.56)	3.71 (0.57)	0.72

Note. Perceived Stress Scale is a cumulative score with higher scores indicating higher perceived stress. The Brief Resilience Scale is a cumulative score with higher scores indicating higher resilience.

*p < .05, **p < .01, and ***p < .001

Characteristics of Service Members with a History of Suicide Attempt

Among Service members who indicated ever having suicidal ideation, 14.6% also reported having made a suicide attempt. Table 3 displays the characteristics of active duty Service members who did and did not report a suicide attempt. The suicide attempt and no suicide attempt groups differed significantly as a function of sex ($\chi^2[1]$ = 6.15, *p* < .05), military pay grade ($\chi^2[1]$ = 17.96, *p* < .001), and perceived stress (*F*[1] = 5.91, *p* < .05).

Results indicate that female Service members were more likely than male Service members to report a suicide attempt. Female Service members comprised 30.1% of the group with a reported suicide attempt but only 19.6% of the group without a reported suicide attempt.

Officers were less likely than enlisted Service members to report a suicide attempt. Officers comprised 15.1% of the group without a reported suicide attempt but only 7.1% of the group with a reported suicide attempt.

Further, compared to the group that did not report a suicide attempt, the group that did report a suicide attempt scored moderately higher on Cohen's Perceived Stress Scale (suicide attempt, M = 3.41, SD = 0.07; no suicide attempt, M = 3.21, SD = 0.04), indicating that Service members who reported a suicide attempt also reported experiencing a higher stress level than those who did not report a suicide attempt.

Table 3
Characteristics of Service Members with a History of a Suicide Attempt

	Suicide Attempt %	No Suicide Attempt %	X^2/F
Total	14.6	85.4	
Age			
17-24	39.5	37.8	2.21
25-34	42.5	38.4	
35-44	16.0	19.1	
> 44	1.9	4.7	
Sex			
Male	69.9	80.4	6.15*
Female	30.1	19.6	
Race/ethnicity			
White	56.7	61.1	0.69
Non-white	43.3	38.9	
Level of Education			
No college	31.6	25.4	2.93
Some college	53.8	51.7	
4-year Degree	10.2	14.6	
Graduate/Professional Degree	4.4	8.3	
Marital status			
Married	51.0	55.6	1.50
Never married	36.4	35.8	
Divorced/Separated/Widowed	12.5	8.6	
Dependents			
Yes	44.4	42.1	0.18
No	55.6	57.9	
Military pay grade			
Enlisted	92.9	84.9	17.96***
Officer	7.1	15.1	
Branch of Service			
Army	44.9	39.1	1.34
Navy	27.2	29.0	
Marine Corps	14.8	15.6	
Air Force	13.1	16.3	
Number of deployments in past 5 years			
None	49.0	47.0	1.39
1	23.5	28.7	
2	19.1	16.0	
3	4.5	4.7	

	Suicide Attempt %	No Suicide Attempt %	X^2/F
4 or more	3.9	3.7	
Combat zone exposure			
Yes	67.9	73.9	0.80
No	32.1	26.1	
Combat operation exposure			
Yes	36.1	40.2	0.55
No	63.9	59.8	
Length of Service (years)			
Less than 3	24.6	19.0	4.09
3 to less than 6	22.6	28.7	
6 to less than 10	25.3	17.3	
10 or more	27.6	35.0	
Overall satisfaction with military way of life			
Very satisfied	8.0	9.8	5.94
Satisfied	50.9	38.4	
Neither satisfied nor dissatisfied	16.6	22.7	
Dissatisfied	14.8	17.9	
Very dissatisfied	9.7	11.2	
Cohen's Perceived Stress Scale, M (SD)	3.41 (0.07)	3.21 (0.04)	5.91*
Brief Resilience Scale, M (SD)	3.73 (0.06)	3.73 (0.02)	0.00

Note. Perceived Stress Scale is a cumulative score with higher scores indicating higher perceived stress. The Brief Resilience Scale is a cumulative score with higher scores indicating higher resilience.
*p < .05 and ***p < .001

Prevalence of Non-Help-Seeking Behavior

Table 4 presents the frequencies of active duty personnel who: (a) sought help ("help-seeker"), (b) consider talking to someone ("non-help-seeker [considered]"), and (c) never considered talking to someone ("non-help-seeker [never considered]"), by military branch. Overall, among Service members who reported suicidal ideation or a suicide attempt since joining the military, 56.7% were help-seekers, 12.9% were non-help-seekers who considered talking to someone, and 30.4% were non-help-seekers who never considered talking to anyone. Rates of help-seeking did not differ statistically by Service (χ^2[5.31] = 5.79, p = .36, and 60.1% were in the Army, 60.0% in the Air Force, 52.5% in the Navy, and 51.8% in the Marine Corps.

Table 4
Percent of Help-Seekers, Non-Help-Seekers (Considered), and Non-Help-Seekers (Never Considered) among Service Members with Suicidal Ideation or Suicide Attempt

	Total %	Army %	Navy %	Marine Corps %	Air Force %
Help-seeker	56.7	60.1	52.5	51.8	60.0
Non-help-seeker	43.3	39.9	47.5	48.2	40.0
Considered	12.9	13.1	14.4	12.1	10.5
Never considered	30.4	26.8	33.1	36.1	29.4

Barriers to Help-Seeking

Figure 3 shows the percentage of Service members in the three help-seeking categories who agreed (or strongly agreed) that the listed barriers are reasons that individuals who need mental health care would not seek help. The most commonly endorsed barriers to help-seeking were: negative impact to career or progress, loss of privacy or confidentiality, and fear of being perceived as "broken" by chain of command or peers. Across these three barriers, non-help-seekers (considered) were somewhat more likely than help-seekers and non-help-seekers (never considered) to indicate that these were the reasons why individuals do not seek help for their mental health concerns. Over 80% of non-help-seekers (considered) strongly agreed or agreed that negative career impact and the fear of being perceived as "broken" were barriers to help seeking.

Review of the write-in responses to the open-ended "Other" item did not produce new barriers unaddressed by the close-ended response options. Most comments were related to career concerns, self-pride, not wanting to be viewed as "broken" by chain of command, and concerns about loss of privacy or confidentiality.
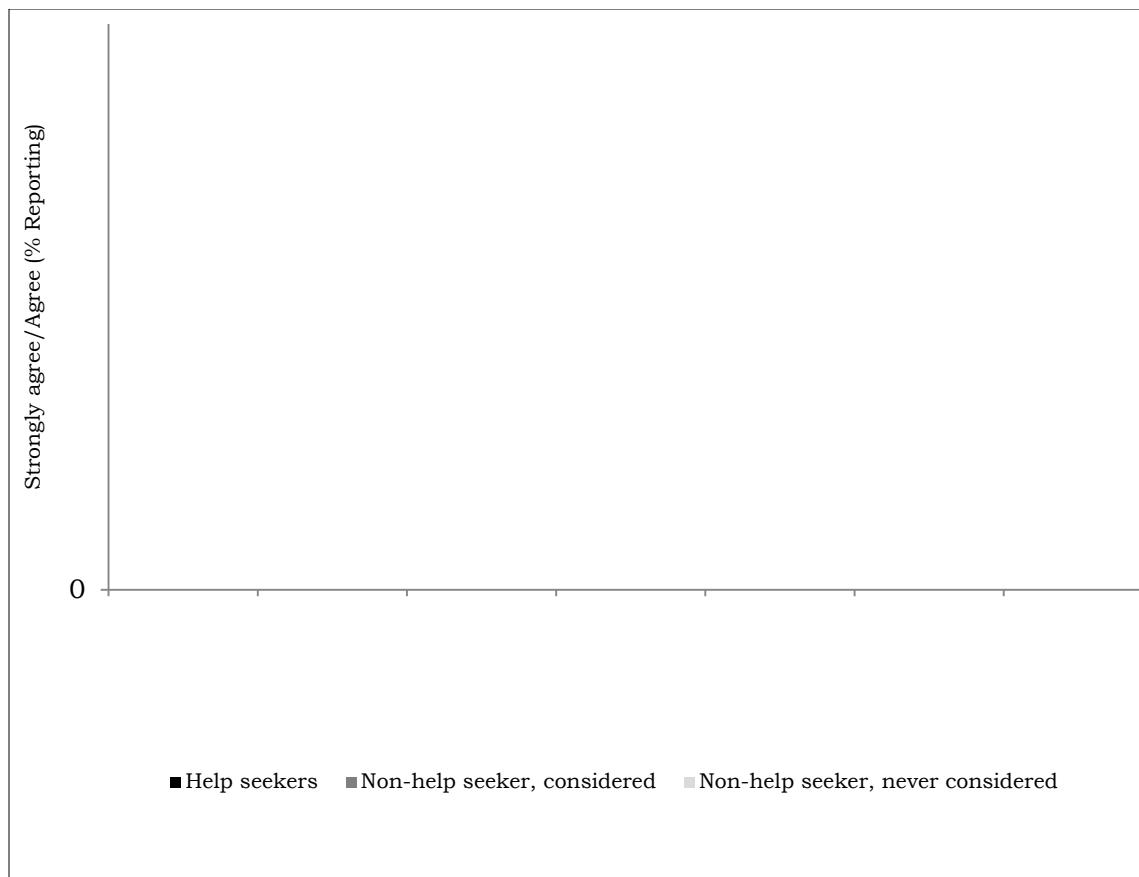
Figure 3 Proportion of Service Members who Agree or Strongly Agree that the Barrier is a Reason why Individuals Avoid Mental Health Care

Factors Associated with Help-seeking Behavior

Bivariate analyses were conducted in order to examine the associations between individual, occupational, and barrier factors and help-seeking. As shown in Table 5, results indicate that six variables were significantly associated with non-help-seeking for suicidal ideation or suicide attempt(s). These six factors were sex, rank/pay grade, knowledge of suicide prevention, skills in addressing suicide, negative career impact, and not knowing who to turn to for mental health care.

Table 5
Characteristics of Service Members by Help-seeking Behavior

	Help-Seeker	Non-Help-Seeker		
	%	Considered %	Never Considered %	X^2/F
Total	56.70	12.90	30.40	
Individual Factors				
Age, *M*(*SD*)	28.99 (0.43)	28.55 (0.77)	30.22 (0.50)	2.39
Sex				
Male	77.37	74.72	85.17	6.90*
Female	22.63	25.28	14.83	
Rank				
Enlisted	88.08	84.79	83.07	8.40*
Officer	11.92	15.21	16.93	
Race/Ethnicity				
White	60.91	69.26	60.72	2.60
Total Minority	39.09	30.74	39.28	
Marital Status				
Married	41.40	51.85	39.44	3.85
Not married	58.60	48.15	60.56	
Dependents				
Have dependents	54.93	60.28	52.64	1.56
No dependents	45.07	39.72	47.36	
Brief Resilience Scale, *M*(*SD*)	3.69 (0.04)	3.80 (0.05)	3.77 (0.04)	2.39
Financial Health, *M*(*SD*)	3.63 (0.06)	3.88 (0.09)	3.69 (0.07)	2.91
Reported Barriers to Treatment Seeking				
Knowledge of suicide Prevention, *M*(*SD*)	4.22 (0.05)	3.88 (0.13)	3.88 (0.06)	12.31*
Skills in addressing suicide, *M*(*SD*)	4.27 (0.04)	4.00 (0.14)	3.91 (0.05)	14.22*
Negative Career Impact, *M*(*SD*)	3.73 (0.07)	4.06 (0.08)	3.93 (0.07)	5.20*
Loss of Privacy or Confidentiality, *M*(*SD*)	3.66 (0.07)	3.84 (0.10)	3.77 (0.08)	1.16
Fear of "broken" perception, *M*(*SD*)	3.86 (0.08)	4.11 (0.08)	3.97 (0.08)	2.53
Lack of confidence in Resources, *M*(*SD*)	3.43 (0.08)	3.50 (0.13)	3.53 (0.08)	0.43
Lack of confidence in command, *M*(*SD*)	3.64 (0.08)	3.75 (0.11)	3.62 (0.09)	0.41
Not knowing who to turn to, *M*(*SD*)	3.13 (0.07)	3.42 (0.10)	3.10 (0.09)	3.52*

	Help-Seeker	Non-Help-Seeker		
	%	Considered %	Never Considered %	X^2/F
Other barriers, M(SD)	3.09 (0.06)	3.17 (0.08)	3.05 (0.07)	0.65
Occupational and Situational Factors				
Overall Stress, M(SD)	3.33 (0.06)	3.30 (0.10)	3.37 (0.05)	0.33
Military Satisfaction, M(SD)	3.22 (0.07)	2.99 (0.12)	3.06 (0.08)	1.71
Number of Deployments, M(SD)	1.81 (0.10)	1.73 (0.14)	1.86 (0.11)	0.28
Ever made a Permanent Change of Station				
Yes	25.84	31.11	26.86	0.78
No	74.16	68.89	73.14	
Combat Zone Experience				
Yes	24.50	22.37	27.54	0.65
No	75.50	77.63	72.46	
Combat Operations Experience				
Yes	43.33	35.51	59.36	1.17
No	56.67	64.49	40.64	

Note. *$p < 0.05$

The six variables significantly associated with help-seeking were subsequently entered into a multivariate logistic regression. Table 6 displays the odds ratios comparing non-help-seekers (considered) or non-help-seekers (never considered) with help-seekers (i.e., the reference group). All factors except for "not knowing who to turn to" remained significantly associated with help-seeking in this model. Being an officer was associated with a 48% increase in odds of being a non-help-seeker (never considered) compared to being an enlisted Service member. Male Service members had a 67% increase in odds of being a non-help-seeker (never considered) compared to female Service members. Knowledge and skills were highly correlated factors; in order to account for collinearity, these two items were averaged to create a composite score of knowledge and skills of suicide prevention. A one-unit decrease in perceived knowledge and skills of suicide prevention was associated with a 53% increase in the odds of a Service member being in the non-help-seeker (considered) group and was associated with a 23% increase in the odds of a Service member being in the non-help-seeker (never considered) group. Compared to help-seekers, an increase in concerns about the career impact of mental health issues was associated with a 23% increase in the odds of being in the non-help-seeker (considered) group. Non-help-seekers (never considered) also indicated that they had greater career concerns about talking to someone about their suicidal ideation or suicide attempt(s) compared to help-seekers, but this result was marginally significant ($p = .05$, $OR = 1.18$, 95% CI [1.00, 1.39]).

Table 6
Odds Ratios of Factors Associated with Non-Help-Seeking

Factor	Type of Help-Seeker					
	Non-Help-Seeker (Considered)			Non-Help-Seeker (Never Considered)		
	Estimate	OR	95% CI	Estimate	OR	95% CI
Rank						
Enlisted	--	--	--	--	--	--
Officer	0.29	1.33	[0.90, 1.96]	**0.39**	**1.48**	**[1.11, 1.97]**
Sex						
Female	--	--	--	--	--	--
Male	-0.08	0.92	[0.52, 1.64]	**0.51**	**1.67**	**[1.11, 2.51]**
Knowledge & Skills [a]	**0.43**	**1.53**	**[1.08, 2.18]**	**0.54**	**1.72**	**[1.39, 2.13]**
Career Impact Concern	**0.21**	**1.23**	**[1.01, 1.51]**	0.16	1.18	[1.00, 1.39]
Not knowing who to turn to	0.09	1.09	[0.92, 1.30]	-0.12	0.89	[0.76, 1.04]

Note. OR = odds ratio; CI = confidence interval. The reference group of the dependent variable is help-seekers. ORs significant at *p* < .05 are bolded.
[a] For ease of interpretation, the "Knowledge & Skills" item was reverse-coded in the model, so that a unit increase in this item represents a decrease in knowledge and skills of suicide prevention.

Sources of Support for Help-Seekers

Slightly more than half of the Service members (56.7%) who reported on the *February 2016 SOFS-A* survey that they had experienced suicidal ideation or a suicide attempt during military service indicated that they had spoken to someone about this. Table 7 shows who help-seekers talked to about their suicidal ideation or suicide attempt. Help-seekers were most likely to report that they chose to speak to a spouse or significant other, a military friend not in the Service member's chain of command, and a mental health provider at a military facility. Other less frequently selected responses were parents or a parental figure, a friend not in the military, a spiritual counselor, and a fellow Service member in the same chain of command. The least frequently selected response options included a general medical doctor at a civilian facility, and military- or civilian-run suicide helplines.

Sources of Support for Non-Help-Seekers (Considered)

Roughly one-third (30.4%) of those who reported on the *February 2016 SOFS-A* that they had experienced suicidal ideation or a suicide attempt while in the military , considered seeking help but did not do so. Table 8 shows the individuals who these non-help-seekers (considered) contemplated talking to about their suicidal ideation and suicide attempt(s). The most frequently selected responses were a spouse or significant other, friend not in the military, a military friend not in the same chain of command, a mental health provider at a military facility, and a spiritual counselor. Less frequently considered sources of support included a parent or parental figure, another individual within the same chain of command, a general

medical doctor at a military facility, or someone at either a military-run or civilian-run suicide helpline.

Reasons for Not Seeking Help for Non-Help-Seekers (Never Considered)

Non-help-seekers (never considered) were asked again the reasons why they never considered seeking help for their suicidal ideation or suicide attempt(s). Table 9 displays the reasons non-help-seekers (never considered) identified for why they did not talk to someone. The most frequently reported reason again was concerns that seeking help would negatively affect their career. Other frequently reported reasons were that the non-help-seeker did not want anyone to interfere, that they would think less of themselves if they could not handle the suicidal ideation or suicide attempt(s) on their own, that they thought coworkers or superiors would have less confidence in them, that they were embarrassed, and that they did not think getting treatment would be kept confidential.

Table 7
Individuals Help-seekers Talked to about Their Suicidal Thoughts and Attempts

	Total %	Army %	Navy %	Marine Corps %	Air Force %
Mental health provider at a military facility	52.9	55.2	43.5	49.0	64.6
Spouse or significant other	48.5	50.4	49.1	39.1	49.3
Military friend not in my chain of command	42.8	44.7	47.6	39.3	33.4
Someone in my chain of command	24.9	25.5	24.8	26.9	22.2
Chaplain, pastor, rabbi, or other spiritual counselor	22.3	26.9	19.0	25.9	13.9
Parent or parental figure	21.9	24.8	20.2	19.0	19.6
Civilian mental health professional at a civilian medical facility	20.1	19.3	18.7	18.7	25.0
Friend who is not in the military	18.6	17.6	14.5	25.6	22.5
Sibling	13.4	9.6	17.7	10.9	17.6
General medical doctor at a military facility	12.0	12.1	13.7	9.6	10.9
Family member other than spouse, significant other, parent, parental figure or sibling	10.1	8.4	11.4	9.8	12.5
Some other individual/resource	7.6	7.8	6.5	11.8	6.1
Someone at a military-run suicide helpline	6.6	6.5	7.2	14.7	0.7
Someone at a civilian-run suicide helpline	3.2	3.4	2.7	6.6	1.2
General medical doctor at a civilian facility	1.3	2.0	0.6	0.1	1.6

Note. Respondents were able to mark more than one option; therefore, percentages do not sum to 100%.

Table 8
Individuals Non-Help-Seekers Considered Talking to about Their Suicidal Thought and Attempts

	Total %	Army %	Navy %	Marine Corps %	Air Force %
Civilian mental health professional at a civilian medical facility	40.9	48.0	39.7	19.9	41.0
Military friend not in my chain of command	40.1	44.4	39.6	33.7	33.6
Spouse or significant other	38.9	28.6	43.0	60.0	41.3
Friend who is not in the military	38.4	35.1	42.7	35.1	41.0
Mental health provider at a military facility	37.3	37.4	39.0	28.3	40.7
Chaplain, pastor, rabbi, or other spiritual counselor	30.9	23.6	44.2	17.3	33.1
Parent or parental figure	29.9	24.7	40.6	31.2	18.1
Sibling	16.8	9.5	24.4	24.4	13.6
Someone at a military-run suicide helpline	15.9	18.6	12.7	22.5	9.6
Family member other than spouse, significant other, parent, parental figure or sibling	15.0	7.5	21.7	23.5	13.8
Someone at a civilian-run suicide helpline	15.0	17.1	14.1	11.9	13.5
General medical doctor at a military facility	13.1	17.5	13.7	3.7	6.5
General medical doctor at a civilian facility	10.3	19.4	6.8	NR	NR
Someone in my chain of command	10.2	11.0	12.4	10.7	2.0
Some other individual/resource	7.5	4.2	9.0	10.0	11.7

Note. Respondents were able to mark more than one option; therefore, percentages do not sum to 100%.
NR: Not reportable.

Table 9
Reasons Non-Help-Seekers Never Considered Talking to Anyone about Their Suicidal Thought and Attempts

	Total %	Army %	Navy %	Marine Corps %	Air Force %
Concerned it would negatively affect career	58.0	51.6	63.2	60.2	58.7
Did not want anyone to interfere	51.0	57.1	46.9	53.9	43.9
Would think less of self if could not handle on own	51.0	45.2	52.4	71.1	39.5
Thought coworkers and/or superiors would have less confidence in individual	45.6	36.0	52.8	50.0	46.5
Embarrassed	43.3	37.1	42.0	54.6	46.5
Did not think treatment would be kept confidential	42.7	36.1	46.4	50.1	41.4
Concerned it might impact security clearance	41.9	36.3	50.6	36.8	41.5
Thought friends and family would have less respect for individual	37.1	34.9	39.7	48.4	24.7
Did not trust mental health professionals	31.8	33.8	25.4	38.2	33.3
Difficult to arrange the time to talk to someone	13.9	11.9	15.9	16.3	11.9
Concerned that prescribed medications would have too many side effects	11.6	7.0	14.8	12.7	13.2
Received treatment or therapy previously and did not think it was effective	7.0	8.2	3.3	6.9	11.6
Did not know where to get help	5.1	6.6	6.2	2.8	2.2
Concerned it would cost too much money	4.3	1.5	7.7	6.1	1.4

Note. Respondents were able to mark more than one option; therefore, percentages do not sum to 100%.

PHASE II: GATEKEEPER FOCUS GROUPS

METHOD

In Phase II of this project, focus groups were conducted at U.S. military installations to understand further the development of mental health concerns and the barriers and facilitators of mental health help-seeking. PERSEREC researchers conducted a total of 26 focus group interviews at Navy, Air Force, and Army military installations. Due to administrative delays, data from the Army installations, Fort Campbell and Fort Bragg, were not available in time for the main analysis, and are therefore not addressed in this results section. The findings from these installations were analyzed at a later time and can be found in Appendix B, along with Army-specific recommendations. The discussion in the following sections refers only to the data from the 16 Navy and Air Force focus groups that were available when this report was written. The Marine Corps was not able to support the focus groups due to competing requirements.

In addition, while the focus group questions primarily focused on the experiences of active duty Service members, gatekeepers were also asked at the end for their perspectives on non-help-seeking in the Reserve and National Guard communities. These findings and recommendations are detailed in Appendix F.

Participants

PERSEREC researchers conducted 16 focus group interviews at Naval Station Norfolk, Keesler Air Force Base, and Joint Base Pearl Harbor-Hickam (JBPHH). Installations were selected for the focus group interviews based on their high operation tempo, recruit training focus, and deployment and redeployment command focus. In addition, these installations were not heavily burdened by other research studies in the recent past. At each installation, gatekeeper-specific focus groups were conducted with: (1) chaplains and religious personnel; (2) law enforcement and security personnel; (3) medical, mental, and behavioral health providers and counselors, and (4) unit leadership. A fifth type of focus group composed of a variety of gatekeeper types was conducted to gather combined gatekeeper perspectives (see Table 10 for further detail on types of gatekeepers that were recruited).

Table 10
Type of Suicide Prevention Gatekeepers

Gatekeeper Role	Example
Chaplains/Religious Programs Specialists	Chaplains, enlisted religious programs personnel and ministry staff, designated unit lay leaders, and highly involved command lay leaders
Law Enforcement & Security Managers	Law enforcement (e.g., Military Police), and installation- and unit-level security managers
Medical, mental, or behavioral health personnel	Installation- and unit-level medical officers and enlisted medics/corpsmen, psychologists, counselors, Military and Family Life Counseling
Unit Leadership	Commanding Officer (O5-O6), Executive Officer (O3-O5), Officer in Charge, Assistant Officer in Charge, Chief of Staff, Senior Enlisted Leader (E7-E9)
Multidisciplinary	Chaplain/Religious Program Specialists, Law Enforcement & Security Managers, Medical and Mental/Behavioral Health Professionals, and Unit Leaders

The research team received 4 hours of focus group interview training: one 2-hour general training session on the focus group interview methodology and one 2-hour training session covering protocol-specific practice. Five facilitators conducted the focus group interviews. The study procedures were reviewed by a Defense Human Resources Activity Exemption Determination Official and determined to be non-human subjects research.

Researchers conducted 16 focus groups across the three sites: 5 at Naval Station Norfolk, 5 at Keesler Air Force Base, and 6 at JBPHH. Because JBPHH is a joint Naval and Air Force base, focus groups for chaplains and religious personnel; law enforcement and security personnel; and medical, mental, and behavioral health providers and counselors included both Air Force and Navy personnel. Focus group sessions for unit leadership were held separately, however, with separate sessions conducted for Navy and Air Force unit leaders. Focus group interviews consisted of 1 to 22 participants, with the size of the focus groups varying based on the size of the installation and the number of gatekeepers available (see Table 11). Focus groups were conducted between November 2016 and January 2017.

Table 11
Number of Gatekeeper Participants by Installation

	Norfolk	Keesler	JBPHH	Total
Chaplains and religious personnel	13	10	8	31
Law enforcement and security personnel	4	7	8	19
Medical, mental, and behavioral health providers and counselors	8	7	16	31
Unit leadership				
Air Force	--	11	10	21
Navy	1	--	12	13
Multidisciplinary	8	11	16	35
Total	34	46	70	150

Procedure

Participants were scheduled and interviewed in a private on-site room, and each focus group met privately for approximately 1.5-2 hours. A lead facilitator and assistant facilitator conducted each focus group session.

Each participant provided verbal consent before beginning the focus group interviews (see Appendix D). Following the informed consent procedure, the facilitator discussed ground rules (e.g., details should not be shared with anyone outside the room) and introduced all present team members.

The focus group questions covered topics related to non-help-seeking, barriers to mental health care, and the impact of existing policies. The focus group questions were organized by subject areas, including: behavioral health help-seeking (e.g., "Do you have Service members who you encounter that are struggling with family issues?"), mental health help-seeking (e.g., "What strategy did you use that you believe was most effective in encouraging Service members to seek care?"), help-seeking gaps (e.g., "Have policies helped to create a more accepting culture about mental health issues?"), and help-seeking barriers and policies (e.g., "Which barriers do you believe Service members would list as the most significant barriers to seeking help?"). The focus group questions also included a final section on concerns regarding help-seeking specific to Reserve and National Guard components (data from these questions are discussed in Appendix F). The set of focus group questions concluded with an opportunity for gatekeepers to ask questions of their own or address any issues that were not discussed (see Appendix D for focus group questions).

The assistant facilitator recorded focus group notes and key quotes in a note-taking template. In addition, focus group interviews were electronically audio-recorded. Focus group sessions were transcribed "near" verbatim by a transcription service, so that background noise, filler words, and utterances were excluded from the text transcript. Data from the transcripts were reviewed, any personal identifiers removed, and verified and corrected by PERSEREC researchers.

Data Analysis

Organization and analysis of data followed a matrix approach, as described by Miles and Huberman (1994) using multiple, independent research analysts coding the text data. Researchers applied a structural coding framework using first- and second-cycle coding methods to code and develop themes. The first stage of coding was focused on code development using *a priori* codes based on the academic literature of mental health services utilization (see Hines, et al., 2014; Hom, et al., 2015; and Zinzow et al., 2013). The purpose of the second round of coding was to apply the codes directly to the transcripts. The third and final round of coding focused on refining the final list of codes and corresponding themes. At least two researchers coded each transcript in the second phase of coding. Inter-rater reliability was calculated using the intraclass correlation coefficient for focus group by pair of raters. ICCs ranged from 0.51 to 0.89, indicating that there was fair to excellent inter-rater reliability (Cicchetti, 1994).

The third round of coding included re-reading the full Naval Station Norfolk, Keesler Air Force Base, and JBPHH transcripts and reviewing the coded content developed during the second round. The goal of the third round was to finalize the major themes discussed in the transcripts. Coded statements from the second coding cycle were reviewed to determine if statements could be combined into categories, whether new categories were needed, or if trivial categories could be combined into a higher-order category or theme. Codes were also sorted by Gatekeeper role to aid in the analysis. A final common coding rubric was developed for analysis of all subsequent focus group interview data (see Appendix E for the final codebook). After completing the three stages of data coding, researchers then identified key quotes that were typical and descriptive of that category.

RESULTS

The content of the focus group discussions fell into the following three higher-order themes: (1) reasons why Service members are experiencing mental health issues, (2) reasons why Service members do not seek help, and (3) reasons why Service members do seek help. Table 12 gives an overview of each of these themes and associated sub-themes, which are discussed in-depth in the following section.

Table 12
Coding Themes and Sub-Themes

Main Theme	Sub-Themes
(1) Reasons why Service members are experiencing mental health issues	• Suicide Ideation and Suicide • When Problems Begin • Stress
(2) Reasons why Service members do not seek help	• Stigma • Career Impact • Issues with Services Available
(3) Reasons why Service members do seek help	• Command Directed Evaluations • A Different Goal than Mental Health Improvement • Trust and Supportive Environment • Policies that Facilitate Mental Health Service Utilization

(1) Reasons why Individuals Experience Mental and Behavioral Health Issues

Gatekeepers in each focus group were asked to describe the mental and behavioral health issues that they have observed while working with Service members. Consistently across all groups of gatekeepers, frequently cited issues included stress, anger, anxiety, depression, suicidal ideation and suicide, and post-traumatic stress disorder. Behavioral health issues such as financial distress, interpersonal conflict, and sexual assault were also identified. Gatekeepers often noted that many of these problems are intertwined, and that behavioral health issues are often easier to identify than mental health issues, in part because people are more open to discussing behavioral health problems than mental health problems.

Suicidal Ideation and Suicide

In discussing suicidal ideation, gatekeepers discussed common behavioral health problems that serve as precursors to suicidal ideation and suicide. Gatekeepers identified relationship conflict and financial distress as common precursors to suicide and suicide attempt(s). Gatekeepers of every type discussed the importance of treating these underlying problems as a critical strategy for reducing mental health distress and suicide risk among military Service members. Gatekeepers of all types expressed knowledge and skills required of their role to be able to identify and manage suicidal ideation and behavior.

Representative Quotes

- "Trust me; we don't need any more suicide awareness training. We're suicide aware. We are aware."

- "I've seen people who have emotional issues that can't handle stress very well, and that kind of veers them off to that suicidal ideation. With that, I've seen people who also have issues with drug and alcohol abuse."

- If I say I'm suicidal everybody is going to know."

- "I think commands feel like they're going to get into some kind of trouble or there's going to be some kind of tainted perception of them, if one or more of their members commit or even talk about suicide."

Where do Problems Begin?

Gatekeepers recognize that some individuals enter the Service with pre-existing mental health conditions, others develop them during the course of their service, and still others have pre-existing vulnerabilities that develop into full-blown mental health disorders as a result of stressors experienced during service. Gatekeepers, particularly those with medical and behavioral health backgrounds noted that many Service members enter the military during a developmental stage during which they are at risk for developing mental health disorders.

Conditions Existing Prior to Service

Gatekeepers of all types expressed concerns that some Service members are entering military service with pre-existing mental health problems. Many of these gatekeepers attribute this problem to insufficient screening at entry or to the related problem of recruiters coaching recruits to not disclose pre-existing mental health problems. Gatekeepers noted that they observe many different types of mental and behavioral health problems in new recruits, ranging from attention-deficit disorder to depression, sometimes at basic training. Themes of untreated childhood trauma, abuse, and neglect were consistently identified as risk factors for development of mental and behavioral health problems before entry or early in service. Gatekeepers noted that better screening at entry would significantly reduce the number of Service members entering with pre-existing mental health conditions.

Representative Quotes

- "It does seem like we have a problem … at the entry point. That there are a lot of things that are being missed—these key conditions that are disqualifying for retention, and are being allowed in."

- "Students come in with what would seem like from my perspective, mental health issues, right from the beginning. And so my concern is that sometimes in the recruiting process, we're not vetting them as well as we probably should, and so they come to basic training, then to tech training after graduating from basic training, with issues right from the beginning. So I've seen that. And it's not just one or two times. I've seen it probably 50 or 60 times."

- "I have supervised many people whose patients have told them, 'I disclosed all these preexisting conditions to my recruiter, who told me not to mention it.'"

- "It's primarily a young adult population with whom we're dealing, and they possibly have had these issues throughout their lives and it's manifesting now,

because for a variety of reasons, we'll just say young adulthood, navigating young adulthood. And not having the skill set with which to deal with some of those underlying issues from childhood trauma, upbringing, socioeconomic status, whatever the case is."

Conditions Developed During the Course of Service

While gatekeepers noted that better screening at entry would significantly reduce the number of Service members entering with pre-existing mental health conditions, these gatekeepers also emphasized that the majority of the mental health problems that they see are not present at service entry, but are developed during the course of service.

Trauma

Traumatic experiences during service were frequently cited as a major contributing factor to the development of mental health conditions by Service members. Trauma was identified as a pre-cursor, not just to the development of post-traumatic stress disorder, but also to the development of other serious mental health conditions, such as depression and suicidal ideation/suicide.

Representative Quotes

- "I've worked with Special Forces for about seven years of my career and through that I worked closely with trauma control, PJ, southeast, that kind of guys, backup airmen, and I see from them it's all developed since they've been in because of the experiences that they've had."

- "I lost count after eight females who came and spoke with me, about an increase of anxiety or memories of sexual harassment or sexual trauma."

- "What you've seen is mental health issues stem from the job. Work related stresses and finances and all those things that contribute to a mental health issue. Folks coming back from deployment, people involved in a significantly traumatic incident."

Stress

By far, the most commonly cited underlying issue leading to the development of mental health problems during military service, including suicide, was occupational stress. Gatekeepers of all types identified occupational stress related to the nature of military missions, military culture, and deployment, as a critical factor affecting the mental and behavioral health of Service members. These gatekeepers observed that many Service members do not have the stress management skills required to successfully navigate stressful occupational experiences.

Representative Quotes

- "Over the past 20 years, as a result of just being in, I've seen people develop what would seem like some mental health issues... from deployments, from the stress and the work environments... just the nature of being in the military."

- "Some people coming in probably have mental health issues, and then some people pick it up as they go along. You know, we're not making cupcakes out here. We're in the business of killing people and breaking their stuff. So, yeah, people develop some problems along the way."

- "It seems a number of our students don't necessarily have coping mechanisms or tools to address those problems that they're experiencing."

(2) Reasons why Individuals do not Seek Help

Throughout the focus group interviews, gatekeepers discussed a variety of reasons why Service members do not seek help when they experience mental health issues. Reasons ranged from Service members' self-assessments determining that they do not need help to practical barriers such as scheduling appointments. The themes generally fell into one of the following categories: perpetuation of stigma, impact on career, and issues with the services available. Themes were not discussed in isolation and, after a thorough review of all findings, it became apparent how these themes were related to one another. The following section presents the most common themes related to why individuals do not seek help, representative quotes from the interviews for each theme, and an analysis of the relationships between themes.

Stigma

Six of the 16 focus groups listed stigma as the main reason why Service members do not seek help. Participants often described stigma as the perception that seeking help for a mental health issue made an individual weak. Overall, gatekeepers agreed that stigma related to mental health was on the decline, but they acknowledged that it is still a leading factor for why Service members do not seek help for their mental health concerns. Command leadership and chaplains differentiated between self-generated stigma and stigma generated by other military personnel. Self-stigma occurred when the main source of these thoughts was intrapersonal and arose from the Service member's own belief system. Stigma generated by peers was categorized by negative comments made by others related to help-seeking behavior. Individuals in the law enforcement/security focus groups also discussed stigma generated by other military personnel, specifically instances where command climate is a contributing factor. This was echoed in some of the interdisciplinary groups when participants explained that administering training and issuing policies are useless if a person's direct command does not encourage help-seeking behavior.

Discussions related to command climate and stigma were also closely related to group discussions on the importance of trust, and in one of the focus groups, lack of trust was listed as one of the main barriers to help-seeking. According to gatekeepers, lack of trust in the system and command leadership was one of the driving factors behind stigma. Participants in the command leadership, medical/behavioral health, and interdisciplinary groups discussed the impact of gossip and misinformation on the perpetuation of stigma. They discussed how a lack of privacy within units contributed to the spread of gossip and misinformation on the implications of seeking mental health treatment. Resultant rumors at the base led Service members to believe that receiving mental health care would lead to being discharged from the military. A medical/behavioral health participant explained that key pieces of information often go missing in the gossip and rumor – in some cases, an individual is discharged from the military due to a severe psychological disorder, such as a diagnosis of schizophrenia or homicidal ideation. Unsurprisingly, this more complete story is not heard around the base and is simplified into, "someone went to mental health and was discharged from the military." These types of rumors and stories persist and contribute to the stigma of mental health treatment and the fear that pursuing treatment may lead to being discharged.

Representative Quotes

- "You have to overcome the hurdle of stigma, with the Service member or a family member, before even trying to get them into the care because they're wrestling with their own personal perception of the stigma associated with mental health and all of that, which I think we've come a long ways, with regard to that, especially with policy. And there's still that personal perception, regardless of policy."

- "But also just being labeled crazy...by your peers or your coworkers. That's one of the barriers for people seeking to get help because they don't want to have that label. Whether it's fair or not, those things happen and it does prevent people from seeking help."

- "When somebody's going to [get] help and if we have some leaders that are making those kinds of comments and making those types of determinations saying, 'Yeah, that's why you're not going to get promoted ahead of this person because you're weak,' then we need to address the problem... That's the kind of people that probably need to be removed from their leadership positions because they're now going off and going away from the vision of the bigger, larger enterprise."

- "I think it's trust. I feel like it's our number one issue: trust in individuals and every leadership. Every command is a different flavor and that's going to vary from command to command regardless of policy. But also trust in the system. It's one thing to say; it's another thing to do."

- "One of the training issues we see here is gossip between junior Airmen, where if one has a mental health issue or makes an ideation, and then ends up being ultimately removed. Then everyone in that career field ends up finding out. So then we have 100 Airmen [hearing about] that negative experience. No matter how true it is or not, that's their first integration into the mental health or help-seeking area."

Career Impact

Concerns about career impact were often identified as the number one reason a Service member may not come forward with mental health issues in 5 of the 16 focus group interviews. These concerns were linked to both real career implications (e.g., missing deployment opportunities) and misperceptions of career impact (e.g., immediately losing a security clearance). The real impacts of seeking mental health treatment often arose from DoD policies and procedures designed to protect Service members. For instance, Air Force gatekeepers spoke about the policy where Service members (from any branch) cannot deploy or transfer (Permanent Change of Station [PCS]) within 90 days of starting a new medication. According to gatekeepers, details of this policy are translated by Service members to mean if they seek help and are put on medication, then they immediately become immobile. Gatekeepers expressed frustration with this policy because it results in flagging of an individual's record and documentation of their immobility. One medical/mental health gatekeeper expressed frustration in this policy because it creates a very binary way of thinking and undermines the message that the military will not discharge Service members for having anxiety and once they are stable on their medication, they are deployable again.

Another example of a policy that serves as a barrier, but is intended to protect Service members is the policy that removes a firearm from individuals with a disqualifying physical or mental health condition (DoDD 5210.56, *Arming and the Use of Force*). All three law enforcement focus groups, across the Services, identified this procedure as a reason for why they would not seek help. Law enforcement personnel are required to carry a firearm for their job; therefore, if banned from being around firearms, they would not be able to fulfill their basic duties as military police. They cited that even if they did not disclose to the rest of their unit they were experiencing suicidal ideation, the mere fact that they were no longer carrying a firearm would generate rumors amongst their peers.

Other gatekeeper groups echoed the military police's duty-related concerns about help-seeking. Gatekeepers specifically discussed experience with personnel in Special Access Programs that require a security clearance. For these individuals, anything that appears to put their eligibility to access controlled environments at question is a risk to their entire career. According to the 13 Adjudicative Guidelines (2003), suicidal ideation may not be considered a discriminating factor by itself, but some of the behavioral health issues discussed under various adjudicative guidelines may be potential security concerns. For instance, if a Service member is

struggling with alcohol dependence or is in serious financial debt, they are at risk of losing their security clearance. Although behavioral health issues are not always directly linked to suicidal ideation, there is evidence of a strong association between the two, and according to gatekeepers, Service members presenting with suicidal ideation are often also experiencing behavioral health issues.

Concerns related to security clearance were not unique to any one group; seven of the 16 focus groups mentioned this as a factor inhibiting help-seeking behaviors among Service members, especially for behavioral health issues (e.g., financial problems and substance use). In one focus group, a gatekeeper explained that there are situations in which a Service member might seek help for an undisclosed issue and ultimately lose their security clearance. Similar to the circumstances surrounding rumors that perpetuate stigma, the details of the story are not known by other Service members and a particular case will be simplified to "he went to get help and then lost his security clearance, even though the military said that was not going to happen." These types of occurrences fuel the misconceptions and stigma surrounding utilization of mental health resources.

Career-specific concerns were also frequently discussed in relation to senior enlisted members and officers seeking care. For this population of Service members who have invested a career in the military, there is heightened concern that seeking mental health care, requesting removal from a high-stress situation, or receiving a "flag" in their records will result in being passed over for future opportunities and promotions.

Representative Quotes

- "A new directive that came out this week, actually, for the Air Force, was that any time someone has started or has any dosage change of a psychotropic med, they instantly get a 90 day profile, which means they can't deploy, they can't PCS, they can't go TDY for 90 days."

- "The stigma is something that we have to continue to work on because people will always have that fear of loss of qualification or security clearance or loss of esteem or whatever, loss of job if they access that care, just for accessing care. So that's the first hurdle, is just getting them willing to get the help, and then, when we encounter these other hurdles on top of that, it's particularly frustrating."

- "If you have to [...] not be armed, then that really affects the duties that you can do and it's very obvious to your peers if you don't have your weapon with you. That can be a social snowball effect that can happen with peers. Spreads like wildfire."

- "Are the current policies regarding PRP [Personnel Reliability Program] and – and all those – you know, TS/SCI [Top Secret/Sensitive Compartmented Information], Top Secret, are some of those policies inhibiting people from

stepping forward? And we would probably say, absolutely, yes, they are. Because if you self-identify regarding anything that we're talking about, and you're on PRP status, [...] – we want to say it goes – you know, they're going to get some help, but in their mind, it goes downhill very fast."

- "Most officers don't want to get help for anything, unless it's like, you know, so bad it's kind of falling apart. [...] and they're career minded, they're going to try and contain it. [...] so it's up or out in the officer corps."

Issues with Services Available

Some features of the available mental health resources were also identified as a potential barrier to help-seeking. The most frequently listed barrier was the impact that appointment times have on a person's day-to-day activities and the inconvenience of taking time off from work to make an appointment. This barrier was often tied to manning concerns and was mentioned in 14 of the 16 focus groups. Gatekeepers explained that when an individual takes time off for an appointment, his/her peers have to fill in for this missed time in order to ensure that the mission is accomplished. This can result in tension within the group and peers may view the individual as a "slacker." Relatedly, gatekeepers spoke about a growing trend of doing more with less. They explained that they were already short-staffed due to the drawdown, but were still expected to complete the same mission as before. As a result, Service members may not want to take any time off work for an appointment, since it will either result in them being behind in their work or expose them to negative comments from co-workers.

Gatekeepers also discussed the related barrier of lengthy wait-times for scheduling an appointment with a mental health care provider, particularly for cases that could not be classified as urgent. Chaplains and some behavioral health counselors observed that the referral process and long wait times presented as barriers to Service members requiring a different level of care. Gatekeepers explained that long wait times were often a result of providers' heavy caseload and that they, particularly chaplains, might be required to bridge the gap in time and care before a Service member could be seen at a clinic. Some gatekeepers from the medical/mental health provider, chaplain, and law enforcement groups pointed out that, in terms of suicidal ideation, there were not enough levels of care. According to their comments, Service members who expressed any type of suicidal ideation were either subject to the lengthy provider referral process or were escalated to an emergency level when it might have been inappropriate to do so.

Lack of confidentiality in some of the programs currently available was also identified as a common barrier to care. While the content of an individual's appointment is protected by the Health Insurance Portability and Accountability Act, the fact that someone is scheduling and attending appointments is not. Gatekeepers explained that this presents a barrier because Service members may not want their command to know that they have appointments scheduled with a

mental health provider. Similarly, some individuals are deterred from seeking care because, depending on the program they participate in, their attendance will be documented in their record.

Representative Quotes

- "The system is broken at a number of levels. And some of it is not the system's fault. They just don't have the bodies. The funding is not there. The bodies are not there."

- "It's an extreme stress on the force that we're so minimally manned, [...] I honestly believe that the load of responsibilities that we're putting on the airmen have consequences to how we're taking care of them personally. We're going to get the mission done..., but consequently the personal human side of it is taking a toll and I think that's exactly what we're seeing [...] the problem is I'm losing bodies to mental health issues because I didn't have time as a supervisor and a leader to take care of, to identify those other things."

- "We need a better intermediate urgent care for people to have access – maybe I'm not quite suicidal, but I could be – and something that you don't have to wait a week or two weeks for. Providers say, "Well, we could see you next week," and that's not going work, but you just don't want to take them to the emergency room."

- "One of the major barriers is that, if I make a referral to mental health, they usually have weeks before they're gonna get seen, and then it's gonna be other weeks before they get seen a second time. There's just the, I assume, the super heavy load that they have at mental health. And the Service members know that, and so it deters them from wanting to go down that road, even when I've won their confidence."

- "They don't want their commander to be able to look at a file or look at any background and then see that they had this issue, that issue, depression, anxiety, or suicidal thoughts - that it might in any way affect their career down the line. So confidentiality is a huge thing."

Relationship between Main Themes

Gatekeepers regularly discussed the barriers of stigma, career concerns, and the services available in relation to one another and delineated the association of the three themes. For example, rumors and misinformation contribute to people's career concerns and perpetuate the stigma of seeking mental health care. Similarly, manning concerns and taking time off work were linked both to stigma and career concerns. Gatekeepers explained that if someone is labeled as a "slacker" for taking time off work, it could negatively impact their career and also feed the perception that someone would leverage mental health services strictly as a means to get out of

work. Lack of confidentiality was identified as contributing to the spread of rumors, which in turn only generates more stigma.

Representative Quotes

- "I had postpartum a long time ago, and when people didn't know what was going on, they made up stories. So that was – it's the whole stigma thing. [...] because I was going for outpatient treatment [... they said] 'Well, she wanted to kill her baby.' I did not want to kill my baby. But that was a rumor that went around. So when my ex-husband told the flight chief, they got their butts ripped, but it was that whole thing. And then you have to come back to that, and you have to have the people still whispering, say whatever else about you, and they don't know the whole damn story."

- "People get kicked out, and they say, 'I got kicked out because I went to mental health.' But they don't tell the whole, full [truth], 'I got kicked out because I was homicidal and wanted to hurt this person, this person, and this person. I hear voices in my head.' That's why you got kicked out. But they don't do that, they hear I got kicked out because I went to mental health. So word of mouth, negative word of mouth is a pretty big barrier, because nobody really wants to say the whole spiel."

- "So they have that internal pressure of, 'if I leave, I'm increasing so many people's workload.' Or even if it's just people in their unit, they're not there to do whatever training. So in terms of those things they know that it's not a secret, they know that if I leave, all these things happen as a result."

(3) Reasons why Individuals do Seek Help

There are many reasons for why a Service member might seek help and utilize available services, and during the focus groups, several themes emerged. Clear motivators for mental health service utilization included dynamics related to military policy, treatment types available, and confidentiality, among others. The following section provides an overview of the most common themes related to mental health service utilization that was discussed in the focus group interviews and representative quotes from the interviews for each theme.

Command-Directed Evaluations

One reason that Service members seek care is that they are informally or formally directed by their unit leadership to utilize mental or behavioral health services. If a Service member or a concerned peer suggests to unit leadership that they may need to seek treatment, leadership might have an informal discussion with the Service member first. They might try to understand what is troubling the Service member and provide support or suggestions. At that time, they would then make a pointed suggestion to seek help via a chaplain, Military and Family Life Counselor (MFLC), or military mental health provider. This is often a time when unit leadership can

rely on the feelings of trust and supportive environment that they have built with their Service members.

All gatekeeper focus groups explained that unit leadership can also utilize command-directed evaluations (CDEs) to compel Service members to go to a specific resource if a more formal intervention is required. DoDI 6490.04, *Mental Health Evaluations of Members of the Military Services*, clarifies commander, supervisor, and mental health professionals' roles in the process; how and what will be communicated; and where documentation is recorded. In general, Service members will comply with the CDE order, but a minority of gatekeepers implied that the individual may opt to not continue attending their appointments after the first one.

Representative Quotes

- "It's commander driven, really. So it's those leaders standing up, saying, you need to go."

- "We call that a "calibration session" and that [serves as a] barrier right before the chief records doing something, right before [the Service member] won't be able to prevent, or not get caught up in something."

- "You are legally using your authority to say – because I usually say, 'Look, let's talk to this guy and see if we can persuade him to go voluntarily,' because as soon as he says 'No.' I'm going to say, 'You're going to go,' and then it's all going to be on paper…"

- "I think as a commander the hard part is, I could say, 'Hey, you're sick, you should go to the med group.' But when it's, 'Hey, you're sick because of mental health,' it becomes this formal CDE you have to be so cautious of."

A Different Goal than Mental Health Improvement

There are certain situations in which Service members seek mental health treatment for reasons other than improving their mental health. All gatekeeper groups, except for chaplains and religious personnel, discussed observing malingering from Service members who had used specific words or phrases, such as ones related to suicidal ideation, in order to be seen by a mental health provider immediately. Gatekeepers noted that Service members may use this tactic to get out of an unwanted or undesirable duty. To a more extreme extent, using specific words or phrases, such as ones related to suicidal ideation, could allow Service members to avoid certain training schools or deployment, or even be used to initiate the separation process. The law enforcement and medical/mental health provider groups indicated that they regularly encountered these types of situations.

Representative Quotes

- "They'll play the system so they don't have to deploy or if they get them off the ship quick and they know that. It's written instruction that says as soon as you do this, you're getting off the ship or moving somewhere else or being sent to another department."

- "We experience this a fair amount, and obviously you don't want to make assumptions about patients who comes in the door, but I think for some folks who get the Med board [Medical Evaluation Board], it is a way out of the military, and getting a paycheck and a double bonus for folks that don't want to be in. So it kind of sets the stage for the possibility of malingering. Not necessarily a lot of good options for a provider, I think we're in a difficult position because to call something malingering, you're really putting yourself out on a limb."

- "Getting out of deployments or whatever the case may be is going to – people are going to talk. But we know from the top that the Commander can't be like, oh, well, since you were suicidal, we're going to demote you. No, you can't do that. We know that."

Trust and Supportive Environment

Focus group participants explained that trust in providers, such as chaplains, MFLCs, and mental health providers, may not be easily established, but is important to facilitating help-seeking among Service members. Gatekeepers discussed that, often, trust begins with a familiarity with a person; and that informal, regular, and positive interactions with unit leadership, chaplains, and other mental health care providers facilitated help-seeking for those individuals. In addition, Service members are apt to trust their peers' recommendations, so when peers discussed their own positive experiences with utilizing mental health services, Service members were more likely to also seek out resources.

Among chaplains, building rapport with Service members is crucial, and confidentiality in their profession was the main reason why Service members would approach them for care. The trusting relationship that a chaplain develops with a Service member allows them to be effective counselors, and chaplains may be able to persuade Service members to see a mental health care provider if they believe that level of care is necessary. In certain situations, chaplains persuade Service members to waive their confidentiality, so that the chaplain can approach mental health services and make the referral for more intensive services.

The idea of building rapport and trust with Service members also was discussed in the context of unit leadership. Focus groups participants advocated for leaders to be sincere and straightforward, to de-stigmatize help-seeking, to maintain confidentiality, and to support a Service member's effort to balance finding time for appointments with their duty requirements.

Gatekeepers spoke about how trust was tied to fostering a supportive command climate and environment. Hallmarks of a supportive environment included a good sense of community, ample peer support, and a people-centered supportive environment in which Service members feel comfortable talking freely about mental health issues and mental health care. Across all gatekeeper roles, suggestions for setting the tone included speaking positively to junior Service members; removing stigmatizing language from conversations; having an open-door policy; having knowledge of options for mental health care services (both on base and in the community); sharing their stories of utilizing mental health services; attending mental health and suicide prevention trainings and setting the example of participation and engagement; having check-in conversations with Service members before resorting to writing a mental health CDE; and providing peer support to fellow senior leaders. Additional gatekeeper suggestions included having planned morale-building activities, structuring work hours to allow people time to utilize mental health services or complete self-care activities, incorporating activities such as Air Force's Wingman Days, gathering to celebrate achievements, developing active sponsorship programs within units, and supporting utilization of programs that foster community such as Morale, Welfare, and Recreation programs and Single Sailor programs.

Representative Quotes

- "Presence breeds trust."

- "We've all been in this business long enough to know that the functionality of any unit always comes from the top."

- "So, it's really taking the time out of your day to interact with the people, not on a mission or work basis but on a personal level and seeing how they're really doing and getting to know them and their family, their likes and their dislikes. Being that mentor."

- "I've had some experiences when patients were referring each other, and they were following through with coming in. So just in providing good quality patient care, people are talking about it and saying, 'Hey, I went to mental health and I had a really great experience. I think you should go, too.' I think people are becoming – are more willing to reach out to each other and say, 'It seems like you're bothered by this. Why don't you go and see mental health about this issue? They were really able to help me out."

- "Something that I've seen that's been powerful is in Commander's Call, where commanders have said, 'I've sought help for X, Y, and Z," and just establishing a culture that – in my last Commander's Call I was at, this commander's this tough dude – everyone knows it – and he plays the part well, but he really had a time of vulnerability during, speaking to all his troops, talking about how he's a commander and you think it's going to ruin your career to go see mental health,

but I saw mental help for X amount of years and I'm a commander, and so it's okay.' And I think that speaks way more volumes than just hand someone a memo that says, 'General so-and-so,' who I will never ever meet or whatever, 'says it's okay to go see mental health.' When your commander or a supervisor or someone really takes the time to say, 'Hey, I sought help, and look at me. It didn't ruin my career.' I think that's way more powerful."

Policies that Facilitate Mental Health Service Utilization

Policies addressing the stigma of mental health care have been successful in reducing stigma, gatekeepers explained, but stigma reduction efforts are still needed. Several gatekeepers cited policy language that encourages help-seeking and presents it as a sign of strength that a Service member would ask for help with an issue. These policies may also emphasize that seeking help not only benefits the individual, but also benefits those around them. Other gatekeepers pointed to policies that encouraged self-referral for services as another example of stigma-reducing policies, because they encourage Service members to seek help before a problem impacts their performance and becomes a larger and more difficult problem.

In addition, policies and guidelines that establish a more supportive environment for Service members were clearly appreciated by many focus group participants. Having one-on-one in-processing briefings for Service members new to the unit has been helpful for disseminating information about resources and fostering a personal connection with leadership. In one Navy focus group, a gatekeeper explained that they have seen great benefits for their sailors from their unit's policy of establishing a peer mentor network that provides a safe space for more junior sailors to support the mental health of one another and speak openly about their concerns.

Medical/mental health providers tended to cite policies that support mandatory training programs as contributing to the mental health stigma reduction and facilitating mental health care utilization. These gatekeepers supported psychoeducation-type trainings as a way to educate Service members on the features of mental health issues and to provide them with information on available resources. However, gatekeepers stressed the importance of having the right person to lead training in order to engage Service members and ensure the effectiveness of training. Unit leadership, religious personnel, and medical/mental health providers also expressed support for primary prevention programs such as life skills and resiliency training programs. Gatekeepers spoke very highly of Navy's Chaplain Religious Enrichment Development Operation workshops, seminars, and retreats, and generally spoke positively of the Air Force's Comprehensive Airmen Fitness program and Navy's Stress Continuum Model as contributors to stigma reduction, with a secondary effect of encouraging more help-seeking behaviors. In terms of suicide prevention, gatekeepers spoke very positively about the Applied Suicide Intervention Skills Training (ASIST) and safeTALK.

Representative Quotes

- "I'm not familiar with all of the policies in terms of self-referral, but it seems like many of them do emphasize a lack of repercussion in case of self-referral, whether it's alcohol abuse or whether it's other types of abuse issues, domestic violence or any of those types of things that could have repercussions because of disciplinary action. Rather, it seems like most of the policies talk about self-referral as a good thing, and that encourages people to step forward, rather than waiting until it becomes a disciplinary issue or performance issue, so that type of language, in all of our policies, is really helpful."

- "I think the, the mandatory training that we have, [the] annual training, helps to reduce that stigma."

- "And so the ward room and the chief's mess and the E-6 First Class mess, they've all established a peer mentor network program. They're all connected socially already within their messes, but what this does is raises awareness for suicide prevention. It says you're going to be implementing this peer network program, not just socially but for this reason, for mental, physical, and spiritual awareness of each other."

- "Just somebody, either peer or age group that's not going to judge them, that's not going to add watches to them or take away stuff, that they can just speak freely… and discuss things and have feelings come out and then that door was opened to feeling better."

Policies: Integrated and Embedded Mental Health

Across all gatekeeper groups and focus group locations, the concept of integrated mental and behavioral health care was uniformly identified as a service that increased mental health service utilization. Integrated mental health came in a variety of formats, including integrating mental health into the total fitness model, integrating mental health services in primary care, and embedding providers and counselors directly into units. Medical/mental health care providers and religious personnel indicated that the integration of mental and spiritual health into the military overall health model helped to reduce stigma and normalize mental health problems. Gatekeepers also spoke about the early successes and encouraging potential of Navy's Deployed Resiliency Counselors, and other programs with an embedded mental health provider, such as Special Operations Force's model. Gatekeepers identified that these embedded personnel are able to build trust and sense of community through regular contact with Service members in a non-traditional setting with a flexible schedule. Because embedded mental health personnel or resiliency teams build trust with Service members, these members may be more likely to accept referrals for elevated levels of mental health care. In a more medical setting, as part of the Behavioral Health Optimization Program (BHOP), mental health care providers work together with medical doctors in a

primary care clinic to provide easier referrals and access to care. Gatekeepers discussed that BHOP is effective for reducing Service member's fears of being seen in the mental health waiting room, and that mental health can then be viewed as part of the primary care visit, rather than treatment for a mental health condition. One participant expressed that they felt that the BHOP was underutilized.

Representative Quotes

- "The embedded person serves as the middle man. It has to be somebody who understands both those worlds."

- "Having embedded psychologists can be very helpful; other embedded resources is helpful in general. Visiting people weekly if you can or just be around where they are so that they're familiar with you. And trying to maybe emphasize a lack of repercussion for a self-referral can be helpful or a good thing, rather than waiting for disciplinary action to seek help."

- "I think that would work, having someone embedded in the unit. So then that way, they're familiar – familiarization in that trust, in that relationship with them. Like I see the captain every day. She comes to do PT with us. She comes out to the post, checks on us, whatever. You know what I'm saying? That type of thing. So then they have that type of relationship and then they can just go, 'Hey, man, this is what's going on with me.' And then you got an open ear and listen, and then just go from there. So I think that would benefit the unit."

- "I think I find BHOP… is much needed to make sure we have that tiered care. I think a lot of people who maybe don't use the prevention services that are nonmedical, – so, you go to medical for a severe condition and I'm not there yet. But then, you do prevention early, – help isn't there either. But the primary care behavioral health, it's that middle group of readily available, you can go see your PCM, it's not a mental health appointment. It's just an extension of seeing your PCM."

Policies: Confidentiality

One major area that faith-based personnel, medical/mental health personnel, and multidisciplinary focus group participants identified as a motivator for Service members to seek help was the confidentiality of certain services.

The two main services identified were the faith-based personnel and MFLCs. MFLCs provide non-medical counseling services for short-term problem resolution and engage in a level of confidentiality "because they do not keep notes" and some rotate every 6 months. Service members can also determine where they would like to meet with their MFLC.

Across all groups, gatekeepers identified chaplains as a widely utilized resource for Service members because they maintain full confidentiality and privileged

communication of their discussions with Service members. Chaplains are often the first point of contact for Service members who are hesitant to utilize mental health services. The therapeutic relationship chaplains build with them over time then allows Service members to feel comfortable to accept a referral to elevated services. Chaplains must get releases and waivers signed to be able to speak with another provider regarding the Service member's struggles.

Representative Quotes

- "I do the best I can, within that, say, 40 minutes, to build rapport with them to where they'll trust me, and when they do that, then they'll accept my referral for them to get the next level of help. The fact that we have 100-percent confidentiality helped to get their foot in the door, and then it's up to me to encourage and build that to where they're willing to go to somebody who doesn't have that. And, so far, I've been able to do that pretty successfully."

- "This is another agency you can go to. You can go to the chaplain, you can go to all of these. But the very first thing that comes out of my mouth is the MFLC. Because of that confidentiality, the lack of tracking the information and from there at least I have them with someone that can push them into another direction if they need to go there."

- "Confidentiality is a huge piece in whether or not people are willing to come and to confide. And just, in order to dispel the myths surrounding that, I'll talk about that a lot when I do classes or speak at formations or all-hands, gatherings, quarters, just to help people understand that, truly, chaplains have 100-percent confidentiality. There are no limits to that."

DISCUSSION

The overall goal of this study was to develop a better understanding of the active duty non-help-seeking population. To do this, researchers answered the following questions:

(1) What are the reasons why Service members experience mental and behaviors health concerns?

(2) What are the characteristics of Service members with a history of suicidal ideation or suicide attempts?

(3) What is the prevalence of non-help-seekers within the active components of the U.S. military?

(4) What are the factors that contribute to non-help-seeking behavior?

(5) What are the factors that promote help-seeking behavior?

Phase I was comprised of analysis of select questions from the *February 2016 SOFS-A* and Phase II was comprised of a qualitative assessment of focus group interviews with Navy and Air Force gatekeepers. Results from Phase I addressed research questions 2-5, and results from Phase II addressed questions 1, 4, and 5. Findings from the two phases were complementary in that they addressed the same issue but from two different perspectives: Service members who are in need of mental health support and gatekeepers positioned to provide support to Service members.

Results from the SOFS-A indicate that 14.5% of the active duty population reported experiencing suicidal ideation during military service. Those endorsing suicidal ideation on the survey were more likely to be female, unmarried, enlisted, and with slightly less education. Within this group that reported experiencing suicidal ideation during military service, 14.6% also reported making a suicide attempt during their service. Those who anonymously reported a suicide attempt on the SOFS-A were more likely to be female and enlisted and reported experiencing higher perceived stress compared to those who did not report an in-service suicide attempt.

Results from the SOFS-A indicate that a significant portion (43.3%) of active duty Service members who experience suicidal ideation or suicide attempts do not seek mental health support or talk about their concerns with anyone. Among non-help-seekers, most never consider talking to someone about their suicidal ideation or attempt (70.2%), but a proportion do consider talking to someone (29.8%). These findings are consistent with other studies showing that a significant proportion of Service members who meet diagnostic criteria for a mental illness do not seek help (see for example, Hoge et al., 2004). Results from the multivariate analyses indicate that male Service members, officers, those who are less confident in their suicide prevention knowledge and skills, and those with higher levels of concern regarding

career impact are less likely to seek help for suicidal ideation or a suicide attempt. Those who discussed their concerns (help-seekers) were most likely to speak with a spouse or significant other, a military friend outside of their chain of command, or a mental health provider at a military treatment facility. Those who considered, but did not seek support, were most likely to report that they had considered talking with these same categories of individuals as well as with a friend not in the military and a spiritual counselor.

During the focus group interviews, gatekeepers reported that mental health issues most commonly experienced by Service members include stress, anger, anxiety, depression, suicidal ideation and suicide, and post-traumatic stress. Service members may not seek help for these issues because of stigma, career impact, and the features of available services. Gatekeepers discussed that Service members do seek mental health services when they are directed by their command to do so, and they generally trust their providers, chain of command, and peers. Across all focus group sessions and locations, gatekeepers identified policies establishing integrated mental and behavioral health care and confidentiality as factors that increased mental health service utilization.

LIMITATIONS

Because the SOFS-A is a confidential, and not an anonymous, survey, Service member responses may be subject to response bias. Results from the SOFS-A are dependent on Service members' accurate self-reports of history of suicidal ideation or suicide attempt(s). It is possible that some Service members who completed the survey did not endorse these items to reflect their actual experiences.

There are also limitations related to the focus group interviews. As with other qualitative studies, the focus group interviews were not designed to be generalizable to the entire military. In fact, discussions with gatekeepers suggest that there are many base-specific concerns related to help-seeking. For instance, while career and clearance concerns were discussed in every focus group, they may have been discussed more or less depending on whether the base was primarily comprised of infantry or intelligence personnel. In addition, military installations that are joint service could impact the overall climate, and differences in senior leadership at each installation also could impact help-seeking behavior. Since it was not feasible to conduct focus groups at every Continental United States and Outside Continental United States military installation, it cannot be guaranteed that these findings are generalizable across the entire military.

RECOMMENDATIONS

This section translates the findings from the present study into a set of actionable recommendations for DoD stakeholders. Recommendations include: (1) Conducting effective suicide prevention training and mental health awareness campaigns, and evaluating their implementation; (2) Establishing programs specifically designed to

encourage officers to seek help, and (3) Addressing Service members' concerns that help seeking will adversely impact their careers. When possible, recommendations for programs or strategies were based on gatekeeper suggestions that were provided during the focus groups.

(1) Conduct Effective Suicide Prevention Training and Mental Health Awareness Campaigns, and Evaluate their Implementation

Findings from the SOFS-A and focus group interviews indicate that Service members recognize the importance of suicide prevention training and mental health awareness campaigns; however, this training must be delivered by appropriate personnel and evaluated periodically. The SOFS-A analyses found that Service members were more likely to seek help for suicidal ideation if they felt confident in recognizing suicide risk factors and knew the appropriate actions to take in order to receive care. During the focus group interviews, gatekeepers discussed the importance of mental health awareness campaigns and training as a means to reduce stigma, normalize mental health care, raise awareness of available resources, and encourage help-seeking. In addition to these psychoeducation-type trainings, gatekeepers generally spoke positively about primary prevention programs, such as life skills and resiliency building training.

Focus group discussions related to the effectiveness of suicide prevention training addressed the direct connection between the success of training and the characteristics of the person administering the training. According to focus group participants the "right" person to lead any suicide prevention or mental health awareness training is someone who is invested in the topic, and ideally someone who has practical experience with the issue being discussed. Gatekeepers also talked about how their experience with giving or attending this training was improved when unit leadership emphasized the importance of the training by attending themselves and displaying genuine interest. Conversely, focus group participants also identified "slideshow" presentations as an ineffective way to communicate suicide prevention training. Gatekeepers identified ASIST and safeTALK as effective programs that provide them with the practical skills necessary to address suicide risk factors. Therefore, when discussing recommendations for suicide prevention education, it is important to acknowledge that not all programs are equally effective and to assess the success of these programs from the Service member's perspective.

Actions

(A)   Design mental health training programs so that they are delivered by knowledgeable and committed personnel, including MFLCs, suicide prevention coordinators, Service members who have utilized mental health services, and veterans who have first-hand experience.

(B)   Assess the level of training saturation and tailor trainings to the audience.

(C)   Stress the importance of the training in addressing the health and functioning of Service members, and therefore of units, to commanders and other leaders. Encourage commanders and leaders to disseminate this message through the chain of command.

(D)   Make ASIST and safeTALK more widely available to Service members.

(E)   Make information on suicide risk factors and prevention publicly available to a wider community of individuals who support Service members (e.g., by posting it on the DSPO website). As reported on the SOFS-A, besides military gatekeepers, non-help-seekers who considered speaking with someone most often considered speaking with a civilian mental health professional, a spouse or significant other, or a friend who is not in the military. These types of individuals are another critical category of "gatekeepers" and may require training in suicide prevention knowledge and skills in order to recognize mental health issues in a Service member and intervene appropriately.

(2) Establish Programs Designed to Encourage Officers to Seek Help

Another finding from the SOFS-A analyses is that officers were significantly less likely to seek help for suicidal ideation or suicide attempt, which is consistent with previous findings on officer mental health help-seeking (Hines et al., 2014, Britt et al., 2016). In the focus groups, gatekeepers explained that senior officers have heightened concerns over the impact of help-seeking for their health needs, particularly their mental health. Because officer promotions have statutory constraints imposed by the Defense Officer Personnel Management Act that created limits on the number of field grade (O4-O6) officers in each Service, there is an "up or out" promotion system that is different from the administrative constraints for enlisted advancement. Consequently, this leads to a "zero defect" culture where the most minor shortcoming can be perceived as an impediment to promotion. Many officers will avoid disclosure of mental health concerns until absolutely necessary because they do not want to be compared unfavorably to peers who do not report mental health issues and, thus, be passed over for future opportunities and promotions. As a result, officers and other senior leaders are likely to rely on their peers for mental health support instead of seeking more formal mental health care.

Actions

(A)   Develop specific programs tailored to encouraging senior leaders to seek help. These programs should be separate from programs for junior enlisted personnel in order to help facilitate anonymity and trust.

(B)   Conduct a review of the current suicide prevention training to ensure that language is inclusive of all Service members and avoids language that may isolate senior leaders.

DISCUSSION

(C)   Provide structured opportunities for Service members to engage in peer-support systems within the military. For example, some gatekeepers in unit leadership focus groups explained that their units have informal groups for junior members where they can find support from their peers. This could be modeled for senior leaders.

(3) Address Service Members' Concerns that Seeking Help will have an Adverse Impact on their Careers

Of the many barriers examined in the quantitative analyses and discussed in the focus group sessions, concerns about career impact were the most commonly cited reason for why Service members do not use mental health support services. Some of the career concerns are associated with the stigma of mental health and concerns about being judged by peers, co-workers, and leaders, while other career concerns are derived from a misunderstanding of what will occur if a Service member seeks mental health care. Continual education and messaging may help reduce stigma and clear misperceptions of adverse career outcomes associated with seeking mental health care.

In analyzing the focus group discussions, it emerged that the most significant career impact concerns come from the real implications of policies that are designed with the safety of Service members in mind. Gatekeepers discussed, for example, specific policies related to deployability (DoDI 6490.07, *Deployment-Limiting Medical Conditions for Service Members and DoD Civilian Employees*) and qualifications for carrying a firearm (DoDD 5210.56, *Arming and the Use of Force*). Policies on deployment-limiting medical conditions outline that Service members diagnosed with certain mental disorders (e.g., psychotic or bipolar disorder) are ineligible for deployment. Service members diagnosed with certain other mental disorders must demonstrate a pattern of stability without significant symptoms or impairment for at least 3 months prior to deployment. In addition, certain prescribed medications are disqualifying for deployment (e.g., antipsychotics, lithium, barbiturates and anticonvulsants). These policies are written to support the safety of the Service member and the health of their units and should not be changed even though they might deter a Service member from seeking mental health care. Instead, the barriers to service utilization created by these policies may be best addressed by a cultural shift, as opposed to a change in policy.

One way to effect meaningful change is for military leaders to be clear that there are real career implications associated with seeking mental health care, but that seeking help does not typically end a military career. Gatekeepers discussed several instances of peers and senior leaders sharing with others how they utilized mental health services and continued on a positive career path, noting that these stories were effective in facilitating mental health service utilization. Gatekeepers also acknowledged that in some cases, the better option for a Service member's mental health is to leave the military, and under these circumstances it would be important to strengthen career and transition support programs that provide

guidance and career training for Service members who are separating from the military. Similarly, focus group participants suggested inviting peers and senior leaders who have successfully used mental health services to share their stories, and bringing in veterans to speak to current Service members about mental health care and how they successfully navigated life outside of the military.

A shift in perception of the career implications of seeking mental health care also requires trust between Service members and their leaders and a supportive environment in which Service members feel comfortable seeking help. Other policies that gatekeepers identified as facilitating mental health service utilization include services that protect the Service member's confidentiality. Several gatekeepers identified aspects of the Sexual Assault Prevention and Response program that could be applied to suicide prevention, including the confidential reporting system and the assignment of an advocate to assist the Service member with obtaining needed resources. In addition, gatekeepers stressed the importance of focusing on prevention and early intervention for mental health concerns.

Actions

(A)   Provide Service members with accurate information regarding the ways in which utilizing mental health service can and cannot affect their career, security clearance, ability to carry a weapon, ability to deploy, etc.

(B)   Shift the perception of policies that currently impact Service member's careers to underscore the safety of Service members and their units.

(C)   Highlight stories from Service members about how seeking help did not end their military career.

(D)   Invite veterans to speak with Service members about life after military service in order to raise awareness of transition planning and services.

(E)   Strengthen career and transition support programs that provide guidance and career training for Service members who are separating from the military.

(4) Recommendations for Future Research

A number of additional issues and themes related to non-help-seeking were discussed during the focus groups; however, these issues did not fall within the scope of this current study. The following topics are potential areas for future research:

(A)   A deep-dive into the specific needs and barriers applicable to various military subpopulations (e.g., Navy's nuclear propulsion and submarine community, Special Access Programs).

- The current project was unable to draw conclusions about the specific needs and barriers of some military subpopulations that were mentioned during the focus groups. This is due to a limited number of gatekeepers

providing information on these subpopulations because they were not the focus of recruitment for the focus groups. Those gatekeepers who were from certain subpopulations did mention that there are unique stressors and concerns among members of those subpopulations when it comes to mental health services.

(B)   Analysis of installation-specific considerations related to implementing suicide prevention training and efforts.

- Gatekeepers made occasional references to other duty locations and how they differed from their current posting in terms of culture and perceptions of mental health help-seeking. This raises the question of how geographic characteristics (e.g., rural vs. more urban surroundings) and installation-specific characteristics (e.g., high turnover in MFLCs) may be associated with help-seeking among Service members of that particular installation.

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APPENDIX A:

DOD MENTAL HEALTH-RELATED POLICIES

DODD 6490.14 - DEFENSE SUICIDE PREVENTION PROGRAM

This DoD directive aims to prevent suicide and reduce stigma related to mental health care utilization by Service members, and prioritizes the need for suicide prevention training, including guidance on how to identify Service members who may be at risk for suicide. This DoD directive also requires the Services to foster a command climate that encourages help-seeking, builds resilience, increases awareness about mental and behavioral health, reduces stigma, and protects the privacy of personnel who seek or receive mental health treatment.

DODI 6490.04- MENTAL HEALTH EVALUATIONS OF MEMBERS OF THE MILITARY SERVICES

This DoD instruction regarding the mental health evaluations of Service members dictates that commanders and supervisors are authorized to require that a subordinate Service member receive a mental health evaluation. The DoD considers the utilization of mental health services comparable to other forms of care that are not stigmatized (e.g., medical). Therefore, these instructions hold the same status as other military orders. A Service member may be referred for an emergency mental health evaluation by a commander or supervisor if they believe that the Service member may harm themselves or someone else. Commanders and supervisors can also submit an emergency referral for Service members who may be experiencing mental health concerns. Commanders and supervisors may also refer a Service member for a non-emergency mental health evaluation for concerns about factors such as fitness for duty, significant changes in performance, and behavioral changes that may be related to mental health. Additionally, Service members may submit a voluntary self-referral if they perceive a need for mental health care. The instruction emphasizes the importance of safety and communication during the referral process as well as command promoting help-seeking and a culture of holistic well-being.

DODI 6490.05 – MAINTENANCE OF PSYCHOLOGICAL HEALTH IN MILITARY OPERATIONS

This DoD instruction pertains to combat and operational stress control (COSC) and requires leadership to develop a climate of prevention and protection in order to enhance performance and buffer the psychological consequences of exposure to combat and other forms of military operational stress. In developing a climate of prevention and protection, leadership receives support from COSC consultants and healthcare professionals. COSC personnel can facilitate implementation of first-response intervention. COSC personnel are trained to identify, evaluate, and distinguish combat stress reactions from diagnosable mental health disorders. Senior enlisted Service members receive annual training in COSC principles.

DODI 6490.06 – COUNSELING SERVICES FOR DOD MILITARY, GUARD AND RESERVE, CERTAIN AFFILIATED PERSONNEL, AND THEIR FAMILY MEMBERS

This DoD instruction calls for a concerted effort to eliminate stigma around seeking counseling support and instead, to view counseling as a means to enhance military and family readiness. This instruction mandates the implementation of non-medical, short-term, solution-focused counseling in order to address concerns such as stress, grief, coping with the deployment cycle, spousal relationships, and parent-child relationships. Chaplains may also provide counseling to individuals, couples, families, and work groups.

DODI 6490.07 – DEPLOYMENT- LIMITING MEDICAL CONDITIONS FOR SERVICE MEMBERS AND DOD CIVILIAN EMPLOYEES

DoD personnel with existing medical conditions are permitted to deploy only if the condition is not expected to be worsened and have a negative impact on mission execution, the condition is stable and not likely to worsen during deployment, necessary medications are available in theater, and there is no need to routine evacuations for evaluations.

MEMORANDUM – CLINICAL PRACTICE GUIDANCE FOR DEPLOYMENT-LIMITING MENTAL DISORDERS AND PSYCHOTROPIC MEDICATIONS

This memorandum provides clinical practice guidance on limitations of deployment for Service members who have been diagnosed with mental disorders or who are prescribed psychotropic medication. According to the memorandum, Service members are ineligible for deployment if they have a current diagnosis or history of a diagnosis of a psychotic or bipolar disorder, and if they are diagnosed with any other mental disorder they must demonstrate a pattern of stability without significant symptoms or impairment for at least 3 months prior to deployment. In addition, the following medications also disqualify Service members from deployment: antipsychotics, lithium, short acting benzodiazepines, barbiturates and anticonvulsants, medications with special storage considerations, and medications that require laboratory monitoring.

DODI 6490.08 – COMMAND NOTIFICATION REQUIREMENTS TO DISPEL STIGMA IN PROVIDING MENTAL HEALTH CARE TO SERVICE MEMBERS

Mental health care providers do not notify a Service member's commander when a Service member receives mental health or substance abuse services, except under specific conditions such as threats to harm oneself, others, or the mission. In the event that a provider notifies a commander of a Service member's utilization of mental health or substance abuse services, the commander is expected to protect the privacy of all information divulged. Commanders are also expected to promote positive regard for Service members who seek mental health assistance.

DODD 5210.56 – ARMING AND THE USE OF FORCE

The purpose of this directive is to establish policy and standards and assign responsibilities for arming, carrying of firearms, and the use of force by DoD personnel. Per this policy DoD Component heads are responsible for suspending arming authorizations for DoD personnel who are no longer qualified to be armed, including individuals who have a medically certified disqualifying physical or mental health condition. If a Service member is determined to no longer be qualified to be armed, the components must retrieve any government-issued firearms, ammunition, non-lethal weapons, and non-lethal ammunition.

SERVICE-LEVEL CHAPLAIN CONFIDENTIALITY POLICIES

SECNAVINST 1730.9 - Confidential Communications to Chaplains

This instruction, which applies to Navy and Marine Corps personnel and the Coast Guard when operating as a service in the Navy under 14 United States Code Section 3, explicitly states that Navy chaplains have a professional obligation to keep private all confidential communications which are disclosed to them by Service members and family members seeking chaplain assistance.

AFI 52-101- Chaplain: Planning and Organizing

This instruction states, "under no circumstances may a chaplain or chaplain assistant disclose privileged communication revealed in the practice of his/her official capacity without the individual's informed written consent."

AR 165-1 - Army Chaplain Corps Activities

This Army Regulation defines confidential and privileged communication and states, "Chaplains may not disclose a confidential communication revealed in the practice of their ministry without the individual person's informed consent."

SERVICE-LEVEL SUICIDE PREVENTION PROGRAMS[2]

OPNAVINST 1720.4A - U.S. Navy Suicide Prevention Program

The Navy's Suicide Prevention Program consists of four primary elements – training, intervention, response, and reporting. The training element describes the annual training provided in order to cultivate an environment in which it is every Sailor's duty to obtain assistance for other Sailors in the event of suicidal ideation or behavior. Training also involves raising awareness regarding the risk factors for suicide, identifying signs and symptoms of mental health concerns, responding to crisis situations, and providing contact information for local support services.

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[2] Although Service-specific policies encourage support for any person needing assistance, these policy summaries reference Service-specific personnel for ease of interpretation.

The second element, intervention, provides Commanding Officers with necessary prevention and intervention plans. Commanding Officers are expected to develop a climate that promotes psychological health (e.g., foster unit cohesion, encourage communication) and to support Sailors who seek help for personal problems. Commanding Officers are also expected to take any safety measures necessary, if there is imminent risk of an individual inflicting personal harm or harm to others.

The response element outlines the required procedures to follow in the event that a Sailor displays suicidal behavior or commits suicide. Command and local mental health resources are responsible for providing support to families and affected personnel. The reporting element requires the reporting of suicide and suicide attempts.

DA PAM 600-24 - U.S. Army Health Promotion, Risk Reduction, and Suicide Prevention

The Department of the Army developed Pamphlet 600-24 in order to explain procedures for health promotion, risk reduction, and suicide prevention. Strategies to prevent suicide include building resiliency (e.g., joining social support groups or faith-based organizations), reducing stigma (e.g., increasing behavioral health visibility), raising awareness (e.g., observing Suicide Prevention Month), and engaging in strategic communication plans (e.g., dissemination of resources). The Army emphasizes the significance of leaders across all levels and their role in executing these strategies. The Army also utilizes the Ask, Care, Escort (ACE) training model. The Ask component involves addressing threats of suicide directly (i.e., ask the fellow Soldier if they have plans for suicide). The Care component involves understanding when someone may be in pain and offering assurances that help is available. The Escort component involves escorting the at-risk Soldier to resources that may help (e.g., chain of command, chaplain). In general, the ACE model encourages Soldiers to talk openly about suicide, take threats seriously, trust suspicions, and respond to cries for help.

AFI 90-505 - Air Force Suicide Prevention Program

The Department of the Air Force provides tiered and targeted suicide prevention training. The first tier provides foundational training to all new Airmen in a face-to-face format. In addition, Airmen complete annual Total Force Awareness Training, which provides information about how to identify and assist people who may be at-risk for suicide. The annual training identifies both risk and protective factors. The Air Force also implements the ACE (Ask, Care, Escort) model. The delivery of this training may be via computer but commanders are highly encouraged to provided suicide prevention training face-to-face in order to encourage group discussions when possible. The second tier provides targeted training designed for groups at higher risk. For Airmen in at-risk groups, face-to-face training is required. Furthermore, supervisors of at-risk Airmen must attend a face-to-face Frontline Supervisors Training and annual maintenance trainings. The third tier provides

training for personnel in units or positions with a high probability of encountering personnel in distress (e.g., security forces, commanders). Airmen that will likely manage personnel in distress receive agency-specific training on Limited Privilege Suicide Prevention, the investigative interview hand-off policy, and procedures for intervention and referral. In addition, all military mental health providers complete annual training for managing suicidal behavior.

MCO 1720.2 - U.S. Marine Corps Suicide Prevention Program

The Marine Corps Suicide Prevention Program emphasizes that suicide prevention should be more than a single activity or training. The Marine Corps policy is that getting help for a fellow Marine in distress is a duty. Individual Marines are expected to provide assistance or notify chain of command if a fellow Marine appears to be showing signs of suicidal ideation. Marines are also expected to participate in suicide prevention training at least once a year. In order to execute the Marine Corps policy and adhere to procedure, commanders are responsible for implementing the suicide prevention program. Implementation involves several components such as raising awareness, training leaders at all levels, and crisis intervention and risk management procedures among Marines who require emergency behavioral healthcare or show signs of heightened risk (e.g., depression, alcohol abuse). The Marine Corps emphasizes the significance of leadership having an active role in recognizing distress and facilitating early intervention.

UNITED STATED CODES RELATED TO RESERVE AND NATIONAL GUARD BENEFITS

Medical and Dental Care: Members on Duty other than Active Duty for a Period of More than 30 Days, 10 U.S.C. § 1074a et seq. (Government Printing Office, 2011)

This U. S. Code and subsequent sections clarify the situations and time frames for military personnel on active duty for more than 30 consecutive days to receive medical and dental care.

Medical and Dental Care for Dependents: General Rule of 2012, 10 U.S.C. § 1076 et seq. (Government Printing Office, 2011)

This U. S. Code and subsequent sections clarify the situations and time frames for the dependents of military personnel on active duty for more than 30 consecutive days to receive medical and dental care.

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA 38 U.S.C. 4301-4335)

This U.S. Department of Labor act secures the job rights for veterans and Reserve and National Guard component members. It protects the civilian jobs rights and benefits of these Service members, establishing guidelines for employers and Service members regarding timelines for reemployment.

APPENDIX B:

ARMY FOCUS GROUP RESULTS

RESULTS OF ARMY FOCUS GROUP INTERVIEWS

In the second phase of this project, Defense Personnel and Security Research Center (PERSEREC) researchers conducted 26 focus groups at U.S. Army, Navy, and Air Force installations to examine further the development of mental health concerns and the barriers to and facilitators of seeking mental health support. Due to administrative delays, the data from the Army installations—Fort Campbell, KY, and Fort Bragg, NC—were not available in time for the initial analysis and thus are not included in the Results section of this report. Once the data were available, we analyzed them using the same procedures used to analyze the Navy and Air Force focus group data. The goal of the analysis was to synthesize the themes around mental health concerns and help-seeking behaviors discussed by the Army gatekeepers during the focus groups. This addendum presents the results of data analyses of 10 focus groups conducted at Fort Campbell and Fort Bragg in January 2017.

METHOD

The Defense Human Resources Activity Exemption Determination Official reviewed the study procedures and determined the study to be non-human subjects research. Just as for the Navy and Air Force focus groups described in the main body of this report, questions posed to Army gatekeepers primarily focused on the experiences of active duty Service members; however, gatekeepers were also asked for their perspectives on non-help-seeking behaviors in the Reserve and National Guard communities. Focus group questions covered (a) the types of mental health issues that Soldiers face, (b) the barriers to care, and (c) the ways in which gatekeepers facilitated and encouraged help-seeking. This section describes the data collection process and analysis approach.

PARTICIPANTS

Ten focus group interviews were conducted at Fort Campbell, KY, and Fort Bragg, NC, in January 2017. These installations were selected based on their high operation tempo and deployment and redeployment commands focus. Both installations are located in rural areas of the country, each more than 60 miles from the nearest major metropolitan area. Additionally, Fort Campbell was selected for having the highest suicide rate among all U.S. military installations.

At each installation, gatekeeper-specific focus groups were conducted with (a) chaplains and religious personnel, (b) law enforcement and security personnel, (c) medical and mental and behavioral health providers and counselors, and (d) unit leadership. A fifth type of focus group composed of a variety of gatekeeper types was conducted to gather combined gatekeeper perspectives ("Multidisciplinary" group; see Table 10 in the main report for further detail on types of gatekeepers recruited). Four focus group facilitators conducted the focus group interviews.

Focus group interviews consisted of 8 to 22 participants, with the size of the focus groups varying based on the size of the installation and the number of gatekeepers available (see Table B-1).

Table B-1
Number of Gatekeeper Participants by Installation

	Ft Campbell	Ft Bragg	Total
Chaplains and religious personnel	8	18	26
Law enforcement and security personnel	7	16	23
Medical, mental, and behavioral health providers and counselors	8	13	21
Unit leadership	8	17	25
Multidisciplinary	10	22	32
Total	41	86	127

PROCEDURE

The same procedure described in the body of this report was used to collect the Army focus group data; it follows the conventions and best practices of conducting focus group interviews (Krueger, 2014). A representative at each installation assisted with recruitment of focus group participants. Participants volunteered to participate in focus group interviews conducted in an on-site room. The focus groups were composed of homogeneous groups of 8 to 22 participants and met privately for approximately 1.5 hours. A lead facilitator and assistant facilitator conducted each focus group session.

Each participant provided verbal consent before beginning the focus group interviews (see Appendix D). After the informed consent procedure, the facilitator discussed ground rules (e.g., details should not be shared with anyone outside the room) and introduced all present researchers.

The focus group questions covered topics related to non-help-seeking, barriers to mental health care, and the impact of existing policies. The focus group questions were organized by subject areas:

- Behavioral health help-seeking (e.g., "What are some of the behavioral health issues you have observed?"),

- Mental health help-seeking (e.g., "What strategy did you use that you believe was most effective in encouraging Service members to seek care?"),

- Help-seeking gaps (e.g., "What are some policies that contribute to the barriers to help-seeking?"), and

- Help-seeking barriers and policies (e.g., "Which barriers do you believe Service members would list as the most significant barriers to seeking help?").

The focus group questions also included a final section on topics related to help-seeking in the Reserve and National Guard components. The set of focus group questions concluded with an opportunity for gatekeepers to ask questions of their own or address any issues not previously discussed (see Appendix D for the full list of focus group questions).

Field notes were taken in a note-taking template and focus group interviews were electronically audio-recorded. A transcription service transcribed the focus group interviews using a "near" verbatim approach to exclude background noise and filler words and utterances from the text transcript. The transcripts were reviewed and any personal identifiers were removed. The accuracy of the transcripts was verified by a comparison to the audio recording.

DATA ANALYSIS

A matrix approach (Miles and Huberman, 1994), with multiple, independent research analysts coding the text data (see Phase II: Gatekeeper Focus Groups, Method), was used to analyze the Army focus group data in January 2018. The research team used the same codebook developed through multiple coding rounds of the Navy and Air Force transcripts (see Appendix E for the final codebook).

Five researchers coded the 10 Army focus group transcripts. At least two researchers coded each transcript during an initial round of coding. Researchers calculated inter-rater reliability using the intraclass correlation coefficient (ICC) for focus groups by pair of raters. In one case (Fort Campbell Multidisciplinary focus group), inter-rater reliability was poor (0.32). Analysis showed that approximately two-thirds of the inter-rater variation in this case could be explained by just five codes (Mental Health: Mental Health Issues; Barriers: Gatekeeper Training/Skills; Barriers: Manning/Staffing Issues; Policies: Policy Implementation; Policies: Policy/Guideline Gap). The two researchers originally assigned to code this transcript met to review their coding results and their use of selected codes. The two researchers then independently recoded this transcript. Those results were then retested for inter-rater reliability, resulting in an increased ICC of 0.89. Final calculated ICCs ranged from 0.55 to 0.89, indicating that there was fair to excellent inter-rater reliability (Cicchetti, 1994). At the conclusion, researchers synthesized and discussed the major themes that emerged.

RESULTS

Three major groups of themes emerged from the focus group interviews. This section discusses the tone of the focus groups and the themes that comprised the major groupings of: (a) reasons mental health issues and suicidal behavior develop, (b) barriers to seeking help, and (c) reasons Soldiers seek help. In addition, this section describes the themes from gatekeepers' discussion of the Reserve and National Guard component.

TONE

Coders agreed that the tone of the Army focus group discussions was generally negative. Focus group participants generally recognized that legitimate mental or behavioral health issues deserved appropriate treatment and support and that there are a number of institutional and cultural barriers to help-seeking. However, there seemed to be some tension over what constituted a legitimate issue and who merited treatment. Attitudes toward help-seeking by more experienced Soldiers were more positive; this suggests a recognition that combat experience and the stresses of a military career can be frequent sources of mental and behavioral health problems. Focus group participants expressed more negative attitudes toward the help-seeking of less experienced Soldiers, particularly those viewed as taking advantage of services for purposes other than getting better. This negative perception was frequently expressed in intergenerational terms and was described as a general lack of resilience among the millennial generation. Because of this tension, many gatekeepers used stigmatizing language when describing issues they observed. In addition, gatekeepers expressed mixed attitudes about the Army's response to mental and behavioral health issues. Many described their own or their subordinates' interactions with treatment and support services in positive terms, suggesting that efforts to prioritize mental and behavioral health issues have had some success in recent years. At the same time, there seems to be a level of cynicism among gatekeepers, who commonly expressed frustration with gaps in policies and available services and poor or inconsistent implementation of programs by "big Army" bureaucracies.

Representative Quotes

- "Every year we have to sit down and take a whole bunch of [computer based trainings] or surveys. It's always constantly a survey. The [attitude] overall is what's the point, there's no action going to be taken. Now we're doing this focus group for a situation that to me, and I've seen an increase – it's not decreasing in suicide, suicidal ideation or suicide attempts or actual suicide. With the amount of workload that's being placed on everybody - okay, we get these focus groups, but where is it going to go? Are they listening?"

- "That soft kind of attitude facilitates that soft Soldier. But correction, making corrections and being a tough trainer of Soldiers is what develops character and develops grit, and gives them the tools to handle things when you're in that type of environment. These guys have never done anything hard in their entire life and that's why they don't have the tools. So when you introduce them to something hard, which is the best medicine for them, it's 'Oh, my gosh,' but then we've got to coddle so much."

- "And we made sure that if you did have a suicide ideation, you were going through the whole process. And you were going to spend three days strapped to a bed, even if halfway through you recognize, 'Oh, this ain't going the way I

thought it was going to go.' That really cut down on the false positives. And I don't see that either where we send them to behavioral health, they go for two hours, and they come back to the unit. And then either we've got to watch them, or tell some NCO to keep eyes on them, or whatever. It comes on the unit to take care of that problem, which is also a good thing, right? That's the problem."

- "I feel when I talk to the psychiatrists that they're very combative with the green suiters. [...] They have a preconceived notion about the problem Soldiers have, and they view us as being the cause of those problems. [...] Every time I've interacted with a psychiatrist, I feel like I'm talking to somebody who's so far gone from what the Army does, that the true diagnosis and impact of that don't line up. So it looks like we're trying to pull one way to get the Soldier back in line, help him out, and the psychiatrist is trying to go pull the other way."

- "So we get Soldiers in who it's their first time away from their families. They live in the barracks. All they do all day is concentrate on the Xbox and they have very, very poor person-to-person interaction... [A] Soldier might feel depressed or feel adversity for the first time and say, 'Wow I must have a real big problem.'"

ACTIVE DUTY COMPONENT FINDINGS

This section describes the three major groups of themes that emerged in the focus group interviews: (a) reasons why individuals experience mental health issues, (b) reasons why individuals do not seek help, and (c) reasons why individuals do seek help.

Reasons Individuals Experience Mental Health Issues

Gatekeepers worked with Service members dealing with a wide array of mental and behavioral health problems. These problems ranged from difficulties adjusting to the military environment to more serious mental health conditions such as depression, anxiety, posttraumatic stress disorder, and suicidality. Most gatekeeper participants agreed that many Soldiers who develop mental health problems during their service come into the Army with existing vulnerabilities, including low resilience, a lack of social or family support, poor coping skills, low adaptability, and even preexisting depression and anxiety. Gatekeepers acknowledged that Soldiers' experiences in the military, such as work-related performance pressure and deployment, were stressors that exacerbated existing individual vulnerabilities and resulted in more serious mental health problems including suicidality. Soldiers usually did not experience just one issue; gatekeepers described how issues were often intertwined and discussed how many Soldiers experienced an accumulation of stressors that compounded one another. For example, an individual may experience financial difficulties that strain family relationships that make it difficult for the Soldier to cope with reintegration after a recent deployment. Some gatekeepers also identified toxic work environments and toxic leadership as additional serious

stressors that contributed to Soldiers' mental health issues. Because of the perception that many Soldiers come into the Army with existing vulnerabilities, gatekeepers expressed frustration with the gaps in screening and accessions processing of individuals they believe are unable to cope with the rigors of military service. Gatekeepers pointed to changes in recruiting standards in previous years and drew a correlation between this occurrence and the increase in the number of mental health, suicidality, and even legal issues among Soldiers.

Representative Quotes

- "If you do a thorough enough history with a lot of [Soldiers] you will find that there is a pattern of poor coping. They come into the military and they are exposed to stressors either through just the military lifestyle or combat, and then it can just goes downhill from there."

- "Deployment issues, people coming back from deployment, spouse cheated, or all the money is gone, financial – big financial situations around here. So depression, anxiety. Depression and anxiety typically around that PTSD issues."

- "If it's substance abuse problems, family problems, they're all compounded, getting in trouble at work, punitive action, and then things just start to compound over and over."

- "If we could screen and make it a little harder, even though I know the Army's like, 'No, we got to have bodies.' I understand that, but we do bring in a lot of people that when you look at their background, and it's like we're not a social experiment. We don't have time, we're not a welfare system that can say, 'Hey, let's take care of you now.' We need to do a job. Our country's given us a mission. If we break you, we'll fix you, but if you came in broken, we're probably not going to be able to fix you. We're just going to have to eventually chapter you out after you make an enormous number of mistakes and problems for us."

Reasons Individuals Do Not Seek Help

Focus group participants identified a variety of barriers to help-seeking among Service members. Specific barriers discussed were disparate, ranging from practical obstacles, such as difficulty scheduling appointments, to cultural biases. Despite the specific variation, barriers generally fell into one or more of the following themes: perpetuation of stigma, career impact, and policy gaps and implementation. The following section presents the most common themes related to why individuals do not seek help, representative quotes, and an analysis of the relationships between themes.

Stigma

Participants agreed that stigma related to mental health remains the most significant barrier to help-seeking among Soldiers, although most agreed that

efforts in recent years to reduce stigma have had some positive impact. Military culture frequently perpetuates the perception that treatment for a mental health condition is an indicator of personal weakness and a threat to unit cohesion. These attitudes may be especially common in combat-arms units. Gatekeepers report a common concern among these unit members that time away from the unit, including time spent in help-seeking, undermines unit cohesion. Time off work creates a burden on other unit members to accomplish assigned missions, which may create tension with leaders and peers who may view the individual as a "slacker." This is exacerbated by pressures across the military to do "more with less" due to budget and personnel drawdowns.

Old-fashioned attitudes toward mental health and the demands of unit commitment are also related to the critical importance of trust on the command climate. Gatekeepers suggested that reducing stigma may be directly related to the ability of commanders to instill trust among their subordinates that help-seeking is effective and that help-seeking efforts will be supported by leadership. Unfortunately, trust can often be undermined by the lack of privacy inside units, which contributes to the spread of gossip about individuals who seek help and misinformation about mental health and the consequences of help-seeking. Privacy protections prevent disclosure of personal health information, but a unit member's absence for mental health treatment may lead to speculation about reasons for the absence based on incomplete or inaccurate information. The resulting rumors contribute to stigma and fears that help-seeking may lead to discharge from military service.

Representative Quotes

- "I think a lot of people don't want to report either because in their own mind it's humiliating. They don't want to look weak because to them coming forward looking for help for, especially, mental health or anything like that to them it makes them look weak because we're in an environment where everyone is supposed to be tough and strong. They don't realize that going to seek help isn't a sign of weakness."

- "You're identified as weak or having a problem or you're missing training. You're missing your responsibilities because you're going off to mental health. You're put into a category oftentimes. That's not every unit. There are some that are supportive but they are almost always individuals within that unit who will ostracize you, who will belittle you – the environment becomes toxic towards you. And I've heard every Soldier I've had talk about that happening to them at some point."

- "There also seems to be a lot of stigma about any kind of going off to an appointment. I mean you see that across the board too. That's still a huge factor. The stigma of not wanting to look like a dirt bag."

Career Implications

Gatekeepers voiced concerns about a number of real and misperceived consequences to career progression as a result of mental health help-seeking. For example, mental health treatment may place an individual in a nondeployable status, and a missed deployment may inhibit career progression. Some policies designed to protect Service members have unintended career consequences, particularly when policies are widely misunderstood, such as the common belief that mental health treatment will result in the immediate loss of a security clearance. Similarly, career Soldiers may avoid help-seeking due to concerns that mental health treatment or "taking a knee" from high-stress assignments will result in a "flag" in their personnel record and the loss of future advancement opportunities. Career consequences fuel the misconceptions and stigma surrounding utilization of mental health resources. Gatekeepers noted that these misconceptions lead some senior leaders and cleared personnel to limit help-seeking to services provided by military chaplains, due to the strict confidentiality rules under which chaplains operate. Additionally, senior personnel expressed concerns about privacy while seeking treatment. In many cases, leaders and subordinates may have to utilize the same service providers; participants frequently expressed concern that leadership is undermined when subordinates observe officers and senior enlisted receiving mental health services.

Representative Quotes

- "Some people are just scared to [go to behavioral health]. In my friend's unit, he's in the infantry, a lot of his leadership tell him, 'If you go to behavioral health, that's the fastest way out of the Army.'"

- "From a junior enlisted point of view, their biggest thing is, 'If I go get something off my mind, am I going to be flagged? Am I going to be unemployable?' […] They [perceive that] no one is explaining if there is going to be a point where they go get help, and someone's going to be like – you know, a mission comes up, and oh, well, you're not technically mission ready? They don't want that to interfere with – and that stops a lot of people."

- "So I don't think there's a barrier for junior Soldiers to seek help because I don't think it's dawned on them this is going to be a career for me. But I think the barrier for your more senior NCOs and officers – it's career progression."

- "The further established you are in your career, the less likely you're going to want to go to the behavioral health. You don't want everyone to know about that, and there are [as we just discussed] a whole bunch of repercussions."

- "…if you have mental issues or concerns, anything that has to do with mental illness or health issues, you're supposed to revoke someone's clearance, and it goes back – bouncing back. If I go seek mental health, and I have a mental

health issue, a commander can revoke my clearance, so am I bouncing back?
Am I being punished for going forward?"

Policy Gaps and Implementation

Focus group responses often highlighted the real and perceived gaps and problems of implementing DoD and Army mental health policies. Gatekeepers' responses suggest there may be widespread confusion over policy requirements, too many opportunities for policy misinterpretation, and lack of policy knowledge at the unit level. This was particularly apparent in discussions of the career impacts of help-seeking. Inconsistent policy implementation and access to services reduce confidence in the military's commitment to mental health. For example, gatekeepers described very different programs and processes available to different populations of Service members, even on the same installation.

Despite major expansion of mental health services in recent years, access to services remains an issue. In some locations, there may be very long wait-times for scheduling appointments for nonemergency situations as a result of heavy caseloads for clinicians. Complex referral processes may impede help-seeking for the appropriate level of care. For example, gatekeepers identified inconsistent experiences when addressing suicidal ideation, ranging from dismissive attitudes by leaders, to inappropriate escalation of cases to emergency level, to dangerously long wait times for referral to specialized care.

Privacy policies and lack of confidentiality in some programs is a frequent barrier to help-seeking. Commanders are required to report and track personnel for medical fitness, including those in mental health treatment. Although detailed medical information is protected in these circumstances, the individual's status may not be. Some Service members may be discouraged from seeking care because they will be identified to unit commanders, while others may feel forced to seek care outside of the military health care system. These reporting and tracking policies may also result in the attitude among leaders that reduces their subordinates' mental health fitness to a "check the block" or "PowerPoint slide."

Similarly, unintended barriers to help-seeking may arise from policies initially designed to improve care for Service members. For example, policies related to deployment eligibility (United States Central Command Individual Protection and Individual-Unit Deployment Policy, "Mod 12") requires those personnel prescribed psychotropic medications to be placed in a 90-day nondeployable status after prescription changes. Given the real and perceived career impacts of missing a unit deployment, this policy may create disincentives to seek medically appropriate treatment in the first place or to report ineffective treatment to providers.

Representative Quotes

- "...from what I've seen, the policies are being used. I've never seen anybody tell a Soldier or imply that a Soldier should not go seek help if they need it. I think the

vast majority of it is leaders not recognizing that there is a problem, or Soldiers not being proactive and going to help take care of themselves, because of the mental stigma. Either leaders see it and don't want to be involved, because they don't know how to deal with it, or Soldiers see it, but don't want to deal with it, because they don't want to be that dead weight."

- "I've seen some providers say you can't PCS because you're having marital discord. Really? I don't care about marital discord. If you're suicidal, homicidal, you probably shouldn't go, but you just need to keep that rapport going with your provider. So a little more clarification on the mental health aspect."

- "I think part of the issue is there's not a lack of resources for the Soldiers. They have resources. It's the lack of implementation on the post for the population. How is it being implemented and how is it being utilized? Because we've got resources a plenty to make Soldiers successful and resilient and not contemplate suicide ever. But it's not working."

- "And policies change all of the time. So they may have sought help when we were under Mod 11 and it was okay. And then guess what? Mod 12 rules changed. Sorry. You can't go."

- "I don't know if we [Army behavioral health providers] do anything to encourage people that have never sought help to seek help."

- "And it's interpretation. Like one of the Soldiers that went to the SRC and got denied deployment and came back and said 'I don't want to see you anymore.' Actually, if you read Mod 12 for that issue, even if they saw behavioral health, you've just got to send a waiver in. They're not non-deployable. They just require a waiver to deploy. But providers at the SRC, I understand they're on the time crunch. They don't want to deal with the waivers."

Relationships between Main Themes

Focus group responses suggest a strong thematic association among the barriers of stigma, career impacts, and policy problems. For example, negative attitudes toward mental health problems and help-seeking are both the result of and reinforced by the rumors and misinformation that arise from lack of confidentiality among unit members. There may also be a significant link between stigmatization of individual weakness and the emphasis in military culture on the critical importance of unit cohesion and mission accomplishment to the stigmatization of individual weakness. In such a culture, career barriers to help-seeking may be a natural consequence of such stigma. Gatekeepers commonly expressed frustration with gaps in policies and available services and poor or inconsistent implementation of programs by "big Army" bureaucracies, leading to a level of cynicism among gatekeepers at the frontlines of policy implementation. Such policy

failures perpetuate stigma among subordinates and weaken assertions that help-seeking is valued by the institution.

Representative Quotes

- "[Leaders are] so busy. They are working from before sunup until well after sundown so they really don't have the time. It's really difficult for them to make the time. They get in once, gosh, the thought of coming in a few more times. How am I going to fit that in? They don't even go to their medical appointments for things that they need surgery on. They put off surgeries for months and things that, at least on the surface, may be to them even more important than this behavioral health stuff."

- "The greatest roadblock to people seeking mental help is the stigma that exists. And you already heard around the table pretty much there's a resounding opinion that the majority of people seem to use behavioral health as a means to get out of the Army, and that's probably not an unfounded idea. But you can imagine down at the unit level what the pervading opinion is by the ground level leaders out there. I mean, no commander, first sergeant, is ever going to openly say that they suspect everyone who goes to behavioral health of trying to get out of the Army. But down there, you know, a young Soldier's team, their squad leader, they're going to hear about it from them. So I think there are probably a large number of initial term Soldiers who just don't want to be in the Army, and they probably are seeking behavioral health as an easy way out. But then there's probably just as many guys who are truly struggling and definitely need help who aren't seeking help, because they don't want to get identified or labeled as somebody who's trying to find an easy way out of the Army. So that's a tough one, and you'll see in various units the degree to which that stigma exists, and that's completely on that unit leadership."

- "If we're going to be able to provide Soldiers with good holistic care, and be able to provide them with the Soldier centered medical care, and be able to get them into the psychologists [care] that are there, and be able to really reduce the stigma to prevent mental health and the increase in suicides, all of those sort of things, we need to have the logistics set up for it, the policies, and an appropriate [level of staffing] to be able to support when we need that. It's a 'big Army' thing. It's nothing we honestly do here, but I mean if we get the word out and someone higher than us actually listens and staffs us appropriately for the division that we happen to have here, I believe we'll finally make some gains."

Reasons Individuals Do Seek Help

Four major themes emerged on the reasons why Service members seek mental health support and use available services. Service members who need care are more likely to seek it when they trust and are comfortable with the provider or resource, when they are comfortable with the level of confidentiality of the resource,

and when they have supportive leadership. Additionally, there is a common narrative that some Service members may use resources to achieve a goal other than mental health improvement. The following section provides an overview of the most common themes related to mental health service utilization and representative quotes from the Army focus group interviews.

Trust in Provider or Program

Gatekeepers consistently emphasized that Soldiers are more likely to seek help if they trust the behavioral health provider and the resources available to them. An individual's trust in supportive leadership and the effectiveness of available services may mitigate barriers to help-seeking such as stigma and career impacts. Soldiers are more likely to speak to gatekeepers about mental health concerns or use other mental health resources if there was already a level of familiarity and comfort with the individual providing the support. This familiarity makes unit chaplains a critical first line of support for many Service members. Many gatekeepers also identified the embedded behavioral health (EBH) model as an example of this approach to encourage Soldiers to seek any needed help. EBH providers are assigned to certain units and work in close physical proximity with their unit. As a result, EBH providers are able to interact frequently with Soldiers in less formal ways that allow Soldiers to become familiar with the EBH provider; some of these interactions include seeing and speaking to Soldiers "in the hallways" or participating in the same physical training sessions as the Soldier they are supporting. Gatekeepers explained that Soldiers then felt more comfortable speaking to the EBH provider about a mental health concern when it arose.

Representative Quotes

- "I've found that when encouraging Soldiers any grade to seek health care requires some rapport, some establishing of trust because we hear this in many, many briefings but it's still very difficult for most people to ask for it. So I make it as easy as possible, sometimes by addressing something very low threat, [such as] sleep issues, and then come back on that as we establish trust."

- "I can't emphasize enough the importance of the BHOs [Behavioral Health Officers] being out of the clinic and visible in the formation. […] For me when I was in aviation I would just wander through [and talk to Soldiers:] 'Hey, guys. Show me what you're doing. Show me what your job is. How do you fix this? What's this part?' That's where I would drum up a lot of my business. They would be [then think,] 'Okay. I talked to her. She was alright. She wasn't scary. Maybe I could run this past her.'"

- "[In the embedded behavioral health model] you could go in for physical therapy, to nutrition. But having that co-location. So sometimes you have this window of opportunity and it's small to engage, but you've got them at a

vulnerable moment and they're willing to talk. You want to be able to maximize that very small window and hand them right over to someone."

Privacy and Confidentiality

One major deterrent for help-seeking among Soldiers is a concern about confidentiality around mental health care use. These concerns lead many Service members to rely on services provided by chaplains or other confidential services.

Chaplains maintain full confidentiality and privileged communication of their discussions with Soldiers and are often the first point of contact for Service members who are hesitant to utilize behavioral health services. Confidentiality allows chaplains to establish trust and strong rapport so that individuals reluctant to seek help may be more likely to accept a chaplain's referral to specialized services.

Military and Family Life Counselors (MFLCs) were identified throughout the focus groups as a confidential resource available for Soldiers. Chaplains in the focus groups discussed encouraging Soldiers to use MFLC services for nonmedical counseling because, while records that identify Service members are kept in a case management system, their records are not connected to the military health system.

Military OneSource was a resource identified by all focus groups as beneficial and confidential. Military OneSource provides up to 12 sessions of nonmedical counseling services per issue. If a Service member requires escalated services or medication management, they are then referred to a medical provider, one that typically does not maintain the same level of confidentiality.

Gatekeepers also described how behavioral health providers found ways to ensure privacy and confidentiality of officers and senior noncommissioned officers concerned with being observed at treatment facilities by their subordinates. Providers accommodated these concerns by scheduling appointments outside of normal clinic hours, meeting with leaders in their offices, and finding ways to ensure that leaders could not be identified in their clinic's waiting room (e.g., a leader may decide to wear civilian clothes to an appointment or the provider may meet the leader as he or she is coming in so that they do not have to sit in the waiting room).

Representative Quotes

- "You got the chaplains, of course, most used asset. Military OneSource is a great source, too. Like he said, MFLC is really good if you want to remain anonymous. So Military OneSource, MFLC, is very good."

- "Because [chaplains] have 100 percent confidentiality, to include suicidal thoughts, ideations, etc. So I explain that to [Soldiers] over and over and over again, because they still don't believe me when I say it sometimes. And they

have this fear of going to get help and what that's going to mean for their career, etc."

- "I know that some patients like talking to the MFLC more, just because it's off the record, it's not going to be anything written down. At our clinic, I have to explain to them that it does go into the medical record, with the MFLC, it doesn't go into the medical record."

- "With at least our senior enlisted, our senior officers, some of them will reach out and tell someone who will call one of our Officers in Charge (OICs) or one of the clinic leaders. And there's a mechanism at every one of those clinics for somebody to be seen more discreetly, [in a way] that doesn't involve waiting in the waiting room. But nobody is going to ask for that unless they're comfortable and they know who to ping; they have a BHO who might advocate for them."

Command Climate

In a theme closely related to trust and confidentiality, gatekeepers explained that Soldiers felt more comfortable seeking and obtaining behavioral health treatment when their leadership fostered a positive command climate and supportive community and environment in which help-seeking was encouraged. Creating this type of command climate is more than just having an "open door policy." It is also about reiterating the message that seeking help is not a sign of weakness, using stigma-free language when discussing mental health utilization, and engaging with and paying attention to suicide prevention and other mental health trainings instead of attending to just "check the block." Gatekeepers noted that leadership actions such as checking in on Soldiers regularly, asking them questions, making sure peers and battle buddies are supporting each other, and ensuring that there is awareness of behavioral health resources within their unit are ways to contribute to this positive command climate and increase help-seeking for mental health concerns.

Representative Quotes

- "I agree that the leadership can truly impact, and they can create help-seeking cultures. I've seen units with a lot of camaraderie, teamwork, Soldiers free to talk, because they trust leadership. And there's toxic leadership that I experienced, that nobody wanted to see anybody."

- "I think the best medicine for guys that really have an issue is the Soldiers that are around him and a team leader and a squad leader who show genuine care and concern. Because as a commander, we don't touch these Soldiers every day. You know we give safety briefs and we talk to them at training events and all that kind of stuff. But we don't individually counsel every PFC in our formations. But that team leader does. And if that team leader is doing his job the right way he knows everything from that Soldier's favorite color to the size of

his shoes. And that kind of knowledge – intimate knowledge – of that Soldier and care of that Soldier is what's going to make that improvement. And it creates that atmosphere or that climate that actually cuts those issues off. Because they have people to talk to and know that somebody cares. And it gives that father or older brother figure in there as well that's the missing ingredient."

- "Command climate is essential because once that Soldier receives help, and he or she receives help for the right reasons, you have a challenge as a command team because you have to fight that stigma. It's one of those things where that Soldier has to go back to his buddies and the command climate is everything. You either have Soldiers who support him or her, or you have Soldiers who ostracize that person because they had an issue in style. So command climate is absolutely everything."

A Different Goal Than Mental Health Improvement

Across focus groups, gatekeepers noted the problematic use by some Soldiers of behavioral and mental health care programs and services for reasons other than mental health improvement. There was a common perception among gatekeepers that this use of services is often "malingering" behavior, although some gatekeepers cautioned that the issue is more complex and may reflect problems related to pre-screening recruits for mental illness and military fitness, policies governing voluntary and involuntary separations beyond 180 days in service, and the disproportionately high demands that troubled early career Soldiers place on available services and their leaders.

In the gatekeeper's experience, these Soldiers sought mental health care to avoid regular duties, to be found unfit for deployment, or to avoid disciplinary action for misconduct. For example, Soldiers may take advantage of reporting policies and procedures around suicidal behavior to avoid deployment. Soldiers also appeared to "use the system" to initiate separation from the Army. Gatekeepers described working with Service members who would state that they are experiencing a serious mental health issue to precipitate an appointment with a behavioral health provider in order to secure a military disability separation rather than a disciplinary discharge. Gatekeepers expressed frustration at those individuals they believed were malingering because they took the attention away from those who truly needed help and occupied already limited resources.

Generally, gatekeepers attributed the inappropriate or unnecessary use of mental health services to first-term Service members who are unable or unwilling to adapt to military service. Some gatekeepers expressed this in generational terms and described a lack of resilience among "Millennials." Other gatekeepers recognized that many new Soldiers may enlist with preexisting mental health conditions that are either undisclosed or become significant after recruits first encounter the stressful environments of military service. This may be the result of inadequate screening during the accession process. It was also suggested that Army policy does

not easily permit discharge for Soldiers who have completed basic and job training; discharge for medical reasons, including mental health, may be more appealing to unsuccessful new Soldiers than other alternatives. To address the occurrences of inappropriate or unnecessary use of mental health services among first-term Soldiers who wish to receive a medical discharge, one gatekeeper in one focus group recommended that the Army implement a policy whereby Soldiers arriving at their first duty station would have a 60- or 180-day window of time in which they could voluntarily separate from the Army. The gatekeeper explained that, in addition to addressing the issue of inappropriate or unnecessary use of already limited resources, this type of policy would allow new Soldiers to treat the Army as "a regular job" that could be left at will.

Representative Quotes

- "Easy way out of deployments. They'll believe whatever a Soldier says, based off of diagnosis, and then if the Soldier's smart enough, [he or she] will play the game until treatment is complete."

- "Soldiers seem to know some catch words that trigger actions. They'll use those very readily, and the actions happen. And then there are Soldiers that I have that I firmly believe need some mental health assistance that know how to play the opposite."

- "It's frustrating because then you're stuck as a provider treating this person that doesn't really have any problems."

- "Who really suffers [are] the Soldiers that actually need real help. It's two populations here that we're dealing with. It's the ones that actually need treatment and then the ones that are basically ruining – making the system harder for the Soldiers that actually need it. And [the provider will say], 'Are you going to send me a Soldier that actually needs recurring therapy? Or are you just going to send me Soldiers that are trying to just get out of the Army? Or you just want to chapter out [the Soldier] and you want to do [the] evaluation on them and get that process – that box checked?' So there you go. You've dedicated [the provider's] day to Soldiers that you know are soaking up all of her time when she has that one patient that she really needs to spend her time on, but she is overwhelmed with all of these other 30 minute appointments. So then what I believe it leads to is – I don't want to say they don't care, [but the provider's attitude is], 'Okay, I'm overwhelmed already and this Soldier really needs the help and they're not getting the help they need.'"

- "I think one of the best things the Army could do for mental health is build in a 60 to 180-day window once you get to your first duty station where you have a free pass to walk out the door. Like a voluntary chapter between 60 days and 180 days when you first get to your unit. You would see mental health care needs. You could reduce the staff by half. You would see inpatient

hospitalization drop 80 percent probably if there was just a way for a soldier who is brand new, who has never been to a duty station yet to walk in and go 'This is not for me. I want to go home.'"

RESERVE AND NATIONAL GUARD COMPONENT FINDINGS

Gatekeepers in the Army focus groups had limited experience with Reserve and National Guard personnel and policies but discussed some of the unique help-seeking issues these personnel encounter. Compared to active duty personnel, it may be even more difficult for Reserve and National Guard personnel to seek mental health care when needed. Gatekeepers explained that, because Reserve and National Guard personnel only train or "drill" together 2 days a month and 2 weeks a year, commanders and unit leadership have limited visibility on the issues that their Soldiers are encountering. In fact, one gatekeeper stated that they had instated a peer support system in their unit that required they have daily contact with their assigned battle buddy. Other gatekeepers, on the other hand, explained that they observed stronger support networks at Reserve and National Guard posts compared to the active duty because they move less often and are more likely to have known their fellow unit members for many years. Because of the limited time during drill weekends, gatekeepers also discussed that Reserve and National Guard personnel are unable to attend fully to suicide prevention training because the focus is on training and being mission-ready. One gatekeeper speculated that this results in Reserve and National Guard members being less prepared to deal with suicide risk situations.

Reserve and National Guard personnel also encounter issues with how and where they are able to access the behavioral health care that they may need. Because eligibility for TRICARE and other resources depends on the Soldier's activation status, there are often lapses in the continuity of care for these personnel when they go on and off active status. Another contributing factor to access to care issues is that Reserve and National Guard personnel may not be near the military behavioral health services that they would be eligible to use. Gatekeepers also explained that some Reserve and National Guard personnel have employer-based health insurance, which may also contribute to issues of continuity of care when, for example, during an activation, they are unable to go to a provider who is in the network of their employer-based health insurance. On the other hand, gatekeepers identified that possession of employer-based insurance is advantageous because the Soldier is able to access behavioral health care that does not have to be reported to the Army.

Gatekeepers also discussed that Reserve and National Guard personnel deal with military stressors in addition to stressors from their civilian lives. Gatekeepers explained that there are high unemployment rates in the reserve component, so these personnel are more likely to have financial problems compared to active duty personnel. For those Reserve and National Guard personnel who have jobs in the

civilian sector, these personnel may encounter uncertainty over the stability of those jobs, despite policies establishing employment protections for these personnel under certain conditions.

Representative Quotes

- "Just because [Reserve and National Guard personnel] are eligible for Tricare doesn't mean that they have it. If they're unemployed, even though the premiums are relatively low particularly in comparison to civilian population, they may or may not have insurance. And they may or may not know where to go. We've got a lot of folks who live in rural areas. I have one guy who is covered by the VA [Veterans Affairs]. He's service connected, but his closest behavioral health clinic through the VA is 40 miles away."

- "Depending on the state - really impacts the type of person that's being activated and brought to us for an evaluation from the behavioral health standpoint. So for that to be a question at the tail end of this, that in itself, the two separate entities that are the Reserve and the National guard, merit this kind of an investigation and discussion on their own because it's entirely different especially for the National Guard given the state management differences across the Guard units."

- "In the National Guard, we have a high unemployment rate as well so there's financial issues that active duty doesn't face quite to the same extent. So suicidal ideation is still a problem. The problem that we have in tracking the actual incidents of suicidal ideation and suicidal attempts is that they're only a Soldier one weekend a month and so, if something happens when they're not at drill we may or may not find out about it for whatever reason. The commander might know but whether or not he communicates that to the medical side of the house is quite sporadic because [their attitude is,] 'Well, he wasn't my soldier at that time and it's taken care of now. It's over.' So we don't really know what the incidence is."

DISCUSSION

Findings from the focus group interviews indicate that Army Soldiers experience a wide range of mental health issues from stress, to trouble adjusting to the military, to anxiety, to posttraumatic stress disorder, to suicidality. Gatekeepers explained that a number of barriers to seeking mental health resources persist, including concerns about a lack of privacy or confidentiality, other Soldiers' negative perceptions of their help-seeking, possible implications for their career progression, and whether available resources and providers are able to address their concerns at the right level of care. On the other hand, according to gatekeepers, help-seeking behaviors were more likely to increase when Soldiers trusted and were familiar with the service provider, when Soldiers felt resources could be accessed privately and with confidentiality, and when there was a positive command climate that

encouraged help-seeking. Coders agreed that the tone of the Army focus group discussions were generally negative, particularly when gatekeepers discussed their perception that a portion of Soldiers used mental and behavioral health reporting policies and procedures to their advantage rather than for mental health improvement. Analysis of the discussion of Reserve and National Guard issues indicated that the Reserve component faces unique access to care and career concern issues compared to active duty personnel.

The findings from the Army focus groups are consistent with the findings from the Navy and Air Force focus groups presented in the main body of this report. Each group identified the same range of mental health issues commonly experienced by Service members, including stress, anxiety, depression, suicidal ideation and suicide, and posttraumatic stress. Each analysis also identified common reasons Service members do seek help, including by command directive and in situations where the help seeker has established trust in the chain of command, the provider, and peers. Across all focus group sessions and locations, gatekeepers identified policies establishing integrated mental and behavioral health care and confidentiality as factors that increased mental health service utilization. Stigma and career impact were identified in both analyses as major barriers to help-seeking. Each analysis also identified barriers and concerns related to policies and services. Last, in terms of the Reserve and National Guard, gatekeepers discussed similar concerns about limited access to care and career concerns.

LIMITATIONS

These results are subject to the same limitations common to any focus group research studies as discussed in the main report. These focus group interviews were not designed to be generalizable to the entire military population. In addition, a limited number of participants had knowledge of the issues facing Reserve and National Guard personnel. Therefore, the findings presented in this appendix concerning members of Army Reserve and National Guard have very limited generalizability.

RECOMMENDATIONS

Because the results of the Army focus groups are consistent with those presented in the main report, the recommendations in the main report apply to the Army as well. The actionable policy recommendations included (a) conducting effective suicide prevention training and mental health awareness campaigns and evaluating their implementation, (b) establishing programs specifically designed to encourage officers to seek help, and (c) addressing Service members' concerns that help-seeking will adversely impact their careers. In addition, recommendations for future research included (a) exploring specific needs and barriers to help-seeking among various subpopulations within each Service, and (b) analyzing installation-specific considerations related to implementing suicide prevention efforts and training.

One theme that emerged in the Army results was not addressed in the recommendations in the main report, but merits further investigation. The generally negative tone of focus group responses suggests some relation between common and accepted organizational practices and poor mental health outcomes. This may be best exemplified in the stigmatizing language used by more experienced Service members to describe mental health and help-seeking among new Soldiers; for example: beliefs that "millennials" have more preexisting conditions or are unable to adapt to Army life, attitudes about deployment-related mental health issues as more legitimate than others, or equating help-seeking and malingering. The responses of some gatekeepers, particularly clinical professionals and chaplains, suggest a recognition of the negative consequences of these beliefs on mental health outcomes. The problem may also reflect unintended consequences of related policies, particularly around prescreening recruits for mental illness and military fitness, voluntary and involuntary separations beyond 180 days in service, and the disproportionately high burden that troubled early career Soldiers place on available services and their leaders.

Although the results of this study do not provide generalizable evidence of this link between stigmatizing practices, Army policies, and poor mental health outcomes, the potential consequences of these issues provide a strong and compelling justification for further evaluation of the following topics:

(1)   The rate of preexisting mental health concerns among recruits;

(2)   Adequacy of recruit screening policies and methods and their impact on readiness, personnel attrition, and mental health outcomes; and

(3)   Cost-benefit analysis of a more liberal separation policy for first-term Service members who are unable or unwilling to adapt to military life, including analysis of accession and training costs, short- and long-term medical and behavioral health service provision, and impact on unit cohesion and readiness.

APPENDIX C:

FEBRUARY 2016 STATUS OF FORCES SURVEY OF ACTIVE DUTY MEMBERS: SUICIDE PREVENTION ITEMS

February 2016 Status of Forces Survey of Active Duty Members

63. Which of the following **best** describes your (and/or your spouse's) financial condition?

☒ Very comfortable and secure

☒ Able to make ends meet without much difficulty

☒ Occasionally have some difficulty making ends meet

☒ Tough to make ends meet but keeping your head above water

☒ In over your head

64. Does your current financial condition _negatively_ impact your military readiness?

☒ Yes

☒ No

☒ Don't know

65. In the past 12 months, have you (and/or your spouse) received financial education support services? *Mark one.*

☒ Yes, and it helped overall

☒ Yes, but it did not help overall

☒ No, I/we did not want these services

☒ No, but I/we wanted these services

☒ Don't know

66. [Ask if Q65 = "Yes, and it helped overall" OR Q65 = "Yes, but it did not help overall"] From which of the following sources have you (and/or your spouse) received financial education support services in the past 12 months? *Mark "Yes" or "No" for each item.*

		Yes	No
a.	Financial counselor on your installation	☒	☒
b.	Military OneSource	☒	☒
c.	Military aid society	☒	☒
d.	Faith-based organization (e.g., church, synagogue, mosque)	☒	☒
e.	Credit counseling agency/service	☒	☒
f.	Financial institution (e.g., bank, credit union)	☒	☒
g.	Other services in your civilian community	☒	☒

67. [Ask if Q65 = "Yes, and it helped overall" OR Q65 = "Yes, but it did not help overall"] **For which of the following issues did you (and/or your spouse) receive financial education support services?** *Mark one answer for each item.*

		Yes, and it helped	Yes, but it did not help	No, and I/my spouse did not want to talk to anyone about this	No, but I/my spouse wanted to talk to someone about this
a.	Creating a budget or spending plan	☒	☒	☒	☒
b.	Eliminating debt	☒	☒	☒	☒
c.	Planning for retirement	☒	☒	☒	☒
d.	Assistance with a financial emergency	☒	☒	☒	☒
e.	Investing	☒	☒	☒	☒
f.	Other	☒	☒	☒	☒

[Ask if Q67 f = "Yes, and it helped" OR Q67 f = "Yes, but it did not help"] **Please specify the other issue(s) for which you (and/or your spouse) received financial education support services. Please do not include any identifying information (e.g., names, addresses).**

[ ]

SUICIDE PREVENTION

Results from the next set of questions will provide DoD and the Defense Suicide Prevention Office (DSPO) with an increased understanding of suicide risk in the military and will allow DoD to develop programs and policies that will better protect and serve you and your peers. Your responses will only be reported in aggregate form. Your individual data will not be reported.

68. **Please indicate your level of agreement with the following statement. The suicide prevention training I received in the past 12 months was effective in preparing me to handle a possible suicide prevention situation.** *Mark one.*

☒ I have not received suicide prevention training in the past 12 months.

☒ Strongly agree

☒ Agree

☒ Neither agree nor disagree

☒ Disagree

☒ Strongly disagree

14   DMDC

Figure C-1 Status of Forces Survey of Active Duty Members

69. How much do you agree or disagree with each of the following statements? *Mark one answer for each item.*

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
a. I have the necessary knowledge of risk factors and behaviors to determine whether a person I work with is in need of help.	☒	☒	☒	☒	☒
b. I have the skills and abilities to take appropriate action if a person I work with is in need of help.	☒	☒	☒	☒	☒

70. How much do you agree or disagree with each of the following statements? Individuals who need mental health care (e.g., for depression, suicidal thoughts, addiction) would **not** seek help because of... *Mark one answer for each item.*

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
a. Negative impact to career or progress.	☒	☒	☒	☒	☒
b. Loss of privacy/ confidentiality.	☒	☒	☒	☒	☒
c. Fear of being perceived as "broken" by chain of command or peers.	☒	☒	☒	☒	☒
d. Lack of confidence in the resources available to solve their problem.	☒	☒	☒	☒	☒
e. Lack of confidence in the chain of command.	☒	☒	☒	☒	☒
f. Not knowing who to turn to.	☒	☒	☒	☒	☒
g. Other	☒	☒	☒	☒	☒

[Ask if Q70 g = "Strongly agree" OR Q70 g = "Agree"] Please specify the other reason(s) individuals who need mental health care would **not** seek help. Please do not include any identifying information (e.g., names, addresses).

71. How much do you agree or disagree with each of the following statements? *Mark one answer for each item.*

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
a. I tend to bounce back quickly after hard times.	☒	☒	☒	☒	☒
b. I have a hard time making it through stressful events.	☒	☒	☒	☒	☒
c. It does not take me long to recover from a stressful event.	☒	☒	☒	☒	☒
d. It is hard for me to snap back when something bad happens.	☒	☒	☒	☒	☒
e. I usually come through difficult times with little trouble.	☒	☒	☒	☒	☒
f. I tend to take a long time to get over set-backs in my life.	☒	☒	☒	☒	☒

72. What is your level of awareness of each of the following support services? *Mark one answer for each item.*

	I never heard of this service	I have heard of this service, but I do not really know what it is	I know what this service is, but I have not used it	I have used this service
a. Military Crisis Line (MCL)	☒	☒	☒	☒
b. Veterans Crisis Line (VCL)	☒	☒	☒	☒
c. National Suicide Prevention Lifeline	☒	☒	☒	☒
d. Military OneSource	☒	☒	☒	☒
e. Military & Family Life Counseling (MFLC) Program	☒	☒	☒	☒
f. DSTRESS Line	☒	☒	☒	☒

APPENDIX C

73. How much do you agree or disagree with the following statement? In the past 12 months, I have been aware of military suicide prevention campaigns (e.g., posters, websites, public service announcements, advertisements).

☒ Strongly agree

☒ Agree

☒ Neither agree nor disagree

☒ Disagree

☒ Strongly disagree

74. What level of messaging would be most effective in presenting the suicide prevention message to you for each of the following? *Mark one answer for each item.*

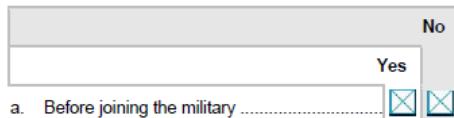|	Need a lot more	Need more	Messaging level is about right	Need less	Need a lot less
a. Posters in work areas	☒	☒	☒	☒	☒
b. Posters on local military installation	☒	☒	☒	☒	☒
c. Posters in common areas	☒	☒	☒	☒	☒
d. Online articles	☒	☒	☒	☒	☒
e. Newspapers, other than online	☒	☒	☒	☒	☒
f. Social media	☒	☒	☒	☒	☒
g. Television	☒	☒	☒	☒	☒
h. Movies	☒	☒	☒	☒	☒
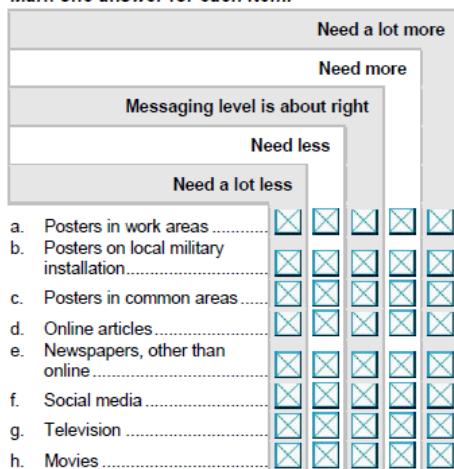
The next several questions ask about a time period in your life when you may have faced some challenges. We understand these are sensitive issues, but the Department wants to know more about members' experiences so they can help others who face similar challenges. Responses to these items are completely voluntary and confidential.

75. Have you ever in your life had thoughts of actually killing yourself?

☒ Yes

☒ No

76. [Ask if Q75 = "Yes"] Have you ever had thoughts of actually killing yourself during the following periods? *Mark "Yes" or "No" for each item.*

	Yes	No
a. Before joining the military	☒	☒
b. Since joining the military	☒	☒
c. Within the past 12 months	☒	☒
d. Within 6 months before leaving for a deployment or another mission	☒	☒
e. During a deployment or another mission	☒	☒
f. Within 6 months after returning from a deployment or another mission	☒	☒

77. [Ask if Q76 b = "Yes" OR Q76 e = "Yes" OR Q76 f = "Yes"] Going back to the time when you thought about killing yourself since joining the military, have you ever thought about how you might actually do it (e.g., taking pills, shooting yourself) or worked out a plan of how to kill yourself?

☒ Yes

☒ No

78. [Ask if Q75 = "Yes"] Have you ever in your life made a suicide attempt (e.g., purposely hurt yourself with at least some intention to die)?

☒ Yes

☒ No

79. [Ask if Q78 = "Yes"] Did you make a suicide attempt during the following periods? *Mark "Yes" or "No" for each item.*

	Yes	No
a. Before joining the military	☒	☒
b. Since joining the military	☒	☒
c. Within the past 12 months	☒	☒
d. Within 6 months before leaving for a deployment or another mission	☒	☒
e. During a deployment or another mission	☒	☒
f. Within 6 months after returning from a deployment or another mission	☒	☒

80. [Ask if (Q75 = "Yes" AND (Q76 b = "Yes" OR Q76 e = "Yes" OR Q76 f = "Yes")) OR (Q78 = "Yes" AND (Q79 b = "Yes" OR Q79 e = "Yes" OR Q79 f = "Yes"))] Since joining the military, have you ever talked to anyone about your thoughts or attempts to kill yourself? *Mark one.*

☒ Yes

☒ No, but I considered talking to someone

☒ No, and I never considered talking to anyone

81. [Ask if (Q75 = "Yes" OR Q78 = "Yes") AND Q80 = "Yes"] **Who did you talk to about these thoughts or actions?** *Mark all that apply.*

- ☒ Spouse or significant other
- ☒ Parent or parental figure
- ☒ Sibling
- ☒ Family member other than a spouse, significant other, parent, parental figure, or sibling
- ☒ Friend who is not in the military
- ☒ Military friend not in my chain of command
- ☒ Someone in my chain of command
- ☒ Mental health professional at a military facility (e.g., psychologist, psychiatrist, clinical social worker, other mental health counselor)
- ☒ Civilian mental health professional at a civilian medical facility (e.g., psychologist, psychiatrist, clinical social worker, other mental health counselor)
- ☒ General medical doctor at a military facility
- ☒ General medical doctor at a civilian facility
- ☒ Chaplain, pastor, rabbi, or other spiritual counselor
- ☒ Someone at a military-run suicide helpline (e.g., Veterans Crisis Line, Military Crisis Line, Military OneSource)
- ☒ Someone at a civilian-run suicide helpline (e.g., National Suicide Prevention Lifeline, 1-800-SUICIDE)
- ☒ Some other individual/resource not listed above

82. [Ask if (Q75 = "Yes" OR Q78 = "Yes") AND Q80 = "No, but I considered talking to someone"] **If you were to talk with someone about these thoughts or actions, who would you talk to?** *Mark all that apply.*

- ☒ Spouse or significant other
- ☒ Parent or parental figure
- ☒ Sibling
- ☒ Family member other than a spouse, significant other, parent, parental figure, or sibling
- ☒ Friend who is not in the military
- ☒ Military friend not in my chain of command
- ☒ Someone in my chain of command
- ☒ Mental health professional at a military facility (e.g., psychologist, psychiatrist, clinical social worker, other mental health counselor)
- ☒ Civilian mental health professional at a civilian medical facility (e.g., psychologist, psychiatrist, clinical social worker, other mental health counselor)
- ☒ General medical doctor at a military facility
- ☒ General medical doctor at a civilian facility
- ☒ Chaplain, pastor, rabbi, or other spiritual counselor
- ☒ Someone at a military-run suicide helpline (e.g., Veterans Crisis Line, Military Crisis Line, Military OneSource)
- ☒ Someone at a civilian-run suicide helpline (e.g., National Suicide Prevention Lifeline, 1-800-SUICIDE)
- ☒ Some other individual/resource not listed above

APPENDIX D:

FOCUS GROUPS QUESTIONS

FACILITATOR INTRODUCTION

Good morning/afternoon. My name is [focus group facilitator name] and I'm joined by [team member names].We are researchers from the Defense Manpower Data Center (DMDC) and are sponsored by the Defense Suicide Prevention Office (DSPO). I'll be facilitating today's focus group interview and [team member names] will be helping today by capturing notes from our discussion.

We will start by obtaining your verbal consent to participate in this focus group.

FOCUS GROUP PARTICIPANT VERBAL INFORMED CONSENT

[AUTHORITY: Title 10 United States Code, Sections 136 and 2358.]

Northrop Grumman Corporation Technology Services Division (NGTS), Defense Personnel and Security Research Center (PERSEREC), and Defense Suicide Prevention Office (DSPO), are partnering to better understand non-help-seeking behaviors among military personnel. Specifically, we want to talk with those who have a role in increasing help-seeking for mental health concerns and suicide ideation or intent.

Your participation in this focus group will include discussing help-seeking among military personnel and barriers to help-seeking on your installation. You will be participating with approximately 9 other people. We are interested in hearing your views and opinions, so there are no *right* or *wrong* answers. Your participation in this focus group is voluntary and you may stop participating at any time. If you decide not to take part in the focus group, there will be no penalty for ceasing your participation. We ask you to please respect the privacy of others by not revealing any information you learn from the other people in the focus group. Your participation will be kept confidential by Northrop Grumman, PERSEREC, and DSPO. The information you give us will be combined with the answers of other participants in a summary report that will not identify you as an individual. However, please keep in mind that we cannot guarantee that the other participants will not reveal information that you gave during the focus group session. The focus group session will take no longer than 1.5 hours.

We will be taking notes and recording today's discussion, so that it can be transcribed at a later time. We are doing this so that we can have the most accurate information about your answers and thoughts, and not so that we identify you as an individual. We will take great care to ensure that your personal information is not connected to your answers in any way. The audio recording will be handled only by project staff, and destroyed once the discussion is transcribed. If any personal information is disclosed during the session, it will not be written down in the notes and project staff will ensure that it is not transcribed later.

There are no physical risks to you from participating in this focus group. You do not have to answer any questions that you do not want to answer. There are no

direct benefits to you from participating in the focus group; however, your responses may help shape policies and operational procedures that will increase help-seeking among Service members.

If you have any questions about your rights as a participant, you can contact the DoD's Human Research Protections Program at (571) 490-5690.

We will now go around the table to obtain your verbal consent to participate in today's focus group session. Please say "Yes" if you agree to participate in this focus group, and "No" if you choose not to participate.

FOCUS GROUP INTRODUCTION

Thank you. Now I will provide more information on what you can expect during today's focus group session.

The objective of our focus group session is to gather information from you about DoD- and Service-level policies and procedures related to situations where a troubled Service member needs help, but chooses not to seek it. Your group is one of several installation-level focus groups who will participate in focus groups interviews.

[*optional:* Other groups include: Chaplains and Religious Programs specialists; Law Enforcement & Security Managers; Medical personnel, Mental/Behavioral Health professionals, and unit leadership.]

We ask that you reflect on your own experiences navigating and implementing policies. Additionally, we would like you to reflect on how interactions with Service members bring forward any procedural gaps that may hinder help-seeking. At no time will you be asked to share any information about an individual Service member. Also, please do not offer any information that may reveal the identity of an individual Service member. Our interest is learning more about situations, processes, dynamics, and potential courses of action to provide help.

There may be times that our conversation may drift from the questions that we planned to cover. Since we have a limited amount of time and a fair number of questions to ask, I may need to bring us back to the questions that we plan to cover today.

Let's get started ~

INTRODUCTION

Let's start with introductions. I'd like you to tell me where you work, years of overall experience, and years of experience in your current role at this installation. Rather than going around the table, we'll do introductions by birth month. So let's start with January…

[Question for rapport building; not for transcription or data analysis]

MENTAL HEALTH HELP-SEEKING

Our first discussion topic is mental health help-seeking. Mental health help-seeking includes seeking help for issues such as depression, anxiety, anger, suicide ideation or attempts, and PTSD. After our discussion about mental health help-seeking, we'll discuss behavioral health help-seeking, which covers issues such as drug or alcohol use/abuse, family issues, or financial issues. First – regarding mental health help-seeking…

(1)   Describe some of the mental health concerns you see working with Service members. Mental health issues could include depression, anxiety, anger, suicide ideation or attempts, and PTSD.

    (a) Does it seem as though they're dealing with pre-existing issues or issues that developed throughout the course of their military career?

    (b) What strategy did you use that you believe was most effective in encouraging these Service members to seek care?

    (c) In your experience, what has been the most helpful policy in encouraging help-seeking behaviors among Service members? What about the policy made it most helpful?

(2)   What are some barriers – policies, procedures, or guidelines – that you or others like you, face when providing mental health support to Service members? *[Assistant Moderator will write participant-generated barriers on a display/dry erase board in the focus group interview room]*.

    (a) Have there been instances where a Service member did not end up seeking care? Why do you think they made that choice?

    (b) Have there been instances where a Service member started receiving care and then discontinued? Why do you think they made that choice?

BEHAVIORAL HEALTH HELP-SEEKING

(3)   On a somewhat similar topic, behavioral health concerns include drug/alcohol use/abuse, family issues, or financial issues. How is help-seeking for behavioral health concerns the same or different from mental health concerns?

HELP-SEEKING GAPS

(4)   What policies, procedures, and guidelines have not been fully implemented that you think would be helpful in providing better services to Service members dealing with suicidal ideation or other mental health and behavioral health issues?

(a) What changes would make these policies more effective?

(5) In your experience, have certain policies helped reduce stigma surrounding help-seeking among your Service members?

(a) If so, why do you suppose that is?

(6) What services and programs have you referred Service members to in the past?

(a) What other services should be available which would help assist Service members and fill in current gaps in service?

HELP-SEEKING BARRIERS AND POLICIES

(7) Looking back at the barriers listed by the group earlier, which barriers do you believe Service members would list as the most significant barriers to seeking help?

(a) Are these potential barriers experienced by Service members, or are they perceptions of what might happen?

(b) Is there a specific policy or guideline that addresses this issue in some way to promote or undermine potential help-seeking behaviors?

(8) From your perspective as a gatekeeper and your work with Service members, if there is one change that could be made to remove the most significant barrier to help-seeking, what would it be?

TRANSITION TO RESERVE & GUARD COMMUNITY

We're nearing the end of our discussion on help-seeking among active duty military personnel. To close out our discussion, we wanted to get your thoughts on how these referenced policies, barriers and gaps may impact those in the Reserve Component.

(9) Do you have experience with Service members from the Reserve Component who were dealing with mental health problems, or even suicidal ideation?

(10) What do you think are the major differences in respect to barriers to help-seeking and gaps in policies and how they are implemented, for the Reserve and Guard community?

(11) Are there any other unique challenges facing the Reserve and Guard community when it comes to help-seeking that you would like to share?

CONCLUSION

That concludes the questions I have today. I'm going to ask _____ [*assistant moderator*] to briefly recap our discussion to make sure we captured the main

themes accurately and provide you an opportunity to mention anything else you feel is important.

Thank you all very much for your time and valuable input.

APPENDIX E:

FOCUS GROUPS CODING RUBRIC

Table E-1
First Level Coding

Category	Codes	Descriptions
Mental Health	Mental Health Issues	What are the identified mental health issues that gatekeepers are seeing?
Mental Health	Behavioral Health Issues	What are the identified behavioral health issues that gatekeepers are seeing?
Mental Health	Developed Through Course of Service	Did these mental health issues develop over the course of service or deployment?
Mental Health	Preexisting	Did these mental health issues exist prior to military service?
Barrier	Career Impact/Career progression	Impact to career or progress, such as concerns about promotion opportunities, not being able to have a weapon, having a Command Directed Evaluation in the record, temporary duty restrictions, and deployability
Barrier	Loss of Security Clearance	Concerns over loss of clearance after seeking mental health care, how that will affect their ability to perform their current job
Barrier	Lack of Privacy/ Confidentiality	Unit leaders often are informed of mental health concerns. Peers find out that someone is seeking care. Policy outlines the conditions under which (e.g., threat to mission) notification to command is necessary. Issues related to the Health Insurance Portability and Accountability Act.
Barrier	Gatekeepers' Help-Seeking	Barriers to seeking help due to one's position, gatekeeper role, or rank; Gatekeepers referring to their own experience with barriers
Barrier	Gatekeeper Training/Skills	The training a gatekeeper receives related to mental health in order to support military personnel
Barrier	Age	Generation gap, developmental age, maturity level
Barrier	Stigma	Any type of stigma (personal, group) for receiving mental or behavioral health services
Barrier	Peer pressure	Negative peer comments on seeking help, shaming a persons' need to seek help, rumors
Barrier	Resource Confidence	Lack of confidence in the resources available to solve their problem, related: lack of confidence in treatment effectiveness
Barrier	"Broken" Perception	Being perceived as "broken" or weak by chain of command or peers, Warrior culture
Barrier	Level of Care	Binary system doesn't allow for intermediate levels of care (i.e., worried well, having a few bad days, father died), High interest list, 90-day profile
Barrier	Confidence in Chain of Command	Lack of confidence in the chain of command
Barrier	Military Culture	A set of shared attitudes, goals, values, and practices; a way of life for a group of people

Category	Codes	Descriptions
Barrier	Manning/Staffing Issues	Barrier to help-seeking resulting from lack of proper staffing, increased workload, or increase tempo
Barrier	Resource Awareness	Not knowing who to turn to; being unaware of services or insurance coverage, visibility of services
Barrier	Practical Barriers	Nontrivial inconveniences that may be associated with (not) seeking treatment (i.e., being in the reserve/guard, length of treatment, wait time between or for an appointment, cost, environment, insurance coverage)
Barrier	Services and Programs (Treatment Types)	Computer-based trainings, alcohol and drug abuse prevention and treatment programs, Resiliency training programs, Suicide awareness programs, Sexual Assault Prevention and Response training, tracking on "high interest list"
Barrier	Morale/Job Satisfaction	Service member unhappy in job role, lack of unit cohesion
Barrier	Funding	Issues that are barriers due to lack of funding or lack of investment in programs and services related to mental and behavioral health
Barrier	Deployment	Deployment related topics, including treatment options during deployment. Service members were deployed at the time care was needed/necessary.
Barrier	Perceived Need/Confusion	Ability to recognize that there is a problem, confusion about need for care
Barrier	Lack of Psychoeducation/Suicide Prevention	Education/knowledge for those who may not be able to recognize that there is a problem/unaware of symptoms of mental health issues
Barrier	Reserve/Guard	Topics related to Reserve and National Guard experiences
Barrier	Reserve/Guard Community	Lack of connection to active duty and to wider community
Barrier	Reserve/Guard Access to Care	Insurance concerns, access to care while active duty vs. in community. Challenges with continuity of care from military to community
Strategies to encourage help-seeking	Treatment/ Intervention Type	Specific services, treatment types or interventions that gatekeepers utilize or to which they refer Service members
Strategies to encourage help-seeking	Provider Confidentiality	Different gatekeepers have different requirements for confidentiality
Strategies to encourage help-seeking	Success Stories/ Examples of Successful Service Utilization	Formal and informal activities where a unit leader (or peer) provides information about their history with utilizing mental health services

Category	Codes	Descriptions
Strategies to encourage help-seeking	Mental Health Awareness Campaigns	Specific mental health awareness campaigns to which gatekeepers refer, such as the ACE model, Stress Continuum (red-green), and ACT (ask, care treat)
Strategies to encourage help-seeking	Prevention Efforts	Focus should be on prevention of developing mental health concerns, instead is reactive/focused on intervention
Strategies to encourage help-seeking	Supportive Community	Having a people-centered supportive environment where Service members feel able to talk freely or seek mental health care, Wingman Days, celebrations
Strategies to encourage help-seeking	Trust	General sense of trust towards service care providers, chain of command, military policy, and that the person can receive the appropriate help
Strategies to encourage help-seeking	Peer Support	Peers talking to one another in one-on-one or in groups, can recognize when a friend needs help and is willing to listen
Strategies to encourage help-seeking	Community Based Services	Service member seeks care in the community, outside of the military, to avoid the stigma of seeking care, or because that is the only resource they have (i.e. Reserve/Guard)
Strategies to encourage help-seeking	Stigma Reduction	Topics related to reducing stigma of mental health issues
Strategies to encourage help-seeking	Gatekeeper Suggestions	Gatekeeper suggestions provided in the focus group that they believe would improve mental health service utilization in Service members.
Policies	Screening	Comments about policies for mental health screening; screening at (e.g. recruitment, basic training, following deployment)
Policies	Training	Comments about training effectiveness, frequency, continuity, and quality
Policies	Policy Implementation	How policies have been implemented, how policies have not been implemented successfully; where the implementation of policy was lacking follow-through.
Policies	Policy/Guideline Gap	Gaps in areas where policies may be needed to support mental health service utilization Areas where guidelines are needed to clarify operational procedures
Policies	Unit Reintegration	Guidelines on reintegrating Service members into units after an event such as deployment or in-patient hospitalization

Table E-2
Second Level Coding

Categories	Codes	Previous Codes and Search Terms
Reasons why individuals experience mental and behavioral health issues	Suicidal Ideation and Suicide	Mental Health Issues
Reasons why individuals experience mental and behavioral health issues	Conditions Existing Prior to Service	Preexisting
Reasons why individuals experience mental and behavioral health issues	Conditions Developed During the Course of Service	Developed During the Course of Service
Reasons why individuals experience mental and behavioral health issues	Trauma	Mental Health Issues; Developed During the Course of Service
Reasons why individuals experience mental and behavioral health issues	Stress	Behavioral Health Issues; Developed During the Course of Service
Reasons why Service members do not seek help	Stigma	Stigma; Military Culture; "Broken" Perception; Peer Pressure
Reasons why Service members do not seek help	Career Impact	Career Impact/Career Progression; Loss of Security Clearance
Reasons why Service members do not seek help	Services Available	Manning; Level of Care; Wait Times; Lack of Privacy/Confidentiality
Reasons why Service members do seek help	Command Directed	Command Directed; and search terms (self-report; made to; had to; forced to; told to)
Reasons why Service members do seek help	Achieve a Different Goal than Mental Health Improvement	Search terms (malingering; don't want to; avoid; get out of; faking it; separate)
Reasons why Service members do seek help	Trust and Supportive Environment	Trust; Supportive Environment
Reasons why Service members do seek help	Policies that Work	Policy Implementation; Policy Guidelines; and search terms (policies; guidelines)
Reasons why Service members do seek help	Embedded Care	Gatekeeper Suggestions; Trust; and search terms (embedded care; BHOP)
Reasons why Service members do seek help	Confidentiality	Confidentiality; and search terms (lack of privacy)

APPENDIX F:

RESERVE AND NATIONAL GUARD—FOCUS GROUP RESULTS

INTRODUCTION

While the majority of the focus group participants were active duty Service members, a few were or had been members of the Reserve or National Guard or had experience working with Reserve and National Guard members. These gatekeepers were able to provide some insights in response to questions posed during the focus groups on the similarities and differences between the Reserve component and their active duty counterparts when it comes to the focal issue at hand. Topics discussed in the following sections relate to stressors and contributing factors that may lead Service members in the Guard and Reserve to utilize mental health care and also identify significant barriers to care that these groups experience. Because only a small portion of the focus group session was focused on topics specific to the Reserve and National Guard components, results of these discussions are presented in this Appendix. This discussion is not an exhaustive review of all barriers to help-seeking faced by members of the Reserve and National Guard components, and additional research specifically looking at this population may be warranted.

The barriers that gatekeepers identified as being similar among the reserve and active duty components include level of care, stigma related to mental health help-seeking, manning concerns, and practical barriers. Gatekeepers also discussed how difficulties with access to care and career concerns differed for Reserve and National Guard members. In addition, gatekeepers also spoke about how differences in the sense of community that Reserve and Guard members experience in the military and within their own communities at home may impact help-seeking.

ACCESS TO CARE

Across all gatekeeper roles, access to care was the leading theme identified as a barrier to mental health service utilization in the Guard and Reserve components. There are several factors contributing to this barrier, including service availability, time, location, insurance coverage, and finances. All focus groups identified that because Reserve and National Guard members typically have inactive duty training drills 1 weekend a month and active duty training 2 weeks a year, often they are not aware of all available military resources and cannot access the resources even if they are aware of them. In addition, during their monthly drill weekend, they often do not have opportunities to seek mental health care because their schedules do not allow for time away from their unit to seek care or because services are not available on the weekends. Several participants in unit leadership focus groups identified that due to manning and training constraints, Guard and Reserve members often cannot find the time to seek treatment. Another aspect of access to care is training location. Several participants noted that if the members are training in a small unit or a more rural location, there are often no conveniently located medical or mental health services available to Reserve and National Guard personnel.

The Reserve and National Guard members' eligibility for military resources is determined by their duty status. Members of the Reserve and National Guard do not qualify for Tricare health insurance unless they are ordered to active duty service over 30 days in a row (10 U.S.C. § 1074a et seq.). In most cases, Reserve and National Guard members rely on insurance from their civilian employers, pay for Tricare themselves, or seek other sources of health insurance coverage. This presents a barrier to mental health service utilization because these members must seek out mental health services in their communities and may not have the option to seek care while training away from their home location. Furthermore, available community providers may not be familiar with the unique mental health concerns facing military Service members. Gatekeepers also mentioned that in many cases, Reserve and National Guard members do not have health insurance at all, presenting a significant access to care issue. Several focus group members noted that the out-of-pocket cost for mental health services can be a significant barrier for members in those components. If they are on active duty status for at least 31 days, it is easier for them to utilize military health services on base. However, because they may be unfamiliar with the location, they often do not know who to speak to or how to find the information necessary to seek mental health services.

Several gatekeepers, including chaplains, unit leadership, and medical/mental health providers identified lack of continuity of mental health care as another important barrier facing Reserve and National Guard members. Participants noted that funding cycles can exacerbate this barrier, particularly if a funding cycle for a Reservist or National Guardsman ends during their mental health treatment. This serves as an interruption to care and raises concerns that the member may be unable to access and utilize mental health services once they return home. If members are able to continue their care with another provider, gatekeepers noted that there is no "warm hand-off" to these mental health service providers and no system to transfer health records, so that there is minimal interruption in the member's care.

Representative Quotes

- "And a lot of their duty is less than 30 days which means they don't get the Tricare Prime. They don't get the access to services that they perhaps need for that very difficult 7 days, 10 days, 14 days that they just did."

- "Basically, you're on your own. Unless you're activated, you're pretty much on your own. You come back once a month to drill and what have you."

CAREER CONCERNS

Career concerns can be an added stressor to a Service member's life and may influence their willingness to utilize available mental health services. Across all focus groups, gatekeepers explained that Guard and Reserve career concerns were related to both their military and civilian employment. In addition to the military

career concerns that affect all members, Guard and Reserve members who seek mental health treatment may also experience unanticipated negative effects on their civilian employment. For instance, when Reservists are placed on a medical hold, they must stay in a military or medical setting until treatment is completed, rather than being able to return to their home of record. Thus, being placed on a medical hold can significantly impact civilian employment and career progress.

Gatekeepers discussed how concerns about civilian careers are an additional stressor on Reservists and National Guardsmen. The Uniformed Services Employment and Reemployment Rights Act of 1994 establishes protections around civilian jobs for the Reserve component under certain conditions. When Reserve and Guard members return from a deployment or training of 30 days or longer, they can seek reemployment with their civilian employers; however, this can be difficult when a company has closed or has re-organized and the position is no longer available. These worries are an additional stressor for Reservists and Guardsmen. Focus group participants identified that these members often come to their drill weekends and 2-week duty with stress from their civilian jobs, and when compounded with the stress of training, they can develop mental and behavioral health related difficulties. Gatekeepers indicated that these individuals would benefit from mental health support; however, as mentioned previously, they do not have time to seek care while on duty or have the ability to take the time off from their civilian jobs to seek care.

Representative Quotes

- "The way the Reserve community is downgraded, it's like more and more requirements are being stacked on them. So, in a weekend, they've got multiple people trainings to get done, so they've got the administrative portion, the primary function, mobilization ready, get ready to deploy."

- "And one of the largest things, not so much for the people who can get orders, like if they can get one-year or two-year orders, but sometimes people – it's the funding cycle of 'Oh, well, we'll fund you up to 180 days,' and then they're in the middle of a mission. And then it's like trying to get their second set of funding and having that anxiety of whether or not they're going to be able to finish what they've started or do they have to wait till the next funding cycle before they come back?"

- "So on weekends they're tasked by their command, and then they're also tasked by an operational chief command. And a lot of the stuff they can't get done. They go home and still failing. So the Navy, more and more, is intruding into their regular life and they have a job and then they also have a jet deployment and be back to work."

- "So all that is not getting paid, but they're not on duty time... They're doing it at home, doing all their training stuff... So, [the] sailor is doing a lot of extra jobs that we take for granted."

- "In general, they just seemed to struggle so much more in regard to productivity and performance and just overall wellness compared to their active duty counterparts. And so I can't know for sure, but I know some of the guard and reservists that were in our medical group talked a lot about how they feel like they're mostly just kind of civilians who access care in the community, and they don't feel like they fit very well. They don't feel very well respected. They don't feel very competent or confident in their duties for the military. And these were like Chief Master Sergeants, Senior NCOs [non-commissioned officers], Lieutenant Colonels, who have never [...] done some of the most basic stuff that's required to be successful."

SUPPORTIVE ENVIRONMENT

In the Military

Several focus group participants identified that when a Reservist or National Guardsman is called to active duty; they do not encounter a welcoming, supportive community, but instead may encounter negative perceptions of their abilities by active component members. There is a perception that they are simply "part-timers" and lack the job skills to work smoothly with active duty Service members. Gatekeepers discussed that active duty members tended to not trust Reservists or Guardsmen to accurately complete tasks, such as properly completing paperwork, or to know basic procedures. These members face an uphill battle in learning a new location's culture, tempo, and job requirements. Members of one focus group complained that it sometimes seemed as though Reserve and National Guard members were almost on "vacation" because they are sometimes bunked in hotels with swimming pools while on deployment.

Minimal contact with supervisors and unit leadership due to the nature of their military time commitments was identified as another important barrier for members of the Guard and Reserve components. As a result, these members may not develop close relationships that they could turn to during times of stress. In addition, there may be insufficient time for supervisors to get to know a member and to observe behavioral changes that may signal a mental health need. Relatedly, if the training location is in a large metropolitan area, the Reservists and Guardsmen often do not know each other; and because of the nature of their position, may not have adequate time to build a support network with one another. Gatekeepers explained that reserve units from rural areas may not face this kind of limitation. Quite often these members might have grown up together or worked for the same civilian employer, and are able to build a stronger support system with a good sense of community. This is often seen as a protective factor, because they have peers they

can speak with, who might encourage them to seek mental health care on base or back home.

Representative Quotes

- "Another big difference between active duty and the Reserve and Guard is that your contact with your supervisor is a lot less. We see our airmen every day. If you're only working two days a week or two days a month, that's the only interaction you get with your supervisor, so I can only imagine how tough that is."

- "So when they have their drill weekends and things like that, they have the challenge of trying to train their folks or check their folks and see if they can detect these signs only within a weekend. Over a two-day period, leaders are trying to figure out, 'What's the health of my force?' I think that's definitely a much more significant challenge on their side because they only really get that one weekend a month or two weeks of the year."

- "I think that they had the most difficulty mental health-wise feeling connectivity with the active duty force. I think that opens up a whole can of worms, but communication, connectivity between guard and active duty."

- "Because we see them as part time workers... They come on, they don't agree, but they don't know what we're doing. Like he said, he's coming in for six months, he's going to sit here for six months, probably, learn how does active duty function, how do they do certain things. In six months he's going to have to learn that. He creates relationships. In six months, he's gone. What happens to those relationships?"

Civilian Life

One theme that developed in several focus groups was that Reservists and Guardsmen face difficulties in their civilian lives and often lack support in regards to their military career. They come back from weekend drills or annual trainings and either cannot talk about what they have done, especially if their position requires a security clearance, or they are not understood by civilian family members and coworkers when they attempt to explain their experiences. They may not feel encouraged to seek out support in other ways, such as mental or behavioral health services. Active duty Service members, however, are constantly surrounded by people who understand their military-specific language and pressures and have easier access to mental health care.

Representative Quotes

- "They get out to wherever they're going and there may be nobody else in the entire town that has been where they've been, done what they've done, has any

experience with what they and their family are going to go through, resources, Fleet and Family and things of that nature, are four states away."

* "Say they have been deployed and they come back and they go back to their civilian side. Civilians have no idea what they've gone through. They cannot even relate. It's just like when we go home unless we have family members that have been in the service ... they don't get it."

* "I think one of the benefits, though, of being a guardsman or a reservist, ... you're there for a long time – you build a community of people that never PCS, who rarely deploy, depending on your command. So you have a support system of your co-workers, and sometimes you even live in the same – one of my neighbors, I rode with to drill weekend, and I saw him all the time, so while you may not have the same kind of access to care as you do on an active duty base,... I think you have deeper connections. You know you're not gonna be there for 3 years and then PCS, so, you're like, 'Hey, this dude might be here – we might be here for 25 years together at the same base, same unit,' so I think that's a benefit, in terms of building those connections."

Reintegration

When Reservists or National Guardsmen are demobilized from longer trainings, temporary duty assignments (TDY), or Continental United States and Outside of Continental United States deployments, they face a period of reintegration into their civilian life. This potentially stressful time can be a contributing factor for some members to seek mental health care services. Reintegration can be difficult for some, and family members and coworkers may not understand or identify with their experiences. These members may have difficulty picking up where they let off in their civilian jobs or their old job may not be there anymore, and they must search for employment immediately.

Regarding barriers to help-seeking during the reintegration process, one chaplain voiced a perception that there is little support for Reserve or Guardsmen when they return from TDY or deployment. Gatekeepers were concerned that the few programs that are available to Reservists and Guardsmen, such as The Warrior Transition Program, and Third Location Decompression programs, are optional for these groups, whereas active duty Service branches may require mandatory participation in decompression programs for members returning from deployments. One focus group participant noted that the Navy has a Resource Referral Tracking Manager, which allows sailors to access care after returning from deployment and to track referrals and follow- up appointments, however, gatekeepers cannot ensure that Reservists engage in these services.

Representative Quotes

- "It's different when you leave active duty, it should be – I don't know how else to call it – the separation health physical exam. It's comprehensive, but the one for Reservists and Guard isn't. It's not comprehensive."

- "I think with members coming back from deployment, some of the biggest mental health issues that we see are...especially with the Reserve population, a lot of them are, underemployed or unemployed and they're going back to that, and they're uncertain to what their employment's going to be when they get back. And we see a lot of them are going from one set of orders to another set of orders and they're for a limited amount of time. And there may be a gap between times. They're okay if they know they're getting that other set of orders, but if they're going back and they're unsure, they have no idea if they'll get another set of orders, if they have to get some sort of employment in the meantime. That's one of the bigger stressors that we see."

- "If you're not on orders of over 30 days then you don't get certain things, but that may have been a TDY that was really brutal for less than 30 days. So coming off the variety of orders, they deployed with all of us so we go and we're all there doing six or seven months a year, two years, whatever together; but when they're done, the support that the Reservists receive and Guard receive on the back end is far less than the active duty. I mean it's almost criminal. [...] They just throw them right back in to going to work."

- "The reserve environment is a whole different set of stressors. You have the immediate stressors that we have, then they have a civilian career they have to worry about and how do those two mesh, and what if you get activated for a year and how do you go through a civilian job."

- "Just leaving service altogether, the transitional assistance programs don't really have any mental health component or aspect other than let's check your medical records and show you how to transition you to the VA."

- "I know there are rules that say if I deploy as a Reserve if I come back they're supposed to protect my job. But then they reorganize the whole company and my job doesn't exist anymore. So they didn't fire me they just reorganized the company... Yeah, well while you were on your vacation [look] who stepped in and handled all of these difficult projects."

RECOMMENDATIONS

(A) Improve access to care by offering mental health appointments and support services to Guard and Reserve personnel during training weekends, including offering evening and weekend appointments.

(B)   Improve access to care by offering remote mental health services (e.g., via telephone or Internet) to all members of the Guard and Reserve, so that these individuals can access support services from providers with experience working with military populations, regardless of their home location.

(C)   Conduct a dedicated study examining issues of access to and utilization of mental health care by Guard and Reserve personnel.

(D)   Provide information to gatekeepers regarding unique circumstances facing members of the Reserve and National Guard components and training in how to best assist these members in utilizing mental health and support services.