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ABSTRACT: Prior research indicates that military officers are less likely than enlisted personnel to seek mental or behavioral health support when such services would be beneficial (e.g., when experiencing suicidal ideation or after a suicide attempt; Ho et al., 2018; OPA, 2017). Barriers to behavioral health resource utilization in the military include public stigma, internalized self-stigma, concerns regarding peer and leader perceptions of work-related abilities, preference for self-reliance, negative attitudes toward behavioral health treatment, and operational barriers (Britt et al., 2016; Greene-Shortridge, Britt, & Castro, 2007; Hines et al., 2014; Kim, Britt, Klocko, Riviere, & Adler, 2011; Nash, Silva, & Litz, 2009; Vogt, 2011). However, research is limited regarding the help-seeking experiences, barriers, and available resources for senior leaders, such as non-commissioned and commissioned officers. This report addresses this gap in the literature. Specifically, we interviewed 32 subject matter experts (SMEs) affiliated with the Army, Navy, Marine Corps, Air Force, and the Office of the Undersecretary of Defense for Personnel and Readiness. Results of SME interviews indicated that, although several behavioral health resources are available to officers, few are tailored specifically to the needs of officers. SME-identified barriers to officer help-seeking behavior were consistent with those previously described in military studies, but SMEs indicated that the concerns were heightened for senior leaders. Based on SME-identified solutions to address barriers, this study concludes with a list of recommendations for changes to the military behavioral health system and officer professional development as well as increases to spouse and family involvement in officer help-seeking and the creation of messaging campaigns targeted specifically to leaders and senior officers.

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# PREFACE

A 2016 Defense Personnel and Security Research Center study found that officers are less likely to speak to someone about suicidal ideation or suicide attempts compared to enlisted personnel. Because the number of studies examining the help-seeking dynamics that military leaders contend with in their leadership positions is limited, the Office of People Analytics conducted this study in 2018 to better understand their help-seeking experiences, barriers, and available resources. Based on the findings from this study, recommendations for addressing identified barriers are offered, as well as ideas for future work in this domain.

Eric L. Lang
Director, PERSEREC

## ACKNOWLEDGEMENTS

The authors would like to thank Dr. Laura Neely and Dr. Adam Walsh from the Defense Suicide Prevention Office for their help with shaping the project goals and providing feedback on the draft report. The authors would also like to express their gratitude to the subject matter experts from across DoD who contributed their insights regarding military leader behavioral health help-seeking.

# EXECUTIVE SUMMARY

Military leaders, such as non-commissioned and commissioned officers, play an important role in motivating, caring for, and setting an example for the people they lead. Leaders also play a key role in fostering a positive command climate of behavioral health and help-seeking. Despite recent data showing that officers are less likely than enlisted personnel to use behavioral health services (Office of People Analytics, 2017), few studies focus on the behavioral health and help-seeking behavior of military leaders. Current research with military personnel indicates that possible barriers to behavioral health care utilization include public stigma, internalized self-stigma, concern regarding peer and leader perceptions of work-related abilities, preference for self-reliance, negative attitudes toward behavioral health treatment, and operational barriers. Because these studies did not focus specifically on the barriers facing officers, there is a need to focus attention on barriers to help-seeking among leaders and the solutions that could encourage them to obtain needed support. Focusing on the behavioral health help-seeking behavior of military leaders not only assists them in effectively contributing to their mission and promoting their own long-term well-being, but may also have the secondary effect of encouraging help-seeking among those they lead.

The Defense Personnel and Security Research Center, a division of the Office of People Analytics, conducted this project in coordination with the Defense Suicide Prevention Office. The goals of this project were to: (a) explore existing barriers that prevent active duty military leaders who would benefit from behavioral health support from utilizing resources, (b) further understand the scope of resources available to Service members that address these barriers, and (c) make recommendations for mitigating barriers to behavioral health resource utilization by leaders.

## METHOD

Using a qualitative approach to explore barriers to help-seeking among leaders, resources currently available to leaders, and solutions for how to increase help-seeking for behavioral health concerns, 24 semi-structured interviews with 32 subject matter experts (SMEs) were completed. A content analysis of SME comments was conducted to explore these topics. SMEs were identified for interviews based on their knowledge of military behavioral health resources and barriers to service utilization that may be unique to leaders. SMEs were affiliated with the U.S. Army, Navy, Marine Corps, Air Force, and the Office of the Undersecretary of Defense for Personnel and Readiness. The group comprised military behavioral health researchers, behavioral health providers (e.g., psychiatrists, psychologists), chaplains, individuals who provide military policy and program oversight (e.g., administration of behavioral health programs or promotions board programs), and senior military leaders with command experience. A number of these SMEs also worked with special communities within the Services, including the Special Forces, surface warfare, submarine, aviation, and military intelligence communities.

## RESULTS

Based on the results of SME interviews and follow-up discussions, we identified five primary barriers to help-seeking among leaders: professional concerns, privacy and confidentiality concerns, lack of confidence in resources, practical barriers, and a preference for self-reliance. The available resources identified by SMEs fell into two main categories: treatment and care options and training and skill-building programs (all SME-identified resources are listed in Appendix B). Finally, we identified four primary themes related to solutions and strategies: adjustments to the behavioral health care system, adjustments to leader professional development, spouse and family involvement in service utilization, and targeted messaging campaigns.

## RECOMMENDATIONS

The following 14 recommendations are proposed to increase the rates of behavioral health help-seeking among military leaders and address their barriers to care:

1. Disseminate recommendations for increasing leader privacy and confidentiality in behavioral health care settings.
2. Create a behavioral health program exclusively for leaders.
3. Expand the use of telehealth services.
4. Separate behavioral health care delivery from behavioral health evaluations.
5. Examine ways to improve behavioral health screening processes.
6. Adopt more community behavioral health practices.
7. Ensure that caring professionals have appropriate clearance levels to best work with the populations they serve.
8. Provide targeted support for clinical professionals with unique privacy and licensure concerns.
9. Tailor and hold separate trainings for leaders.
10. Integrate self-care into the promotions system.
11. Make one-on-one meetings with providers mandatory at certain career touch points.
12. Offer more trainings and outreach to military spouses and families.
13. Strengthen messaging campaigns that aim to dispel behavioral health care myths.
14. Encourage leaders to share examples of their own successful utilization of behavioral health resources.

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# INTRODUCTION

Leadership doctrine emphasizes the importance of military leaders in motivating, caring for, and setting an example for people they lead (Department of the Army, 2012; Department of the Air Force, 2011; Department of the Navy, 2014; Richardson, 2017). Leaders, such as non-commissioned and commissioned officers, play an important role in promoting the health and functioning of their units (Britt, Davison, Bliese, & Castro, 2004) and fostering a positive command climate of behavioral health and help-seeking (Britt, Wright, & Moore, 2012). However, few research studies have focused on the behavioral health and help-seeking behavior of military leaders themselves, despite recent data showing that officers are less likely to use behavioral health services compared to enlisted personnel, even if they may benefit from assistance (Hines et al., 2014; Office of People Analytics [OPA], 2017). Extant research indicates that barriers to behavioral health care utilization among military personnel include public stigma, internalized self-stigma, concern regarding peer and leader perceptions of work-related abilities, preference for self-reliance, negative attitudes toward behavioral health treatment, and operational barriers (Britt et al., 2016; Greene-Shortridge, Britt, & Castro, 2007; Hines et al., 2014; Kim, Britt, Klocko, Riviere, & Adler, 2011; Nash, Silva, & Litz, 2009; Vogt, 2011). However, these studies do not focus specifically on the barriers facing military leaders.

Given the importance of military leaders in fostering a culture of help-seeking and dispelling the stigma of behavioral health care (e.g., Department of Defense Instruction [DoDI] 6490.08 *Command Notification Requirements to Dispel Stigma in Providing Mental Health Care to Service Members*) as well as the unique characteristics of leader duties, attention needs to be focused specifically on barriers to help-seeking among military leaders and the solutions that could encourage them to obtain needed support. In addition, a recent study conducted by OPA found that among Service members who experienced suicidal ideation or attempts, officers were less likely than enlisted personnel to have reached out to someone about their experience (Ho et al., 2018). Based on comments from focus groups with those who support military suicide prevention efforts (i.e., suicide prevention gatekeepers), Ho et al. recommended further study of the issue of help-seeking among officers with the goal of providing resources specifically tailored to officers. Focusing on the behavioral health help-seeking of military leaders not only assists them in effectively contributing to their mission and promoting their own long-term well-being, but may also have the secondary effect of encouraging help-seeking among subordinates.

OPA provided support for the current project, and the Defense Personnel and Security Research Center—a division of OPA—conducted this examination of barriers and resources for leader help-seeking in coordination with the Defense Suicide Prevention Office. The purpose of this project was threefold:

- To explore existing barriers that prevent military leaders who would benefit from behavioral health support from seeking resources.

- To understand the scope of resources available to Service members to address these barriers.
- To make recommendations for how to mitigate barriers to behavioral health care utilization by leaders.

## BACKGROUND

Service members are at an elevated risk of exposure to traumatic events compared to the general population, and many experience major depressive disorder, posttraumatic stress disorder, suicidal ideation, and interpersonal conflicts after returning from combat (Milliken, Autcherlonie, & Hoge, 2007; Sareen et al., 2007; Vogt, 2011). In 2016, approximately 14% of Service members reported a history of suicidal thoughts, with approximately 15% of those individuals indicating they had attempted suicide at some point in their lives (Walsh & Walsh, 2017). Given these serious concerns, it is critical that Service members utilize available behavioral resources.

### Current Resources

A variety of services, initiatives, and trainings are in place to offer Service members accessible behavioral health support throughout their time in service (Acosta et al., 2014; Bagley, Munjas, & Shekelle, 2010; Coll, Weiss, & Yarvis, 2011). Examples of such resources include psychotherapy and psychiatric care, non-medical counseling,[1] chaplain services, 24-hour crisis hotlines, as well as alcohol and drug abuse prevention and treatment programs. Further, a variety of DoD-wide and Service-level initiatives are designed to promote a supportive command climate, reduce stigma related to seeking help, build Service member resilience and behavioral health knowledge, prevent suicide, and support DoD family wellness (Ho et al., 2018, Hurtado, Simon-Arndt, McAnany, & Crain, 2015). For example, DoD and each Military Branch have dedicated suicide prevention programs as well as confidential chaplain services. Additionally, training opportunities teach Service members about important topics (e.g., how to strengthen one's resiliency in the face of stress; how to contribute to suicide prevention efforts). Each of these resources supplements broader initiatives to improve Service member life satisfaction, physical wellness, social relationships, and work performance (Schwerin, 2006; Trail et al., 2017). Of note, few existing resources are tailored to the unique needs of non-commissioned and commissioned officers.

Despite the availability of a variety of behavioral health and non-medical counseling options, many Service members who could benefit from services refrain from utilizing them (Britt, 2000; Milliken et al., 2007). For example, Hoge and colleagues (2004) found that only 23% to 40% of Service members who reported significant behavioral

[1]Non-medical counseling services are short-term, solution-focused counseling designed to support clients experiencing significant personal and family stressors. Individuals experiencing diagnosed psychiatric conditions, suicidal thoughts, substance abuse, or sequelae secondary to assault are referred for higher levels of care.

health problems received professional help in the previous year. Among Service members who experienced suicidal ideation and had a suicide attempt since joining the military, 43% indicated that they did not speak to anyone about their suicidal ideation or suicide attempt. Even after accounting for a number of barriers to behavioral health treatment and basic demographic characteristics, officers were 30% more likely than enlisted personnel to be in the group of Service members who indicated that they did not speak to anyone about their suicidal ideation or suicide attempt (Ho et al., 2018; OPA, 2017).

### Barriers to Behavioral Health Utilization Among Service Members

Several barriers to seeking formal services have been documented that may collectively explain much of the behavioral health service underutilization by Service members (Coleman, Stevelink, Hatch, Denny, & Greenberg, 2017). A recent focus group conducted with suicide prevention gatekeepers noted that stigma, concerns regarding career impact, and perceptions regarding the effectiveness of available services were major themes for non-help-seeking behaviors in Service members (Ho et al., 2018).

Stigma is a well-known barrier to behavioral health care utilization and adherence. Service members may be concerned about repercussions from leadership (Hoge et al., 2004) or believe that they should handle problems on their own (Stecker, Fortney, Hamilton, & Ajzen, 2007). Further, they may see individuals with psychiatric conditions as responsible for their problems (Cooper, Corrigan, & Watson, 2003). There is an important distinction between public stigma (the public's view of individuals living with mental illness, such as assumptions of dangerousness, incompetence, or general "badness") and self-stigma (an internalization of public stigma) (Corrigan & Watson, 2002; Kim et al., 2011). Wade and colleagues (2015) noted that self-stigma may be more critical than public stigma in predicting help-seeking behavior, suggesting it is especially important to focus attention on decreasing self-stigmatizing thoughts in Service members to increase help-seeking behavior. Likewise, negative attitudes about psychological problems and the effectiveness of treatments have also been linked to lower treatment utilization (Kim et al., 2011; Kessler et al., 2001; Vogel, Wester, Wei, & Boyson, 2005).

Adler, Britt, Riviere, Kim, and Thomas (2015) highlight the importance of considering factors other than stigma in understanding Service member behavioral health treatment seeking. Based on associations between post-deployment surveys and treatment seeking in Soldiers, they noted four important factors associated with seeking treatment: professional concerns, preference for self-management, practical barriers, and positive attitudes. Professional concerns included career ramifications, unit member perceptions of the individual, appearance of weakness, and the potential impact on security clearance. Preference for self-management included low trust in behavioral health professionals, a belief that strong people help themselves, and confidence in the individual's own ability to help him or herself. Practical barriers included being unsure where to get help, difficulty scheduling an appointment, and inadequate transportation to appointments. Positive attitudes included the belief that

counseling is helpful and that it requires courage to seek help. Of note, preference for self-management and negative attitudes about treatment utility were especially relevant predictors of treatment underutilization.

Greene-Shortridge et al. (2007) identified organizational barriers that may impact help-seeking. They suggest that barriers such as a lack of anonymity, difficulty attending appointments during the work day, and increased risk of losing a security clearance could be avenues for policy change that could increase help-seeking. Service members have also noted significant concerns regarding the confidentiality of their medical records and have noted concerns regarding whether commanding officers will use treatment information to inform career-related decisions (Benjamin, 2011; Vogt, 2011).

### Barriers to Behavioral Health Utilization in Senior Leaders

Several efforts have furthered understanding of barriers that undermine behavioral health utilization by Service members. However, few published studies specifically consider the unique needs of Service members of higher rank. Compared to enlisted personnel, warrant and commissioned officers are less likely to be diagnosed with psychiatric disorders, report suicide-related thoughts and behaviors, or report negative feelings such as nervousness, stress, lack of control, being overwhelmed, anger, or difficulty coping, but are more likely to avoid seeking help for these concerns (OPA, 2017; Riddle et al., 2007; Walsh & Walsh, 2017). Effective leaders are imperative to enhancing unit resiliency (Bartone, 2006), navigating dangerous environments (Campbell, Hannah, & Matthews, 2010), and providing behavioral health-related leadership and support (Adler, Saboe, Anderson, Sipos, & Thomas, 2014; Britt et al., 2004). Thus, it is critical to address the barriers that may prevent leaders from effectively seeking help for behavioral health concerns that could hinder their effective force management.

Behavioral health care utilization and barriers to care in leaders are relatively understudied, although some research has found that service underutilization is especially pronounced in military leader groups. For instance, in a survey of Army personnel, warrant and commissioned officers were more likely than enlisted personnel to indicate that they avoided seeking treatment for attitudinal reasons (e.g., preference for self-management, perceived ineffectiveness of treatment, stigma, and embarrassment). They were also especially likely to report discontinuing treatment because they no longer needed the assistance compared to enlisted personnel (Naifeh et al., 2016). In one study, approximately 11% of officers reported having experienced suicidal thoughts and 7% reported they have attempted suicide in their lifetimes. Of those who reported a history of suicide-related thoughts and behaviors, officers were less likely than enlisted personnel to have talked to someone about it (49% versus 58%, respectively). Officers were also more likely to note that they never *considered* talking to someone about it (37% versus 29%, respectively) (Walsh & Walsh, 2017). Those officers who did not seek help noted it was often because of concerns of negative career impact (60%), lack of confidentiality (46%), loss of confidence by coworkers or superiors (45%), thinking less of themselves if unable to handle it on their own (44%),

potential impact to their security clearance (44%), embarrassment (41%), or not wanting others to interfere (36%) (OPA, 2017). Note that officer results available in the Status of Forces Survey focus on warrant (W1-W5), junior (O1-O3), and field-grade officers (O4-O6) (OPA, 2017). Given lack of comparable data for general and flag officers, attention should also be focused on their needs and barriers to behavioral health service utilization. Focus group data suggest some barriers may be especially relevant for those in command positions: lack of confidentiality; being perceived as shirking responsibilities while attending an appointment; or fear of limitations being placed on deployability status, access to special positions, or security clearance (Ho et al., 2018).

Additionally, those in military leadership roles face notable demands related to career performance to meet mission expectations while simultaneously supporting the well-being of their units. For instance, in addition to discussing a commander's need to meet mission-specific demands, Bartone (2006) discusses the importance of a commander's leadership style in promoting hardy, resilient unit member responses to stressors. Nash (2011) notes that military leaders are expected to mitigate stressors, identify stress reactions, connect unit members with behavioral health-related training and services, and help reintegrate personnel who have been removed from duty for recovery. Further, they are expected to exemplify courage and fortitude so that unit members can rely on them as a source of strength during challenging times (Nash, 2011). Research indicates that leaders typically take a supportive stance regarding their subordinates seeking help for combat and operational stress (Vaughan, Farmer, Breslau, & Burnette, 2015). However, leaders who themselves are experiencing unmanaged behavioral-health-related difficulties may be detrimental rather than beneficial to their own units (Nash, 2011). Given that military leaders have a relatively low likelihood of seeking support when needed, there appears to be a particular need to focus on how to reduce barriers to help-seeking among military leaders.

## CURRENT STUDY

The purpose of this study was threefold. With an emphasis on DoD active duty warrant officers, mid- and field-grade officers, and general and flag officers experiencing behavioral health concerns, we sought to answer the following research questions:

1. What barriers to behavioral health help-seeking exist for warrant officers (W1-W5), mid- and field-grade officers (O4-O6), and general and flag officers (O7 and above) who experience behavioral health concerns?
2. What effective resources are available to warrant officers, mid- and field-grade officers, and general and flag officers who experience behavioral health concerns that address the barriers identified in Research Question 1?
3. What strategies can be implemented or expanded to address barriers to help-seeking in warrant officers, mid- and field-grade officers, and general and flag officers that are currently unaddressed or insufficiently addressed?

# METHOD

This project used a qualitative approach to explore barriers to help-seeking among active duty leaders, resources currently used by leaders, and solutions to increase help-seeking for behavioral health concerns. Semi-structured interviews were conducted with subject matter experts (SMEs) and content analysis was used to explore these themes.[2]

## PARTICIPANTS

Based on their knowledge of military behavioral health resources and barriers to service utilization that may be unique to leaders, SMEs were identified and recruited using a snowball sampling approach. First, four SMEs with previous knowledge and familiarity with the topic were recruited. SMEs then recommended one to three other individuals who had familiarity with the topic. In total, 24 semi-structured interviews were conducted with 32 SMEs between December 2017 and April 2018. Individual interviews were conducted with 20 SMEs, and 12 were interviewed in groups of two to five. SMEs were affiliated with the U.S. Army, Navy, Marine Corps, Air Force, and the Office of the Undersecretary of Defense for Personnel and Readiness). They included military behavioral health researchers, behavioral health providers (e.g., psychiatrists, psychologists), chaplains, individuals who provide military policy and program oversight in behavioral health or promotions (e.g., policy development, policy execution, program management), and senior military leaders with command experience. A number of SMEs also worked with special communities within the Services, including the Special Forces, surface warfare, submarine, aviation, and military intelligence communities. Of note, SMEs recommended speaking to those from special communities given their unique help-seeking concerns and because some special communities had behavioral health programs specific to their population of Service members.

## PROCEDURE

SMEs received an e-mail invitation to participate in a semi-structured interview along with background information on the project. SMEs who expressed interest in participating were scheduled for a phone interview and received the anticipated interview questions to review 3 to 5 days before the scheduled call. Interview protocols included both a core set of questions and additional questions tailored to each SME's background. For example, SMEs with a research background received questions on relevant research and findings, whereas SMEs with promotion board experience received questions on the military promotion process. Core questions focused on the following topics: unique barriers to help-seeking among warrant, field- and mid-grade,

[2] The procedures were reviewed by a Defense Human Resources Activity Human Protection Administrator (HPA) who determined that this study did not meet the definition of human subjects research. Therefore, a full review was not necessary.

and general officers; resources that address the barriers facing this military population; and solutions for how to encourage help-seeking among those who may need it. Table 1 displays the type of information captured in the interview protocol and sample interview questions. The full list of core interview questions sent to SMEs is provided in Appendix A.

**Table 1**
**Interview Topics and Sample Questions**

| Type of Information | Sample Question |
|---|---|
| Barriers | What are some of the barriers to help-seeking that are common among warrant officers (W1-W5), field grade officers (O4-O6), and general officers (O7-O9)? |
| Resources | What are the DoD-wide or Service component-wide resources, such as programs, services, training, or initiatives, that are designed to address the barriers you listed? |
| Solutions | What ideas do you have for both (a) reasonable solutions and (b) outside-the-box possibilities that could increase help-seeking behaviors, given existing barriers? |
| Research | Could you point us to any other relevant research pertinent to officer help-seeking? |
| Promotions | In your experience and opinion, how does military culture affect promotion board outcomes (e.g., zero-defect mentality)? |

Interviews were conducted by five researchers, with one to two researchers leading each 45- to 60-minute phone interview. Following the interview, each SME received a copy of the interview notes for review and was given the opportunity to confirm or correct the information. SMEs were asked to review the notes by a certain date and were informed that no response indicated tacit approval of the notes. Sixteen sets of interview notes were reviewed and approved by the SMEs and eight sets received tacit approval. All interviews were included in data analysis.

## DATA ANALYSIS

A structural coding framework with multiple rounds of review was used to analyze the interview data and to develop informative themes. In the first round of review, a conventional approach to content analysis was used (Hsieh & Shannon, 2005), which entailed four individuals independently developing coding categories based on examination of the collected interview data. The codes were discussed and a coding scheme was agreed on that organized the data into three categories corresponding to the research questions: (a) barriers to leader help-seeking, (b) existing resources that support psychological well-being, and (c) strategies that could be expanded or developed to address barriers to leader help-seeking. In the second stage, the coding scheme was applied to the interview notes. To ensure researchers coded interview notes consistently and reliably, regular meetings were held to reach consensus on how to apply the codes to the interview comments. In the final stage of analysis, researchers independently reviewed the coded content, then met to synthesize codes into themes and to identify opportunities to combine or split themes. Finally, researchers agreed on

the final themes and subthemes within the three categories (barriers, resources, and strategies). As an additional reliability check, one researcher who did not participate in the prior review rounds reviewed and coded all interview comments independently and validated the final themes and subthemes. Themes and subthemes are described in detail in the Results section of this report.

# RESULTS

To address the three research questions, the content of all SME interviews was coded according to the three categories: (a) barriers to leader help-seeking, (b) existing resources that support psychological well-being, and (c) strategies that could be expanded or developed to address barriers to leader help-seeking. Researchers identified five primary themes in the barriers category, two in the resources category, and four in the solutions category. Table 2 shows the main themes identified for each category.

**Table 2**
**Category and Associated Themes From SME Interviews**

| Category | Themes |
|---|---|
| Barriers to leader help-seeking | • Professional concerns<br>• Privacy and confidentiality concerns<br>• Lack of confidence in resources<br>• Practical barriers<br>• Preference for self-reliance |
| Existing resources that support psychological well-being | • Treatment and care options<br>• Trainings and skill-building programs |
| Strategies that could be expanded or developed to address barriers to leader help-seeking | • Adjustments to the behavioral health care system<br>• Adjustments to officer professional development<br>• Increasing spouse and family involvement<br>• Messaging campaigns |

## BARRIERS

SMEs described a number of reasons why leaders are less likely to seek behavioral health resources even while encouraging and supporting their units to do so. These reasons include professional concerns, privacy and confidentiality concerns, lack of confidence in resources, practical barriers, and a preference for self-reliance. SMEs explained that, although the barriers they identified are not unique to leaders, they are likely heightened for higher-ranking personnel compared with more junior personnel. This may be due to their elevated responsibilities and the high-profile nature of their careers. In addition, the leader's own attitudes and behaviors concerning behavioral health and help-seeking impact the help-seeking behavior of the unit. One SME reiterated this and noted a conclusion made in an Adler, Saboe, Anderson, Sipos, and Thomas (2014) study that when "soldiers rated their leaders high on [behaviors promoting management of combat operational stress], soldiers also reported better mental health and feeling more comfortable with the idea of seeking mental health treatment."

Figure 1 shows the themes and subthemes identified within the "barrier" category. Circles denote subthemes, rectangles denote barriers (i.e., themes), and arrows denote associations. SME comments on professional concerns, lack of confidence in resources, practical barriers, and preference for self-reliance indicated that SMEs saw a direct association between these barriers and leader help-seeking behavior. However, analysis

of comments on privacy and confidentiality indicated that these concerns were closely associated with professional concerns and were related to help-seeking behavior through this barrier. All of the barriers, subthemes, and their associations with leaders' help-seeking behavior are described in detail in this section.

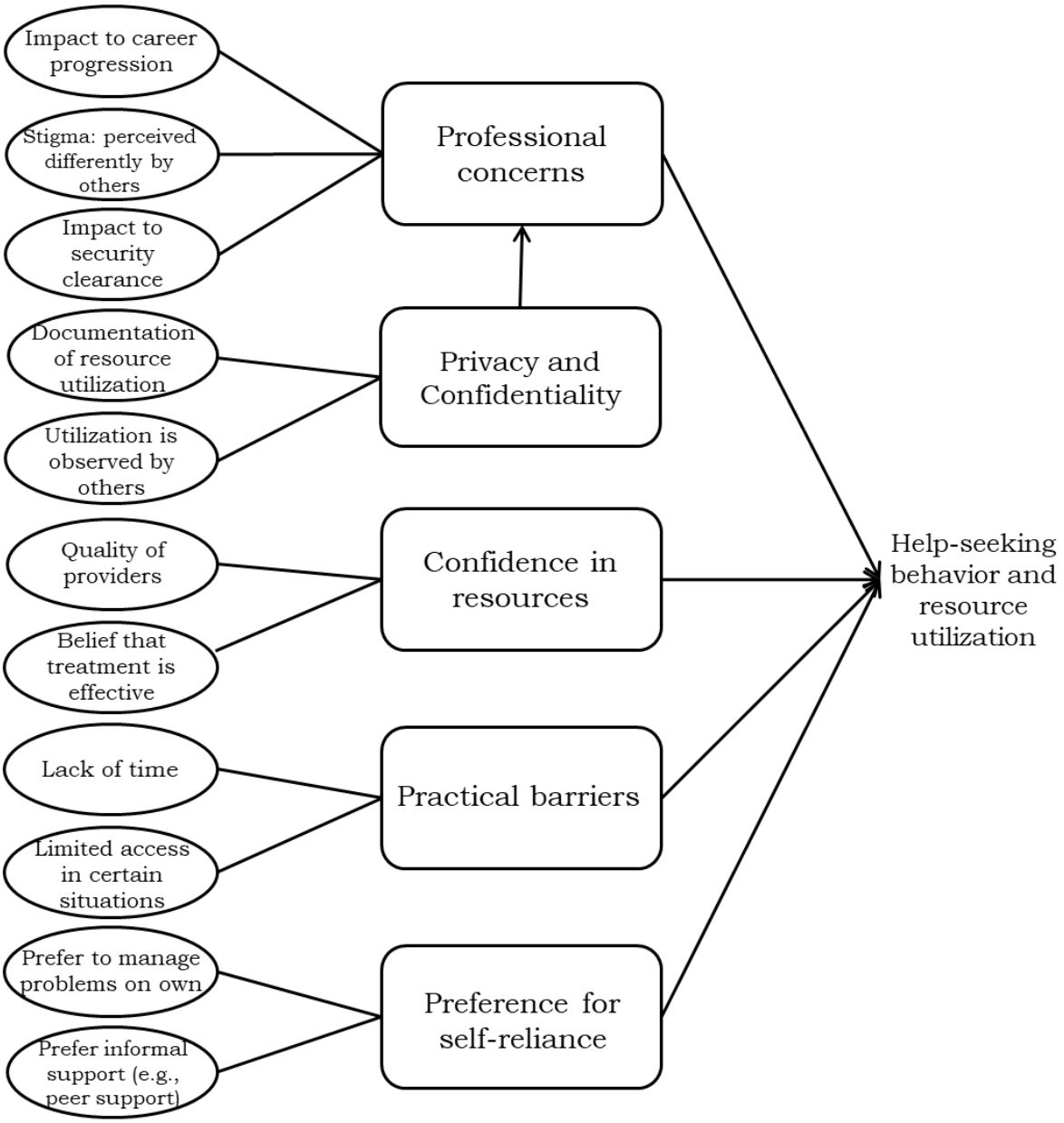


**Figure 1 Conceptual Diagram of Barriers to Help-Seeking Behavior for Leaders**

### Professional Concerns

Professional concerns over seeking behavioral health care were frequently mentioned by SMEs. Specifically, they identified concerns about career ramifications, fears of being perceived differently because of behavioral health issues (stigma), and impact to security clearance as major impediments to leaders seeking behavioral health support.

The military has a hierarchical structure in which there are limited positions at higher ranks. Consequently, SMEs explained, career progression and promotions are "extremely competitive." Leaders are career-minded individuals who may be concerned that taking the time to seek behavioral health care may interfere with being selected for certain duties or educational and professional development opportunities. Consequently, leaders often suppress their behavioral health concerns until retirement, which is when they are more likely to seek help.

In the promotion selection process, missing career development opportunities may put an individual at a disadvantage for successful promotion in comparison to their peers. SMEs clarified that, because there is no discussion of an individual's medical well-being during the promotions selection process, at times voting members of the promotion board are not provided the context in which an individual missed certain career milestones (e.g., a previous behavioral health challenge that is now well-managed). Because these sorts of extenuating circumstances are not provided, leaders and officers may adopt a "zero-defect mentality." These military leaders may then avoid any actions that may interfere with achieving career milestones or that may be inaccurately perceived as adverse medical or misconduct information during selection board evaluations (e.g., Navy Field Code 17). SMEs pointed out, however, that this type of "zero-defect" view is explicitly discouraged among voting members of selection boards.

In addition, some SMEs agreed that the fear of career repercussions was "bigger than reality" and indicated that, in general, Service members are actually more likely to have career-related problems due to untreated behavioral health issues. Other SMEs clarified that research indicates individuals experiencing serious behavioral health concerns were more likely to experience career ramifications, including early attrition from the military. No clear conclusions were drawn in these studies regarding how utilization of behavioral health treatment contributes to career ramifications, but early self-referral for behavioral health treatment was found to be one way to sustain a military career (Hoge, et al., 2002; Rowan & Campise, 2006; Rowan, Varga, Clayton & Zona, 2014; Ghahramanlou-Holloway et al., 2018).

Relatedly, SMEs explained that career progression relies on favorable evaluations from superiors and that leaders fear that seeking behavioral health support could be perceived as an inability to handle stressful situations. In addition to this internalized stigma of concerns about perceptions their superiors may have, leaders may also worry about how they would be perceived by Service members they lead if it was known they sought behavioral health support. One SME noted that the most senior leaders are seen as "the rock" of the organization and may experience pressure to "be perfect" in the spotlight. Therefore, leaders may believe that their units will question their leadership and decision-making skills if they know that they sought behavioral health care. SMEs explained that leaders—particularly those in special communities such as military intelligence—avoid any kind of behavior that they believe will cause others to question their competence, ability, or judgment. Similarly, military leaders who practice with state licenses (e.g., lawyers, nurses, physicians, psychologists) may avoid

pursuing help because they fear losing their licenses to practice in their respective fields in both military and civilian sectors.

Many SMEs also discussed leaders' significant concerns about the impact of using behavioral health care on security clearance eligibility. SMEs explained that leaders are more likely to be in positions that require a security clearance, particularly in special communities such as military intelligence. Many of these individuals fear that seeking behavioral health care will result in the loss of their security clearance because the Standard Form 86 questionnaire for national security positions requires disclosure of psychological and emotional health information. SMEs described their efforts to clarify for Service members and leaders that disclosure of behavioral health care use on this form rarely results in denials or revocation of the security clearance. However, SMEs admitted that this misunderstanding persists and contributes significantly to career concerns for leaders considering behavioral health treatment.

### Privacy and Confidentiality Concerns

SMEs frequently discussed leaders' behavioral health care privacy and confidentiality concerns. The two main subthemes that emerged were concerns about being seen by others when accessing behavioral health care and that the documentation of their utilization is not confidential.

Privacy refers to a person's interest in limiting other people's access to information about him or herself, whereas confidentiality refers to the right to maintain private information divulged in the course of a professional relationship (Folkman, 2000). SMEs explained that leaders' concerns about privacy include the chance that subordinates will see them in a clinic waiting room and determine that they are accessing behavioral health care. In terms of confidentiality, leaders were concerned with how their engagement with behavioral health resources is recorded and by whom and when the information may be accessed and viewed. SMEs who were medical officers themselves pointed out that medical providers may avoid military behavioral health care because their medical records could be accessed by fellow medical officers.

SMEs discussed the impact of privacy and confidentiality concerns on help-seeking behavior through the lens of professional concerns. For example, leaders are concerned that subordinates may see them seeking behavioral health care and question their leadership and decision-making abilities. Further, leaders are concerned that their superiors may be informed of their engagement in behavioral health care and may question their ability to handle stress, with resultant detrimental impacts on their perceived deployability or on their career progression. Such concerns sometimes lead leaders to seek services off base (described in more detail in the Resources section).

SMEs discussed the importance of behavioral health care providers protecting the privacy and confidentiality of their patients, while other SMEs argued for the need to inform commanders of behavioral health care treatment seeking so that commanders can make informed decisions about the readiness of their units. The tension between a commander's right to know for operational planning and a patient's right to

confidentiality was highlighted in one SME's discussion of DoDI 6490.08 *Command Notification Requirements to Dispel Stigma in Providing Mental Health Care to Service Members*. This DoDI states, "Healthcare providers shall follow a presumption that they are not to notify a Service member's commander when the Service member obtains behavioral health care or substance abuse education services." The SME explained that not notifying commanders of a Service member's engagement with behavioral health care interferes with commanders' abilities to support their personnel and to make operational decisions (e.g., who deploys and for how long). Although there are nine exceptions to this policy—including imminent risk to self, others, and the mission—in the SME's assessment, providers who do not have a military background are not well-equipped to judge when withholding information on treatment engagement constitutes a risk to the mission. The SME explained that a growing number of health care providers in the military system are civilians. As civilians, they do not possess an "*a priori* understanding of what military personnel do" and, therefore, have limited understanding of the situations in which they should report to the commander that a Service member is receiving treatment. The SME noted that the policy lacks guidance on what constitutes a "risk to mission," what should be reported to the commander, and how the information should be shared with the commander.

SMEs also noted that there is very little confidentiality for the person who expresses suicidality. The individual is "marked" as a high-risk client and is discussed at meetings centered on keeping the individual safe and determining whether they need to be hospitalized. Suicidal behavior is different from other behavioral health issues and may be the most challenging area for striking a balance between commanders' right to know for operation and risk management decisions and patient confidentiality rights.

### Lack of Confidence in Resources

Two subthemes emerged that described why leaders may lack confidence in the available resources: concerns about the quality of providers and the perception that treatment may not be effective. SMEs described how some leaders become well-acquainted with the behavioral health care system and resources through the process of providing behavioral health support to their units. Many leaders have been involved in requesting Commander-Directed Evaluations or monitoring those in their units placed on "high-interest lists" for expressing suicidal ideation. Such procedures are important in helping commanders maintain the safety and security of personnel. However, firsthand experiences may make leaders especially aware of limits to confidentiality offered by the military behavioral health system and career-related risks secondary to seeking help—especially related to disclosing suicidal thoughts or behaviors. SMEs speculated that familiarity with behavioral health policies and procedures may result in some leaders having positive opinions of the system and others having negative perceptions.

SMEs discussed that some leaders may believe that treatment is not effective or that military behavioral health providers will not be effective in helping them manage a behavioral health problem. These beliefs may come from directly observing their

subordinates' treatment experiences or their own negative experiences with providers. One SME pointed to the study by Adler and colleagues (2015) that found "positive attitudes, or the belief that counseling is helpful and takes courage, were associated with an increased likelihood of treatment-seeking over time." The authors discussed the importance of portraying individuals seeking treatment as courageous and responsible in addition to generating confidence in behavioral health treatment efficacy. However, some SMEs noted the difficulty in doing this when there is research indicating the ineffectiveness of some treatments, particularly those for suicidality. SMEs also explained that program evaluation conclusions that some military behavioral health programs are ineffective also undermine confidence in military resources. These SMEs called for more research and investment in evidence-based approaches to behavioral health care.

### Practical Barriers

SMEs identified lack of time and limited access to services as practical barriers to help-seeking behavior. They agreed that leaders have demanding schedules that limit their time to attend to personal health. Leaders must balance their work and family obligations, and seeking behavioral health services takes time away from their families and jobs. When leaders do schedule health appointments, they often perceive an expectation from their command to prioritize work activities over medical appointments. Alternatively, leaders prioritize the needs of their unit over their own and often cancel behavioral health appointments to attend to work-related matters.

SMEs explained that long wait times to obtain a behavioral health appointment also serve as barriers to leaders seeking care. Sometimes leaders seek help from non-military community-based providers instead of military resources in an effort to maintain their privacy. However, SMEs noted that some individuals are deterred by the amount of time it takes to attend appointments off base, the process by which others need to be notified so they can leave the installation, or the cost of paying out of pocket for services.

SMEs indicated that a leader's current mission (e.g., deployed, at sea) also affects access to services. Some SMEs highlighted that Service members have limited access to high-quality behavioral health support when deployed to remote areas or while on submarines or smaller ships. Stressors are notable in these contexts, and, even if a Service member could benefit from professional services, they may not have immediate access to a behavioral health care provider. For example, at a submarine base, SMEs indicated that there is access to more comprehensive services when in port. When "underway," the availability of care is limited to a single corpsman with limited training in psychiatric treatment.

### Preference for Self-Reliance

Two main self-reliance subthemes that emerged were preference for self-management of problems and reliance on peers for informal support. Leaders are often referred to as "go-getters" and "hard-chargers" who prefer to manage their own problems. SMEs

explained that these qualities are desirable attributes in leaders because they tend to work in intensely stressful environments and have a high degree of responsibility for high-stakes decisions. High-ranking leaders are expected to have strong organizational and management skills, including the ability to lead people, manage their own time, and take care of their personal problems. A downside of these expectations is that leaders—especially those at the O-4 rank and above—may be expected to have developed strong coping skills that preclude the need to seek help. In addition, some leaders may also adopt the view that if "others have pushed through, then so can I." One SME explained that research indicates that this preference for self-reliance or self-sufficiency is significantly associated with less treatment-seeking over time (Adler et al., 2015).

Based on previous research, SMEs explained that a preference for self-reliance is different from self-stigma (Adler et al., 2015)—the internalized belief that others will view or treat the individual differently because of a behavioral health issue. SMEs indicated that the submarine forces and other specialized occupational fields (e.g., nuclear, pilot, intelligence, military police, clinical personnel) are particularly known for their cultures of self-sufficiency and preference for self-management in an environment where physical or psychological fitness requirements are especially stringent. SMEs noted that leaders in these fields are even less likely to seek behavioral health support and may instead rely on peers for support in the face of stressors.

## RESOURCES

There are many behavioral health resources available to military personnel. When asked about effective resources that leaders use, SMEs identified resources that fell into two categories: (a) treatment and care options, and (b) training and skill-building programs. This section provides a broad overview of the types of resources available based on SME comments and discusses notable aspects of the resources (e.g., how the resource addresses barriers or other successful characteristics of the resource). Several examples of resources are also presented in this section, and a comprehensive list of resources identified by SMEs can be found in Appendix B. The appendix also indicates whether particular resources are leader-specific or applicable to all Service members. Note that this section and Appendix B do not exhaustively cover all military behavioral health resources. Rather, they include resources that SMEs identified as effective and commonly used by leaders.

### Treatment and Care Options

SMEs generally agreed that Service members experiencing serious mental health issues should receive treatment from a clinical provider (e.g., psychiatrist, psychologist). For non-acute issues, SMEs discussed other non-medical resources (e.g., non-medical counseling, chaplain services, web-based informational resources) that aim to help Service members cope with the stressors they encounter. SME comments on clinical and non-medical resources—including behavioral health, embedded

behavioral health, non-medical counseling, chaplains, and performance optimization resources—are discussed in detail in this section.

**Behavioral Health Clinicians and Providers**

The military treatment system is the standard care provider for all Service members. Military treatment facilities provide 24-hour inpatient care as well as outpatient behavioral health care during typical business hours with scheduled appointments. SMEs explained that, unfortunately, there are often long waiting times for initial appointments with outpatient behavioral health care providers because they are fully booked several weeks in advance. SMEs also explained that treatment sessions within the military medical system are documented in a Service member's medical record for continuity of care (DoDI 6490.10, *Continuity of Behavioral Health Care for Transferring and Transitioning Service Members*). The Health Insurance Portability and Accountability Act of 1996 provides data privacy and security provisions for safeguarding medical information, and DoDI 6490.08 provides guidance for balancing patient confidentiality rights and the commander's "right to know" for operation and risk management decisions.

Although many leaders may use the military treatment system to obtain support for their behavioral health concerns, SMEs explained that an unknown, but not insignificant, number of leaders may seek care off base from a non-military "community" provider. SMEs explained that officers may use their TRICARE health insurance to see off-base providers in an effort to maintain privacy. However, as mentioned in the previous Practical Barriers section, treatment utilization covered by TRICARE is recorded in the leader's medical record. Thus, some leaders instead pay out of pocket in an effort to maintain even greater privacy and confidentiality.

Examples of Resources:

- Military Health System (see p. 66)
- Executive Medicine Clinic (see p. 64)
- Give an Hour (see p. 75)

**Embedded Behavioral Health**

The resource most frequently identified as "very useful" by SMEs was the embedded behavioral health (EBH) model. According to SMEs, EBH was first developed to support specific military populations, including Special Forces personnel, aviators, and those working with nuclear materials. Based on research and feedback from Service members, EBH is currently one of the preferred behavioral health programs. SMEs noted EBH is now most commonly offered to combat units and that full implementation of EBH across the entire force, while desirable, is restricted by funding and resources.

EBH programs are popular resources for several reasons. Embedded providers engage in "walk-around" care and interact with Service members frequently to build rapport and trust and to normalize speaking to an EBH provider. EBH providers are physically collocated with their units, are easily accessible by Service members, and their conversations with Service members are confidential. Several SMEs pointed out that EBH often acts as a gateway to more intensive services. A Service member is more likely to accept when a trusted EBH provider suggests more intensive services. The EBH provider can help the Service member navigate the system and provide a more successful hand-off to a behavioral health clinic or hospital. SMEs indicated that the EBH program has been associated with a decrease in hospitalization and utilization of network TRICARE services among Service members and an increase in treatment and outcome monitoring.

Examples of Resources:

- EBH components of Preservation of the Force and Family, Marine Corps Embedded Behavioral Health Prevention Capability, and Combat and Operational Stress Control (see p. 64, 74, 73, and 63)
- Embedded Mental Health Program (see p. 64)
- Navy's Deployed Resiliency Counselors (see p. 71)

**Non-medical Counseling**

SMEs frequently identified non-medical counseling as a resource available to leaders. The two main DoD non-medical counseling programs are Military OneSource and Military and Family Life Counseling (MFLC). Non-medical counseling is "short-term, confidential, solution-focused counseling for personal and family issues that do not require treatment through the military health system" (Trail et al., 2017). SMEs highlighted the confidentiality of such programs, noting that, although identifiable records are kept, Service members' utilization is not recorded in their medical records or reported to their chain of command. Military OneSource provides up to 12 free telephone-based counseling sessions per issue. Military OneSource's non-medical counseling resource offers flexibility to leaders who have highly scheduled lives and may not be able to attend appointments during normal clinic hours at a military treatment facility. The MFLC program employs "walk-about" counselors (known as MFLCs) who, similar to EBH providers, work to build rapport with Service members and to normalize the use of behavioral health resources. When MFLCs provide non-medical counseling to Service members, they can meet with Service members outside of their offices (to increase privacy), and they do not take or keep notes of what is discussed during their sessions to maintain a sense of confidentiality.

SMEs discussed a recent evaluation of these two non-medical counseling programs that found that most users experienced a reduction in problem severity and in the impact of the problem on their lives over the short and long term. Most users reported positive experiences with these non-medical counseling programs and expressed

favorable perceptions and experiences with the non-medical counselors (Trail et al., 2017). Despite strengths of these programs, SMEs indicated that some policies and procedures limit use by leaders. For example, Military OneSource has limits on the number of sessions and treatment options available, depending on the help-seeker's needs and eligibility. Those with Axis I psychiatric conditions or who have expressed suicidality are not eligible to participate in non-medical counseling and instead must be referred to a primary care provider or behavioral health professional. In these cases, the counselor will conduct a "warm" hand-off to the chosen provider and will follow up with the individual after referral. However, SMEs explained that some leaders may not act on the referral, ultimately "falling through the cracks." SMEs identified a reluctance to use Military OneSource services that may be related to a lack of understanding of how the services work—particularly that no record of use is kept in a Service member's military medical record. SMEs suggested that non-medical counseling should be used as a gateway to more intensive services if needed (e.g., in the case of suicidal ideation).

Examples of Resources:

- Military OneSource (see p. 65)
- Military and Family Life Counseling Program (MFLC) (see p. 65)
- Marine Corps' Community Counseling Program (see p. 73)

**Chaplains**

Several SMEs identified chaplains as another resource that leaders may use for support. Chaplains provide spiritual guidance to their units under a total confidentiality policy, unlike counselors and other behavioral health care staff. Leaders who are concerned about information being placed in their medical records might approach chaplains about behavioral health concerns. One SME explained that the stigma associated with seeking support from a chaplain is less than the stigma associated with seeking support from behavioral health care providers. In addition, chaplains are often a trusted resource because they work with and deploy with their assigned units. Their familiarity to the unit builds trust and increases help-seeking among Service members. Similar to non-medical counselors and EBH providers, chaplains often act as gateway providers who may conduct hand-offs to other providers if a person needs support outside of their skill set.

Examples of Resources:

- Chaplain Corps (see p. 63)
- Chaplains-Care Program (in development) (see p. 63)
- Mental Health Integration for Chaplain Services (see p. 63)

**Performance Optimization**

In an effort to focus on prevention (i.e., to "get to the left of the problem"), SMEs explained that leaders and Service members are generally receptive to a holistic

approach to health, particularly when framed as a human performance optimization opportunity. SMEs identified Total Force Fitness (TFF) as a holistic model and approach to health and well-being that is used and implemented in the military. TFF characterizes fitness across eight domains: physical, environmental, medical, spiritual, nutritional, psychological, behavioral, and social health.

The Special Operations Command (SOCOM) Preservation of the Force and Family (POTFF) program is based on TFF and uses a dedicated team of providers and performance optimization staff to support the healthy functioning of Special Forces personnel. One aspect of the approach is increased communication among providers and staff who focus on different aspects of the eight domains. SMEs indicated that, often in the course of working on their physical performance, Special Operators may reveal behavioral health concerns to the physical-health-focused POTFF staff. Because the POTFF staff are collocated, they can quickly bring in a behavioral-health-focused staff member to work with the Special Operator. In this way, SMEs explained, POTFF staff are able to find openings to address behavioral health concerns and to address them more readily when they arise. SMEs also noted that Service members were more open to discussing behavioral health concerns when framed as a performance optimization opportunity rather than a behavioral health problem.

The TFF model promotes the idea of focusing on all aspects of fitness as a way to alleviate the factors and stressors that may contribute to behavioral health issues. According to SMEs, this approach underscores that behavioral health issues are not stand-alone problems. TFF is presented to Service members as a way to optimize their own performance. It capitalizes on leader preferences for self-reliance by emphasizing self-care practices that contribute to the optimization of their functioning and performance.

Examples of Resources:

- Army's Performance Triad (see p. 69)
- SOCOM's Preservation of the Force and Family (POTFF) (see p. 74)
- Consortium for Health and Military Performance (see p. 64)

### Training and Skill-Building Programs

Trainings mentioned by SMEs fell into two categories: mandatory training for all Service members and trainings for officers and senior leadership. SMEs indicated that annual suicide trainings mandated for all Service members include destigmatizing language and encourage help-seeking for behavioral health concerns.

The trainings for senior leadership range from 1- to 3-hour trainings to a 1-year leadership development course. The trainings often ask participants to reflect on their own needs, how they would seek help, and how they could support the help-seeking of the Service members they lead. Some training topics focus on resilience and holistic care practices and some may focus specifically on suicide prevention and post-

traumatic stress disorder. Several SMEs felt that the "tone" of some trainings is becoming more effective because of a focus on normalizing the fact that people experience stress and respond in different ways and because of a greater emphasis on resilience.

Several SMEs also identified that there can be a negative perception of behavioral-health-related trainings. Reasons include the length of time for each training and the number of trainings that leaders must attend. Several SMEs also noted that some leaders question the efficacy of the trainings, resulting in a lack of "buy-in" from commands. SMEs consistently identified three types of training and skill-building programs that are widely used: resilience building, operational stress control, and online resources.

Examples of Resources:

- Navy Annual General Military Training (see p. 72)
- Professional Military Education (see p. 67)
- Army's Ask, Care, Escort Training (see p. 68)

**Resilience Building**

SMEs identified the Army's Comprehensive Soldier Fitness Master Resilience Training (MRT) as one of the major resilience-building efforts in the military. The program focuses on building resilience so that soldiers are psychologically healthy and able to deal with stressors and other issues. The goal is to teach people to practice resilience in their everyday lives. SMEs indicated that the primary training is effective but that the train the trainer model has not worked well. The material is difficult for participants to teach others, thus they are not able to transfer the skills they learned. Other SMEs also expressed skepticism about how the skills are taught and whether those skills induce changes to behaviors and thoughts that allow someone to be psychologically healthier and better equipped to deal with problems. SMEs explained that the effectiveness of the program also depends on the quality of the MRT instructor and whether there is "buy-in" from command.

Examples of Resources:

- Army's MRT (see p. 69)
- Army's Battlemind Training (see p. 69)
- Navy's Mind Body Resilience Training (MBRT) (see p. 72)

**Operational Stress Control**

The goal of Navy's Combat Operational Stress Control and Operational Stress Control is "the prevention, identification, and treatment of stress problems arising from military training and operations." The program uses the Operational Stress Continuum Model to help identify when a Sailor may be experiencing a higher level of stress and is in

need of support. The 4-hour course is required for commissioned officers, chief petty officers, and senior enlisted personnel and teaches leaders how to promote resilience and psychological health in themselves and the people they lead. SMEs indicated that the training is completed prior to deployment and is available to nondeploying Sailors based on availability.

#### Online Resources

SMEs described a number of online resources that they sometimes recommend to Service members who want information on behavioral health and resources. SMEs noted that online resources allow individuals to explore symptoms and treatment options privately. Online resources allow for self-directed care and can be accessed at a time that is convenient to the Service member. However, SMEs indicated that there is generally low awareness of these websites and that Service members may not take the time to seek them out on their own. In addition, SMEs observed that the websites can be difficult to navigate.

Examples of Resources:

- Breathe2Relax (see p. 66)
- Army's Family Readiness Group Website (see p. 69)
- Man Therapy (see p. 75)

## SOLUTIONS

SMEs offered a number of solutions to encourage military leader help-seeking behavior. Solutions included adjustments to the military behavioral health care system, adjustments to officer professional development, increasing spouse and family involvement in service utilization, and increasing messaging campaigns.

### Adjustments to the Behavioral Health Care System

As discussed in the Practical Barriers section, SMEs acknowledged several factors that may deter leaders from seeking behavioral health care within the military medical treatment system. Behavioral health provider SMEs who worked within the military medical treatment system described how they adapted aspects of their processes to be more mobile and flexible to increase the privacy of help-seeking leaders. SMEs explained that they would schedule appointments with leaders outside of normal clinic hours or would meet with them outside of medical facilities (e.g., the leader's office, a non-medical building, a training venue). For leaders coming in during normal clinic hours, providers devised ways to minimize the amount of time the leader spent in clinic waiting rooms, such as having leaders complete and e-mail necessary forms before an appointment or meeting the leader in the hallway and walking together into the provider's office. SMEs also indicated that some leaders would wear civilian clothes when attending behavioral health clinic appointments to reduce their identifiability.

The following sections describe other adjustments to the current behavioral health care system that SMEs suggested.

**Exclusive Behavioral Health Program for Leaders**

SMEs offered a number of suggestions to accommodate leaders in the current clinical behavioral health treatment system. One suggestion is to have an exclusive behavioral health care program for officers and senior leaders such as the Executive Medicine Clinics at Walter Reed National Military Medical Center, Dilorenzo Tricare Health Clinic, and Fort Belvoir. According to SMEs, Executive Medicine Clinic providers are selected for their professionalism, acumen, and ability to work in teams to provide health care to leaders. An exclusive behavioral health resource for officers could address some senior leader privacy concerns about being seen at the behavioral health clinic by Service members in their units, and it could be set up with privacy as an utmost concern.

Another SME suggestion was to have on-call providers available to leaders. The SME explained that on-call providers would provide leaders with easier access to behavioral health care and that the program should be set up so that leaders can be seen more quickly (i.e., the day they reach out for assistance). This solution would address the practical barrier of leaders not having time in their schedules to go to appointments and the related issue of leaders not prioritizing their health care appointments given the many meetings and management issues they may prioritize over their own needs.

**Telehealth**

SMEs indicated a great deal of support for telehealth and other direct delivery models that remove the need to go to a clinic in person to engage with behavioral health resources. Such a solution would address both privacy and confidentiality concerns of leaders who do not wish to be seen accessing behavioral health resources at an on-base clinic. Further, it would alleviate constraints on leader schedules that make it difficult to attend appointments during normal clinic hours. SMEs noted that there is a growing use of telehealth in the civilian medical field and explained that, in the military, telehealth is now available in situations in which a medical asset cannot be deployed to the site of need. However, in other areas where telehealth is not fully utilized, Service members must travel to a particular physical location to access a webcam that connects them to the remote provider.

**Separation of Behavioral Health Evaluation and Care Delivery Components**

SMEs suggested changes to the military behavioral health care system to increase help-seeking at all ranks. One recommendation was to delineate two roles that current behavioral health care providers play in the force readiness and preservation system. Currently, all behavioral health care providers are tasked with performing command-directed evaluations, fitness-for-duty evaluations, and other evaluations relevant to the military system overall. Behavioral health care providers are responsible for conducting these evaluations in addition to providing clinical services. A recommended change

would be to have two distinct sets of behavioral health care personnel: those who conduct mandatory evaluations and those who deliver behavioral health care. The purpose of clearly delineating these roles would be to increase behavioral health care confidentiality, thus separating a Service member's care utilization information from information shared with commanders. The SME mentioned that several organizational issues would need to be considered, but that separating these components may address some of the existing barriers to resource utilization.

Another SME recommended altering the current annual health assessment so that all leaders are required to speak with a provider every year. The SME suggested examining the current evaluative system to improve its usefulness in screening and assessing Service members annually for behavioral health care needs. According to the SME, Service members know how to respond to the self-report questions to avoid screening positive for behavioral health issues such as depression, anxiety, or post-traumatic stress disorder. For example, Service members returning from deployment know that, if they affirmatively answer certain Post-Deployment Health Assessment questions, they will be held for treatment and their return home will be delayed. The SME suggested strengthening the policies around this assessment and others like the Periodic Health Assessment to ensure that leaders complete their assessments regularly and accurately.

**Community Behavioral Health Approach**

Another SME recommendation was to strengthen the military's development and emphasis on community behavioral health approaches. Such holistic methods integrate medical and non-medical providers, are designed to be accessible, and focus heavily on wellness and prevention (Community Mental Health Act, 1963). The SME advocated for this model because it is designed to address all levels of care, from prevention to inpatient services. For instance, a Service member who experiences occasional psychiatric symptoms in acute stressful situations may be best served by a combination of prevention services (e.g., resilience training, stress management skills courses, yoga) with readily available support from more intensive services if needed (i.e., individual psychotherapy, psychiatry, or inpatient services in the military treatment system). In the current behavioral health system, it is possible that such an individual would be precluded from non-medical counseling (i.e., if they had a history of suicidal thoughts) but may not meet the threshold for psychotherapy if not experiencing a diagnosable psychiatric condition. A community behavioral health model would focus on making a variety of levels of care accessible to all Service members, reducing structural barriers, and supporting individuals with social work or case management support to help navigate their support options.

The SME explained that better implementation of a community behavioral health approach should be supported by epidemiological surveys assessing Service members on the eight Total Force Fitness domains of physical, environmental, medical, spiritual, nutritional, psychological, behavioral, and social health to understand fully all of the behavioral health needs of the military population. The SME indicated that there have

not been enough epidemiological surveys conducted with Service members. As a result, the military community does not adequately understand what services should be provided to meet the needs of Service members. Some SMEs recommended more population surveillance of the TFF domains. Other SMEs also noted a need to conduct more research into treatment modalities to improve the care provided to Service members as well as to provide better evidence to Service members that the treatment modalities can be effective in treating their behavioral health concerns. SMEs expressed the opinion that many Service members remain skeptical of treatment, training, and provider effectiveness.

**Case Management and Social Work**

Other SMEs discussed the need for case management and social work support outside of the community mental health context. SMEs expressed support for an increase in case managers who can help individuals navigate large and complex systems to access needed resources. SMEs acknowledged that there are "plenty" of resources available to Service members, but that it can be difficult for Service members, including officers, to identify the resources they need on their own. SMEs also suggested embedding case managers in units to help commanders support their personnel at all rank levels, but acknowledged that there are likely limited resources to fund such positions currently.

In addition to case management, another SME advocated for "pure social work" to help individuals with their everyday stressors. This SME indicated that providing support to leaders for daily stressors such as marital problems, childcare difficulties, or child behavior issues could have a greater impact on Service member well-being compared to focusing solely on interventions that equip people with tools to be more psychologically healthy and resilient.

**Address the Unique Concerns of Military Subpopulations**

SMEs who work with Special Forces noted that one of the reasons Special Operators hesitate to pursue behavioral health care is the nature of their work and the limitations of what can be discussed with a provider who does not have a security clearance. For populations with higher security clearance requirements, SMEs recommended that the care providers have an appropriate level of clearance so that Service members can address work-related issues more freely without fearing that they will divulge classified information in discussions with behavioral health care providers.

For the population of military clinicians with limited access to off-base behavioral health resources, SMEs noted the loss of confidentiality that they would likely experience if seeking care within their workplace as well as potential fears of losing their licenses if they were identified as unable to perform their clinical roles. SMEs recommended developing specialized support to assist licensed professionals who contend with limited access to care by non-peers as well as licensure and military career progression concerns. SMEs felt that the licensing boards should offer confidential assistance to those in their fields, but that support at the DoD-level would also be beneficial.

### Adjustments to Leader Professional Development

Some trainings are tailored and delivered to an officer audience, but typically only when requested by leadership. SMEs explained that such requests are becoming more common now that there is greater evidence of the importance of behavioral health in general and the simple tools that can make a difference in psychological health. In addition, leadership is more likely to request this type of targeted training because their stressors are different from those experienced by subordinate Service members. SMEs indicated that leaders prefer not to talk about their difficulties in front of their staff to avoid being misunderstood or creating doubts about their decision-making capabilities. SMEs acknowledged that resources are currently tailored to certain populations and cultures within the military and that this has helped successfully and effectively deliver the information.

In addition to tailoring existing trainings, SMEs recommended integrating self-care into leader professional development to better emphasize its importance. Some SMEs indicated that leaders are evaluated primarily on combat readiness of their units, with less emphasis placed on the numbers of sexual assaults, suicidal ideation, and other problems reported in their units. If these sorts of facets of readiness were prioritized, leaders would likely place more focus on addressing sexual assault and suicidal ideation. One SME recommended training upcoming leaders to focus on certain leadership and help-seeking behaviors. Another SME suggested requiring all upcoming officers to attend a one-on-one session with a counselor at certain touch points in their careers, such as at the time of graduation from command school. During the session, they could converse freely with the counselor about any topic, such as discussing tips on how to help individuals in their unit. A requirement to meet face-to-face with a counselor might open the individual to a previously unconsidered avenue for help-seeking and also help normalize the process of help-seeking. The experience could also be a positive one that the leader can reference when communicating with their unit members about behavioral health resources.

Another SME suggestion was to develop a way to reward self-care among officers, such as making it an evaluation component during the promotion process. The SME explained that leaders could demonstrate skills in self-care or in the behavioral health care of their unit as a way to show a competency in this area.

### Spouse and Family Role in Service Utilization

SMEs who are behavioral health care providers noted that leaders they treated often came to them at the urging of their spouses and families. SMEs explained that spouses of many married leaders are likely to see behavioral health crisis warning signs before coworkers and to quickly identify that a Service member is struggling and needs behavioral health support. One SME noted that this may not be the case for all married leaders because they may exhibit different behaviors in the workplace than in the domestic setting.

SMEs pointed out a number of resources available to spouses to support the well-being of their Service members, themselves, and their families. They also noted that, despite efforts to engage spouses and families, the military cannot mandate that spouses participate in trainings or engage with programs and resources. However, due to the important role spouses play in encouraging help-seeking among leaders, SMEs suggested ways to further engage them in supporting the well-being of Service members. Suggested strategies include encouraging spouses to develop a post-deployment plan for talking with the leaders about how they are "different after getting back." SMEs also acknowledged that providing information and education to spouses is critical. SMEs found that spouses are often unaware of the resources available to Service members and suggested incorporating this information into Newcomer Orientation or at military protocol trainings for spouses. SMEs also pointed out the importance of tailoring the information to spouses of leaders in a way that encourages the leaders to use the resource themselves. Too often, leaders view resources through the lens of how they will help their personnel and not necessarily in terms of how they will help them personally.

### Messaging Campaigns

SMEs speculated that leaders who would not seek help themselves may subtly communicate their opinions to others through word choices or an attitude that conveys that they are just "going through the motions" of informing their unit of behavioral health resources. Such subtle cues may discourage help-seeking in the unit and undermine the important role of leaders in encouraging all ranks to seek behavioral health care as needed. However, SMEs noted that there are currently few messaging campaigns aimed at leaders; most Service members featured in behavioral health promotion and awareness campaigns are enlisted personnel.

SMEs discussed various current messaging approaches that aim to encourage help-seeking, including communications campaigns and dissemination of infographics that encourage early self-initiated help-seeking and dispel myths around the impact to security clearances, career progression, and firearms access. SMEs also suggested that more messaging could be done, but that focusing on stigma reduction or seeking help as a sign of strength may not be as useful as focusing on other issues. SMEs recommended that strategic communication plans should be tailored to appeal to leaders, their roles, and their communication style. For example, the message "Get help to support your career" may be particularly effective in encouraging leaders to seek needed help. SMEs also stressed the importance of consistent repetition of these messages, for example, at Commander's calls.

Some SMEs indicated that certain leaders do not have a problem with help-seeking and express this by wearing their uniforms to appointments, going early to appointments, and engaging with other junior personnel in the waiting room. SMEs generally agreed that such efforts could be supported systemically by having more leaders share their experiences of successfully seeking behavioral health assistance. SMEs explained that, although these types of success stories are sometimes shared,

they usually come from leaders who are at the end of their careers rather than from current leaders in the midst of treatment who may still be competing for promotions. SMEs indicated that more transparency from leaders would be powerful.

Finally, SMEs also suggested information campaigns to provide Service members with more accurate information concerning treatment effectiveness and what is likely to happen if someone seeks behavioral health care. One messaging campaign that is currently being developed will focus on "decreasing the black-and-white thinking" that seeking help will end a military career and that individuals have no other career options if the military is not a good fit for them.

# DISCUSSION

The objective of this research was to expand on previous work indicating that leaders are particularly unlikely to seek assistance when facing psychological difficulties (Ho et al., 2018; OPA, 2017). This research project, one of only a few studies to examine the help-seeking behavior of military leaders, relied on the expertise of SMEs to elucidate leaders' barriers to using existing resources and to develop recommendations for structural and programming changes to overcome the identified barriers. This section maps the SME-identified resources to the barriers and discusses how these resources address these barriers. It concludes with a review of study limitations and recommendations for programmatic changes and future research that could address acknowledged barriers.

## RESOURCES THAT ADDRESS PROFESSIONAL CONCERNS

A number of the resources identified by SMEs address the described barriers to help-seeking, with some addressing a particular barrier more directly than others. For example, all SMEs spoke of leaders' concerns about the potential impact of seeking behavioral health treatment on their career progression, which is a commonly reported barrier to treatment-seeking (Greene-Shortridge et al., 2007; Hoge et al., 2004; Zinzow et al., 2013). SMEs pointed to messaging efforts that are a small part of resilience and psychological health trainings as well as dedicated behavioral health promotion and awareness campaigns that emphasize the following: (a) seeking help is a sign of strength, (b) career implications are more likely if issues are not addressed, and (c) security clearance eligibility revocations are rare. SMEs also explained that messaging campaigns that highlight other leaders' experiences with behavioral health care effectively underscore the message that seeking help is a sign of strength and that career progression is rarely impeded.

Based on the resources that SMEs identified, trainings and messaging campaigns (e.g., mandatory suicide prevention awareness training) currently address some of the professional concerns that leaders may have when considering whether to pursue behavioral health support. However, it appears that these concerns persist and a more concentrated effort is needed to directly address the most pressing professional concerns—those related to impact on career progression and security clearance eligibility.

## RESOURCES THAT ADDRESS PRIVACY AND CONFIDENTIALITY CONCERNS

Consistent with other research, another frequently discussed barrier to help-seeking was leaders' concerns about their privacy and confidentiality when seeking behavioral health care treatment (Greene-Shortridge et al., 2007; Ho et al., 2018). Several resources and policies aim to mitigate these concerns. As examples, chaplains operate under full confidentiality (Military Rule of Evidence 503; Department of the Air Force, 2018; Department of the Navy, 2008; Joint Service Committee on Military Justice, 2016), and non-medical counseling provided by Military OneSource or MFLCs is

confidential (Trail et al., 2017), although counselors are required to follow laws regarding duty to report imminent risk to self or others. DoDI 6490.08, *Command Notification Requirements to Dispel Stigma in Providing Mental Health Care to Service Members*, also directly addresses Service members' concerns about confidentiality. The policy advises providers not to report to commands if a Service member has self-referred for behavioral health treatment except in certain cases. The policy outlines these command notification requirements and noted exceptions, which include harm to self, others, and mission. The goal of the policy is to "foster a culture of support in the provision of mental health care." On the other hand, no formal resources or policies directly address leaders' concerns about their privacy in seeking behavioral health care. Instead, there are several informal ways in which providers work with a leader to protect his or her privacy. For example, the provider may meet with a leader outside of the behavioral health clinic or schedule the leader's appointment outside of normal clinic hours. The provider's flexibility helps build trust with the leader and assists in maintaining the leader's privacy.

Although SMEs noted the utility of informal processes to increase leader privacy, formal policies and an expansion of dedicated executive programs are needed to ensure consistency in meeting confidentiality concerns of leaders.

## RESOURCES THAT ADDRESS LACK OF CONFIDENCE IN RESOURCES

SMEs noted that leaders often lack confidence in the resources available and may question the effectiveness of treatment. Other studies have also noted this barrier (Adler et al., 2015). Behavioral health promotion and awareness campaigns within the military—such as Mental Health Awareness Month and the Real Warriors campaign—promote the message that behavioral health treatment is effective. This type of education is the only resource discussed by SMEs that addresses leaders' lack of confidence in available behavioral health resources.

Further work in this area would be beneficial, especially campaigns that provide focused messaging to leaders about their own behavioral health care rather than focusing exclusively on helping Service members under their command. Such efforts would be bolstered by informational pamphlets and early discussions between clinicians and their leader clients concerning research on treatment effectiveness and the importance of client engagement in treatment.

## RESOURCES THAT ADDRESS PRACTICAL BARRIERS

A number of practical barriers also lower leaders' likelihood of seeking needed behavioral health care. In particular, SMEs discussed that leaders have constraints on their time and encounter limited access to behavioral health resources in certain operational settings; they also experience long wait times, which results in decreased access to care. The resources that currently address leaders' lack of time are telehealth services and non-medical counseling, which are available outside of normal "business" hours and can be accessed remotely (i.e., the leader does not need to go into the clinic).

For those who are eligible, Defense Health Agency Connected Health and the Executive Medicine Clinics are resources that can accommodate leaders' busy schedules. Further, embedded behavioral health providers and telehealth are being used more frequently to address the issue of limited access to care during deployment.

Continued efforts are needed to make these resources accessible to more Service members, especially where access remains limited (e.g., on deployment, at sea). Further, efforts to continue expanding services to personal devices (i.e., cellular phones, personal computers) will reduce the burden on those who must access telehealth services at hub locations.

## RESOURCES THAT ADDRESS THE PREFERENCE FOR SELF-RELIANCE

SMEs also described leaders' preference for self-reliance as a barrier to help-seeking behavior. Leaders tend to believe that they should be able to handle problems on their own, which is compounded by a culture that presumes leaders have coping skills that preclude them from needing help. Resources that address these barriers are trainings that emphasize seeking help as a sign of strength as well as resources that enable self-reliance and self-enhancement behaviors (e.g., resilience-building programs, performance-optimization programs, and information or resources accessible online). Resilience-building and performance-optimization programs aim to provide leaders with tools to improve their ability to handle stressors on their own; information and resources provided online allow leaders to read and learn about psychological well-being and behavioral health treatments on their own. These types of resources allow individuals to seek out information or ways to address certain problems on their own, which aligns with leaders' preferences for self-reliance.

However, these resources appear to be provided only passively to leaders. More work could be done to understand how to address this barrier throughout the military behavioral health system.

## LIMITATIONS TO EXISTING RESOURCES

As noted, a variety of military resources are available to provide behavioral health care support to Service members, such as chaplain and behavioral health services, skill-building programs, and informational websites. Appendix B demonstrates the breadth of DoD-wide and service-specific resources that promote active duty Service member behavioral health. Although at least one currently available resource addresses each barrier salient to military leaders, some barriers are more directly or thoroughly addressed than others. For instance, previous studies have consistently identified Service members' concerns about confidentiality, so the military developed specific programs and policies to mitigate these concerns (e.g., confidential non-medical counseling). Of note, very few (12 of 80, or 15%) of the SME-identified resources are tailored specifically to leaders, with 11 of these 12 in the form of trainings that provide general leadership or behavioral health knowledge designed to help them support Service members under their command. Only one—Executive Medicine Clinics—was

identified as a dedicated resource designed to directly support leader behavioral health treatment by offering services that address time, privacy, and security demands of leaders. Although it is unrealistic to expect every resource to be tailored specifically to leaders, there is room for expansion of dedicated options that address practical barriers (i.e., increased privacy and after-hours access with expanded executive clinics, telehealth, and embedded resources) as well as messaging campaigns that expressly address leader concerns (i.e., messaging that challenges misinformation regarding career ramifications and treatment effectiveness).

## LIMITATIONS

The limitations of this study include restricted generalizability. That is, findings from this study may not be generalizable to the entire population of military leaders. Although we met the target enrollment of 25 SMEs, the small number of participants who contributed may not represent all perspectives on this topic because we did not use a random sampling approach. However, we believe that this limitation is mitigated by the fact that SMEs were selected based on their extensive experience, which enhanced their breadth and depth of knowledge of the topic. In fact, comments by an individual SME may represent the perspectives of many others in their field (Weiss, 1994). Further, researchers' perspectives and interests may have biased the interpretation of qualitative data (Weiss, 1994). To safeguard again researcher bias, themes and subthemes found in this study were validated by another researcher who completed an independent content analysis of the SME interview data. In addition, findings from this project are consistent with previous studies.

# RECOMMENDATIONS

Based on SME discussions of plausible solutions, 14 recommendations for how to increase help-seeking behavior among leaders are presented below. These include suggested changes within four domains: the military behavioral health system, officer professional development, spouse and family involvement in service utilization, and targeted messaging campaigns. We note which barriers are most directly addressed by each recommendation (see also Table 3) and, when possible, which DoD office may be responsible for addressing the recommendation.

**Table 3**
**Barriers to Behavioral Health Resource Utilization Addressed by Study Recommendations**

| | Barrier | | | | |
|---|---|---|---|---|---|
| **Recommendation** | **Professional Concerns** | **Privacy & Confidentiality** | **Confidence in Resources** | **Practical Barriers** | **Preference for Self-Reliance** |
| 1: Disseminate recommendations for increasing leader privacy and confidentiality in behavioral health care settings | ✓ | ✓ | | ✓ | |
| 2: Create a behavioral health program exclusively for leaders | ✓ | ✓ | | ✓ | |
| 3: Expand the use of telehealth services | | ✓ | | ✓ | |
| 4: Separate behavioral health care delivery from behavioral health evaluations | | ✓ | | | |
| 5: Examine ways to improve behavioral health screening processes | | | ✓ | | |
| 6: Adopt more community behavioral health practices | | | | ✓ | ✓ |
| 7: Ensure that caring professionals have appropriate clearance levels to best work with the populations they serve | ✓ | | ✓ | | |
| 8: Provide targeted support for clinical professionals with unique privacy and licensure concerns | ✓ | ✓ | | | |
| 9: Tailor and hold separate trainings for leaders | ✓ | | | | ✓ |
| 10: Integrate self-care into the promotions system | ✓ | | | | ✓ |
| 11: Make one-on-one meetings with providers mandatory at certain career touch points | | | ✓ | | |
| 12: Offer more trainings and outreach to military spouses and families | | | | | ✓ |
| 13: Strengthen messaging campaigns that aim to dispel behavioral health care myths | ✓ | ✓ | ✓ | | |
| 14: Encourage leaders to share their own successful utilization of behavioral health resources | ✓ | | ✓ | | ✓ |

## IMPLEMENT CHANGES TO THE MILITARY BEHAVIORAL HEALTH SYSTEM

SMEs made a number of suggestions based on their observations of the current behavioral health system. The following recommendations are intended to improve the care and treatment of leaders and to increase their help-seeking behavior.

### Recommendation 1: Disseminate Recommendations for Increasing Leader Privacy and Confidentiality in Behavioral Health Care Settings

Barriers Addressed: Professional Concerns, Privacy and Confidentiality, Practical Barriers

The medical departments of each Service Branch should disseminate recommendations to military behavioral health providers for addressing leaders' barriers to care. For instance, to the extent possible, behavioral health providers could be more mobile and flexible to accommodate the busy schedules of leaders and their privacy and confidentiality concerns. Behavioral health providers could also schedule appointments with leaders outside of normal clinic hours or meet with leaders outside of medical facilities, such as at the leader's office, in a non-medical building, or at a training venue. These suggestions from SMEs are consistent with previous research, such as a study by Zinzow and colleagues (2012) that found that changing service delivery formats (e.g., alternate schedules or different treatment locations) may be beneficial for addressing barriers to help-seeking. If an appointment is scheduled outside of normal clinic hours, behavioral health providers should ensure that the clinic is minimally staffed for patient and clinician safety.

Another suggestion that SMEs described was minimizing the amount of time that leaders spend in the clinic waiting rooms. Behavioral health care providers should provide ways in which leaders can complete necessary medical forms before their appointment. This could easily be done by uploading intake paperwork to the local military installation's mental or behavioral health clinic website or by emailing the documents to the leader prior to the first appointment.

Such suggestions could also be disseminated by the Psychological Health Center of Excellence, which maintains a website with guidance, trainings, and a blog that provides information relevant to behavioral health clinicians: http://pdhealth.mil/news/blog.

### Recommendation 2: Create a Behavioral Health Program Exclusively for Leaders

Barriers Addressed: Professional Concerns, Privacy and Confidentiality, Practical Barriers

The Defense Health Agency and the Service Branch's medical departments should examine ways in which they can set up an exclusive behavioral health care program for leaders. The model for such a program could be the Executive Medicine Clinics at Walter Reed National Military Medical Center, Dilorenzo Tricare Health Clinic, and Fort Belvoir. The Executive Medicine Clinics are comprehensive health care programs that

provide personalized care to Active Duty Flag/General Officers, their beneficiaries, and other eligible personnel. Specifically, the Executive Medicine Clinics provide primary care, assistance with the specialty referral process, coordination and planning of appointments, expedition of administrative paperwork, coordination of eligible patients' physical exams and the Periodic Health Assessment, case management services, secure and confidential care, and access to health benefits advisors (Fort Belvoir Community Hospital, n.d.). These services are provided to meet the numerous time, privacy, and security demands of individuals in executive-level positions. An exclusive behavioral health program for leaders could have these features, along with on-call providers who would facilitate access to behavioral health care when the leader needs it.

### Recommendation 3: Expand the Use of Telehealth Services

Barriers Addressed: Privacy and Confidentiality, Practical Barriers

One of the most promising avenues for mitigating barriers to officer help-seeking may lie in the expansion of Military Health System telehealth capabilities, as indicated in a recent report from the Office of the Under Secretary of Defense for Personnel and Readiness (2017). According to this report, the largest proportion of telehealth encounters within the Military Health System is for behavioral health care. The services provided to Service members include individual psychotherapy, telepsychiatry, medication management, and group therapy. Providers are able to connect with patients using clinical video teleconferencing equipment, webcam-based applications, and telephone calls from military treatment facilities in garrison and in operational environments. Well-designed telehealth services can offer leaders significant flexibility regarding access during extended hours and in remote locations. Further, they increase the feasibility for continued care with the same clinician in the event of permanent changes of station. However, in many instances, patients are still required to go to designated physical locations (patient spoke sites) to access services, which may limit privacy and after-hours options. Continued focus on enhancements to technology (e.g., network services in remote locations) and efforts to increase access on personal devices in private locations will further reduce barriers to effective and agile behavioral health care.

### Recommendation 4: Separate Behavioral Health Care Delivery from Behavioral Health Evaluations

Barrier Addressed: Privacy and Confidentiality

In addition to their clinical duties, all mental and behavioral health care providers are currently tasked with performing command-directed evaluations, fitness-for-duty evaluations, and other evaluations that are relevant to the military system overall. A recommended change would be to have two distinct sets of mental and behavioral health care personnel: those who conduct mandatory evaluations and those who deliver mental and behavioral health care. The purpose of clearly delineating these roles would be to increase mental and behavioral health care confidentiality, thus

separating a Service member's care utilization information from evaluative information that is shared with commanders. Similar arguments for separating evaluation and delivery of clinical services functions have been made in the DoD personnel security context (Shedler & Lang, 2015; Dickerhoof, Wortman, Osborn, & Smith, 2018).

### Recommendation 5: Examine Ways to Improve Behavioral Health Screening Processes

Barrier Addressed: Confidence in Resources

The Defense Health Agency should examine ways to improve current screening processes for behavioral health care concerns. One issue that the Periodic Health Assessment and Deployment Health Assessments face is that Service members may answer self-report questions inaccurately to avoid certain outcomes, such as being held for a treatment that delays their return home. One SME recommendation is to examine ways in which the process could be improved so that Service members, including leaders, would be more likely to accurately respond to screening questions. One way this recommendation could be implemented would be to require all leaders to meet face to face with a provider to discuss their behavioral health. A similar approach has been proposed within the Special Operations Forces that would mandate biennial mental health physicals for all Special Operators (Horton, Macemon, & Moore, 2018).

### Recommendation 6: Adopt More Community Behavioral Health Practices

Barriers Addressed: Practical Barriers, Preference for Self-Reliance

DoD and the Services should shift the emphasis of the military behavioral health system from a clinical approach to a community behavioral health approach with an integrated system of medical and non-medical providers. Community behavioral health targets all members of a population, is accessible where people live and work, takes a holistic approach to health, is delivered by community members in partnership with experts, promotes wellness, and focuses largely on prevention (Community Mental Health Act, 1963). Community behavioral health is similar to the Total Force Fitness approach that SOCOM uses in the POTFF program. The POTFF initiative supports human, psychological, spiritual, and social performance among its personnel with a team of dedicated providers (e.g., physical therapists, operational psychologists, strength and conditioning coaches, athletic trainers, physician's assistants, medical doctors, case managers, psychiatric technicians, non-medical counselors, social workers, embedded MFLCs). Consistent with the community behavioral health approach, the POTFF provider teams work with all members of the SOCOM community, are easily accessible where members work, take a holistic approach to the members' health, and focus on prevention.

### Recommendation 7: Ensure That Caring Professionals Have Appropriate Clearance Levels to Best Work with the Populations They Serve

Barriers Addressed: Professional Concerns, Confidence in Resources

According to SMEs who work with Special Forces, one reason Special Operators hesitate to pursue behavioral health care is the nature of their work and limitations on what can be discussed with a provider who does not have a security clearance. Because most well-validated psychotherapies for posttraumatic stress disorder require the client to discuss traumatic experiences in great detail (Watts et al., 2013), effective care requires being able to freely discuss some details of the deployment context without negative ramifications. SMEs recommended that leaders in high-security clearance positions have access to providers with commensurate clearance levels to facilitate free discussion of work-related concerns in treatment without inappropriately divulging classified information.

Additionally, it is important to consider whether definitions of "need to know" could be clarified in the context of disclosure of information to a treatment provider with appropriate clearance. According to DoD 5200.02, *Procedures for the DoD Personnel Security Program (PSP)*, an individual who holds classified information must determine whether a recipient has the appropriate eligibility *and* a requirement for access to the information "in order to perform tasks or services essential to the fulfillment of an official U.S. Government program." Given that Service member readiness may be impacted by untreated psychological symptoms, it could be argued that disclosure of some classified information to a treatment provider with appropriate clearance could be interpreted as allowing clinicians to perform their essential tasks in support of military readiness. Clarifications and messaging campaigns from DoD, coupled with targeted hiring of clinicians who have or can obtain high-level clearances, could help to ensure that top leaders are able to confidently disclose necessary details to their clinicians to receive appropriate treatment.

### Recommendation 8: Provide Targeted Support for Clinical Professionals with Unique Privacy and Licensure Concerns

Barriers Addressed: Professional Concerns, Privacy and Confidentiality

SMEs highlighted unique privacy concerns endorsed by military clinicians (e.g., psychologists, medical doctors) who may face the choice of foregoing needed behavioral health treatment or seeking treatment at their place of work. Despite being at an elevated risk of burnout, compassion fatigue, and vicarious traumatization (Linnerooth, Mrdjenovich, & Moore, 2011), they may be left with limited treatment options, especially while deployed. Additionally, medical and psychological staff and other licensed professionals (e.g., Judge Advocates) may avoid treatment if they believe they face career ramifications in the form of suspended or revoked licenses if identified as being unable to perform in a professional capacity secondary to severe psychological symptoms or substance dependence.

Linnerooth et al. (2011) noted that many licensed professionals avoid formal psychotherapy for fear of licensure and career ramifications, but that many are open to coming to the office of a clinical peer for "coffee" on a regular basis. Consistent with SMEs, they highlighted the power of informal off-the-record peer support as a

mechanism for licensed professionals to receive some relief. Such interactions should be structurally facilitated (e.g., open-door policies, informal interactions, embedded professionals). Continued work to expand the number of behavioral health care staff can decrease the likelihood of sole providers having no informal behavioral health peer support.

SMEs also recommended the development of specialized support within the DoD for professionals with unique clinic privacy and licensure concerns. Because of concerns about privacy and dual relationships, it may be useful if they are granted increased access to telehealth treatment options (e.g., evening appointments, higher maximum number of appointments with Military OneSource, access to telehealth services from clinical psychologists to manage symptoms that typically exclude individuals from Military OneSource access).

Finally, SMEs recommended messaging campaigns that provide factual information about the infrequency of license revocations and the importance of seeking help for difficulties before they become unmanageable. Such campaigns would be beneficial to assuage career concerns of licensed professionals who could benefit from behavioral health support.

## IMPLEMENT CHANGES TO PROFESSIONAL DEVELOPMENT

SMEs made a number of suggestions that would integrate behavioral health and wellness into the formal professional development of leaders. The goals of the following recommendations are to improve leaders' experiences with behavioral-health-related mandatory trainings and to emphasize the importance of behavioral health by integrating it into leaders' professional development.

### Recommendation 9: Tailor and Hold Separate Trainings for Leaders

Barriers Addressed: Professional Concerns, Preference for Self-Reliance

Behavioral health trainings should be tailored to leaders and conducted separately from those for their subordinates. This best practice was discussed by SMEs and is consistent with other studies in which leaders indicated a need for separate behavioral health or skill-based trainings that take into account rank differences and allow leaders to discuss and learn about these topics with their peers rather than subordinates (Ho et al., 2018). The Army War College Senior Leader Sustainment Program and the Navy Operational Stress Control Program Leader Courses are examples of leadership development programs that cover behavioral health and well-being topics. However, general trainings, such as suicide prevention and skill-building trainings (e.g., Army's Master Resilience Training), are not designed typically to address the concerns of leaders alone. Skill-building trainings, such as those focused on performance enhancing skills or skills for coping with stress and anxiety, may also address leaders' preference to be self-reliant, while also equipping leaders with skills in seeking out relevant resources when needed. SMEs and previous research indicate that

tailoring these trainings to leaders would make the trainings more meaningful and impactful to this population.

### Recommendation 10: Integrate Self-Care Into the Promotions System

Barriers Addressed: Professional Concerns, Preference for Self-Reliance

Self-care and the promotion of behavioral health among unit members should be an evaluative component of the officer promotions system. Officers could be credited in the promotion evaluation process if they are able to demonstrate behavioral-health-related leadership as described by Adler and colleagues (2014). Behavioral-health-related leadership is based on the combat operational stress control strategies to address stress associated with deployment but can also be applied more generally. The specific behaviors that Adler and colleagues (2014) identify that subordinates may be able to observe in their leaders include:

- refraining from judgment of individuals who seek behavioral health help,
- encouraging individuals to seek help for stress-related problems,
- demonstrating concern for how families are dealing with stress,
- intervening when individuals display stress reactions,
- encouraging individuals to express emotions following losses and setbacks, and
- reminding individuals after intense experiences that they are there to serve with honor, serve a mission, and serve a greater purpose.

Evaluating leaders on behavioral-health-related leadership or on self-care abilities would serve to emphasize the importance of these behaviors as a component of readiness. Leaders would also be incentivized to engage in these leadership behaviors and to encourage these behaviors among their subordinates.

### Recommendation 11: Make One-on-One Meetings With Providers Mandatory at Certain Career Touch Points

Barrier Addressed: Confidence in Resources

Upcoming leaders would benefit from one-on-one sessions with a behavioral health care provider at certain points in their careers, such as at the time of graduation from command school. There should be no designated topics for these one-on-one sessions, and the leader should be able to discuss any topic or ask any questions of the behavioral health care provider. For example, the leader could ask about how to support the behavioral health of his or her unit or could inquire about other resources available to Service members. This requirement may help to reduce stigma around behavioral health care by demystifying behavioral health providers and normalizing the act of seeking help. In general, many people hold negative views of behavioral health care providers (Sartorius et al., 2010). Positive interactions with and exposure to military behavioral health care providers could reduce the negative views that some upcoming leaders may hold. This approach is similar to that used in mental illness

stigma reduction efforts whereby interpersonal contact with individuals with mental illness can decrease stereotypes and negative attitudes toward mental illness (Corrigan, Morris, Michaels, Rafacz, & Rusch, 2012).

## INCREASE SPOUSE AND FAMILY INVOLVEMENT IN SERVICE UTILIZATION

Many leaders who seek treatment do so at the urging of their spouses. The intimacy of the spousal relationship places spouses in a position to notice behavioral health changes and crisis warning signs. Further, because Service member combat-related psychiatric symptoms may have a significant impact on family well-being and spousal roles (Temple, Miller, Banford Witting, & Kim, 2017), it is important to provide spouses of leaders (and other key family members and friends) with information about relevant resources and support regarding how to connect their spouse with care if needed.

### Recommendation 12: Offer More Trainings and Outreach to Military Spouses and Families

Barrier Addressed: Preference of Self-Reliance

Although a number of resources are available to military spouses and families, there is an opportunity to expand training and outreach to spouses and other family members in support of leader and family wellness. Based on SME suggestions, it may be valuable to provide support to leaders and their military spouses in laying out a post-deployment plan for explicitly discussing how the leader may feel "different after getting back" and ensuring that spouses have easy access to information about available supportive resources. Because most spouse support programming is not mandatory, Newcomer Orientation or military protocol trainings for spouses may be ideal opportunities to provide spouses with information and training. Multilevel approaches that align with preferences for self-management while providing messaging at various intervention levels and greater support for those with greater need are demonstrated to be effective for parenting and relationship support (Heyman et al., 2015). This model could be adapted to help military spouses provide well-informed support for leaders. Notably, such approaches align with the *Military Family Fitness Model* (Bowles et al., 2015) as well as SME recommendations to expand holistic approaches to Service member wellness—namely, that in addition to treatment for psychological symptoms, Service members benefit from consistent support related to daily stressors such as marital and child behavior difficulties or childcare challenges.

## CONDUCT TARGETED MESSAGING CAMPAIGNS

SMEs noted two important areas of targeted messaging that may be effective in supporting leader help-seeking: dispelling myths related to behavioral health care and highlighting leaders willing to speak about their positive experiences utilizing behavioral health care. The importance of developing targeted campaigns to address these areas is discussed in this section.

### Recommendation 13: Strengthen Messaging Campaigns That Aim to Dispel Behavioral Health Care Myths

Barriers Addressed: Professional Concerns, Privacy and Confidentiality, Confidence in Resources

DoD and the Services should strengthen messaging campaigns that dispel behavioral health myths. SMEs discussed several examples of these myths, each of which would be a valuable topic for messaging campaigns targeted directly to leaders.

- Messaging campaigns could provide statistics about the relative frequencies of negative career outcomes related to untreated versus treated behavioral health problems. SMEs noted that untreated severe mental illness is much more likely to lead to negative career ramifications, including separation from service, than is seeking treatment for a behavioral health concern (Westphal, 2007). Indeed, early self-referral for treatment is one way to sustain a military career (Ghahramanlou-Holloway et al., 2018; Hoge et al., 2002; Rowan et al., 2014).
- A challenging but important topic that could be addressed is the association between self-reported suicidal ideation and behavior and career outcomes. SMEs noted that many personnel are likely to be returned to duty after treatment related to suicidal ideation, but that there were cases in which suicide-related behaviors were severe enough to lead to separation from service.
- Messaging that highlights DoDI 6490.08 (*Command Notification Requirements to Dispel Stigma in Providing Mental Health Care to Service Members*)—especially that health care providers are, in most situations, not to notify commanders regarding behavioral health care or substance abuse education services—would be valuable, coupled with education about the specific exceptions to this rule.
- Messaging campaigns could highlight the confidential nature of specific resources, especially the confidentiality policies of the chaplain corps and the non-medical counseling programs.
- Another potential messaging campaign could focus on the way behavioral health information is used in promotion board processes. Specifically, in the promotion selection process, a "zero-defect" view is explicitly discouraged among voting members of the Board. Messaging campaigns that explain what information is (and is not) considered in promotion boards could be quite valuable in addressing career-related concerns.
- Another myth that could be dispelled with messaging campaigns is related to the likelihood of negative impact of disclosing behavioral health information on the Standard Form 86 on security clearance outcomes. Although clearance denials or revocations are extremely rare, this myth persists and has a significant impact on leaders' willingness to seek behavioral health care.

As a final note, when messaging campaigns are developed, it would be beneficial to include information that documents the effectiveness of treatments to decrease

symptoms, improve quality of life, and promote positive career outcomes when such data are available. Of note, efforts should be made to clarify that a variety of online resources are available for those who prefer self-management and that campaigns are relevant to leaders rather than focused on their subordinates.

### Recommendation 14: Encourage Leaders to Share Their Own Successful Utilization of Behavioral Health Resources

Barriers Addressed: Professional Concerns, Confidence in Resources, Preference for Self-Reliance

Leaders have a powerful influence on personnel performance and motivation (Britt et al., 2004), and domain-specific leadership is associated with positive personnel outcomes (e.g., sleep hygiene leadership; Gunia, Sipos, LoPresti, & Adler, 2015). SMEs highlighted that leader attitudes and behaviors related to behavioral health and help-seeking likely impact help-seeking in their unit (Adler et al., 2014). Messaging campaigns that amplify the message of leaders who found value in behavioral health treatment are likely to have positive impacts on the help-seeking of other leaders and unit personnel by increasing confidence in treatment efficacy and by normalizing leaders' management of their needs with appropriate support.

- SMEs recommended highlighting these leaders as courageous and responsible in managing their needs.
- Such messaging campaigns could also highlight how managing behavioral health concerns led the leader to higher quality work performance and, ultimately, continued promotion.
- Tailored messages for specific subpopulations may be especially effective. As one example, a message might highlight how a self-sufficient Special Forces leader who preferred self-management sought and learned from a variety of online resources and gained support from peers, but then ultimately opted to seek additional confidential support from a chaplain.
- Most existing messaging has come from leaders nearing retirement or Veteran status; messages will be especially powerful if they highlight mid-career leaders, especially those in highly competitive career trajectories.
- Efforts that highlight how help-seeking did not negatively impact specific credentials (e.g., security clearance, professional licensure) in special populations would also be very beneficial.

## FUTURE RESEARCH DIRECTIONS

Programming within the Services that focuses on the recommendations above will likely increase the accessibility and utilization of behavioral health support in military leaders. In addition to these SME suggestions, an intervention designed to reduce barriers and encourage utilization of resources among Service members could also increase use of behavioral health support among military leaders. Future research

efforts should focus on program evaluation for existing and new efforts. Specifically, studies should examine whether service utilization rates increase for leaders after program adjustments are made. Further, continued efforts to evaluate the effectiveness of programs for leaders (e.g., reduction in symptoms, increase in readiness, continued minimal likelihood of negative career consequences) would be especially valuable, as positive results could be used for future messaging campaigns. Finally, given that leaders may be particularly open to treatment as they near retirement or separation, further study of the effectiveness of support available to ensure continuity of care as they transition to the Veterans Health Administration system is needed.

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# APPENDIX A: INTERVIEW QUESTIONS

**General Questions:**

1. Please introduce yourself and tell us about your current role.
2. In this study, we are interested in the barriers to help-seeking for behavioral health concerns among mid-level and senior leaders. In your experience, what are some of the common barriers to help-seeking for:
    a. Warrant officers (W1-W5).
    b. Field grade (O4-O6) and general (O7-O9) officers.
3. What are the DoD-wide or Service component-wide resources, such as programs, services, training, or initiatives that are designed to address the barriers you listed?
    a. What information, services, or support does the resource provide?
    b. Who is eligible to access this training/resource?
    c. [If the resource is a training]: What is the training requirement (e.g., annual, periodic, etc.)?
    d. [If the interviewee works with the Special Operations Community]: Tell us more about the Preservation of the Force and Family (POTFF) model and in what ways it might facilitate help-seeking among officers.
4. Do you have any overview materials about this resource that you could share with us, such as brochures, slide decks, or program manuals?
5. Despite there being many resources available to Service members, utilization of these resources is lower than expected. What is it about these resources that dissuades officers from using them?
6. When thinking about officers who did seek help for mental health concerns, what was the primary driver behind their decision to seek help?
7. What ideas do you have for both (a) reasonable solutions and (b) outside-the-box possibilities that could increase officer help-seeking behaviors, given existing barriers?
8. Is there anyone else that you recommend we speak with regarding officer help-seeking?

**Research-Related Questions:**

9. Can you point us to any results from program evaluations of specific DoD resources that we might find useful?
10. Could you point us to any other relevant research pertinent to officer help-seeking that we should pay close attention to?

**Promotions-Related Questions:**

11. Would you please give us a brief description of the promotion board selection process for our population of interest?
12. In your experience and opinion, how does military culture affect board outcomes (ex: zero-defect mentality)?

13. How are unmet “milestones” because of mental health issues viewed in the promotion record review process?
14. How do board members view a “Field Code 17” that stems from mental health issues?
15. In your opinion, what changes should be made to the promotion board selection process to mitigate fears over career progression when it comes to help-seeking among warrant (W1-W5), field grade (O4-O6) and general (O7-O9) officers (ex: strategies, policy, or procedural changes)?

# APPENDIX B: RESOURCES IDENTIFIED BY SUBJECT MATTER EXPERTS

Table 4 lists all resources (programs, services, trainings, or initiatives) that were identified by subject matter experts when asked to describe the behavioral and mental health resources used by leaders. Resources are ordered by DoD-wide, Service-specific (Army, Navy, Marine Corps, and Air Force), and non-DoD sponsors. Note that this is not a comprehensive list of all military behavioral health resources.

**Table 4**
**Resources Identified by Subject Matter Experts**

| Resource | Description | Specific to Leaders |
|---|---|---|
| **DoD-Wide Resources** | | |
| **Chaplains and Behavioral Health Based Training for Chaplains** | Chaplains are officers who provide spiritual and religious support to Service members and their families. They are located on base or are embedded within a unit and serve on deployments. Chaplains must hold privileged information in confidence, unless the Service member provides informed consent release information to a third party. Because of this obligation of confidentiality, Service members often speak to chaplains about their behavioral health concerns.<br>**Additional information:**<br>https://www.army.mil/chaplaincorps http://www.navy.mil/local/chaplaincorps/<br>https://www.airforce.com/careers/specialty-careers/chaplain<br>http://www.hqmc.marines.mil/Agencies/Chaplain-of-the-Marine-Corps/<br><br>The Veteran's Administration Mental Health Integration for Chaplain Service and Uniformed Services University's Chaplains-Care Program, which is in the research and development phase, are two examples of programs and initiatives to train Chaplains on how to identify mental-health-related symptoms and on how to work with those experiencing mental health problems.<br>**Additional information:** https://www.mirecc.va.gov/mentalhealthandchaplaincy/MHICS.asp<br>https://socialpsych.uconn.edu/wp-content/uploads/sites/883/2017/09/9-DRP-SEPTEMBER-2017-NEWSLETTER-VOLUME-42c-ISSUE-9.pdf | No |

| Resource | Description | Specific to Leaders |
|---|---|---|
| **Combat and Operational Stress Control Programs (COSC)** | All branches of the military have a program to help prevent, identify, and address the negative psychological consequences of exposure to stressful or traumatic events in combat or military operations. Skills training throughout the deployment cycle on health promotion and stress reduction allows for early detection of developing stress reactions. These programs often use the stress continuum model to teach about various levels of stress and raise awareness of stress reactions.<br>**Additional information:**<br>http://www.navy.mil/local/nccosc/<br>https://phc.amedd.army.mil/topics/healthyliving/bh/Pages/CombatOperationalStressControl.aspx<br>http://www.marines.mil/Portals/59/Publications/MCTP%203-30E%20Formerly%20MCRP%206-11C.pdf?ver=2017-09-28-081327-517<br>http://www.pdhealth.mil/topics/deployment-health/air-force-cosc<br>http://www.med.navy.mil/sites/nmcphc/documents/lguide/op_stress.aspx#scm | No |
| **Consortium for Health and Military Performance** | The Consortium for Health and Military Performance is a research consortium that focuses on human performance optimization.<br>Subject matter experts (SMEs) described the development of courses (e.g., "Force Fitness Instructor") and curriculum for degree-seeking students to train Service members on human performance optimization.<br>**Additional information:**<br>https://www.usuhs.edu/champ<br>https://www.hprc-online.org | No |
| **Defense Health Agency Connected Health** | Defense Health Agency Connected Health (formerly the National Center for Telehealth & Technology) works to develop novel health technology solutions (e.g., telephone, video, and mobile applications) that increase access to health care providers and facilitate help-seeking behavior.<br>**Additional information:** http://t2health.dcoe.mil/ | No |

| Resource | Description | Specific to Leaders |
|---|---|---|
| **Embedded Behavioral Health (EBH) & Embedded Mental Health Program** | Goals of EBH and the Embedded Mental Health Program include improving Service member access to behavioral health care, increasing readiness, and preventing or intervening early when behavioral health concerns arise. EBH providers provide "walk-around" care and may be psychologists, social workers, psychiatric nurses, case managers, or behavioral health technicians.<br>**Additional information:**<br>https://armymedicine.health.mil/My-Health/Embedded-Behavioral-Health<br>http://www.airforcemedicine.af.mil/Resources/Mental-Health/<br>http://www.csp.navy.mil/Blog/Blog-Post/Article/1113830/comsubpac-embedded-mental-health-program-emhp/<br>http://www.marines.mil/Portals/59/MCO%201700.41.pdf | No |
| **Employee Assistance Program (EAP)** | The purpose of EAPs is to help employees resolve personal issues such as marital, financial, or emotional problems that may affect their work performance. EAPs employ a wide array of service and modality options to address employee (and their family member) needs.<br>**Additional information:**<br>https://www.opm.gov/policy-data-oversight/worklife/employee-assistance-programs/ | No |
| **Equal Opportunity (EO) Programs** | From DoD Directive 1350.2: EO programs work to ensure fair treatment for military personnel, family members, and civilians without regard to race, color, gender, religion, national origin, sexual orientation, or gender identity and provide an environment free of unlawful discrimination and sexual harassment.<br>**Additional information:**<br>DoD Directive 1350.2 *Department of Defense Military Equal Opportunity Program*<br>https://www.deomi.org/ | No |

| Resource | Description | Specific to Leaders |
|---|---|---|
| **Executive Medicine Clinic** | Executive Medicine Clinics are comprehensive health care programs available to eligible individuals, including active duty and retired Flag/General Officers and their beneficiaries. Designed to meet the time, privacy, and security concerns of those they serve, these clinics support all patient health care needs and can assist in coordinating specialty or preventive care.<br>**Additional information:**<br>http://www.wrnmmc.capmed.mil/Health%20Services/Medicine/Medicine/Executive%20Medicine/SitePages/Home.aspx<br>http://www.fbch.capmed.mil/healthcare/executive_medicine.aspx | Yes |
| **Family Advocacy Programs** | The Family Advocacy Program works to prevent and respond to child abuse and neglect and domestic abuse or intimate partner violence in military families by providing education and awareness programs, victim advocacy, counseling, and other types of support.<br>**Additional information:** http://www.militaryonesource.mil/-/the-family-advocacy-program | No |
| **Financial Management Programs** | Each Service Branch offers a financial management program to assist Service members in establishing and maintaining sound personal financial management practices.<br>**Additional information:**<br>http://www.militaryonesource.mil/financial-counseling<br>https://www.armymwr.com/programs-and-services/personal-assistance/financial-readiness<br>https://www.public.navy.mil/bupers-npc/support/21st_Century_Sailor/readiness/Pages/Personal-Financial-Management.aspx<br>http://www.afpc.af.mil/Benefits-and-Entitlements/Financial-Readiness/<br>http://www.usmc-mccs.org/index.cfm/services/career/personal-financial-management/ | No |

| Resource | Description | Specific to Leaders |
|---|---|---|
| **Leadership Meetings With Service Members** | Commander's Calls, All-Hands Calls, All Hands Briefs, Friday Morning Messaging, etc., are recurring meetings used to inform Service members of mission status and current priorities. SMEs explained that these meetings may sometimes be used to discuss topics such as resilience, operational stress control, help-seeking, and available mental health resources.<br>**Additional information:**<br>http://www.af.mil/About-Us/Commanders-Call-Topics/ http://navylive.dodlive.mil/tag/all-hands-call/ | No |
| **Military and Family Life Counselors (MFLCs)** | The MFLC program provides individual face-to-face non-medical counseling services and presentations to units on behavioral health.<br>**Additional information:** http://www.militaryonesource.mil/military-and-family-life-counseling | No |
| **Military Crisis Line** | The Military Crisis Line is a national network of local crisis centers that provide free and confidential emotional support to Service members and veterans in suicidal crisis or emotional distress. Crisis workers strive to ensure the caller is safe, help them develop a safety plan, and assist with locating local resources for follow-on support.<br>**Additional information:** Military Crisis Line (1-800-273-8255); https://www.veteranscrisisline.net/ActiveDuty.aspx | No |
| **Military OneSource** | Military OneSource provides free and confidential resources for eligible Service members, including short-term non-medical counseling (in-person or via telephone, secure video, or online chat), articles, tips, and policy information for those experiencing challenges related to deployment, relationships, stress management, parenting, grief, and spouse employment.<br>**Additional information:** http://www.militaryonesource.mil<br><br>Chill Drills, a downloadable resource provided by Military OneSource, is designed to teach users how to relieve the symptoms of stress via progressive muscle relaxation, improving sleep, slowing one's heart rate, and lowering one's blood pressure.<br>**Additional information:** http://www.militaryonesource.mil/products#!/detail/55 | No |

| Resource | Description | Specific to Leaders |
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| **Military Spouse and Family Support Programs** | Various programs within the Armed Forces and DoD focus on spouses and families. A major goal of these programs is to inform spouses about topics such as benefits, available programs, and physical and mental health care.<br>**Additional information:** https://www.defense.gov/Resources/Community-Resources/militaryspousesupport/ https://myseco.militaryonesource.mil/portal/<br>https://www.cnic.navy.mil/ffr.html<br>http://www.usmc-mccs.org/index.cfm/services/family/unit-personal-and-family-readiness/<br>https://www.goarmy.com/benefits/soldier-and-family-services.html | No |
| **Military Health System** | SMEs discussed various aspects of the Military Health System including<br>• Military Treatment Facilities<br>• Physicians and clinicians (e.g., Primary Care Physicians, Flight Surgeons)<br>• Physician's Assistants<br>• Behavioral Health Technicians<br>• Social Workers.<br>**Additional information:** https://tricare.mil/FindDoctor/AllProviderDirectories/Military.aspx<br>http://www.med.navy.mil/sites/nmotc/nami/academics/Pages/FlightSurgeon.aspx<br>https://www.airforce.com/careers/detail/aerospace-medicine-specialist-flight-surgeon<br>https://www.goarmy.com/careers-and-jobs/amedd-categories/medical-corps-jobs/flight-surgeon.html | No |
| **Mobile Applications** | A variety of mobile phone applications ("mobile apps") have been developed to support Service member psychological well-being. Examples include apps that provide stand-alone support for emotion regulation, mindfulness, relaxation, and breathing. Others are designed to be used in conjunction with clinical care (e.g., assessment of insomnia or concussion-induced symptoms, or enhancement of Cognitive Processing Therapy or Acceptance and Commitment Therapy). For instance, Breathe2Relax—designed for the military but available to the public—is a relaxation mobile application that trains people in deep breathing to support well-being and mental health.<br>**Additional information:**<br>http://t2health.dcoe.mil/products/mobile-apps<br>http://t2health.dcoe.mil/apps/breathe2relax | No |

| Resource | Description | Specific to Leaders |
|---|---|---|
| **Newcomer and Spouse Mandatory Briefings** | Mandatory newcomer briefings for new unit members and/or their spouses provide information about the installation, available resources, and helping agencies. | No |
| **Office of the Surgeon General Health and Wellness Program for Senior Leaders (Pilot Program)** | One SME noted that the Office of the Surgeon General piloted a health and wellness program for leaders, which included an annual in-person general health screening with a mental health provider. | Yes |
| **Peer Support** | Informal peer support involves fellow service members supporting each other by listening and providing knowledge, experience, and social and emotional support.<br><br>BeThere Peer Support Call and Outreach Center, a formal DoD program for all Service members, provides confidential 24- hour, 7-day-per-week support via phone, text, e-mail, or chat services.<br>**Additional information:** https://www.betherepeersupport.org/ | No |
| **Post-Deployment Decompression Programs** | Decompression programs are designed to help Service members gradually transition from deployment to home environments. Third-location decompression programs are brief (e.g., 48- to 72-hour) programs held in a location that is neither the deployment location nor the home site. Many programs offer educational sessions, optional individual treatment sessions, celebrations of accomplishments, and unstructured leisure time.<br>**Additional information:** Hacker Hughes et al. (2008); Schneider et al. (2016); Wood et al. (2017) | No |

| Resource | Description | Specific to Leaders |
|---|---|---|
| **Professional Military Education (PME)** | PME courses are designed to increase professional knowledge and understanding of a military service branch. PME topics may include mental health awareness, prevention, and topics related to resilience and performance optimization.<br>**Additional information:**<br>https://usnwc.edu/Student-Information/Online-Professional-Military-Education<br>https://marinecorpsconceptsandprograms.com/programs/investing-education-and-training-our-marines/marine-corps-university-mcu-and-professional<br>http://www.tradoc.army.mil/INCOPD/index.html http://www.afpc.af.mil/Force-Development/Military-Developmental-Education/ | Yes |
| **Psychological First Aid** | Psychological First Aid, developed conjointly with the National Child Stress Network and the Department of Veterans Affairs, is a therapeutic approach for mental health providers and first responders to assist people in the immediate aftermath of a disaster or terrorist event. It aims to reduce initial distress and foster short- and long-term adaptive functioning.<br>**Additional information:** https://www.ptsd.va.gov/professional/materials/manuals/psych-first-aid.asp | No |
| **Psychological Health Center of Excellence** | The Psychological Health Center of Excellence advances the readiness and psychological health of Service members, Veterans, and their families by developing and implementing evidence-based treatments and support tools, promoting a culture of psychological health, conducting psychological health research with the goal of translating research into clinical practice, integrating behavioral health into primary care, and providing program evaluation and monitoring services.<br>**Additional information:** http://www.pdhealth.mil/about-phcoe | No |
| **Serious Incident Report and Commander's Situational Report (SITREP)** | Commands use Serious Incident Reports and SITREPs to provide timely information on critical situations, such as suicide-related behavior. One Navy SME explained that when a SITREP for suicide-related behavior arrives at the Suicide Prevention Program Office, a senior officer personally reaches out to the unit's commander to express support, concern, compassion, and care for the unit and commander's well-being. The Admiral also emphasizes the resources available to the commander and stresses the importance of using any needed resources. | Yes |

| Resource | Description | Specific to Leaders |
|---|---|---|
| **Sexual Assault Prevention and Response; Sexual Harassment Assault Response Prevention Programs** | Sexual Assault Prevention and Response and Sexual Harassment Assault Response Prevention programs provide sexual assault awareness and prevention training, victim support, and mental-health-related services.<br>**Additional Information:** http://www.sapr.mil/<br>http://www.af.mil/SAPR.aspx<br>http://www.public.navy.mil/bupers-npc/support/21st_Century_Sailor/sapr/Pages/default2.aspx; http://www.preventsexualassault.army.mil/<br>http://www.usmc-mccs.org/index.cfm/services/support/sexual-assault-prevention/ | No |
| **Substance Abuse Programs** | Substance abuse programs in the U.S. Military support the prevention, treatment, and recovery of substance abuse and misuse conditions.<br>**Additional information:** https://www.army.mil/standto/2016-09-13 http://www.public.navy.mil/bupers-npc/support/21st_century_sailor/nadap/Pages/default2.aspx/<br>http://www.airforcemedicine.af.mil/ADAPT/<br>http://www.usmc-mccs.org/services/support/substance-abuse/ | No |
| **Suicide Prevention Program Offices** | Suicide Prevention Program offices provide support to Service members who experience suicidal ideation or engage in suicidal behaviors. Support focuses on identifying stressors and risk factors, providing education, and connecting Service members with mental health services.<br>**Additional Information:** http://www.armyg1.army.mil/hr/suicide/<br>http://www.usmc-mccs.org/services/support/suicide-prevention/<br>http://www.af.mil/Suicide-Prevention/<br>http://www.public.navy.mil/BUPERS-NPC/support/21st_century_sailor/suicide_prevention/Pages/default.aspx | No |
| **Total Force Fitness (TFF)** | TFF is a holistic concept of health that emphasizes optimization of individual functioning and performance. TFF focuses on eight domains of fitness: physical, environmental, medical, spiritual, nutritional, psychological, behavioral, and social health. TFF forms the basis of Special Operations Command's (SOCOM) POTFF program.<br>**Additional information:** https://www.hprc-online.org/page/total-force-fitness | No |

| Resource | Description | Specific to Leaders |
|---|---|---|
| **Army Resources** | | |
| **Army Ask, Care, Escort Training** | Army Ask, Care, Escort is an annual suicide prevention and awareness training that emphasizes how to identify signs of individuals who may be at risk for suicide and how to intervene.<br>**Additional information:** http://www.armyg1.army.mil/hr/suicide/training.asp | No |
| **Army Resiliency Directorate** | Army Resiliency Directorate oversees the Army's well-being programs that support readiness and governs certain human resources policies and programs.<br>**Additional information:** http://www.armyg1.army.mil/hr/default.asp | No |
| **Army War College Senior Leader Sustainment Program** | The Army War College offers students a Senior Leader Sustainment Program, which integrates training on medical readiness, personal fitness, and insights on human factors to prepare leaders to be healthy, ready, resilient, and at peak fitness performance.<br>**Additional information:** https://www.armywarcollege.edu/experience/seminarExperience.cfm#six | Yes |
| **Battlemind Training** | Battlemind Training is a pre- and post-deployment training program designed to build Soldier resiliency, confidence, and mental toughness. The pre-deployment training focuses on psychological readiness in a deployed environment. The post-deployment training focuses on the transition from combat, emphasizing barriers to help-seeking, relationships, safety, and normalizing symptoms and common reactions to combat.<br>**Additional information:** http://www.armyg1.army.mil/dcs/docs/Pre-deployment%20Battlemind%20Training%20Brochure%2011%20SEP%2006.pdf | No |
| **Center for Army Leadership** | As part of the Combined Arms Center, the Center for Army Leadership provides leadership development services, conducts research on leadership, and manages the Army Leader Development Program.<br>**Additional information:** https://usacac.army.mil/organizations/mccoe/cal | Yes |
| **Comprehensive Soldier and Family Fitness (CSF2)** | CSF2 was designed to build resilience and enhance the performance of Soldiers, civilians, and families. CSF2 trainings and tools focus on how to face challenges, manage stress, and enjoy life through preparation, sustainment, and enhancement.<br>**Additional information:** http://ready.army.mil/ra_csf.htm | No |

| Resource | Description | Specific to Leaders |
|---|---|---|
| **Engage Skills Training** | Engage Skills Training focuses on bystander intervention and empowering action in difficult situations. The training is designed to enhance communication and teach Service members how to manage professional confrontation. | No |
| **Family Readiness Group Website** | The Family Readiness Group website provides family members a way to access documents, view media, participate in online forums, access information on mental health topics, and stay up-to-date on their Soldier's unit.<br>**Additional information:** https://www.armyfrg.org/skins/frg/home.aspx | No |
| **Master Resilience Training (MRT) Skills Course** | MRT is designed to support Soldier performance enhancement and resiliency by teaching skills culled from sports and performance psychology. Soldiers may become trainers by attending a 10-day program. One SME noted that MRT Performance Experts teach skills related to attention control, confidence, energy management, goal setting, and imagery that can be used for physical fitness, marksmanship, and other challenging tasks.<br>**Additional information:** http://www.usar.army.mil/Featured/Resources/master-resilience-training/ | No |
| **Performance Triad (P3) Program** | P3 focuses on optimizing human performance (e.g., physical fitness, cognitive dominance, emotional resilience) and total Army resilience by offering programming related to improving sleep, nutrition, and physical activity.<br>**Additional information:** https://p3.amedd.army.mil/ | No |
| **Sergeants Major Course** | The Professional Military Education institution's Sergeants Major Course educates senior enlisted leaders in critical thinking, leadership skills, and communication skills.<br>**Additional information:** http://usasma.armylive.dodlive.mil/smc/ | Yes |
| **Soldier for Life – Transition Assistance Program (SFL-TAP)** | The SFL-TAP (formerly Army Career and Alumni Program) is a Commanders' Program that provides transition assistance to eligible Soldiers as they prepare to separate from the Army. SFL-TAP includes online presentations, benefits information, workshops on achieving post-transition occupational goals, and support with résume preparation and job searching.<br>**Additional information:** https://www.sfl-tap.army.mil/default.aspx | No |

| Resource | Description | Specific to Leaders |
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| **Air Force Resources** | | |
| **Air Force Limited Privilege Suicide Prevention Program** | The Air Force Limited Privilege Suicide Prevention program provides limited confidentiality protection under specific circumstances to Air Force members who pose a genuine risk of suicide and seek treatment because of the stress associated with impending disciplinary action under the Uniformed Code of Military Justice.<br>**Additional information:** https://www.wingmanonline.org/WingmanOnline/media/WingmanOnlineResources/AF-Suicide-Prevention-LPSP-Brochure.pdf?ext=.pdf | No |
| **Air Force Medical Service** | The Air Force Medical Service provides medical and mental health support for Air Force Service members to ensure readiness and mission success.<br>**Additional information:** http://www.airforcemedicine.af.mil/<br>http://www.airforcemedicine.af.mil/SuicidePrevention/ | No |
| **Key Spouse Program** | The Key Spouse Program is a Commander's Program that supports partnerships between spouses, families, and unit leadership. It is designed to establish a sense of community and peer support, enhance family resiliency, and promote readiness.<br>**Additional information:** https://www.usafservices.com/Home/SpouseSupport/Keyspouseprogram.aspx | No |
| **U.S. Air Force Academy Introduction to Behavioral Sciences Course** | Introduction to Behavioral Sciences courses are offered as part of the Air Force Academy's Behavioral Sciences major. Topics covered include psychological concepts (e.g., mental health issues, resilience) that can be applied to all military populations.<br>**Additional information:** https://www.academyadmissions.com/wp-content/uploads/2016/11/BEHAVIORAL_SCIENCES_MAJOR.pdf | Yes |

| Resource | Description | Specific to Leaders |
|---|---|---|
| **Navy Resources** | | |
| **Navy Caregiver Operational Control** | Navy Caregiver Operational Control is a variation of COSC developed by the Navy Bureau of Medicine and Surgery to help Navy caregivers learn to identify and take action to safeguard against occupational stress, compassion fatigue, and burnout in themselves and others.<br>**Additional information:**<br>http://www.med.navy.mil/sites/nmcsd/nccosc/serviceMembersV2/buildResilience/nccosc-provides-caregiver-training-to-mercy-crew/index.aspx | No |
| **Chief Petty Officer 365 Program** | The three-phase Chief Petty Officer 365 Program emphasizes leadership qualities, team building, readiness, work-life balance, and resiliency.<br>**Additional information:** http://www.navy.mil/mcpon/docs/CPO%20Guidance%20Final%20(signed).pdf | Yes |
| **Navy Equal Opportunity (EO) Program's Command Resilience Team** | The Command Resilience Team, which includes 10 to14 leaders and behavioral health personnel, conducts command climate assessments by conducting focus groups, interviews, and record reviews; analyzing the Defense Equal Opportunity Management Institute organizational climate survey; and collecting observations into an executive summary. The executive summary, weighing morale, teamwork, and communication, describes the current health and functioning of a unit.<br>**Additional information:** *OPNAVINST 5354.1G*<br>https://doni.documentservices.dla.mil/Directives/05000%20General%20Management%20Security%20and%20Safety%20Services/05-300%20Manpower%20Personnel%20Support/5354.1G.pdf | No |
| **Navy Deployed Resiliency Counselors** | Navy Deployed Resiliency Counselors are embedded licensed civilian counselors who provide counseling services and support to Sailors while on deployment and as needed at homeport. They also provide psychoeducational prevention training on topics such as stress reduction, suicide prevention, and substance abuse prevention.<br>**Additional information:** http://www.navy.mil/submit/display.asp?story_id=79003<br>Deployed Resiliency Counselor Program Trifold Navy MWR.pdf | No |

| Resource | Description | Specific to Leaders |
|---|---|---|
| **Deep Dives** | Deep dives are multidisciplinary suicide case reviews completed by the Navy Suicide Prevention Office. They are conducted to identify behavioral patterns and lessons learned by reviewing medical and personnel records, deployment health assessments, prescriptions, and laboratory tests.<br><br>**Additional information:** http://www.dspo.mil/Portals/113/Documents/2017%20Conference/Presentations/Attempted%20Suicides%20and%20Suicide%20Deaths%20in%20the%20United%20States%20Navy.pptx?ver=2017-08-11-105042-533 | No |
| **Every Sailor, Every Day** | "**21 Days of Total Sailor FITmas" Campaign**<br>This campaign provides tools and tips to develop and sustain healthy habits during the winter and holiday season. The areas covered include healthy eating, physical fitness, financial responsibility, family strength, spiritual wellness, and behavioral and psychological health.<br>**Additional information:** https://navstress.wordpress.com/2017/12/14/celebrate-this-fitmas/<br>http://www.public.navy.mil/bupers-npc/support/21st_Century_Sailor/suicide_prevention/spmonth/Pages/default.aspx<br>https://www.dvidshub.net/video/443330/21-days-fitmas-navy-ship-shape-program<br><br>**"Sailors on the Street" Videos**<br>An advertisement campaign featuring interviews with Sailors on their experiences with stress, their tactics to manage their responses, and how they utilize self-care practices.<br>**Additional information:** https://navstress.wordpress.com/2017/10/19/fall-into-healthy-stress-navigation-with-sailors-on-the-street/; http://www.public.navy.mil/bupers-npc/support/21st_Century_Sailor/osc/Pages/Materials.aspx | No |
| **Navy Annual General Military Training** | All Sailors complete annual general training. One of these trainings is on suicide prevention. The annual suicide prevention training includes information on risk factors, stress reduction, peer support, and how to respond in times of personal crisis.<br>**Additional information:** http://www.public.navy.mil/BUPERS-NPC/SUPPORT/21ST_CENTURY_SAILOR/SUICIDE_PREVENTION/COMMAND/Pages/default.aspx | No |

| Resource | Description | Specific to Leaders |
|---|---|---|
| **Navy Fleet and Family Support Program** | The Navy Fleet and Family Support Program is organized into three areas: Core Family Readiness, Sexual Assault Prevention and Response Program, and the Navy Gold Star Program. Within the Core Family Readiness area, there are the Counseling, Advocacy, and Prevention programs that provide non-medical counseling and crisis response support.<br>**Additional information**: https://cnic.navy.mil/ffr/family_readiness/fleet_and_family_support_program.html<br>https://www.cnic.navy.mil/ffr/family_readiness/fleet_and_family_support_program/clinical_counseling.html | No |
| **Navy Human Factors Board/Council** | Human Factors Boards and Councils review human factors as well as personal and professional characteristics to assess individual readiness. Board and Councils are designed to support and help a Service member get back to their duties.<br>**Additional information:** https://www.cnatra.navy.mil/local/docs/instructions/5420.13.pdf | No |
| **Navy Leadership Ethics Courses** | Navy leaders (e.g., Commanding Officers, Executive Officers, Command Chiefs, and their spouses) complete short courses to develop greater understanding of leadership and ethics topics. Portions of some courses address operational stress control topics.<br>**Additional information:** https://usnwc.edu/naval-leadership-and-ethics-center/Courses | Yes |
| **Navy Medicine Website** | The Navy Medicine website provides information and links to resources regarding physical and mental health care for Navy Service members and their families.<br>**Additional information:** http://www.med.navy.mil/Pages/default.aspx | No |
| **Navy Mind Body Resilience Training** | Navy Mind Body Resilience Training's flexible training spanning 8 to 14 hours teaches mind-body concepts. Its core curriculum focuses on stress resilience, mindfulness, meditation, flexible thinking, communication, valued living, problem solving, with optional modules on sleep management and mindful leadership.<br>**Additional information:** www.navy.mil/local/nccosc/<br>Heath Care Provider Burnout - Lippy.pdf | No |

| Resource | Description | Specific to Leaders |
|---|---|---|
| **Navy Operational Stress Control Program Leader Courses** | These 3- to 4-hour Navy Operational Stress Control courses promote stress awareness and management, resilience building, and resource access. They teach leaders to assess individual- and unit-level stress and how it affects families and suggest leadership interventions to support unit members.<br>**Additional information:** http://www.public.navy.mil/bupers-npc/support/21st_Century_Sailor/osc/Pages/Training.aspx;<br>http://www.public.navy.mil/bupers-npc/support/21st_Century_Sailor/osc/Documents/DPL%20OSC%20Info%20Sheet_FINAL.pdf | Yes |
| **Navy Resilient Workforce Summit** | This summit focuses on building a stronger workforce by discussing matters related to resiliency, ethics, counseling, family support, and transitions and developing increased awareness for related programming. | No |
| **Navy Sailor Assistance and Intercept for Life Program** | The Navy Sailor Assistance and Intercept for Life Program is an intervention program for Service members identified with a suicide-related behavior. Its evidence-based approach provides immediate assistance, regular risk assessment, care coordination, and support during reintegration into their job roles for 90 days after a suicide-related behavior.<br>**Additional information:** *NAVADMIN 208/16; NAVADMIN 027/17*<br>http://www.public.navy.mil/bupers-npc/support/21st_Century_Sailor/suicide_prevention/command/Pages/SAIL.aspx | No |
| **Navy Suicide Prevention Gatekeeper Training** | Training for Suicide Prevention Gatekeepers, such as corpsmen, families, attorneys, and other staff, educates participants on suicide prevention, risk assessment, and safety planning.<br>**Additional information:**<br>http://www.public.navy.mil/bupers-npc/support/21st_Century_Sailor/suicide_prevention/command/Pages/GatekeeperTraining.aspx | No |
| **Marine Corps Resources** | | |
| **Community Counseling Program** | The Community Counseling Program supports Marines and families via short-term non-medical counseling, behavioral health education, care coordination, and referrals to other resources.<br>**Additional information:** http://www.usmc-mccs.org/index.cfm/services/support/community-counseling/ | No |

| Resource | Description | Specific to Leaders |
|---|---|---|
| **Conquering Stress with Strength Workshop** | The Marine Corps Family Team Building offers a family focused workshop on coping, relaxation, and problem-solving skills.<br>**Additional information:** http://www.usmc-mccs.org/index.cfm/services/family/marine-corps-family-team-building/ | No |
| **Embedded Behavioral Health Prevention Capability (EBHPC)** | EBPHC personnel are embedded supports who provide active duty and reserve Commanders' behavioral health expertise on prevention efforts that can be used in their units. EBHPC provides SME knowledge of resiliency, behavioral health prevention, and holistic fitness to leaders to support mission readiness. EBPHC personnel analyze and evaluate information and statistics related to trends in Fitness of the Force metrics. They do not provide counseling or case management.<br>**Additional information:** http://www.marines.mil/Portals/59/MCO%201700.41.pdf | Yes |
| **Force Preservation Council and Human Factors Board** | The Force Preservation Council offers junior leaders a resource to learn actionable plans to assist at-risk Marines and to help them access needed services.<br>**Additional information:** http://www.marines.mil/Portals/59/Publications/MCO%201500.60.pdf?ver=2016-08-23-114836-707<br><br>Human Factors Boards and Councils review human factors as well as personal and professional characteristics to assess individual readiness. Boards and Councils are designed to support and help Service members get back to their duties.<br>**Additional information:** http://www.safety.marines.mil/portals/92/docs/cg_mci_west_hfb_policy-letter.pdf | No |
| **Marine Intercept Program** | The Marine Intercept Program supports Marines and Sailors identified as experiencing suicidal ideation or a suicide attempt by providing follow-up contact, developing safety plans, and assisting in care coordination of mental health services.<br>**Additional information:** http://www.hqmc.marines.mil/Portals/61/Docs/HQ%20Svc%20BN/WeeklyGouge/MArine%20Intercept%20Program%20TriFold%20w%20CCP%20number.pdf | No |

| Resource | Description | Specific to Leaders |
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| **Regional Training Coordinators** | COSC Regional Training Coordinators act as resources to leaders, assist in research, and provide training and care on matters related to COSC, such as the Operational Stress Control and Readiness initiative.<br>**Additional information:** http://www.marines.mil/Portals/59/MCO%205351_1.pdf | No |
| **SOCOM Resources** | | |
| **Families OverComing Under Stress** | Families OverComing Under Stress offers resilience training and practical skills related to the challenges of military life for military children, families, and couples. Programs include resilience training, consultations, skill-building groups, and educational workshops.<br>**Additional information:** https://www.focusproject.org/ | No |
| **POTFF** | The SOCOM POTFF initiative is intended to enhance resiliency skills in SOCOM personnel and their family members with emphases on human, psychological, spiritual, and social performance areas. POTFF staff include physical therapists, operational psychologists, strength and conditioning coaches, athletic trainers, physicians assistants, medical doctors, case managers, psychiatric technicians, non-medical counselors, social workers, and embedded MFLCs. Peer Network Coordinators support POTFF's social performance domain by providing seminars that teach skills on stress management, suicide awareness, and suicide prevention.<br>**Additional information:**<br>http://www.353sog.af.mil/Portals/79/BROCHURE_POTFF%20Services3%202105_sanatized.docx?ver=2016-01-08-154644-280 | No |
| **Warrior Care Program (Care Coalition)** | Care Coalition provides advocacy for wounded, ill, and injured Special Operations Forces Service members and their families after life-changing events. Efforts focus on supporting their recovery, rehabilitation, and reintegration process.<br>**Additional information:** http://www.socom.mil/care-coalition/ | No |

| Resource | Description | Specific to Leaders |
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| **Non-DoD Resources** | | |
| **American Foundation of Suicide Prevention** | The American Foundation of Suicide Prevention focuses on enhancing awareness of suicide-related issues, raises money for research, and supports those affected by suicide.<br>**Additional information:** https://afsp.org/ | No |
| **Applied Suicide Intervention Skills Training (ASIST)** | ASIST is a 2-day interactive workshop on understanding and preventing suicide. ASIST workshops are conducted at many military installations and are available to leaders, family members, and community members.<br>**Additional Information:**<br>https://www.sprc.org/resources-programs/applied-suicide-intervention-skills-training-asist<br>https://www.livingworks.net/programs/asist/ | No |
| **Give an Hour** | Give an Hour is a nonprofit organization with a network of volunteer professionals who provide free mental health care to Service members, Veterans, their families, and survivors of large disasters and traumas.<br>**Additional information:** https://giveanhour.org/ | No |
| **Man Therapy** | Man Therapy is a targeted effort to reduce suicide deaths by men aged 25 to 54 years old. Main goals are to increase awareness and help-seeking of men through humor.<br>**Additional information:** http://www.mantherapy.org/ | No |
| **MentalHealth.gov** | MentalHealth.gov provides links to U.S. government mental health information, including information and links to national resources.<br>**Additional information:** https://mentalhealth.gov/ | No |

| Resource | Description | Specific to Leaders |
|---|---|---|
| **National Suicide Prevention Lifeline** | The National Suicide Prevention Lifeline is a national network of local crisis centers that provide free confidential emotional support to individuals in suicidal crisis or emotional distress, 24 hours a day. Crisis workers strive to ensure the callers are safe, help them develop a safety plan, and assist with locating local resources for follow-on support.<br>**Additional information:** National Suicide Prevention Lifeline (1-800-273-8255); https://suicidepreventionlifeline.org/ | No |
| **Non-Military Community-Based Mental Health Providers** | Civilian mental health providers—such as psychologists, social workers, marriage and family therapists, and licensed professional clinical counselors—are available to Service members in their local community. Domestically, some providers accept TRICARE health insurance (although active duty Service members must be referred and pre-authorized) and some providers offer a sliding pay scale for clients who choose to self-pay.<br>**Additional information:** https://tricare.mil/CoveredServices/Mental/GettingMHCare/SelectProvider<br>https://tricare.mil/CoveredServices/Mental/GettingMHCare/ADSM_Apptshttps://www.psychologytoday.com/ | No |
| **PsychArmor Institute** | The PsychArmor Institute offers free courses on military culture and the needs of Service members and Veterans to civilians who could benefit from greater knowledge in these areas (e.g., medical providers, caregivers, employers, nonprofits).<br>**Additional information:** https://psycharmor.org/ | No |
| **Suicide Alertness for Everyone** | Suicide Alertness for Everyone is a half-day training program that teaches people to identify signs of suicidal ideation in others and to refer at-risk individuals to appropriate resources.<br>**Additional information:** http://public.militaryonesource.mil/products?program=olw | No |
| **Wounded Warrior Project** | The Wounded Warrior Project raises awareness of, and develops programming for, severely injured Veterans and their families as they transition to civilian life. safeTALK<br>**Additional information:** https://www.woundedwarriorproject.org/ | No |