



SAMANTHA E. DINICOLA, SHIRLEY M. ROSS, BRANDON CROSBY, REBECCA JENSEN,
IRINA A. CHINDEA, SUSAN G. STRAUS

An Evaluation of Task Force True North Initiatives for the Promotion of Resilience and Well-Being Within the Air Force



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Preface

Task Force True North (TFTN) is an Air Force effort to improve well-being and resilience in airmen and their families by implementing a series of initiatives designed to engage airmen and their families early, encourage airmen to seek help, and place services and resources in locations where airmen can more easily access them. These initiatives have been undergoing beta testing at four locations: Whiteman Air Force Base (AFB), Minot AFB, Joint Base Elmendorf-Richardson, and Beale AFB. The Air Force asked RAND to talk with leaders, providers, and airmen at the four beta test locations to evaluate perceptions of the initiatives and opportunities for improvement with the goal of expanding TFTN to a broader section of the Air Force.

This report provides background information on TFTN and its initiatives—Welcome Centers, NORTH STAR, Religious Support Teams, Embedded Mental Health Teams, and Operational Support Teams—followed by a collection of perspectives gathered from interviews and focus groups with key stakeholders at the beta test locations. The report concludes with a series of recommendations for ways that each of the initiatives can reach its full potential to improve airmen’s resilience and well-being. A companion study, *Alternative Approaches for Expanding the Air Force’s Task Force True North Program*, addresses options for expanding TFTN more broadly across the Air Force.

This research was sponsored by the Air Force Directorate of Integrated Resilience and was conducted within the Manpower, Personnel, and Training Program of RAND Project AIR FORCE (PAF) as part of the project Task Force True North Interim Qualitative Analysis.

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Summary

Issue

Task Force True North (TFTN) is a collection of five initiatives chartered by the vice chief of staff of the Air Force to improve resilience and well-being in airmen and their families. In July 2018, a beta test, or pilot, of the five TFTN initiatives began across four Air Force installations: Whiteman Air Force Base (AFB), Minot AFB, Joint Base Elmendorf-Richardson (JBER), and Beale AFB. The Air Force asked RAND to undertake a qualitative analysis of the perceptions of key stakeholders across all TFTN initiatives to assist in determining what is or is not working well. If the TFTN objectives are being met, the Air Force is planning to extend the initiatives to additional installations.

Approach

The RAND team conducted interviews and focus groups with key stakeholders, including leadership, providers, and airmen, during two sets of base visits to each of the four beta test locations. Thematic analysis of the data collected from the base visits allowed the team to identify key findings related to each of the initiatives and TFTN as a whole, as well as changes in perceptions in the six months between the first and second set of base visits.

Key Findings

Four of the five initiatives are perceived positively by stakeholders and continue to show good promise. Given TFTN's perceived impact to this point, as well as its potential for continued improvements to airmen resilience and well-being, the RAND team believes the qualitative data support an expansion of these four initiatives across a broader section of the Air Force. The Welcome Centers, Religious Support Teams (RSTs), Embedded Mental Health Teams (EMHTs), and Operational Support Teams (OSTs) all demonstrate expected progress toward being fully operational and providing value for airmen and are well regarded by the majority of stakeholders. The NORTH STAR initiative, a quantitative data collection effort in partnership with New York University, was not successful, and it was terminated during the beta test period.

Each initiative has faced challenges that require resolution prior to the expansion of TFTN. The EMHT initiative, in particular, was hindered by the disadvantages associated with a contracted workforce, compounded by poor administrative processes and inconsistent human resources policy on behalf of the contracting company. Recommendations to address this major policy challenge and other policy and programmatic challenges are included in the report.

Table S.1 reflects the progress of the initiatives at the time this report was written. The chart indicates the status of each of the five initiatives across the four beta test locations, and the full interpretation appears in the text of the report.

Table S.1. Overall Initiative Status

	Welcome Center	NORTH STAR	RSTs	EMHTs	OSTs
Whiteman AFB		Terminated after Phase 1			
Minot AFB					
JBER					
Beale AFB					

NOTE: Green indicates an operational initiative that received largely positive feedback from participants; yellow indicates a mostly operational initiative, with the exception of some challenges that could be addressed going forward; red indicates an initiative with a number of challenges that will take great effort to address going forward to be considered operational; and gray indicates that the initiative was not implemented at that base.

Recommendations

The RAND team developed ten recommendations to address key issues and concerns found in the report. The first four of these recommendations are listed below and address major policy considerations that must be taken into account prior to expansion. The next five recommendations focus on programmatic changes that can be made to strengthen the probability of future success of the initiatives. The final recommendation proposes an implementation plan for institutionalizing the initiatives in the Air Force. The team believes the successful implementation of these recommendations will pave the way toward a successful expansion of the four current TFTN initiatives.

The RAND team's first major recommendation is for the Air Force Directorate of Integrated Resilience to continue the evaluation of the TFTN initiatives, given their potential for helping airmen and their families and the need for scalability. This recommendation would include a comprehensive evaluation of TFTN using both qualitative and quantitative data, collected across multiple points in time and focused on measures of effectiveness. Evaluations at different points in time would allow for the continuous improvement to the initiatives. The second policy recommendation is to pursue authorizations and funding for civil service providers, in lieu of contracted professionals, to fill the EMHT and OST member roles. The third recommendation provides critical caveats for continuing the use of contractors as an option, if civil service providers are not considered a viable plan. The final policy recommendation is to plan for the scalability of TFTN and its individual initiatives if they are to be expanded across the Air Force, including changes that would need to be made for different populations and locations. These four recommendations, along with the five programmatic recommendations and the final recommendation for institutionalizing the initiatives, are detailed in Chapter 9 of the report.

Acknowledgments

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Abbreviations

AF/A1Z	Air Force Directorate of Integrated Resilience
AFB	Air Force base
AFI	Air Force Instruction
BASE-I	Base-Area Social and Economic Index
CONOPS	concept of operations
DAF	Department of the Air Force
DoD	Department of Defense
EMHT	Embedded Mental Health Team
HIPAA	Health Insurance Portability and Accountability Act of 1996
HPW	Human Performance Wing
ICT	information and communication technology
JBER	Joint Base Elmendorf-Richardson
LCSW	licensed clinical social worker
MDG	medical group
MHC	mental health clinic
NCO	noncommissioned officer
NYU	New York University
OST	Operational Support Team
PAF	RAND Project AIR FORCE
PCS	permanent change of station
PM	program manager
POTFF	Preservation of the Force and Family
PPE	personal protective equipment
PT	physical training
RST	Religious Support Team
TFTN	Task Force True North
USAF	U.S. Air Force
USSOCOM	U.S. Special Operations Command

1. Introduction

Background

The U.S. Air Force (USAF) has long recognized the need to support airmen and their families, and it has provided a variety of resources over intervening years to foster resilience, well-being, and a culture of community. Many of these resources have been effective, but some have not fulfilled their expected potential due to either barriers that keep them from being utilized or gaps between what the resources can support and what airmen need. As a result, the Air Force is continuing to seek program enhancements to improve its ability to support airmen and their families.

Airmen and their families have a variety of needs, and the Air Force typically considers these needs in terms of the “physical, mental, spiritual, and social aspects of everyday life.”¹ When these needs are not met, issues (such as physical injuries, mental health disorders, or difficulties in relationships) can emerge, and when these issues are not addressed early enough, negative behavioral outcomes may result that can affect not only the individual airmen but also their families, units, leadership, and the Air Force as a whole.

Negative behaviors can include increased substance use, domestic violence, and suicidality. A number of helping agencies—typically on-base locations staffed to provide a variety of resources—throughout USAF seek to support airmen and family needs, including wing-level chaplains; on-base mental health clinics (MHCs); Airmen and Family Readiness Centers offering programs to assist with family life, financial management, relocation, and careers; and Alcohol and Drug Abuse Prevention and Treatment programs. However, some barriers may exist that prevent all airmen who need these services from utilizing them. Barriers can include a high operational tempo in some units, physical distance from the facilities where these resources are housed, lack of understanding of the resources available, stigmas surrounding help-seeking behaviors, and concerns about possible negative career implications due to being considered “unfit to serve.”

The Air Force, as well as other services, has experienced an alarmingly high rate of deaths by suicide among its members. *Air Force Magazine* reported that 78 airmen took their own lives between the beginning of 2019 and August 1, 2019, resulting in Air Force Chief of Staff Gen David Goldfein ordering a one-day stand-down of operations.² Not only is this number

¹ U.S. Air Force, “Air Force Resilience: True North,” webpage, undated.

² Brian W. Everstine, “USAF Orders Stand-Down to Combat Rising Suicide Rate,” *Air Force Magazine*, August 1, 2019; Paul D. Shinkman, “Air Force Chief Grapples with Suicide Scourge: ‘I Don’t Have a Solution,’” *U.S. News & World Report*, August 12, 2019.

disturbing on its own, but it is also of grave concern because it is comparable to the total number of airmen deaths by suicide in the full 2018 calendar year.³ Adding to these concerns are the 186 deaths by suicide of family members across the services.⁴ While it is important to note that the data for dependents and spouses have only been made available for calendar year 2017, and data are not available for individual services, this number of deaths further illustrates the need for programs that focus on the well-being and resilience of both airmen and their families.

In view of these continuing grave concerns, Vice Chief of Staff of the Air Force Gen Stephen W. Wilson chartered Task Force True North (TFTN) in 2016 to identify gaps in existing programs and means to address them, including improvements to existing resources and the development of new resources. TFTN utilized the U.S. Special Operations Command's (USSOCOM's) Preservation of the Force and Family (POTFF) model as a guide for assisting airmen in overcoming their reluctance to seek help, particularly as related to medical and mental health care.⁵

Task Force True North Goals

TFTN was formulated to address shortfalls in existing Air Force programs focused on airmen resilience and well-being. The program has three overarching goals: optimize airmen performance, increase resilience of airmen and their families, and decrease negative and violent outcomes. These goals guide each aspect of TFTN as it progresses toward the POTFF-based objectives of addressing systemic risk, leveraging integrated and coordinated community support infrastructure, decreasing perceived risk of negative outcomes and connecting airmen to services, and utilizing evidence-based interpersonal and self-directed violence prevention.

As discussed in the next section, the TFTN program involves a number of initiatives, including improved access to existing resources at the unit level and new features of previously existing resources embedded with the airmen, all working to increase the mental, physical, emotional, and spiritual capacity of the Air Force. To reach the overarching TFTN goals, these initiatives are designed to engage airmen and their families early, encourage airmen to seek help, and place services and resources in locations where airmen can more easily access them (i.e., at the squadron or group level).

³ Office of the Under Secretary of Defense for Personnel and Readiness (OUSD [P&R]), "Annual Suicide Report: Calendar Year 2018," September 2019; Shinkman, 2019.

⁴ OUSD (P&R), 2019.

⁵ For more information on POTFF, see U.S. Special Operations Command, "POTFF," webpage, undated.

Initiatives

TFTN utilizes five different initiatives to bring valuable resources to airmen:

- The **Welcome Center** is a base-wide initiative that aspires to function as a one-stop shop for airmen in-processing that would typically require multiple days and touch points to complete. This initiative also focuses on preparing airmen and their families prior to their arrival on base by providing ample information and a *sponsor* on base to discuss the onboarding process.
- The **NORTH STAR** initiative was intended to address “secretive problems” faced by airmen, using broad-based surveys to bring the prevalence of these issues to the attention of commanders. It also provided a number of small-scale resources to allow airmen to address their own concerns privately. Due to a number of issues related to NORTH STAR, this initiative was terminated during the course of this study.
- **Religious Support Teams** (RSTs) bring wing-level chapel resources to the group level by embedding a chaplain and a religious affairs airman as a group asset to provide religious, spiritual, and personal support to airmen and their families in a more accessible way.
- **Embedded Mental Health Teams** (EMHTs) provide each squadron with a licensed clinical social worker (LCSW) and a mental health technician at the group level to conduct unit circulation, education, and limited scope counseling within the unit and promote resilient and help-seeking behavior. These resources also enable early intervention for situations wherein airmen might otherwise not seek help until their problem requires medical or mental health interventions.
- **Operational Support Teams**⁶ (OSTs) embed six mental and musculoskeletal health and resilience experts in a unit for a 90-day rotation, during which they determine unit-level (as opposed to airmen-specific) needs, develop and implement interventions to address these needs, and evaluate the unit’s use of the interventions to ensure it will continue to utilize them effectively.

A TFTN program manager (PM) is a civilian federal government employee assigned to each base to oversee these initiatives and provide support to the personnel, which can include acting as a conduit between the base and the Air Force Directorate of Integrated Resilience (AF/A1Z), working through day-to-day issues and concerns with providers and stakeholders, and working with wing and group leadership to determine what, if any, changes need to be made to ensure the effectiveness of the initiatives. The TFTN PM works most closely with the Welcome Center and EMHT initiatives, taking the lead on Welcome Center stand-up and EMHT integration.

Beta Test

To test the effectiveness of these initiatives that were designed to improve the well-being and resilience of airmen and their families, AF/A1Z launched a three-year beta test of the initiatives

⁶ At the time of this study, OSTs were included as part of the TFTN initiatives at two of the four beta test locations. Since then, OSTs have been moved out from under the set of TFTN initiatives and into a program within the Air Force Surgeon General’s office. However, our OST-related findings and associated recommendations remain in this report.

in July 2018 across four bases—three bases selected randomly and one purposefully. The 711th Human Performance Wing⁷ (HPW), located at Wright-Patterson Air Force Base (AFB), provided support as the beta test was developed; it conducted an assessment of eight *risk indicators*, including domestic violence, sexual assault, alcohol-related misconduct, suicide risk, age, gender, marital status, and Air Force specialty code. From the set of bases determined “high risk” by this assessment, HPW randomly selected three: Minot AFB, Joint Base Elmendorf-Richardson (JBER), and Beale AFB. Whiteman AFB was selected specifically to receive the beta test for these initiatives because of recent high-profile suicide attempts on the base.

Each of the bases received the Welcome Center, NORTH STAR, EMHT, and RST initiatives. Only Whiteman AFB and JBER received the OST initiative, in addition to the first four initiatives. This difference in design of implementation was put in place to assess whether the more intensive OST initiative resulted in any significant differences in outcomes at the bases that received it as compared with those that did not. It is important to note, however, that other variables may have had an impact on the outcomes of the initiatives at each of the bases—including differing mission sets as well as the implementation and management of the initiatives—that would prevent the direct comparison of outcomes across the bases. In addition to these four bases, the 711th HPW selected three *control bases* to receive only the NORTH STAR survey so that changes at the bases could be tracked in the absence of other initiatives. The three control bases were Ellsworth AFB, Mt. Home AFB, and Ramstein AFB.

To evaluate the effectiveness of the initiatives at each of the bases and determine whether the initiatives should be expanded across the Air Force, AF/A1Z established an evaluation plan involving a number of quantitative analyses. These included the NORTH STAR survey referenced previously, Air Force personnel metrics—including domestic violence, sexual assault, alcohol-related misconduct, sick leave utilization, and Article 15s, among others—and a Global Assessment Tool derived from the U.S. Army’s version of a self-assessment of physical and psychological health. However, the analysis of personnel metrics and development of the Global Assessment Tool did not come to fruition, and given that NORTH STAR was terminated midstudy, it is not currently possible to quantitatively assess the effectiveness of TFTN.

Study Objective and Approach

When it became apparent that planned quantitative efforts to evaluate the outcomes of the beta test would not come to fruition, AF/A1Z asked RAND Project AIR FORCE to perform a qualitative analysis of TFTN across the four beta test locations. The objectives of this evaluation were to determine the success of the initiatives based on the perceptions of key stakeholders,

⁷ The mission of the 711th HPW is the advancement of “human performance in air, space, and cyberspace through research, education, and consultation.” Wright-Patterson Air Force Base, “711th Human Performance Wing,” webpage, undated.

identify strategies for improvement in TFTN and its initiatives, and provide recommendations regarding whether and/or how to expand the initiatives across the Air Force.

The RAND team addressed these objectives by conducting one-on-one interviews with senior leaders (wing and group commanders) and by conducting focus groups of roughly four to eight participants, including leaders (squadron commanders, chiefs, senior noncommissioned officers [NCOs], “supervisors,” and first sergeants), airmen, providers, and other stakeholders at the four beta test locations. The purpose of the interviews and focus groups was to gather perspectives on the outcomes of the initiatives including both key challenges and successes. These qualitative data were analyzed using thematic analysis, and the findings were compared across two phases of data collection, scheduled roughly six months apart to determine whether perceptions of TFTN changed over time. The first set of visits (henceforth referred to as “Phase 1”) occurred in February 2019 and included conversations with 202 participants. The second set of visits (henceforth referred to as “Phase 2”) occurred during July and August 2019 and included 195 participants.

Appendix A provides a more detailed description of the methodology used for this study.

Limitations

Our study had several limitations with respect to opportunities for data collection that should be considered in reviewing our findings and recommendations. One such limitation was our inability to speak with airmen during Phase 1 due to a lengthy approval process regarding the protection of human subjects. Additionally, as further discussed in Appendix A, we spoke with only a small number of airmen—35 total—during our visits, partly due to approvals and scheduling, which extended our timeline into the summer permanent change of station (PCS) rotational cycle. As a result of the small number of participants in the airmen groups and the lack of awareness among some airmen of the initiatives (due to recent incoming PCS or low provider manning), the findings presented throughout this report include minimal direct quotes from airmen. However, the perspectives of airmen that we were able to obtain informed the findings and recommendations throughout the report, particularly those related to airmen participation and provider fit.

Another limitation was the lack of qualitative data collection prior to the implementation of the initiatives and within the first seven months of implementation, at each of the four beta test bases. The formal study was commissioned after the start of the beta test, and data collection could not begin until the seven-month point. Analysis was dependent on the perspectives of our participants regarding changes they had observed. Additionally, the scope of the report did not include qualitative data from the control bases, so qualitative comparisons could not be made between bases that did not receive the beta test of the initiatives and those that did. A final limitation related to the scope of the report was the focus on qualitative data only. In the absence of quantifiable measures, our findings are based on the observations of our participants and their

subjective perceptions. Therefore, we cannot conclusively measure the outcomes of these initiatives, only what leadership, providers, and airmen have observed in their units.

Despite these limitations, the information gathered during this study provides the Air Force with the experience and perceptions of the intended users of these services, and at several organizational levels and across ranks. These perceptions of the targeted airmen will be critical to the Air Force's understanding as it makes its decisions about continuance of the programs and expansion across locations.

Structure of This Report

The remainder of this report provides additional detail about the specific initiatives, documents findings, and recommendations. Chapter 2 includes a review of previous RAND and other related work on well-being and resilience, as well as Department of Defense (DoD) efforts. Chapters 3 through 7 then turn to the specific initiatives that constitute TFTN, providing key findings for each of the initiatives, including how implementation of the initiatives varied across the four beta test locations as well as any variation between Phase 1 and Phase 2 of our base visits. As the RSTs and the EMHTs (Chapters 5 and 6, respectively) complement each other, there are some references in Chapter 5 to topics explored more thoroughly in Chapter 6. The authors have tried to provide necessary information to understand the chapter on its own, but appreciating the comparisons made requires reading the findings chapters for both initiatives. Chapter 8 discusses overarching findings relevant across multiple TFTN initiatives. Finally, Chapter 9 describes recommendations for the Air Force to consider as it moves forward with TFTN.

There are two appendixes included in this report. Appendix A provides a detailed description of the methodology of the report. Appendix B includes the protocols used in interviews and focus groups with stakeholders.

2. Dimensions of Well-Being and Resilience

In 2010, then–Chairman of the Joint Chiefs of Staff Admiral Michael Mullen called for a new approach to well-being throughout the armed forces. This framework, named Total Force Fitness, identified eight dimensions of well-being and resilience.¹ Motivated in part by the tempo and nature of deployments over the past decade-plus of engagements in Iraq and Afghanistan and supporting efforts, the Air Force previously asked RAND Project AIR FORCE to examine resilience among airmen, their families, and units to reinforce and enhance strengths and prevent and reduce harmful consequences of stressors, from mood disorders, substance abuse, poor mental and physical health, and family problems. The resulting work was a series of eight reports (along with a summary report) reflecting the dimensions identified by DoD as part of Total Force Fitness, all of which contribute to overall well-being in the face of challenges.²

TFTN seeks to promote the well-being and resilience of airmen and their families through a range of interventions, supports, and programs. The scope of well-being and resilience being considered is broad, and the levels at which well-being and resilience are targeted include the individual, family, unit, and community. The scope of this study did not allow for a comprehensive review of the vast empirical and theoretical literature on resilience and well-being. Rather, the purpose was to inform the development of the research protocols through a review of previous RAND and other work directly related to the Total Force Fitness construct, and to well-being and resilience and related factors.

¹ Michael Rounds, “The Principal Challenge of Realizing Total Force Fitness: Changing Our Readiness Culture,” *Military Medicine*, Vol. 175, Supp. 8, 2010.

² This work was published in a series of nine RAND reports. Douglas Yeung and Margret T. Martin, *Spiritual Fitness and Resilience: A Review of Relevant Constructs, Measures, and Links to Well-Being*, Santa Monica, Calif.: RAND Corporation, RR-100-AF, 2013; Regina A. Shih, Sarah O. Meadows, John Mendeloff, and Kirby Bowling, *Environmental Fitness and Resilience: A Review of Relevant Constructs, Measures, and Links to Well-Being*, Santa Monica, Calif.: RAND Corporation, RR-101-AF, 2015; Sean Robson, *Psychological Fitness and Resilience: A Review of Relevant Constructs, Measures, and Links to Well-Being*, Santa Monica, Calif.: RAND Corporation, RR-102-AF, 2014; Sean Robson and Nicholas Salcedo, *Behavioral Fitness and Resilience: A Review of Relevant Constructs, Measures, and Links to Well-Being*, Santa Monica, Calif.: RAND Corporation, RR-103-AF, 2014; Sean Robson, *Physical Fitness and Resilience: A Review of Relevant Constructs, Measures, and Links to Well-Being*, Santa Monica, Calif.: RAND Corporation, RR-104-AF, 2013; Karen R. Flórez, Regina A. Shih, and Margret T. Martin, *Nutritional Fitness and Resilience: A Review of Relevant Constructs, Measures, and Links to Well-Being*, Santa Monica, Calif.: RAND Corporation, RR-105-AF, 2014; Sarah O. Meadows, Laura L. Miller, and Sean Robson, *Airman and Family Resilience: Lessons from the Scientific Literature*, Santa Monica, Calif.: RAND Corporation, RR-106-AF, 2015; Regina A. Shih, Sarah O. Meadows, and Margret T. Martin, *Medical Fitness and Resilience: A Review of Relevant Constructs, Measures, and Links to Well-Being*, Santa Monica, Calif.: RAND Corporation, RR-107-AF, 2013; and Juliana McGene, *Social Fitness and Resilience: A Review of Relevant Constructs, Measures, and Links to Well-Being*, Santa Monica, Calif.: RAND Corporation, RR-108-AF, 2013.

We provide a review of previous RAND work on factors that contribute to well-being and resilience in the military and specifically in USAF, what interventions and forms of support are best supported by the evidence, and how to evaluate such programs. The RAND series describes interventions and supports for each dimension, along with indicators that USAF and researchers can use to measure health as well as the impact of interventions. The literature summarized here can inform the evaluation of TFTN to date as well as recommendations for its future undertakings. The discussion of the constructs, interventions, and evaluations associated with different types of fitness draws from the corresponding RAND report on each of the eight dimensions. However, we do not cite the original sources associated with each finding; instead, we refer readers to reports in the series.

Dimensions of Well-Being and Resilience

The eight dimensions are medical, nutritional, environmental, physical, social, spiritual, behavioral, and psychological fitness.

Medical fitness is most often framed, particularly for airmen, as a measure of deployability and readiness.³ It is usually defined as the ability to perform the duties required of the job without suffering time away from work, loss of quality of life, or the risk of endangered health. Medical fitness is connected to nutritional, behavioral, and mental fitness.

Nutritional fitness is associated with consuming the nutrients required to support health and readiness and to enhance resilience against stressors while minimizing the consumption of less useful or harmful nutrients.⁴ Nutrition is increasingly linked not only with physical health and the risk of developing chronic conditions but also with cognitive function and mental health. A particular challenge of nutritional fitness is the conventional, standard American diet, which is marked by excessive intake of total calories as well as disproportionate intake of processed foods, refined grains and sugars, unhealthy fats, and alcohol. Because of the relationship between meals with family and friends, nutritional fitness also has a social component.

Environmental fitness is defined as the knowledge, skills, and behaviors necessary to function successfully in a given (usually work) environment and to cope appropriately with the stressors of that environment.⁵ Many military occupations involve environmental stressors, which can generally be mediated in two ways: prevention and protection. Prevention refers to minimizing exposure to stressors, such as ensuring the safe containment of dangerous substances or noise abatement in the workplace. Protection helps safeguard the health of the airmen when prevention cannot remove stressors. Protection includes personal protective equipment (PPE), such as ear

³ Shih, Meadows, and Martin, 2013.

⁴ Flórez, Shih, and Martin, 2014.

⁵ Shih et al., 2015.

protection, insulation from temperature or environmental pollution, and clothing, such as gloves or reinforced boots, to avoid injury while working.

Physical fitness refers to the performance-related characteristics of the body.⁶ It is influenced by nutrition, medical fitness, environmental stressors, and, to some extent, psychological and social factors. In the military context, physical fitness is generally assessed with respect to performance, and as such, standards often vary according to the demands of the job. More generally, physical well-being means the individual is physically fit enough to carry out normal activities for their lifestyle and enjoy a good quality of life. Physical fitness is also associated with medical fitness in that it is a powerful predictor in the aggregate and, to some extent, at the individual level of medical outcomes, including morbidity, mortality, and likelihood of developing chronic conditions.

Social fitness describes the degree to which airmen and their families can initiate, develop, and maintain relationships that help them to manage stressors and develop personal resilience.⁷ These include family relationships, coworkers, friends, neighbors, and members of faith communities or other groups with shared interests and activities. This support can be emotional (having someone to listen and provide positive social reinforcement), instrumental (having someone to get a ride to an appointment or babysit), or informational (having someone who can provide information about job opportunities or support programs). Such relationships can include virtual communities that exist and meet online or through social media rather than in person.

Spiritual fitness refers to the capacity for a framework of beliefs and values around ultimate purpose to provide resilience and strength.⁸ While the term *spiritual* is most commonly understood in reference to religion, secular and atheist philosophies and belief systems can equally serve as sources of spiritual fitness. Believing in an overarching purpose to life can provide perspective during challenging or painful times and is reflected in a higher self-assessed quality of life. While research on how spiritual fitness confers other benefits is still developing, and findings sometimes conflict, some work suggests that the meditative aspects of prayer and meditation and the communal aspects of spiritual life are linked to better mental and behavioral health. Belief that a greater organizing logic underlies human existence can also drive posttraumatic growth and facilitate coping and recovery after trauma. Shared spiritual beliefs can also improve marital and family relationships.

Behavioral fitness is defined rather narrowly for the purposes of the military's construct of total fitness, as it can touch on any of the other seven dimensions.⁹ Taking its cue from the work on Total Force Fitness published in 2010 at the request of the chairman of the Joint Chiefs of

⁶ Robson, 2013.

⁷ McGene, 2013.

⁸ Yeung and Martin, 2013.

⁹ Robson and Salcedo, 2014.

Staff, this *Military Medicine* article restricts its discussion to elements of behavioral health that incorporate health-related behaviors rather than underlying psychological factors.¹⁰ These behaviors are alcohol use and abuse, tobacco use, illicit drug use, overweight and obesity, and sleep.

Psychological fitness refers to cognitive and emotional aptitudes related to resilience and well-being.¹¹ This includes beliefs about the self that are accurate and supportive of well-being, such as self-esteem and a realistic sense of agency. The ability to recognize, regulate, and adapt to both positive and negative emotions is another element of psychological fitness. When confronted with stress, the capacity for developing an effective coping strategy is a function of these cognitive and emotional aspects of psychological fitness.

It must be noted that the taxonomy dividing well-being and resilience into eight dimensions, while corresponding with DoD work on Total Force Fitness, is somewhat subjective. As the definitions of the dimensions and discussion of interventions make clear, there is some overlap among the dimensions. Furthermore, as the literature suggests and our base visits confirmed, the experience of airmen and their families is that these dimensions cannot be separated from each other in practice. Behaviors in one dimension are linked with other aspects of health. We observed a number of examples of these interconnections in our visits.

For example, during the first two rounds of base visits, military personnel and clinical staff described how physical injuries of airmen, injuries that impair their ability to carry out job tasks, can lead to symptoms of anxiety or depression. Poor nutrition, excessive use of tobacco or alcohol, or injuries from overtraining can reduce airmen performance on physical fitness tests, which may influence their work evaluations and performance. Substance abuse can be a response to psychological or social stressors and can contribute to them. Similarly, unhealthy behaviors regarding eating, exercise, and sleep can be a consequence and/or a cause of physical and mental health problems. For example, sleep-related behavioral health is particularly important because chronic sleep loss is linked with reduced physical and mental resilience.

While moderate and infrequent consumption of alcohol can serve as a buffer against stress, heavy, chronic, or uncontrolled drinking, as well as the use of illicit drugs or abuse of prescribed drugs, are linked with a range of physical and mental health problems, absenteeism and reduced performance at work, and erosion of personal relationships. Similarly, while smoking can serve as a coping mechanism against stress, it can cause physical harm even at fairly low levels of consumption, a problem that is complicated by the physical and mental stress associated with smoking cessation. Disordered eating may evolve as a coping mechanism but is also linked with psychological, medical, and physical health problems. The emphasis on TFTN initiatives

¹⁰ Wayne B. Jonas, Francis O'Connor, Patricia Deuster, and Christian Macedonia, "Total Force Fitness for the 21st Century: A New Paradigm," *Military Medicine*, Vol. 175, August 2010.

¹¹ Robson, 2014.

working together and making referrals to other providers within MHCs for problems beyond their scope supports the interconnected nature of dimensions of well-being.

Interventions for Dimensions of Fitness

This section addresses common interventions to support well-being in each dimension of fitness. It addresses the costs, benefits, and limitations of interventions. We conclude by noting factors that influence the effectiveness of interventions, including delivery methods and local base environment.

Medical fitness is best supported by preventive care to maintain well-being, including regular checkups, screenings, and immunizations. When medical stressors exist, they tend to be acute or chronic. Acute medical problems require prompt access to the appropriate medical care and rehabilitative support, while chronic medical conditions involve both medical support and intervention and lifestyle changes to manage the condition. For members of the military and their families, financial barriers to adequate medical care are less likely to be a problem since they typically have access to care through the military, although the delays sometimes associated with accessing care through DoD can reduce effectiveness.

Various health and well-being programs that encourage lifestyle changes (such as weight loss, exercise, and smoking cessation, for example) have been shown to be effective in improving medical outcomes and reducing days lost to illness. Prompts or other supports in the form of text message or app-based reminders, support groups, and access to advice and incentives in the form of gift cards or other small rewards increase buy-in and participation in such programs.

Nutritional fitness interventions can be targeted to individuals and families, the community, and the broader environment. For individuals, the provision of nutritional information is the most basic intervention, which can be supplemented by classes and support groups around healthy meal planning. For individuals with disordered eating, individual or group behavioral counseling can be effective in changing food consumption patterns. For communities, changing the food offerings and portion sizes in cafeterias and grocery stores on base influences nutritional fitness, as does raising the prices on less healthy options or removing them entirely (for example, as some schools have made sugary drinks unavailable to students). The availability of a range of food options in the environment around the base is also a factor with respect to restaurants, fast food, and grocery stores.¹²

¹² The relationship between the area around a base, its socioeconomic activity, and the health of the USAF community living both on and off base is discussed in Sarah O. Meadows, Laura L. Miller, and Jeremy N. V. Miles, *The Association Between Base-Area Social and Economic Characteristics and Airmen's Outcomes*, Santa Monica, Calif.: RAND Corporation, RR-132-AF, 2014.

Environmental fitness interventions that are most important and successful involve providing adequate PPE and routines and discipline to ensure its correct and consistent use. Education, peer and management support, leadership by example, and the incorporation of PPE into work routines increase the use of PPE and decrease workplace injury and mortality. Notably, financial incentives to reward compliance have not been shown to be effective, although other measures, such as recognition of high compliance rates for units, are somewhat effective. Similarly, punitive measures for noncompliance aimed at individuals or units are minimally effective and work only in the short term, although reporting inadequate compliance to unit leadership is more successful.

For some categories of environmental stressors, supervisors can offer support to individuals as the airmen become acclimated to new or additional stressors. Equipment, experience, and exposure over time can help mitigate temperature and altitude stress. In addition to PPE, strengthening exercises and better ergonomic work practices, which can involve both equipment (work stations optimized for height and limb length) and training (physical therapy to protect or rehabilitate potentially weak points) can mitigate musculoskeletal stressors.

Physical fitness interventions, such as nutritional interventions, can occur at a number of levels. Education and information can give individuals the understanding of why physical fitness matters as well as possible ways to increase their fitness. In communities, promoting a culture of physical fitness through physically active leisure activities and providing behavioral supports to shift patterns of behavior can increase fitness. At the environmental level, providing facilities for physical activity, from playgrounds and walking trails to gyms and sports leagues, increases physical fitness.

Social fitness interventions take a range of forms. The creation of social networks and connections can build social fitness; these can range from formal support groups and information networks to informal social gatherings, such as playgroups or coffee get-togethers. Physical infrastructure can support the creation of these networks by providing places for people to meet, such as community centers, religious centers, and recreation centers. High-traffic areas where information about social supports can be posted and widely accessed, such as bulletin boards at the centers mentioned above, commissaries, schools, and places of work, also contribute to social fitness. Geographic displacement is a particular concern for the military that can be an obstacle to these types of social interactions. However, virtual meeting places and bulletin boards can mitigate this impediment by creating online spaces for dialogue, requesting and finding social support and information, and publicizing opportunities for developing social capital; that is, the network of community and friendship ties that can provide formal and informal support.

A particularly important aspect of social fitness is related to cognition and perception; even if rich social resources exist, if individuals believe they cannot find help or cannot access the support, their social fitness is diminished. Examples of perceptual barriers include social anxiety, or the perception that these groups are not welcoming to newcomers. In some cases, psychological counseling to address faulty cognitions and provide education about the extent and accessibility of these resources is an important component of effective social fitness interventions.

Spiritual fitness interventions vary widely among faith traditions, and culturally appropriate interventions are particularly sensitive in this dimension. Interventions typically involve cultivating a sense of meaning or purpose, even in the context of challenges or suffering, and translating that sense of meaning or purpose into action when faced with personal, interpersonal, medical, career, or other difficulties. Interventions can be as informal as regular participation in worship, study, or fellowship or can involve individual counseling and spiritual guidance and instruction in areas ranging from the teachings of a tradition to prayer and meditation.

Spiritual guidance can be a useful adjunct to medical and psychological care for people suffering from physical or mental health challenges or in attempting to strengthen a difficult marital or family relationship. However, it is important that chaplains and their staff not be put in the role of a doctor or therapist, although they can serve as a point of contact for health professionals and can serve a particularly valuable role in this capacity for individuals and groups who are more resistant to seeking out mental health support.

Behavioral fitness interventions vary widely with the nature and degree of the problem being treated and the commitment of the airmen or their family members to establishing healthier behavior. Interventions to improve behavioral fitness can include cognitive behavioral therapy, support groups, medical evaluation and treatment, or pharmacological treatment. In some cases, changes to policy and the environment can improve behavioral health. Many behavioral fitness interventions require specific certifications or skills, beyond the LCSW or chaplain credentials.

Sleep interventions are an example of a behavioral health problem that can require different or multiple modalities. Sleep disorders usually require some diagnosis as to the root cause of the poor sleeping habits, which can be behavioral, psychological or stress related, or physiological. Cognitive behavioral therapy, either one-on-one or in a group setting, can be effective for mildly disordered sleep after relatively few sessions. More intense therapy, particularly mindfulness-based stress reduction, is associated with improved sleep, but this can involve a more significant time commitment for the client and requires a teacher or therapist with additional specific training. For more severe cases, temporary use of medication to create healthier sleep habits can be used in conjunction with behavioral therapy. When physiological causes, such as sleep apnea, contribute to difficulty sleeping, medical specialists might determine that assistive devices are necessary.

Smoking cessation is another example of an intervention that includes many components. Smoking cessation depends heavily on individual motivation, which can be enhanced by external factors, one of the most effective of which is the price of cigarettes, but these factors are beyond the control of individuals who are motivated to quit. Interventions that are more amenable to USAF influences include education about the medical and other benefits of quitting smoking; access to support groups, whether in person, by telephone, or online; and the use of alternative nicotine delivery either as a transition to cessation or as a form of harm reduction if complete cessation is not feasible to airmen. Cognitive behavioral therapy to create healthier responses to the urge to smoke or to cope with effects of cessation influences smoking cessation outcomes. Environmental supports, such as limited areas in which smoking is permitted, limiting access to

cigarette purchases on base, and increasing the price of cigarettes on base, can also influence quitting behavior.

Psychological fitness interventions can generally be grouped into inward and outward interventions. Inward interventions include teaching awareness and acceptance of the individual's emotional responses and moods, identification of stressors and responses to stressors, and mindfulness around thought processes, including identifying faulty cognitions. Outward interventions involve teaching and mastering skills, such as selecting appropriate coping strategies in the face of stressors; reframing perceptions of situations to promote optimism and a sense of agency; and learned optimism. Important components of psychological interventions for the client are recognizing that events (e.g., career or marital difficulties, trauma, life changes—even when desired or positive) can exert a powerful influence on emotions, responses, and cognitions and help the client identify ways to address and sometimes change external circumstances to improve fitness.

Evidence-based mental health interventions for psychological fitness can range from facilitated or peer-led group supports to intensive one-on-one counseling with accredited therapists (e.g., licensed clinical psychologists, social workers, or psychiatrists). The extent and duration of interventions also varies with the nature of the issue being addressed. For many airmen, the stress of preparing for a deployment, adjusting to a new baby, or the death of a loved one might be met with short-term counseling or support groups. At the other end of the spectrum, the death of a loved one or the effects of long-term trauma may require more intensive and longer-term treatment by accredited practitioners.

Evaluating Effectiveness

There are some key challenges in evaluating the effectiveness of interventions designed to enhance resilience. Resilience is defined in different ways depending on context, and the meaning of resilience varies in each of the eight dimensions of Total Force Fitness, as discussed above. The lack of precision and specificity in the use of the term makes meaningful comparisons among programs difficult. While the tailoring of resilience programs to meet the particular needs of individuals, families, units, installations, and leadership teams is likely to be useful, evaluating these programs will be difficult in the absence of a standardized definition of well-being, fitness, or resilience.¹³

Medical fitness tends to be one of the easiest to evaluate for dimensions of well-being because many objective and validated measures are available. Results of regular physical exams and screenings, as well as participation rates in these and other forms of preventative care, are

¹³ Discussed in Lisa S. Meredith, Cathy D. Sherbourne, Sarah J. Gaillot, Lydia Hansell, Hans V. Ritschard, Andrew M. Parker, and Glenda Wrenn, *Promoting Psychological Resilience in the U.S. Military*, Santa Monica, Calif.: RAND Corporation, MG-996-OSD, 2011.

the most common measures of medical fitness for generally healthy airmen and their families. Self-reported measures of well-being, including frequency and intensity of physical pain and ability to carry out normal day-to-day activities, are easy to collect and have been found useful in the aggregate in predicting outcomes. For acute and chronic illness or injury, evidence-based benchmarks exist for treatment and rehabilitation of the former and effective management of the latter (for example, in monitoring A1C levels for diabetics or the time until return to normal activity after a musculoskeletal injury).

Nutritional fitness is most often evaluated when there is reason to believe a problem already exists, as when airmen or their family members are at an unhealthy weight or when illness linked with nutrition is suspected or diagnosed, such as when testing reveals unhealthy lipid, blood sugar, or vitamin levels. Communitywide obesity rates and some illnesses or nutrient deficiencies are indicators of widespread poor nutritional fitness. Other community indicators include consumption patterns at dining facilities and commissaries on base. Food logs are a useful tool for evaluating an individual's nutritional fitness but can be time consuming for the individual and are only as useful as the record keeper is thorough.

Environmental fitness interventions can be measured most crudely through mortality and injury rates related to workplace stressors and preventive/protective measures. However, as these are measures of acute failure and may be low-frequency events, other measures can be more useful, such as audits of the use of PPE, evaluations of the culture of safety, and the use of reporting mechanisms, such as safety hotlines, for potential threats to environmental fitness. These aggregate measures require outside organizations either to conduct the evaluation or to provide the reporting mechanism.

Physical fitness interventions are easily measured for airmen as physical fitness evaluation is a routine job requirement. In addition to physical fitness testing as carried out routinely for airmen, schools that administer physical fitness tests based on time required to perform specific exercises or the number of repetitions possible before exhaustion are useful objective gauges of physical fitness and improvement. Indirectly, activity logs can be used to measure an individual's fitness and changes in their fitness. An example of an aggregate measure of evaluating physical fitness interventions is observing participation and utilization rates for physical fitness infrastructure, since this reflects changing patterns of physical activity to support physical fitness. Since physical fitness influences medical fitness, mental health, and sleep hygiene, some effects of changes in physical fitness can be observed by studying indicators related to these dimensions of health. Fitness trackers can also reveal changes in individual and aggregate behaviors.

Social fitness at the individual level is usually measured through surveys. At the community, unit, or neighborhood level, participation rates provide a measure of the effectiveness of social resources and interventions to increase social fitness with respect both to breadth of engagement (how many parents of young children have contact with child development centers or playgroups, for example) and depth of engagement (number of times parents of young children access help at

a center or attend a playgroup). At the community level, high crime rates and frequent relocation are considered signs of low social fitness, although both of these indicators are less useful measures for military families (particularly those living on base, since frequent moves are not a function of instability), and crime rates on bases are broadly lower than in similar civilian communities since the bases are functionally closed and actively policed sites.

Spiritual fitness interventions are particularly resistant to objective evaluation. Subjective assessments of spiritual health can be used to evaluate both individuals' perceptions of their spiritual fitness and how these are influenced by interventions. While there are some benefits to participating in a spiritual community and meeting with spiritual advisers, it is difficult to measure how effective these encounters are in enhancing spiritual fitness, as simply compared with measuring the frequency of such encounters. Chaplains can also assess the resilience and spiritual fitness of airmen and their family members whom they counsel, but there is an element of subjectivity in these assessments as well.

Behavioral fitness interventions are typically evaluated through self-reporting, although in some cases the effectiveness of the intervention can be externally evaluated. Self-reports of sleep, wakefulness, and fatigue during the day indicate the effectiveness of interventions to improve sleep hygiene, and fitness tracking devices and sleep lab studies can provide objective data on effectiveness, although the latter is costly. Self-reporting for smoking cessation can be verified with a saliva test that detects nicotine. Self-reporting for reduced alcohol consumption or cessation of alcohol or illicit drug consumption can be verified with lab tests for presence of the drug or for markers linked to overconsumption of alcohol. For smoking, alcohol, and substance abuse, self-reporting is less reliable, while lab testing is reliable but expensive. At the community level, decreased purchasing of cigarettes and alcohol are a metric of the success of interventions, as are observations of smokers in public smoking areas, and corollaries of unhealthy alcohol consumption, such as arrests for drunkenness, underage drinking, or driving under the influence of alcohol.

Psychological fitness interventions are usually evaluated through self-assessments via survey tools or through psychological diagnostics by clinicians. As individual survey results can vary based on immediate influences and mood, they are less valuable an indicator of effectiveness than either the trend of an individual's responses over the course of treatment or the assessments of a group of people involved in an intervention, such as a unit participating in an intervention. Given the importance of external factors in psychological factors, it is also important to distinguish between the effectiveness of interventions and the beneficial or harmful effects of events in the patient's life that may not be amenable to psychological fitness interventions.

Other Factors in Intervention Effectiveness

Beyond the eight dimensions into which the Total Force Fitness classes resilience and well-being, and the interventions aimed at those eight areas, existing research indicates some factors that influence when and how interventions can achieve better results. These include tailoring

content and delivery to the audience and the context; choice of delivery channel, such as online versus in person, individual or in groups, and formal or informal; and the environment around the intervention.

An early attempt at boosting airmen resilience throughout the force used a combination of a slide presentation and a training manual, entitled *Airman Resilience Training*, briefed to all deploying airmen. While the goal was to provide as many people as possible with information to help them cope with the stresses of deployment and reintegration postdeployment, the intervention was not particularly well received, according to airmen's observation of briefings and feedback.¹⁴ Major criticisms included adding another slide presentation to a schedule already overcrowded with briefings and failing to differentiate the material from similar presentations, lack of tailoring to audiences due to the attempt to create universally relevant materials, the passive nature of a scripted presentation, and uneven and often inadequate training for the briefers. These criticisms suggest that interventions should be developed with the needs of specific audiences in mind and delivered by personnel with the necessary skills and experience.

Many interventions can be delivered through different means, as information and communication technology (ICT) facilitate everything from telemedicine to research on available social and cultural resources. ICT use can increase social support, particularly when airmen and their families are separated from loved ones by distance. However, in-person contact, when available, tends to be more effective than ICT contact, and ICT contact with people known to the airman or family member is more effective than from someone only known online. This indicates that while virtual coaching or behavioral therapy might have value, ICT is more likely to be helpful as a supplement to, not replacement for, in-person contact with support personnel. Relatedly, extroverts using ICT as a supplement to in-person social activity have greater well-being than do introverts using ICT as a replacement for in-person social activity. Airmen are more likely to use ICT to seek information on physical health than on mental health. When airmen use ICT to learn about mental health, USAF's or DoD's websites are much less commonly chosen as resources than are such sites as WebMD, search engines, government agencies outside DoD, nonprofit medical information online, or even magazines and open-source information sites.¹⁵

The environment around a base also influences stressors, stress buffers, resources, and options for interventions for airmen and their families, regardless of whether they live on base. The Air Force has rated areas around bases by the Base-Area Social and Economic Index (BASE-I),

¹⁴ Discussed in Gabriella C. Gonzalez, Reema Singh, Terry L. Schell, and Robin M. Weinick, *An Evaluation of the Implementation and Perceived Utility of the Airman Resilience Training Program*, Santa Monica, Calif.: RAND Corporation, RR-655-OSD, 2014.

¹⁵ Discussed in Laura L. Miller, Laurie T. Martin, Douglas Yeung, Matthew D. Trujillo, and Martha J. Timmer, *Information and Communication Technologies to Promote Social and Psychological Well-Being in the Air Force: A 2012 Survey of Airmen*, Santa Monica, Calif.: RAND Corporation, RR-695-AF, 2014.

with higher scores reflecting more resources for public infrastructure, stronger civil society in the form of active neighborhoods and associations, and often better economic health. Higher BASE-I scores are positively correlated with some measures of well-being, such as increased economic prospects for dependents (which may reduce financial pressure on the family), greater safety and school quality, and higher satisfaction with health care providers. These factors are associated with reduced stressors and greater well-being in a number of dimensions. However, higher BASE-I scores are also linked with less base cohesion and less use of base recreation facilities and programming. This can impair social well-being within the Air Force community. The factors reflected in the BASE-I score are almost entirely independent of the Air Force, but well-being and resilience supporting programs can take into account the influence of the surrounding area on the base community when planning programming and interventions.¹⁶

Because the environment around a base is largely outside DoD's control but very relevant to the well-being of airmen and their families, this work suggests that the four installations we study will be slightly different from each other in this regard. Tailoring content to specific groups and individuals and effective choice of delivery method (or range of delivery methods) are within the control of the Air Force. As all three of these factors influence the effectiveness of interventions designed to increase fitness, the evaluation of TFTN and recommendations for improvements should consider these factors.

Additional Factors of Interest

Reviews of suicide prevention programs in the military conclude that, while research design and variations in reporting make a rigorous meta-analysis difficult, the consistency of effects observed means that "multicomponent interventions in military personnel probably reduce the risk of suicide."¹⁷ These multicomponent interventions included populationwide education, screening, and more intensive efforts to support and provide resources for those deemed at high risk through screening, self-reporting, or observation. Another study of best practices around suicide in the military included recommendations that were largely responsive, such as clinical reviews following a suicide and more thorough data collection around suicides. More proactive and preventative measures included identifying populations at higher risk for more targeted interventions. "Populations at higher risk" consisted of three major categories: those individuals with mood or personality disorders, those facing legal or disciplinary proceedings, and those experiencing relationship crises.¹⁸ This is consistent with the multilayered initiatives in TFTN,

¹⁶ Discussed in Meadows, Miller, and Miles, 2014.

¹⁷ Steven C. Bagley, Brett Munjas, and Paul Shekelle, "A Systematic Review of Suicide Prevention Programs for Military or Veterans," *Suicide and Life-Threatening Behavior*, Vol. 40, No. 3, 2010.

¹⁸ Mark A. Zamorski, "Suicide Prevention in Military Organizations," *International Review of Psychiatry*, Vol. 23, No. 2, 2011.

that include unit- and populationwide education measures, as well as resources for individuals, families, and subgroups at higher risk.

A 2015 study of potential avenues for innovation in suicide prevention identified a number of promising interventions, some of which are consistent with the TFTN CONOPS and initiatives. Developing protective factors, which correspond with resilience broadly, and spiritual and social fitness in the eight-dimension Total Force Fitness construct is one such line of effort that corresponds with the RST and EMHT initiatives as well as the goals of increasing help-seeking behavior and decreasing stigma. Means restriction, which refers to limiting or regulating access to firearms or medications for those with suicidal ideation or who are at high risk, is another approach to suicide prevention in the early stages of intervention development and evaluation. While policies exist that temporarily or permanently restrict access to weapons and sensitive facilities for individuals with certain physical or mental health issues, they are not specifically oriented toward suicide prevention, as much as protection of national security and other personnel. Restricting access to firearms and medication for those in high-risk groups for suicide remains an effective intervention in civilian populations, although it has not been evaluated for the military.¹⁹

Preservation of the Force and Family

TFTN is modeled on the POTFF program implemented in USSOCOM in 2011. POTFF identified four primary domains of well-being: human (meaning physical), psychological, social, and spiritual. Explicitly designed to include family and other social contexts of service members, the programs and staffing of POTFF are built on an understanding of the domains of well-being as being interrelated. While challenges and stressors in one area may have implications for others, so should interventions address not only the primary problem that may be identified with only one domain but also its effects on other domains of well-being.²⁰ A recent review of POTFF practices recommends a high degree of collaboration not only between providers and practitioners in different fields related to well-being (including medical doctors, psychologists and social workers, and chaplains) but also between practitioners and researchers to ensure that current best practices and state-of-the-art knowledge inform interventions.²¹

¹⁹ Kenneth R. Conner and Kelsey Simons, “State of Innovation in Suicide Intervention Research with Military Populations,” *Suicide and Life-Threatening Behavior*, Vol. 45, No. 3, 2015.

²⁰ Ryan M. Pearce, *Applying Lessons Learned from the United States Special Operations Command’s Human Performance Program to the United States Air Force’s Comprehensive Airman Fitness*, Maxwell, Ala.: Air University, Maxwell AFB, 2016.

²¹ Colleen M. McBratney and Sarah J. de la Motte, “Collaboration Needed on Human Performance Optimization for Combat Athletes,” *Military Medicine*, Vol. 183, No. 7–8, 2018.

Summary

The TFTN interview protocols and preparation for the site visits were informed by the work described above. This work itself drew on a new approach to military readiness, well-being, and resilience stemming from the chairman of the Joint Chiefs of Staff's Total Force Fitness model, which identified eight dimensions of fitness. The TFTN evaluation also draws on literature on the broader social effects on military readiness, as well as suicide prevention. It also considers the evaluation of the POTFF program that inspired TFTN. The interview and focus group protocols from which the findings of the next six chapters are drawn reflect this existing literature.

3. The Welcome Center

The Welcome Center is the first of the TFTN initiatives this report will discuss in depth. The Welcome Center is a base-level initiative that is intended to act as a “one-stop shop” for the onboarding process for airmen and their families upon arriving at a base, a process that can typically take substantial time and effort spread out over several days or weeks. The objective of the Welcome Center is to allow all in-processing or onboarding activities to occur in one location in an expedited manner, as well as to offer the opportunity to work with staff in a one-on-one setting to ensure specific needs are met and questions answered. The previous process for onboarding involved airmen making appointments at different locations with medical, dental, finance, housing, travel, and other offices, a disaggregated process that could take weeks and that slowed airmen’s abilities to integrate rapidly into their new units. The Air Force’s long-standing sponsorship program, a program that connects airmen and their families to a sponsor on base prior to their arrival, has also been pulled into the Welcome Center initiative.

All Welcome Centers are intended to provide a single destination for airmen and their families to carry out the administrative procedures necessary to arriving at a new installation and participate in orientation activities. The former include reimbursement for travel costs, obtaining credentials and access cards to move around the base, registering for medical and dental care and transferring necessary health information, finding suitable housing on or off base, and registering children for school. The latter includes information about the challenges and benefits of living in the region, activities for individuals and families, employment opportunities for spouses, and any regulations or customs specific to the installation.

Each of the four Welcome Centers largely succeeds in this mandate. There is variation between the bases in terms of effectiveness. Whiteman has the most success at providing all services and information during the same day and is considering adding out-processing based on the same model. However, Whiteman still occasionally needs to push some appointments to a later date. Minot lacks a dedicated facility and shares space with the medical clinic, which results in a less welcoming and more institutional feel. JBER has the additional challenge of being a joint base, meaning that newcomers must attend additional joint orientations, leading to an increase in briefings. JBER also makes a particular effort to reach out to incoming airmen before their arrival, in part because travel to Alaska is more complicated than for most other installations. Finally, Beale lacks full buy-in from the various offices and agencies needed for in-processing and thus struggles to provide all services at the same time and place.

The base’s TFTN PM oversees the Welcome Center in collaboration with the existing base entities typically involved in onboarding. The staff handling the day-to-day operations of the Welcome Center varies by base.

During the RAND study team’s Phase 1 visits, only Whiteman had properly implemented the full Welcome Center concept, with JBER and Beale providing some services and Minot not yet operational (and leaders not fully aware the initiative was underway). During the Phase 2 visits, Whiteman and JBER were performing up to standard, although with some issues noted later in this chapter, while Minot and Beale were operational but with substantial room for improvement. Table 3.1 summarizes the status of the Welcome Center initiative at each of the bases across the two sets of visits. The remainder of this chapter provides further detail and specific information regarding our Welcome Center findings.

Table 3.1. Welcome Center Status Overview

	Whiteman	Minot	JBER	Beale
Phase 1	Green	Red	Yellow	Yellow
Phase 2	Green	Yellow	Green	Yellow

NOTE: Green indicates an operational initiative that received largely positive feedback from participants; yellow indicates a mostly operational initiative with the exception of some challenges that could be addressed going forward; and red indicates an initiative with a number of challenges that will take great effort to address going forward to be considered operational.

Phase 1

The Welcome Center, unlike the other TFTN initiatives, does not have licensed “providers,” but the RAND team was able to discuss the initiative with the TFTN PMs, leaders, and senior leaders and visited the Welcome Centers at Whiteman AFB and Beale AFB. The Welcome Center at each base was at a different stage of maturity, and therefore each base will be discussed separately. At all bases, some leaders and senior leaders were unaware of their base’s Welcome Center, and most did not have firsthand knowledge of the center’s effectiveness as they and most of their direct reports had arrived on base prior to the Welcome Center’s startup.

Whiteman Air Force Base

Of the four bases, the RAND team found that the Welcome Center at Whiteman was implemented closest to the original concept for the initiative and the most rapidly. Seen as fulfilling its intent as a one-stop shop for airmen new to the base, the Welcome Center was universally praised by leaders and senior leaders. During Phase 1 or at the time of the first visit, the Welcome Center was located in a small building with several offices and an open waiting area. Incoming airmen would go to each of the several offices and speak to a staff member that would guide them through a different aspect of in-processing. Airmen would be given access to helpful services and resources, such as booking medical visits or information about local schools.

In particular, stakeholders praised the Transport Management Office for reimbursing airmen for their travel upon arrival. One senior leader reported that the staff toured the Welcome Center at Hurlburt Field, which was successfully established in September 2014 for all in-processing actions, and applied best practices learned from that base. Discussions with Welcome Center staff indicated that they were planning to expand into out-processing as well.

Minot Air Force Base

Minot's Welcome Center was not operational at the time of our first visit, and only one leader was aware of the Welcome Center as a TFTN initiative. The personnel who were tasked with developing the Welcome Center expressed confusion and frustration about the perceived lack of direction and support from TFTN leadership. While financial resources were allocated to the Welcome Center, one focus group participant involved with the Welcome Center said that it was difficult to access the funds and that, more broadly, lack of personnel and resources were a problem. As a result, the Welcome Center had not been established, so no airmen had been served.

Joint Base Elmendorf-Richardson

Participants saw the Welcome Center at JBER as a generally positive addition to the base. The personnel at JBER's Welcome Center have a goal to have airmen mission ready within 30 days of arriving at the base. The Welcome Center also reaches out to airmen before they arrive to discuss their upcoming in-processing and give airmen a checklist of things they should prepare to make the move easier. At the time of the first RAND visit, Welcome Center staff estimated that it took airmen approximately three weeks to become mission ready; thus, the staff was meeting its goal.

However, the JBER Welcome Center had some room for improvement. Although the Welcome Centers are intended to have a dedicated space, at JBER the Welcome Center shared space with the Military and Family Readiness Center. While the center made a significant contribution to assisting the transition of airmen to the base, leaders reported that airmen were not always pleased with their Welcome Center experience. The most common complaint about JBER's Welcome Center was centered on the briefings about base resources, regulations, personnel, and issues particular to the base's region and population. These briefings are important, but participants in two of the leadership groups mentioned that airmen were inundated with briefings and that the Welcome Center's briefings could be redundant. As one leader recalled, "There is lots of negative feedback about the joint briefing being the same as the Air Force briefing, and all the people get all the information which is not very helpful, and people can glaze over." This complaint was raised in two separate discussions. Focus groups with leaders revealed that most were unaware of the Welcome Center at JBER and thus unaware of these complaints.

Beale Air Force Base

Located in one building, the Welcome Center at Beale consisted of offices and a large waiting space with games, toys, computers, and television sets. At the time of the RAND team's first visit, the Welcome Center was undergoing renovations, and staff members indicated that the space would be growing.

Most leaders had not received any feedback on how well the Welcome Center was running. However, in two discussions, leaders indicated that they were pleased with how the center staff treated the airmen. As one leader described, "Now they all get treated like commanders. Before, you were like cattle, just thrown in, but now you get one-on-one discussions with counselors and you can feel like an individual. It's a big bonus. . . . Like the [EMHT and RST] providers, the Welcome Center gets them to open up about being new." Unit leaders also praised the Welcome Center for streamlining the process along with reaching out to the airmen to tailor in-processing. One leader described the center thus:

The person who runs the Welcome Center . . . will email out and reach all the incoming airmen. . . . [He or she] basically can see are they married, can streamline the welcome package so they don't get welcome packets with info they don't need. [He or she will] tailor it to their situation, education or relocation if it might be helpful, and offer a Key Spouse, so not only can the airman have a sponsor but the spouse and even the kid can have a sponsor, so we've seen a lot of feedback there. It's a good piece.

Phase 2

As in the Phase 1 visits, the readiness and functions of each Welcome Center varied by installation. The administrative control and staffing remained inconsistent between the four Welcome Centers. At all the bases, a large proportion of airmen and leaders had not used the Welcome Center, having arrived prior to its launch. The major difference between Phase 1 and 2 is that during the latter visits, all four Welcome Centers were operational, and all physical infrastructures were either complete or functional despite ongoing improvements.

Whiteman Air Force Base

Leaders at Whiteman AFB were the most positive about the Welcome Center, reporting uniformly excellent feedback from airmen who had arrived since the center's opening and been in-processed there. Focus group participants who had arrived at Whiteman after the Welcome Center started operations also spoke highly about their personal experiences. For example, one squadron commander reported, "I appreciated it and I used it. Everything was done in one day and it was great." While leaders reported that new airmen appreciated the convenience of the Welcome Center, they did not fully grasp how big an improvement it was over previous in-processing, whereas those who had been in the Air Force longer and who had PCS'd beforehand reported that it is "a big deal."

While Whiteman is in many ways the most accomplished base in terms of this initiative, with strong statistics on rapid in-processing that is used as a model by other bases within and outside TFTN, it takes a different approach from its counterparts. Rather than providing a large amount of information in a short time, it aims to facilitate service delivery, prioritizing appointments over briefings. Stakeholders perceive this approach as so efficient and successful that they are now developing a parallel out-processing procedure at the Welcome Center. However, trimming down the information and contacts that are part of the single-day in-processing can also have disadvantages. Where appointments with providers did not occur on the first day, as when program representatives were not on-site, the Welcome Center scheduled subsequent appointments, in essence no longer carrying out all in-processing in one day. Further, some supervisors reported a lapse in communicating this information when extra appointments were required, resulting in phone calls asking why airmen had missed appointments, when neither the airmen nor the supervisors knew about it, and the airmen had already begun work duties.

Minot Air Force Base

During Phase 2 visits, the Welcome Center was in operation, and the research team visited the site for the first time. The Minot Welcome Center is located on the third floor of the Medical Group (MDG) building and includes a computer station where airmen can complete forms with supervision from Welcome Center staff, a number of private rooms and offices for one-on-one meetings with representatives from different base entities, and rooms for spouse and family member resources. Minot AFB leaders generally expressed appreciation at the convenience of having many services and in-processing points of contact in one place, although one commented that, while this was useful for airmen, it was more appropriate for these representatives to come directly to senior leaders for in-processing instead of expecting senior leaders to go to the Welcome Center.

Minot's Welcome Center is still maturing as of the writing of this report. One leader described it as "another example of a manpower requirement that takes away my men . . . but didn't account for anything else," reflecting a sense that the Welcome Center was not yet good value for the money and time it required, because its benefits were not clear. Many leaders were not aware that the Welcome Center was actively in-processing airmen. At the same time, Minot leadership has ambitions for the Welcome Center to expand to a "Welcome Campus" that will conduct both in-processing and out-processing and be colocated with the thrift shop, Airman's Attic, Cinderella's Closet, and temporary billeting facilities. This expansion would create a central physical location with a variety of base resources that might be valuable to airmen new to the base.

Joint Base Elmendorf-Richardson

The RAND team visited the JBER Welcome Center during Phase 2. The center has space in the "log cabin," a distinctive and centrally located building on the Air Force side of the base.

There are screens for slides during briefings, computer stations, seating areas, and a small work area for the dedicated Welcome Center staffer. A range of literature on local programs, resources, recreation, and the Anchorage area is also available in the Welcome Center.

A senior leader at JBER reported understanding the Welcome Center helps significantly with in-processing new airmen. The staff member there reaches out to inbound airmen before their arrival, both to connect ahead of time and to learn what information might be of most use to airmen based on their lifestyles, family structure, or particular needs of their households. Additionally, JBER has travel considerations not applicable to continental U.S. installations, and the Welcome Center provides this information proactively to reduce obstacles during the move.

JBER's Welcome Center offers abundant resources and is in the process of upgrading its dedicated facility with useful tool, such as a machine to create Common Access Cards on-site. One challenge facing JBER, however, is that all airmen arriving to the joint base are required to attend joint orientation, with components relevant to the Army's Fort Richardson side of base as well, increasing the time burden on airmen since they have joint and Air Force in-processing. Additionally, although it is valuable to have all major people-centered services on the base address incoming airmen and their families, it can also lead to a very long day as well as information overload when airmen and their families are expected to take in several presentations on top of taking care of paperwork requirements.

Beale Air Force Base

Leaders at Beale AFB considered the Welcome Center to be useful to airmen based on reports they had heard, and they also considered it useful for themselves and their families when they had in-processed through the Welcome Center. Airmen who had used the Beale Welcome Center for in-processing spoke positively of it, although one mentioned that waiting a week for in-processing was still less than ideal, and the orientation should take place as soon as possible after arriving at a new installation.

The Welcome Center at Beale was generally well received by airmen and leaders, but it was in the midst of administrative turmoil. A lack of cooperation and organization among the offices that supply representatives for in-processing at the Welcome Center made it difficult for the TFTN PM to create the expectation that the Welcome Center would have representatives available consistently. An employee from the Airmen and Family Readiness Center who worked at the Welcome Center gradually became the de facto director and, with the support of one of the senior leaders, took a more active role in administering the Welcome Center, informally removing it from under the TFTN umbrella.

Conclusion

All four Welcome Centers progressed toward the goals of the initiative between Phase 1 and Phase 2 visits. The Welcome Centers are intended to provide an efficient, timely, and

comprehensive orientation for new airmen and their families, helping them to integrate into their new communities and jobs and making them aware of resources that can help with this adjustment. Whiteman remained a high performer and was preparing to implement out-briefs as well. Minot made perhaps the biggest strides forward, as it went from virtually nonexistent to largely functional. JBER's Welcome Center became more established and is running smoothly. At Beale, the Welcome Center has hit some administrative snags, with a lack of clarity about lines of authority and what other groups on base are required to provide for the Welcome Center.

Overall, Welcome Centers are well received by users and leaders, and support for the concept is high. Additionally, Welcome Centers provide benefits and are available to all new service members arriving, not only those whose units are receiving TFTN services. The challenges and best practices observed in these four centers, such as streamlining appointments and minimizing passive briefing time, provide useful lessons both for refining the existing Welcome Centers and for expanding the program to new installations.

4. NORTH STAR

The NORTH STAR initiative consisted of multiple efforts to help prevent or respond to secretive problems, or problems that tend to be unknown to leaders, such as substance misuse, suicidality, or domestic violence. The principal activities of NORTH STAR were a survey of airmen conducted at six-month intervals and an intervention consisting of the dissemination of resources to airmen. The NORTH STAR initiative was terminated after three iterations because of poor survey response rates, perceptions of invasiveness of survey questions, and perceptions of ineffectiveness of the preventive and remedial resources.

The NORTH STAR survey was developed by a team of mental health researchers within the Family Translational Research Group at New York University's (NYU) College of Dentistry. The survey consisted of questions addressing alcohol misuse, suicidality, relationship satisfaction, partner emotional abuse, financial stress, resiliency, PTSD, parenting satisfaction, anger, coping, insomnia, depression, and spirituality to attempt to understand their prevalence among airmen. The results were aggregated to the squadron or group level and shared with the commander. The commander would then work with the NYU team to choose small-scale, evidence-based interventions, such as mobile phone applications, websites, or other literature, that airmen could use anonymously as a means of addressing their concerns. One example of such an intervention is a mobile phone-based budgeting application that helps users address their financial well-being concerns. The NORTH STAR survey was repeated every six months to track changes in the type and prevalence of secretive problems and determine airmen needs.

The RAND team did not conduct an independent evaluation of the survey or the sampling and analysis methods employed by the NYU team, and the findings shared throughout this chapter are based on the perceptions of interview and focus group participants.

The NORTH STAR survey was unpopular with nearly all interviewees and focus group participants in Phase 1, although a small number of leaders saw value and the potential for value more generally in a survey designed to provide quantitative feedback on problematic behaviors. Among the concerns associated with NORTH STAR was that it was time consuming, added to survey fatigue, alienated airmen, was perceived to be so detailed as to compromise confidentiality, and did not provide useful feedback to leaders on the base. Furthermore, leaders were told both that the survey was voluntary and that they should achieve an 80 percent completion rate, which they perceived as incompatible directives. Additionally, leaders involved with survey administration reported that the negative feelings associated with NORTH STAR were at risk of extending to TFTN more broadly.

Between the two phases, NORTH STAR was canceled, and therefore only Phase 1 findings are discussed. The cancellation was responded to with near-universal appreciation during Phase 2 visits. Table 4.1 provides an overview of NORTH STAR's status in Phase 1, illustrating the broad discontent with the initiative.

Table 4.1. NORTH STAR Status Overview

	Whiteman	Minot	JBER	Beale
Phase 1				
Phase 2	Not applicable			

NOTE: Red indicates an initiative with a number of challenges that will take great effort to address going forward to be considered operational.

Phase 1

When asked which of the initiatives they found least valuable, the vast majority of senior leaders in interviews and leaders in focus groups identified NORTH STAR. According to participants at two different installations, the resistance to the NORTH STAR survey led to spillover resistance to the broader set of TFTN initiatives as there was confusion among leaders and airmen regarding the differences between TFTN and NORTH STAR. One squadron commander reported, “If squadron commanders begin to believe that the NORTH STAR survey is inseparable from the True North program, they will begin to doubt or cast off highly useful components of True North.”

Successes

Positive feedback about NORTH STAR, when it was put forward, was most frequently expressed by senior leaders. Of 27 senior leader interviewees, 3 individuals observed benefits from NORTH STAR and the reports they received about survey data. One of these senior leaders noted that the results enabled them to initiate conversations with squadron commanders about specific areas of concern, and 2 more expressed a general appreciation for the data that they received about their airmen and units. Another senior leader also said, “The NORTH STAR survey helped illuminate parenting issues that otherwise would not have been discovered.”

Among the participants in leader focus groups, three said NORTH STAR gave them additional insight into secretive behaviors, and one said the survey results made it possible to better tailor programming for their airmen. Even when the information was anonymized, one squadron commander saw value in the feedback, saying, “It just keeps me up at night seeing I’ve got eight people say they’ve got suicidal ideation.” These four positive observations were drawn from 20 focus groups, each including between three and eight leaders; positive responses to NORTH STAR were from a small minority of participants. An additional leader said that there was useful information about airmen in the NORTH STAR results, but there were more effective

ways of obtaining that information, such as interaction with airmen and frequent meetings with senior NCOs and junior officers who interact more closely with junior airmen.

Challenges

NORTH STAR Burden on Airmen and Leaders

The team found a number of obstacles to airmen's participation in the NORTH STAR survey relating to the timing of the survey, the length of time required to complete the survey, and the need for computer access. Other concerns were related to perceptions around the survey or lack of understanding of its purpose. Senior leaders and focus group participants identified NORTH STAR as just one of a number of surveys administered once a year or more, resulting in a general sense of survey fatigue. NORTH STAR's administration often coincided with that of other surveys, increasing this effect.

The survey was computer administered. For units that do not spend much time in an office setting or do not have ready access to computers, such as maintenance or security forces, this created an additional obstacle to completing the survey. One leader said, "A huge percentage of my population doesn't work with computers, so it's not realistic for them to take the time to take it." Enabling airmen to use a mobile phone application to take the survey was one possibility raised in a leader focus group to relieve this pressure. The survey was also time consuming and, according to some participants, repetitive. "My [participation] numbers plummeted because it's too long, and I took it and I actually got angry," one leader said, "and I've had some airmen think they're trying to trick them because they ask the same question in different ways." While repetitive questions are common in survey design, in a survey with other flaws, conducted in an atmosphere of mistrust, they exacerbated the problem.

Focus group respondents also reported airmen concerns about confidentiality. To enable better tracking of change over time, NORTH STAR began with questions to link surveys from the same airmen across various iterations, such as the first three letters of the city or town in which they were born. This was not done to link surveys with specific airmen, only to evaluate how anonymous individual airmen changed in their responses over time. However, these questions created a perception that the survey was not anonymous and led to a reluctance to disclose sensitive information or tendency to enter false information about one's identity. There were additional concerns that airmen simply "clicked through" the identifying questions, selecting the first option, irrespective of its content and whether it is applicable to the individual. According to a squadron commander, as a result of deliberately inaccurate or random inputs, "We had more African American female E-4s take the survey than exist in my unit." Compounding airmen's fears that their responses might not be kept confidential was their perception that the survey's results were disregarded, since they received no feedback or reports of findings after completing the survey. One senior leader who took the survey also noted that unless the purpose of the survey was explained to participants, they would not see the value of spending their time completing it.

Participation Pressures

Leaders described feeling pressured to ensure high participation rates on a voluntary survey and reported using a range of approaches in attempts to increase participation rates, which themselves could have influenced the accuracy of responses. Some leaders passed along repeated requests and encouragement to complete the survey; others used incentives to increase participation. Pressure for high response rates, which was perceived to come from very senior levels of the Air Force, contributes to the hostility felt toward the survey by leaders. One senior leader identified two problems with NORTH STAR: pressure to participate inducing resistance and the intensely personal nature of the questions such that “nobody answers honestly.”

While the NORTH STAR survey was officially voluntary, leaders and providers mentioned instances of pressure to ensure high participation rates. Different respondents reported being told the goal was 80-percent to 85-percent participation, which they considered unrealistically high even for compulsory surveys. The Defense Organizational Climate Survey, the administration of which is mandatory while participation is voluntary, was described as compulsory by several focus group participants. In instances when the Defense Organizational Climate Survey had a response rate between 20 percent and 25 percent, they reported, it was considered to have high participation. The survey designers for NORTH STAR set an unrealistically high goal for participation. According to one participant, “Our wing commander applied an unreasonable amount of pressure on us to get high response rates. The data should not be trusted one iota because of the amount of force applied to get those surveys filled out.”

The pressure to ensure high response rates was also incompatible with a survey that was voluntary, a tension noted by many leaders and senior leaders. Some squadron commanders reported frequent emails from superiors urging them to increase their unit’s participation, which they relayed to their airmen. Other squadron commanders used positive incentives, such as pizza or time off for high or perfect completion rates, while recognizing the distorting effect this might have. As a senior leader put it,

I have the power to make them do [the survey], but they [unidentified superiors] do not want me to make them. They want 85 percent participation in the survey, but they don’t want it to be mandatory. If you want me to hit a number, I can hit the number, but if it’s voluntary, then you need to accept that people have a choice and might not do it.

NORTH STAR Survey Design, Implementation, and Analysis

Another factor contributing to leader disapproval of NORTH STAR was widespread concern about the design and structure of the survey. In addition, the purpose of the survey was not properly communicated to leaders, with many misunderstanding the role of NORTH STAR within the broader TFTN initiatives. Many leaders reported receiving no feedback after the surveys, which added to the perception that it was not a useful tool. In some cases, this was due to TFTN decisions about how to distribute results of the survey (i.e., to some bases and not to others).

When unit leaders did receive feedback from NORTH STAR, they questioned its relevance given the design of the survey and analysis. Many NCOs and squadron leaders who had taken the survey themselves found it to be poorly written, repetitive, and confusing, and they described it as seeming out of touch with Air Force life and culture. Additionally, it was structured in such a manner that respondents had to answer questions that were not relevant to their situations. For example, respondents who reported not consuming alcohol still had to answer a number of questions related to drinking behaviors to proceed through the survey, and respondents who were not in a relationship similarly had to answer questions about their satisfaction with their relationship. Ultimately, frustration with the survey combined with overall survey fatigue led many respondents to simply click on the first option for a question to complete the survey as rapidly as possible, according to focus group participants who either filled out the survey themselves or overheard airmen discussing the survey.

One squadron commander commented, “Air Force averages we are being compared to are old (2007) and this makes the entire inference they attempt to make unreliable,” referring to statistics on secretive behaviors for their units compared with existing data sets. Another leader said that it was not clear if the average benchmark against which units were evaluated was derived from USAF at large or from the USSOCOM units that had participated in programs similar to TFTN. Without this information, the comparison was hard to understand and had little value for leaders. More broadly, given the different demands on different types of units, participants expressed doubt that comparing their unit to one with a different role or an Air Force average would yield useful results or insights.

Some groups reported inconsistent variation of the survey, such as the inclusion of different groups of respondents between iterations. It was also unclear to interviewees, focus group members, and the RAND team whether factors specific to installations, such as seasonal affective disorder in bases in the north or those that suffered the impact of a natural disaster, were incorporated into the survey analysis. These perceived problems with methodology may have harmed the integrity of the data and subsequent analysis, according to many respondents. Certainly, NORTH STAR was perceived as less credible because of such factors.

Focus group participants also expressed reservations and misunderstandings about the purpose of NORTH STAR. One leader believed that the results of the survey would influence the level of resources devoted to TFTN initiatives at the unit level but was unsure if more problems would lead to increased resources or would be seen as a sign of the initiatives’ failure and lead to fewer resources. Others understood the survey instrument to be a tool only for evaluating the effectiveness of TFTN initiatives rather than a measure of unit well-being, and they expressed skepticism that the survey would be useful in that capacity.

Evidence-Based Interventions

The results of NORTH STAR communicated to units included the anonymized results of the survey and served as the basis for a discussion with NYU researchers about evidence-based

“light touch” interventions. The recommendations emerging from this process that were mentioned most often by respondents were the web or phone applications, for which the RAND team found little support from leadership during our interviews and focus groups. Leaders who tried to use the applications themselves reported dissatisfaction with both the concept of recommending an application to address a social or personal problem and often with the applications themselves. These applications were widely seen as unhelpful and unlikely to be used by airmen, according to leaders.

While some applications were seen as potentially valuable by leaders, leaders believed they were insufficient without other support. For example, one leader who reported that mindfulness and meditation as personally helpful believed that a mindfulness application would not be useful to airmen unfamiliar with the concept. Another leader believed that an application that helps users track spending would only be useful for someone with a budget, which is not provided along with the application.

More broadly, a number of participants mentioned that recommending applications as solutions to secretive behaviors, such as substance abuse, self-harm, or domestic violence, seemed inconsistent with the emphasis in TFTN more broadly on help-seeking behaviors and face-to-face connections with providers. “Just overhearing and observing airmen’s communications, it’s clear, [the apps are] not good and not liked. It’s the tangible hands-on, face-to-face communication that helps. People don’t want that on their phone,” one leader said about responses to NORTH STAR application recommendations. Several participants thought the applications were out of touch, possibly due to the perception of NORTH STAR researchers that younger airmen would prefer a technology-based solution. Respondents believed that the applications did not appeal to the younger cohort who make up the largest segment of the population participating in the initiatives. One squadron commander described the applications as “a Generation X solution to a Millennial problem.”

Conclusion

Negative feedback on the NORTH STAR intervention far outweighed any positive feedback, supporting the cancelation after Phase 1 of our data collection. Although the execution was unsuccessful, some participants still saw the benefit of collecting this information to provide quantitative data on secretive problems both to inform leadership of issues within their units and to evaluate the outcomes of the TFTN initiatives. The value of such data is further discussed in Chapter 9 of this report.

5. Religious Support Teams

RSTs act as a group-level resource to provide a variety of religious, spiritual, and personal support to airmen and their families and to group leadership. The RST is comprised of two uniformed Chaplain Corps members: an Air Force chaplain and a religious affairs airman (sometimes called the chaplain's assistant or superintendent of religious affairs), and the RST is embedded in the group to provide unit ministry (including both spiritual and religious support) and religious programs with the goal of improving airmen resiliency. RST services are 100-percent privileged, and the scope of RST services is broad but includes the following:

- unit engagement to establish relationships with airmen
- pastoral care, including informal emotional and spiritual or faith-based support
- pastoral and spiritual counseling, including formal one-on-one counseling
- crisis intervention counseling
- informed referrals to other care options
- religious support, including rites, rituals, worship services, and scripture studies
- classes, seminars, workshops, events, and retreats focused on airmen resilience, strong marriages, and healthy family relationships
- advice and assistance to leadership.

While the RST is a group asset and reports to the group commander, the team is still expected to maintain a working relationship with the wing chaplain and can coordinate with other Chaplain Corps personnel on some wing functions, although they cannot be tasked by wing or base chapel programs. To fulfill their roles as embedded group assets, RSTs receive a budget that they can use for airmen and family events, programs, or services. Although they follow the command structure of the group in which they are embedded, they must follow spending policy for wing and base chapel funds in Air Force Instruction (AFI) 52-105.

RSTs are among the most highly valued assets of TFTN according to perspectives gathered during site visits, and RST members are considered by key stakeholders to be reliable, trustworthy, and highly committed to airmen well-being. According to respondents, their status as uniformed personnel contributes to the airmen's positive attitude toward RSTs and the more generally favorable reception they receive.

The RST initiative remained fairly stable across both phases of our study, as illustrated in Table 5.1. During both visits, the RAND team found that RSTs were respected and trusted and seen as accessible by airmen and leaders. According to focus group participants, particularly useful characteristics of the RST role include the range of individuals whom the RSTs could help and when and where airmen and their families could go to get help. RSTs, it was noted, are able to help all airmen and their families, even those recipients who did not share their religious beliefs or perspectives.

In Phase 2 of our research, these perceived strengths persisted, and there had been very little turnover in RST personnel. However, these successes aside, factors beyond the control of the RSTs had a detrimental effect on RST programming and activities at Whiteman and Beale. One of these factors was staffing shortages in EMHTs (described and evaluated in the next chapter). As vacancies increased, airmen who were accustomed to having access to one-on-one counseling with an LCSW turned to the RSTs. RST personnel often found themselves stretched thin as they attempted to fill this gap. Another complication to RST service delivery noted in Phase 2 was the confusion about which AFIs apply to chaplain spending. This administrative misunderstanding prevented RSTs from delivering programming as often or in as timely a manner as they would have liked and as the CONOPS envisioned.

Table 5.1. Religious Support Team Status Overview

	Whiteman	Minot	JBER	Beale
Phase 1				
Phase 2				

NOTE: Green indicates an operational initiative that received largely positive feedback from participants; yellow indicates a mostly operational initiative with the exception of some challenges that could be addressed going forward.

Phase 1

RSTs have a number of advantages not necessarily enjoyed by other initiatives. Both chaplains and religious affairs airmen are uniformed personnel whose roles are understood independently from TFTN. In their roles as TFTN team members, RSTs build on this existing trust and familiarity through unit circulation whereby they can interact with airmen more frequently and directly than can a conventional chaplain. They also have funds to use for programs that could directly and indirectly increase resilience and create opportunities for interactions between the RSTs and airmen. As might be expected for a new role within the military, there are concerns among some chaplains about their career paths after an assignment that is not part of the traditional progression for chaplains.

Successes

Familiarity and Accessibility

According to focus group and interview data, chaplains and religious affairs airmen, as uniformed personnel, can relate to the challenges of Air Force life faced by airmen in a way that civilian counselors sometimes cannot. Airmen are also already familiar with the concept of

chaplains and the role they play in the military. At all four installations, the RAND team heard in focus groups that RSTs are generally trusted and respected and seen as reliable team members who are deeply committed to the airmen. Their status as active-duty personnel with security clearances also enables them to be present in all areas where airmen work, including those inaccessible to civilian contractors or for which escorts would otherwise be required. From their first day, RST members can participate in Air Force life, be present in work environments, and even in some cases learn how to work alongside the airmen in the units they support, which gives the RSTs a level of familiarity and credibility with airmen upon which they can build relationships.

One question the RAND team asked of RSTs was how often they find themselves unable to support airmen due to lack of bandwidth, and one chaplain participant simply replied, “It isn’t in me to do that.” This quote sums up much of the feedback about RSTs, who are able to meet with and counsel family members and can meet in airmen’s residences or in coffee shops, not just in offices, and at any time, not only during office hours. This flexibility and accessibility are valued not only by leaders and senior leaders but especially by the airmen, according to RST members. In a crisis, RSTs are often able to respond quickly, regardless of when or where they are needed. A senior leader described the chaplains as “the single most trusted enterprise” involved with TFTN.

The rapport the chaplains establish with the airmen helps them to provide support during stressful periods. A senior leader described incidents in which one chaplain accompanied an airman to the Sexual Assault Prevention and Response Office to go through the reporting process after an assault, and another traveled with an airman to a hospital off base during a medical procedure; the leader concluded that “they’re making a huge difference by being there and being willing to listen.” RSTs who track the number of contacts they make have data to support this perspective, with one unit having 2 visits to a chaplain per month prior to the RST’s integration and between 25 and 40 per month after the RST’s integration. A senior leader at a different base did not share specific numbers but described visits to chaplains as having “dramatically increased” since the implementation of TFTN.

Chaplains also provide services that may improve outcomes in less urgent situations than those requiring direct intervention. One chaplain spoke of meeting with an airman repeatedly over months, helping to develop coping mechanisms for dealing with stress that eventually reduced the airman’s use of alcohol. The support RSTs provide for marriages was also praised by many leaders, who referred to marriage retreats and classes, as well as couples’ counseling, as helpful services. Chaplains themselves expressed that even when a marriage cannot be repaired, counseling and communication skills can lead to a lower-conflict separation.

RSTs provide absolute confidentiality, a feature that is highly prized by airmen. Many leaders cited the confidentiality of chaplains as a reason why airmen seek them out. Beyond the assurance of privacy, the difference in approach of chaplains was also described as attractive to some airmen. “Some folks go to mental health or a social worker, and they have to document it. With the chaplain, it’s just between me and the chaplain. If you’re having a bad day, you may be

misconstrued or misdiagnosed. . . . I feel more comfortable with the chaplain than with mental health,” one leader said during a focus group.

One LCSW endorsed this advantage of RSTs: “I have confidentiality in mental health, but there are times . . . when I tell the airman, ‘Maybe you should go and talk to the chaplain,’” acknowledging the limits of LCSWs as compared with chaplains. As another participant put it, “You can tell [the chaplains] where the bodies are buried.”

A Resource for Leaders

Chaplains are available to all, but some make a point of being available to leaders for more than consultation on unit morale and climate, even seeking leaders out proactively. “I talk to my chaplain every week,” said one colonel about this outreach to leadership, after noting the relatively low number of peers at the installation. “It has nothing to do with religion, but I know he will listen. It’s hard for me to talk to anyone else about my doubts, my concerns.” A squadron commander expressed appreciation for the chaplain’s periodic office visits, when the chaplain asks, “How are you doing?” and “I don’t want to hear an automatic ‘I’m OK.’”

More broadly, RSTs are a resource for leaders on unit morale and can report on the effect of changes in policy or circumstance on morale. While individual cases are kept confidential, they can advise commanders in general terms if they are seeing increases in particular problems and how improvements might be made.

At one installation right before the holidays, the RSTs determined that one-fifth of airmen (according to the leader discussing the RST initiative) had no plans to travel to friends or family and had no one in the area. The RST staff arranged for supervisors to host dinner for all interested airmen without holiday plans and funded gift bags for them. This was presented as an example of how chaplains can identify needs that might not be obvious to leaders and help to ensure that the needs of airmen, families, and the unit are met while building a sense of community in the process. “It’s good for morale, and that’s a hard time of year for most people. Things like that take time, and most of us don’t have the money or the effort to do as well as chaplains do. They catch things like making sure everyone has someone around,” a focus group participant said.

Resources Available

RSTs have significant resources, particularly funding, for TFTN programming, which enables them to provide services that attract participation. Examples of workshops or classes sponsored by chaplains that would carry a cost for participants in civilian life include financial awareness and planning seminars and “love languages” education around communication styles. One senior leader said that classes focused on specific skills, such as parenting or budgeting, had lower participation levels than social events, but the intent was that “the right people go, so the ones who are going are the ones who need it.” Three of the four installations also reported RSTs providing overnight marriage retreats at local resorts.

These resources also provide RSTs with points of entry into airmen's lives and the chance to engage with them in primarily recreational settings to establish and build relationships. RSTs at one installation drove several hours to pick up locally unavailable fast food, which they distributed to airmen before a major exercise, an activity that drew high praise in focus groups almost a year after the fact. Ski trips and other excursions, sometimes aimed at specific groups such as single airmen or families, are another way in which RST resources provide opportunities to make connections among chaplains and unit personnel and families. RSTs are also able to tailor their use of resources to the needs of their unit, with activities ranging from lunches or dinners that create social connections to training in small group leadership.

Working Across Denominational Boundaries

Chaplains have clerical credentials from the governing bodies of their respective denominations but have a mandate to attend to the spiritual needs of all airmen and their families, including those of a different denomination or faith or those without a religious preference. "We describe it as 'chaplain to some, pastor to all,'" according to a chaplain in one focus group. In focus groups with leaders and interviews with senior leaders, the role of chaplains in identifying the needs of airmen and working either to meet those needs or to connect airmen with other resources was often cited as a major strength of the RST program.

Many chaplains make explicit efforts to meet the needs of airmen who are not of the same faith or denomination. One provider mentioned facilitating connections between airmen and churches in the nearby city, in cases where airmen sought a faith community that was distinct from their work community or not represented in the base population. Another senior leader illustrated this with an example of a chaplain who was asked a question by an airman from a different faith tradition; the chaplain researched appropriate ways to help the airman. Chaplains also work to convey the message that their services are not limited to any faith or even to faith in general. After offering a financial planning course based in Christian teaching, one chaplain made a point of offering a second session with less emphasis on faith. "Our chaplain bills it as something that fits with his faith, but not 'God told me to budget,'" recounted a squadron commander at that base.

More broadly, most programming carried out by the RSTs and their response and support during times of crisis transcends religious or denominational boundaries. "More times than I can count," one leader said in a focus group, "we've had someone in a dire situation, thinking of suicide or with a death in the family, and the first place we walk them down to is the RST. They're naturally the leaders in those crises." Members of units in which an airman had died by suicide, in two different installations, spoke of the way chaplains had supported the whole unit, making themselves available around the clock, as well as overseeing funeral arrangements. Their effectiveness in a crisis in part results from their integration into the units during less difficult times. "You see [our chaplain] out there at the gate at night checking IDs, out with the forces where they go, and very involved," according to a participant in a leader focus group.

Challenges

Career Paths and Evaluations

During the first set of base visits, the RAND team found that the unique role of chaplains within the military and within TFTN presented some administrative challenges, which were reflected in the experiences of RST members. Since their role as part of embedded teams is new, they face circumstances not shared by other chaplains not in embedded teams.

The duties of RST chaplains differ somewhat from those of traditional chaplain roles, which can present potential professional difficulties for some chaplains. Since 100 percent of their time is devoted to supporting the unit in which they are embedded, RST chaplains have no allotted time that is officially designated for more traditional ecclesiastical duties, such as preaching on Sundays or holding regular services. The prospect of skill degradation has implications for assignments after a chaplain's assignment to a TFTN RST comes to an end and they are assigned to a more traditional role. This prospect presents a personal and professional development challenge, but for some denominations, it could be a more formal obstacle. Some chaplains are required by their accrediting denominational body to log a certain number of hours of ecclesiastical work to maintain their credentials. "Because we're endorsed by a body, if we're not doing those things, it could become an issue," stated one RST member.

A related issue is the question of evaluation. In traditional assignments, performance evaluations are written by senior chaplains. In TFTN assignments, by contrast, chaplains were evaluated by the commanders of the groups in which they were embedded, and commanders may not be as equipped to assess the strengths and weaknesses of chaplains.

The nature of the RST chaplain position also requires experienced clergy, according to another chaplain in a provider focus group. "It's not a place for learning on the job; pastoral formation must take place before they get on the job. TFTN entails an industrial ministry role, ministering directly to airmen away from a chapel setting." Matching chaplains with RST billets should therefore take a number of factors into account, including previous experience and ability to manage this unconventional role.

Another administrative challenge is the structure under which RSTs operate. "Lines of communication have been a challenge," according to one chaplain, who said it was unclear whom to call for challenges related to funds, the CONOPS guiding the program, or management issues. Currently the chain of command is directly through the commanding officer of the unit to which the RST is attached, but this chaplain suggested a chain of command involving a senior chaplain at each of the four TFTN bases through whom other chaplains could address problems or obtain information or resources. A base chaplain not involved with TFTN was serving that function informally, the TFTN chaplain said. "I shouldn't be calling the Pentagon for answers," another RST chaplain said in that focus group about the need for a central point of contact with the chain of command, "but I have no one here to ask."

Personal Fit

In instances in which leaders describe chaplains as not meeting their unit's needs effectively, the leaders often characterized the issue as a matter of personal fit with the unit or the mission. One senior leader described a chaplain whose approach to engagement was to offer office appointments for which airmen could sign up. "I don't have airmen who sit at a desk all day—they're out at the gate, they're manning security, they're delivering fuel," the senior leader said. "The intent of TFTN is to have ready access. I've encouraged the chaplain to actually engage at the point of attack. If it is a deeper issue that you need a closed-door meeting, then by all means let's schedule a counseling session."

Where chaplains are unavailable to meet demand for counseling in a timely manner, leaders often attributed this to personal style rather than to the broader mission of the RSTs or the chaplaincy. "His communication is poor," said a focus group participant, who reported little contact with the embedded RST. Another leader expressed frustration that the unit's RST took a passive approach rather than proactively seeking out opportunities to connect with airmen but noted that colleagues' units had better experiences.

Religious Association as a Disadvantage

Some focus group participants reported hearing that airmen were reluctant to seek help from a chaplain due to the chaplain's association with religion or even that they felt this reluctance themselves. "In our society, people will gravitate to a [LCSW] more than a chaplain," a senior leader said in an interview. Another leader in a focus group suggested that even those open to a religious counselor might have been less open to one of another faith or tradition: "If I'm an atheist, do I want to see a chaplain? But let's say if I'm a Christian, is this guy the same denomination as me?" Even in the context of events run by chaplains with no religious function, such as dinners, some leaders said that it was hard to persuade airmen of a different denomination than the chaplain or with no religious affiliation to participate. "Our society is less religious, and no matter how you slice it, a chaplain has religious connotations, especially among Millennials," one leader said, discussing junior airmen and the RSTs. This leader's approach was to deemphasize the religious aspect of the chaplaincy: "I say, he's a trained counselor first; there could be a religious side, but the main reason is he's a trained counselor with 100 percent confidentiality."

Given that religious identification can dissuade some airmen from seeking help, one chaplain pointed out the need "to choose faith groups that can support the entire population." Another chaplain observed that some of the denominations from which chaplains were most readily available were those "who are not prepared to embed or minister to the entire population." While many focus group participants mentioned the universal nature of chaplains' work, in some cases, either the perception or the reality of an inability to connect with a chaplain across denominational or religious lines may hamper access.

Phase 2

In the second set of site visits, RSTs were described by leaders as valuable parts of their team, who gave them insight into morale, well-being, and other trends within their units. Leaders appreciated the role played by RSTs as providers who thoroughly understood Air Force culture and could “lean forward and put themselves in a unit.” In some cases, they also mentioned how valuable it was for chaplains to make themselves available as resources for leaders as well as the airmen they led. “From a readiness perspective, they make us more effective,” according to a unit leader. At the same time, RSTs at Whiteman and Beale in particular were more heavily burdened by the demands of individual counseling in Phase 2 interviews, as EMHT staffing levels had fallen. Additionally, lack of clarity about spending guidelines hampered the ability of some RSTs to provide programming.

Successes

Phase 2 visits resulted in a deeper understanding of the successes encountered in Phase 1, as the strengths described by leaders were echoed in the airmen focus groups.

Reliability

Chaplains are known quantities within the Air Force, so they are accessible to airmen through familiarity and also through their reliability. RSTs were described as having an “open door policy” and being available whenever they were needed. In those cases in which leaders reported difficulties of airmen setting up a consistent schedule with EMHTs or with the MHC, RSTs were able to provide consistency as well as access outside of regular office hours. Notably, RSTs also have significantly less turnover than EMHTs. While RST chaplains and religious affairs airmen are likely to be reassigned after three or four years, this time frame represents a longer tenure than is currently typical for EMHTs. Additionally, there is an institutional continuity with chaplains due to their well-established presence and role in the Air Force and the military.

Confidentiality

The complete confidentiality granted to chaplains and therefore to RSTs also enables them to support commanders without eroding the trust of airmen. “When airmen see the social workers meeting with commanders . . . that is terrifying. They think something sneaky is happening,” according to a supervisor, who pointed out that the same effect does not hold true with chaplains or religious affairs airmen. Confidentiality also removes one obstacle to seeking help: the fear of sensitive information being shared or causing professional or personal harm. “I’ve had people who don’t want to talk to someone [who is] writing stuff down,” according to one leader, “so they’ll go talk to the chaplain instead.” Another leader described referring airmen to RSTs almost all the time, rather than EMHTs, because of the confidentiality they provide, whereas the MHC and LCSWs “share some details with command.”

This confidentiality comes with a cost for leadership. While RSTs provide leaders with general information about problems they see frequently and they do provide support for leaders on ways to boost morale and cohesion in general, they can seldom share the sort of information that would allow leaders to take specific action to help individuals. As explained by one leader: “We know there was a significant issue they worked with an airman on, but we don’t know who or what, [and we’d like] to be able to address that as commanders to keep others from having the same problem.” If the problem were physical injuries from too much running, this senior leader said, they could act on that to reduce future injuries, but the inability to get similar information on mental or emotional health issues was frustrating, even as the leader expressed understanding of why confidentiality was essential. As an RST member pointed out, confidentiality also restricts the possibilities for chaplains to take part in collaborative care. None of the providers or leaders who mentioned this, however, saw it as a reason not to maintain confidentiality but simply as a factor to be considered.

Accessibility

RSTs have fewer constraints on their counseling than do EMHTs. Where the latter are restricted to limited scope counseling with airmen outside the clinic, RSTs can meet with family members alone or with the airman, at times and in places that are not within the scope of practice for LCSWs. This flexibility is valued by airmen and leaders of all ranks. When comparing RSTs to traditional chaplaincies, a leader said that, previously, they were used to seeing the chaplain at the chapel and occasionally visiting airmen. “This [RST] chaplain here—no kidding—he has a desk in the headquarters with our NCOs there. When our airmen are changing out, he’s there talking to them.” At several installations, leaders and airmen praised their RST for participating in unit physical training (PT). RSTs were also described as willing to go above and beyond to reach airmen who need their care. For example, one senior leader described an incident where an anonymous note about self-harm was found, and “the chaplain took a sleeping bag and slept in the unit to figure out who was in need of help.” As further discussed in the next chapter, limits on practice, access to secured areas, and unfamiliarity with Air Force culture typically prevent EMHTs from taking such measures, whereas RSTs can help and reach out more proactively.

Although chaplains are religious and affiliated with a specific religion, they are accessible to all airmen and have communicated this accessibility effectively. The interviews and focus groups in Phase 2 confirmed this assessment. “I don’t follow an established religion, and they know it, and they’ve never given me grief for it; they’re always supportive when I need to talk to them,” said a leader who also recommended RSTs to airmen. One chaplain described their mission as providing “religiously neutral, spiritual support.” Another chaplain said they sometimes saw apprehension as “a result of misinformation: they think we will be judgmental or preachy.” At that same installation, one leader said that the chaplains often reinforced the fact that they were there to support all airmen and their families. An airman in a focus group said that “our chaplain is open about his religion, but he’s open to all religions. He’s also there for mental health purposes and highlighted his 100 percent confidentiality.”

Resources and Trips

Airmen at all four installations spoke highly of off-site day trips and retreats coordinated by the RSTs. While the value of a break from the base and regular worksite was significant to them, so was the opportunity to explore the local area or to try out a new outdoor activity. Airmen, supervisors, and leaders again mentioned marriage retreats as being valued and in high demand, during Phase 2 focus groups. Beyond the recreational aspects of the day trips, leaders spoke of their effectiveness at increasing resiliency in teams and for individuals. “It’s more effective when you couch the resiliency initiatives in a fun environment,” according to one squadron commander. These events also help to create social interactions outside the workplace. “People normally want to stay home and play video games, so [a trip] forces relationships. It just happens, it creates community within the unit,” said another squadron commander. The trips also serve as a point of contact with the RSTs in a casual setting, subsequently reducing barriers to reaching out for help.

The financial resources available to RSTs are seen as an asset, particularly in this regard. Retreats targeting single airmen, married couples, and families help develop coping skills for participants and provide an opportunity to decompress. Frequently, stakeholders indicated that participation is driven by access to food or activities. “They have figured out how to provide a small incentive to encourage participation,” according to a senior leader. When RSTs brought meals to the flight line at lunch, it had two benefits, one airman said: “The flight line doesn’t have time to get food from outside . . . [and] the opportunities to interact with other people; it’s like little pockets of happiness.” While chaplains emphasized that they could connect with airmen even without money, particularly through unit circulation and maintaining a presence, and that connection was the most important element, they believed that their ability to provide free food or retreats away from work attract even more airmen to the RSTs.

Challenges

Lack of Clarity on Religious Support Team Spending

At Whiteman, after an episode in which RSTs used funds for programming judged inconsistent with AFIs, all spending was required to obtain Judge Advocate General approval, which created a significant administrative burden and delay. Stakeholders reported that this obstacle has had lasting implications for RST activities. “When we started doing these events, we followed the CONOPS and the Chaplain Corps AFI. We weren’t just straying off doing what we want,” said one RST member. The confusion over which set of instructions applied, as well as the need to gain approval from many different offices, “started a ripple effect. We were confused. . . . As this happened, there were less and less events. Even now, the stress of ‘Can we do it? Is it appropriate?’ is challenging.”

While Whiteman had the most acute problems, other installations had similar challenges. RSTs at JBER reported difficulties in going through their usual channels for obtaining bids, due to confusion about the applicable guidelines for chaplaincy spending versus the guidelines for general spending. This lack of clarity reduced the programs available to airmen, created

frustration and administrative load for RSTs, and led to events being advertised and then canceled.

At Beale, RSTs were reluctant to fund events related to resilience where there was spending on food and drink, due to previous difficulties in obtaining approval for similar events or having had approval withdrawn. RSTs were reluctant to fund even elements of events that did not involve alcohol and were concerned they could not justify supporting face painting and balloon animals at a family picnic designed to build resilience. Participants in interviews and focus groups reported events being canceled due to confusion about whether TFTN funds could be used for food at events with family members or civilians or with airmen only.

Excess Demand due to Embedded Mental Health Teams Short Staffing

Many RSTs and leaders raised as an issue the increased demand on chaplains for counseling. One factor in this increased demand was growing acceptance and awareness of the RSTs, and another was the belief that existing problems were being addressed, both positive indicators. A third influence, however, is the high proportion of unfilled EMHT positions, for which the RSTs consciously tried to compensate, the consequence of which is less available time for programs.

Concerns About Career Paths

Chaplains again expressed some concerns about how an assignment that was not an established part of the career field trajectory might influence their future in the Air Force. While being evaluated by an officer who was not also a chaplain was less prominent a concern during Phase 2, another issue arose: one chaplain explained how, while he or she had been nominated for awards in previous assignments when their immediate superior was a chaplain, this was not possible as a TFTN RST chaplain. The chaplain's immediate superior encouraged self-nomination, explaining that even if they were not comfortable doing so, it was important for the future of the TFTN RST program to show that it was possible to be recognized in a less traditional assignment. Religious affairs airmen typically support chaplains directly, and serving in this new RST role is an addition to the career path. To ensure that being part of an RST is seen as a desirable assignment and attracts high-performing personnel, it is essential that chaplains and religious affairs airmen who serve on RSTs are not at a disadvantage with respect to awards, promotions, or subsequent assignments.

The Nature of Religious Support Teams—Religious and Part of Task Force True North

A few leaders mentioned the possibility that the intrinsically religious nature of the chaplains might be a barrier for airmen who might be more comfortable with the LCSWs “because of the religious tie-in” with chaplains. However, all such references were expressed as hypotheticals. By contrast, at each installation, RSTs were described as explicitly open to caring for airmen of any or no religion. While leaders seemed aware of the possibility that airmen might be deterred from seeking an RST for this reason, none had examples of this actually happening—but many had examples of RSTs supporting and helping airmen of different faiths.

Another feature of RSTs at some installations is that they are not always understood, by airmen or leaders, to be part of TFTN. When discussing a morale event, one supervisor said that “people from TFTN didn’t go, only the chaplain.” Airmen also referred to events coordinated by TFTN RSTs as if they were under the aegis of the chaplaincy in general, distinct from TFTN. With respect to the ability of RSTs to provide services and reach airmen, the perceived affiliation of RSTs is unimportant. The perceived affiliation, however, could possibly be important to future evaluations of the program.

Conclusion

Many of the aspects of the RSTs that were so highly valued by participants in Phase 1 remained highly valued in Phase 2. Some of these strengths are intrinsic to the nature of the chaplaincy: they are uniformed personnel, fluent in Air Force culture, and provide absolute confidentiality. Fewer participants in Phase 2 than in Phase 1 reported issues with chaplains being inaccessible to airmen because of their denomination or their role as clergy, although some mentioned a concern that this could be a potential issue.

The challenges found in Phase 1 often persisted in Phase 2, particularly the concern about career paths and how a (currently) atypical assignment might influence chaplains’ future options. Some chaplains mentioned the need to adapt to their role as providers linked to units, rather than installations or chapels.

The significant new challenge in Phase 2 was a function of the increased demand for individual counseling in a population that had been given access to one-on-one counseling with EMHTs, only to have that access reduced by provider staffing shortages. Also in Phase 2, the RAND team heard that confusion over which set of spending guidelines apply to chaplain spending and activities actively hampered the ability of RSTs to plan and deliver programs as intended by the CONOPS. Ensuring that RSTs can deliver preventive and educational programming with minimal administrative overhead and reducing their counseling burden by ensuring that the EMHT initiative is fully staffed and resourced will help RSTs to fully realize their potential.

6. Embedded Mental Health Teams

TFTN's EMHTs have as their objectives to promote resilient behavior, decrease stigma around accessing mental health and resiliency support, encourage help-seeking behavior, prevent negative outcomes (such as absenteeism, self-harm, or poor relationships at home and at work), intervene early, and enhance mission effectiveness. Each team consists of a mental health technician embedded at the group staff level and LCSWs embedded at the squadron level (typically one per squadron, resulting in about four per group). These team members are contracted civilian professionals, unlike the uniformed RST members. They perform a variety of functions:

- unit circulation to promote interactions and familiarity between the LCSW and airmen in their squadron and between the mental health technician and airmen in their group
- limited scope counseling with LCSWs involving confidential, short-term (five sessions of about 30 minutes each) problem-focused counseling, with the understanding that cases requiring more intensive counseling or treatment need to be referred to the MHC
- subsequent mental health care by the LCSWs in the MHC, for referred cases
- education in the form of daily interactions, workshop-style events, and formal classroom instruction on factors that affect resiliency, emotional and physical health, social functioning, healthy coping, and effective problem solving, all of which can be provided by LCSWs or the mental health technician
- command consultation to guide decisions and make recommendations for ways to boost morale, prevent disciplinary problems, and improve behavioral health habits, carried out by LCSWs
- resource and referral information to help the unit understand what is available either from other base services or the EMHTs themselves

It is important to note that the mental health technician cannot conduct limited scope counseling or subsequent mental health care for referred cases, but they can support LCSWs in these functions by helping to coordinate appointments with airmen. The LCSWs are expected to spend about 10 to 20 percent of their time providing mental health care in the MHC, 20 to 30 percent of their time conducting limited scope counseling in the unit, and the remainder of their time on unit circulation and other nonclinical activities. While the LCSWs and mental health technicians report primarily to the commanders of their respective units, they are also involved with other lines of authority, such as with their contracting company, the MHC or mental health flight commander, and the TFTN PM on base.

Additionally, because the EMHT members are dealing with sensitive information, many guidelines and policies are involved. Some of these are consistent with civilian mental health care practice, such as those related to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). However, some features of practice differ in a military context, such as using

DoD standards for documentation and obtaining informed consent in a context in which confidentiality has more constraints than in civilian practice. Additionally, there are a number of issues specific to working with a military population such as understanding wing structure, professional boundaries, Personnel Reliability Program status, and arming recommendations for unit members required to bear firearms. These issues are laid out in the TFTN CONOPS and a variety of AFIs, which can be difficult to understand in terms of their application, particularly for a contracted civilian without MHC or other Air Force experience.

The EMHT initiative has the potential to be a highly impactful program of major benefit to airmen. Leaders consistently praised the value of the program, and many units receive strong support from their EMHT members and their services. Unfortunately, major challenges persist that prevent the EMHT initiative from reaching its full potential.

The largest and most pressing is the issue of EMHT attrition. With high turnover at Beale, JBER, and Minot, the EMHT initiative will not be sustainable unless the issues resulting in the attrition are addressed. Challenges with the contracting company that recruits and hires many civilian staff members for TFTN, including the EMHTs, have contributed to turnover issues, as recruiting concerns and a lack of adequate support have prevented the EMHT initiative from retaining providers.

Along with attrition, leaders and providers reported that LCSWs and mental health technicians were experiencing ongoing conflicts with the MHCs. Issues related to training, time spent at the clinic, and interpersonal disagreements have led to contentious relationships between some EMHT members and the base MHC staff. Although some leaders and providers noted that airmen may be more comfortable speaking with EMHT providers because they are not members of the Air Force, the EMHTs' civilian status has led to some complications. EMHT members' lack of familiarity with the Air Force and the military more generally, as well as the absence of appropriate security clearance when coming on board, have been identified as barriers to their successful integration in the unit.

The overview of the EMHT initiative at each base is presented in Table 6.1. Rationale underpinning these ratings is provided in the remainder of this chapter.

Table 6.1. Embedded Mental Health Team Status Overview

	Whiteman	Minot	JBER	Beale
Phase 1				
Phase 2				

NOTE: Yellow indicates a mostly operational initiative with the exception of some challenges that could be addressed going forward; red indicates an initiative with a number of challenges that will take great effort to address going forward to be considered operational.

Phase 1

The first set of discussions with leaders, senior leaders, and providers at the four bases revealed that the EMHTs were generally well received, but the program also faced some criticism. Participants consistently praised the LCSWs and mental health technicians for their positive interactions with airmen and their coordination of successful educational events. However, participants also noted major challenges for the initiative, including EMHT members' lack of knowledge of Air Force culture or prior experience with the military, the lengthy process of receiving necessary credentials for conducting limited scope counseling sessions, and the time it takes for EMHTs to attain appropriate security clearances allowing them to reach airmen in secure areas.

Successes

Airmen Trust Providers

Trust is key for the providers to be able to connect with the airmen and enhance overall willingness to seek out the EMHT services, and EMHT members indicated that they were able to gain the trust of both airmen and leaders at their bases. As one LCSW noted, "At first, they were very cautious and guarded but have observed that I am just there to help them, and they check in to say 'hi' periodically or want some kind of basic education on topics." Both unit leaders and EMHT members consistently discussed how airmen were often wary of the EMHTs or unsure about the services provided. As time went on, however, some LCSWs became more comfortable in their units, and airmen became more accepting. Participants also noted that informal conversations with airmen worked to build trusting relationships and convince airmen that they could speak to the LCSWs about any issue.

When leaders were asked how well the EMHT initiative was meeting the goals of TFTN, the majority of leaders and senior leaders indicated that more airmen were seeking help as a result of the initiative. As one leader noted, "The number of people on mental health profiles has increased, so there is some kind of increase in help-seeking behavior, and mental health issues are being raised that were otherwise not before." The increase in help-seeking behavior was perceived to be related to the accessibility of the EMHTs as well as the LCSWs' civilian status. Participants noted that some airmen are more comfortable speaking to a civilian. One leader stated, "Some people prefer to see people that they do not perceive as a 'threat' rank-wise, and so that may feed into program success since providers are not active-duty military." The civilian status of the EMHT members leads some airmen to seek them out because they feel more comfortable with someone who is not in uniform and who will not affect their career. As another leader stated,

Our airmen love talking to someone not in the military. And they just like having someone to go in and complain to. They wouldn't normally do something like that in the chain of command. They just want to complain. I know, because they tell me that they love going to vent to the mental health providers. They love the non-blue suiter who's not a part of the unit who listens but has input with me. They know we don't talk about [things that would go against] HIPAA, but they know [our LCSW is] a conduit to discuss the culture of the unit.

Not all participants shared this view, however, as others noted some airmen would rather speak to someone with active-duty experience, as discussed later in this chapter.

Support from Leadership

In each of the focus groups with EMHT members, participants brought up feeling supported by leaders in their unit. EMHT members discussed how leaders helped them establish their services, introduced them to the unit, and taught them about the Air Force. One EMHT member stated:

I agree with that—the one thing—with how accommodating they were to civilians who had not previously had exposure to a military setting or had not been in that setting. If I got rank wrong, they cut us a lot of leeway and helped us to make the shift and transition into working in this setting. That was very helpful. Had they not been as open, it would have made this even more challenging. They made the effort to say, “We appreciate you being here.”

EMHT members also praised leaders for their efforts to destigmatize the EMHT services. As previously stated, airmen’s concerns about the negative repercussions of mental health treatment may prevent them from seeking help. With proper support from leadership, airmen may be less apprehensive. One EMHT member recounted:

They have flight calls, their supervisors run it, and the supervisor had been the one who saw both mental health and religious support, and it was amazing when [they] stood in front of people and said, “I had this thing, and I went to this provider and the chaplain, here’s what happened.” And when a leader shares the experience and they see that there’s no reprimand, and not only that but observed improved job performance as [the supervisor] worked through challenges. That was incredibly effective.

EMHT members often cited leadership referrals as a major factor in recruiting airmen to EMHT services and events. Leaders themselves echoed this importance, as more than half of the focus groups with leaders discussed how they had referred airmen to use the EMHT services. Along with recommending airmen to the services, leaders communicated with the LCSWs to gain their perspectives on the well-being of the unit.

Challenges

Embedded Mental Health Team Members’ Lack of Air Force Knowledge

An important challenge for many EMHT members is their lack of experience with the Air Force in particular and with the military in general. Many LCSWs and mental health technicians are not familiar with the culture of military organizations and the Air Force, the responsibilities of the airmen, the language used by the Air Force, or the chain of command. Some leaders and EMHT members expressed that they felt as though this lack of experience hindered their ability to effectively provide their services. Without prompting, a quarter of the leaders brought up

concerns about the lack of Air Force experience, while more than half of the focus groups with LCSWs and mental health technicians discussed challenges resulting from their lack of familiarity with the Air Force. As one leader discussed,

The embedded mental health teams have had a higher barrier to overcome, higher wall to clear, coming in as outsiders, with no knowledge of the Air Force, not knowing the mission, not wearing the uniform. The chaplain and chaplain assistants are more relatable, they wear the uniform, they grew up in the Air Force. Our [embedded] mental health [teams] are working really hard to overcome that, working hard to get out to where the airmen work, making themselves visible, so the airmen become more comfortable.

Furthermore, some leaders mentioned that some airmen would prefer to receive help from someone who knew more about the Air Force. The lack of firsthand knowledge about the stressors and challenges unique to the Air Force may prevent airmen from connecting with the EMHTs. However, this was mentioned as more of personal preference for some airmen, not a structural issue with the initiative. Uniformed counselors, such as chaplains, can have advantages and disadvantages in terms of connecting with airmen, and the same is true for civilians, such as LCSWs. By offering both, TFTN is providing different points of access to make it easier for airmen with different preferences to access support.

Security Clearances Necessary to Reach Airmen

LCSWs in EMHTs had private offices to conduct limited scope counseling, but counselors as well as leaders report high value from unit circulation, in which social workers dedicate time to walking around the unit and conducting informal conversations. Furthermore, some airmen spend most of their time working at their posts and do not have the time to go see the LCSW or mental health technician in their office. However, many EMHT members cannot reach airmen working in secure areas and thus cannot always deliver services. One leader said:

[My airmen] work in a protection Level 1 area, and without clearance [the LCSW] can't have access. And we have to escort [the LCSW] if [the LCSW] goes out there . . . and so that means [the LCSW] also can't do [their] job in private, right? With an armed escort official standing there, that's not how counseling works, defeats the purpose. Same is true for other guys in the field, they cannot go alone or be in private.

As the leader described, some EMHT members can reach secure areas with an escort, but the presence of the escort will prevent airmen from having private conversations with them. At the time of the first set of base visits, some EMHT members had received their clearances, but the clearance issue is likely to persist as long as new EMHT members are contract hires. The issues surrounding the security clearances were a point of contention for some leaders as well, who felt that security policies were being compromised. Concerns about security policy were mentioned

by leaders in a few units with strict security procedures, and they mentioned feeling pressured to expedite access to sensitive areas. One leader recalled:

The providers themselves didn't know why they needed these accesses. It was forced . . . and they don't have secret clearance, and I . . . don't know anything about them. They might have walked in from Walmart and said, 'I'm a social worker' and now they're getting access to everything. We need to roll this out better if it continues so it's in accordance with security policy.

Civilians Cannot Use Limited Scope Counseling Sessions

EMHT members are being brought on board to serve active-duty airmen, a mandate that does not include the units' civilians. While civilians are welcome to participate in events hosted by the EMHTs, they cannot go to providers for counseling sessions. This issue was brought up in a large majority of the focus groups with EMHT members, and the complaints primarily focused on the inability to counsel the airmen's close family members, including spouses and children. As one LCSW recounted, "The family retreat last August produced significant results; I had people come in and ask me, 'Can I see you for couples counseling?' And I said no, which was a huge frustration." The LCSWs described how their inability to speak to airmen's spouses and families severely hindered their ability to serve the airmen. When the EMHT members were asked to list the common mental health needs of airmen, each group listed marital or relationship problems as a major issue. Under the current structure, EMHT members are unable to help couples with civilian spouses, as services are for active-duty members only. However, RSTs can meet with civilian spouses and families, so EMHT members refer many of their airmen to the chaplains when these issues arise.

Credentialing Necessary for Counseling Sessions

An important feature of the EMHT initiative is limited scope counseling sessions with the airmen. However, before LCSWs can have the opportunity to conduct these sessions, they must receive appropriate credentials from the Air Force, access to the clinic's computerized records, training in using DoD-specific documentation, and a period of peer review of their sessions. Obtaining the appropriate credentials is a time-consuming process that can take months and, in some cases, prevent the LCSWs from doing a large part of their job. One leader complained: "The first six months, ours was not even qualified; [they were] just sitting in [their] office getting paid." This long process also resulted in a greater burden on the MDGs at the bases, who oversee the credentialing of the LCSWs. Half of the leaders from Whiteman AFB, Minot AFB, and Beale AFB raised the credentialing process as a challenge. LCSWs at JBER were credentialed before joining the base, and therefore none of the focus groups from JBER discussed issues with the process.

Embedded Mental Health Team Members' Time at the Mental Health Clinic

According to the CONOPS, EMHT members are supposed to spend 10 to 20 percent of their time providing mental health services in the MHCs, although many reported spending even more

time. In every discussion with EMHTs, time spent at the clinic was identified as either an ongoing challenge or something they wished they could change about the initiative.

EMHT members provided multiple reasons for their extended time at the clinic, with the most common reason being the heavy workload of tasks that had to be completed there. Others noted that the administrative duties added to the time spent at the clinic. One LCSW recalled, “When we do mental health, I am there [at the clinic] all day seeing patients back to back. After that, documentation takes another whole day. If there is a computer issue as we had last week, then I am behind, and this is a stressor for me.” In some cases, excessive time working in the MHC was a function of a requirement to carry out some treatment for unit airmen in clinic facilities, even when both the airman and LCSW would have preferred to remain in the unit office. In other cases, LCSWs were tasked with seeing airmen from units other than their own TFTN-assigned unit in order to alleviate the counseling burden on the clinic.

Both leaders and providers expressed the judgment that LCSWs’ time at the clinic took away from their abilities to become deeply embedded in the unit and support the airmen. As previously stated, the LCSWs perceive high value from being physically in the unit and having the opportunity to directly connect with the airmen as they do their work. However, with so much time being spent at the clinic, providers expressed concerns that they were not perceived as truly embedded. Some leaders felt this way as well, as one-third of the focus groups with leaders expressed concerns about the LCSWs’ time spent at the clinic. One described this conflict: “[Our LCSW is] so hamstrung, [our LCSW] wants to be here, everyone I’ve talked to wants to be here, but they all say, ‘Well, I can’t do this because I have to be at Mental Health on these dates, I can’t see them here today in this building.’”

Concerns regarding excessive time at the clinic extend beyond the availability of the EMHT members. While they are more difficult to reach in the clinic, they also run the risk of being seen as an extension of the clinic instead of embedded LCSWs. Several unit leaders described situations where the team LCSW was spending most of his or her time at the clinic, leading their airmen to believe that they would be taken to the clinic if they ever spoke to the LCSW. As stated, the stigma of being treated by mental health professionals can pose a major barrier to airmen seeking help, so the association of EMHT providers with the MHCs is a major concern.

High Attrition at Minot and Whiteman

Minot and Whiteman AFBs have experienced high EMHT attrition. At Minot, multiple EMHT members left the initiative after completing one year of their contract. At Whiteman, some EMHT members were fired for inappropriate conduct. Leaders and providers have expressed concerns with attrition, as it takes a long time for the providers to get established in their embedded units. As previously discussed, providers need time to get their security clearances to gain access to secure areas on base, receive appropriate credentials to provide counseling sessions, and build a rapport with airmen in their units. As one unit leader at Whiteman stated, “With embedded providers, there was turnover and exhaustion at first

regarding how to acculturate the providers. At first there was infighting among the providers, and some had to go because of behavioral issues.”

Along with the administrative burden of obtaining appropriate clearances and certifications for providers, when the providers leave, the airmen lose the bonds and trust they have built with them. Furthermore, participants have indicated that the high turnover has led airmen to believe the EMHT members will only be in their units for a short time, and they speculated that airmen may become hesitant to truly connect with them. As one provider recalled,

When I first got here, one of the first questions from at least two airmen was “Will I see you next time, or when are you leaving?” That was their introduction to me. They were tired of telling the same things to new people; they expect the uniformed people to leave because that’s part of their job, but for a civilian person, they want to see consistency in the civilian population.

At Minot, the high attrition rates led to some confusion about the terms in the contract. As a result of EMHT members leaving after one year, several unit leaders believed that their contracts were only written for one year. (The contracts are written for three years.) The confusion about the contracts has added to concerns and confusion about the initiative among the airmen and leadership. One leader summarized concerns by saying, “The other thing I see coming is—the contract is a one-year contract, so they spent a year building trust and rapport with airmen, and then next month all those providers leave and we get new providers, so you have to start all over.” These frequent changes in providers led to frustration among leaders and airmen and may hinder the initiative’s ability to succeed.

Phase 2

Discussions from the second set of base visits demonstrated that in units that retained their EMHTs, leaders and providers still believed the initiative was well received, citing well-attended events, successful limited scope counseling sessions, and positive interactions between airmen and EMHT members. However, the overall functioning of the EMHT initiative declined. Attrition had become an increasingly important issue at three of the four bases during Phase 2, with high levels of vacancies and replacements. Without the appropriate levels of staffing, the EMHT initiative will not be able to be sustained.

Challenges

Attrition

The change of greatest importance between the two visits was the increase in EMHT attrition. Aside from Whiteman, EMHTs at the other bases lost many LCSWs and mental health technicians, which severely damaged the success of the initiative. Beale, in particular, suffered the greatest losses, with only two of the eight LCSWs remaining during Phase 2. Without sufficient providers, the initiative cannot provide its intended services. Often, LCSWs reported

needing to support multiple units to fill in for the lost providers. This issue was brought up in approximately three-quarters of the discussions in Phase 2, compared with only one-quarter of the discussions from Phase 1.

This heavy attrition leads to many issues, including the perceptions of the sustainability of TFTN as a whole. As one leader stated:

I realized the wheels were coming off, because we were losing providers. People were starting to trust, we were taking the stigma away, and the program was working, and then all of a sudden, they're not available. . . . It's worse to have a program that worked and people trusted and then is taken away than never having it in the first place. I have a lot of concern for the longevity of the program, especially with the shortage of providers, and also the negative impact of people falling through the cracks now that we're so short staffed.

Participants across the bases expressed similar concerns, as airmen would develop trust in their LCSWs, only to lose them after a relatively short period. Airmen who grow accustomed to their LCSWs may have to find new sources of support or do without. The attrition also puts more pressure on other EMHT members and RST chaplains who fill in gaps and support the units who have lost embedded LCSWs. Unit leaders also expressed frustration about having to share LCSWs. One stated:

A lot of the Task Force True North [EMHTs] quit; that has pushed more people outside of my unit to use our embedded provider. I am a true advocate for help. But, as a commander, I am selfish because, with other units coming to [my LCSW], [they] cannot handle my unit, the one that [my LCSW] is in fact assigned to. Mental health [clinic] will tell people to find whatever [TFTN] provider still exists if their embedded health provider quit.

Frequent turnover remains a challenge even when open positions are filled with new professionals. Bases need to train the new EMHT members, and new relationships need to be established, both of which take time. For EMHT members, learning about their base, their units, the proper procedures, and the Air Force as a whole is a long process. Repeating this process for each new LCSW and mental health technician adds extra stress to the units they are intending to support. As one leader commented:

If you have turnover every 12 months, don't see how it would succeed without military experience. Several months just to figure out chain of command. Then some were gone seven months later. If you're not here for a duration, I don't see how you can do it. The duration concerns me. How do you build trust/faith and confidence if it's a rotating door?

With such turnover challenges, leaders were concerned that airmen may begin to lose faith in the program as a whole. With no guarantee that their particular EMHT member will be in place for a reasonable period, an airman may resist connecting.

The issue of high attrition has been complicated by difficulties with the contracting company responsible for filling the contracted positions across the TFTN initiatives, which failed to

replace EMHT members in a timely manner. This was a particularly significant issue at Beale and Minot. One senior leader stated: “It’s been a challenge. We haven’t had a mental health technician in four months, and we’re down to two mental health providers, and one is planning to leave next month. The contractor just isn’t keeping up with the hiring demand.”

Along with failing to replace EMHT members, the contracting company has been criticized for their recruiting practices. EMHT members described situations where the contracting company would give misleading or inaccurate information about the position to make it more attractive. The contracting company was also reported to often forgo hiring practices such as vetting or interviewing in an effort to accelerate the hiring process. As one EMHT member described: “[The contracting company’s] problem was that they rushed us up here, said what they needed to say to get us here. They need to have a better understanding of what this job is.”

With the accelerated hiring and misinformation that the contracted providers describe, some EMHT members arrived at their bases with unrealistic or inaccurate expectations of their roles and responsibilities. Several participants stated their beliefs that these problems may have contributed to the high rates of turnover. A variety of reported issues with the contracting company, including the lack of proper contractor vetting, dissemination of misinformation, and miscommunication, affect more than just the EMHT initiative—they may threaten the success of TFTN as a whole. For that reason, additional information on the negative feedback the RAND team received regarding the contracting company can be found in Chapter 8.

Embedded Mental Health Team Conflicts with the Mental Health Clinics

During the second set of visits, discussions from Phase 1 regarding the relationship between the EMHTs and the MHCs continued, and the underlying issues were brought into clearer focus. Tensions appeared to stem from three issues. The first is the understaffing of clinics and the additional burden imposed on them by certifying and training new EMHTs. The second is the concern reported by some MHC staff about the quality and competence of the EMHTs assigned to them for training. The third is the difficulty inherent in assigning different jurisdictions to groups working within the same space, leading to clashes involving resources and authorities.

Interviewees and focus group participants from the MHCs emphasized that training new workers presented a burden under the best of circumstances. This burden was compounded by the fact that many clinics were unable to meet existing needs, referring less urgent airmen cases as well as their dependents to community care because of lack of capacity. While many personnel at the MHC understood that the long-term goal of TFTN was to reduce the demand for their services, thereby ultimately helping them, in the short term the effect was to require them to train additional personnel when they were already not meeting critical needs, and this demand fostered resentment.

These tensions were heightened by the perception among some MHC staff and management that the LCSWs recruited for TFTN and sent to them for training did not meet clinic standards for competence and professionalism. This lack of confidence in contracted LCSWs may be

a factor in the hostility many LCSWs perceived on the part of MHC staff. The relationship between the two groups—MHC staff and EMHTs—appeared to worsen, and it sometimes led to individual friction as well.

Finally, while the ultimate function of the EMHT initiative is complementary to the MHC and could lead to a lesser burden on the latter by improving preventive and proactive behaviors, in the short term there was conflict over who “owned” certain cases and roles. EMHTs who had established rapport with an airman in a unit believed it to be poor practice when they were required to move their counseling sessions to the MHC and have their work supervised by an MHC staff member. MHC staff, on the other hand, were concerned that if LCSWs were not following military standards of care or documentation policies, or worse, if they were not providing adequate care to an airman in distress, the MHC might be blamed.

These conflicts have been identified as a contributing factor for the high turnover. Both leaders and providers at these bases cited instances where LCSWs decided to leave because of negative interactions with the MHC. Much of the conflict stemmed from the stress of training the EMHTs on the part of the MHC staff, beliefs that the EMHTs were not qualified, and disagreements surrounding the roles and duties of the EMHTs. One EMHT member left after being asked to serve on a medical separation board for an airman they counseled, which they considered a conflict of interest; while this issue only arose once, it has the potential to create conflict in the future if contracted civilian LCSWs, who perceive their duty of care to be toward their patient, find themselves asked to take actions that could harm their patient’s career.

Training and Credentialing

Both EMHT members and MHC staff believe that training has placed a burden on their relationships. At each base, the MHC staff were responsible for training EMHT members on staff safety, facility safety, applicable AFIs, the Personnel Reliability Program, and proper documentation. The process of training and accrediting LCSWs to the standards of the MHC appeared to be poorly defined, with different individuals and different bases describing different standards. However, clinic staff perceived the process as imposing a substantial burden on both the clinic staff and the counselors. The counselors can be delayed, at times for many months, in beginning their duties as EMHTs. Several LCSWs described delays of six to seven months between arriving on base and being able to provide full clinical services to the airmen in their units.

One TFTN PM described new LCSWs and mental health technicians reading AFIs for days at a stretch, which they reported was often on one computer monitor shared between them, without any active training or assistance from MHC staff. As the PM described:

The colonel said, “Get them out and embedded.” But they weren’t prepared to treat people according to DoD standards. I can’t train them because I’m not a clinician, MHC can’t train them because they don’t have the staff or the time, and there’s more and more hostility [at the clinic]. Providers just don’t want to go there.

A mental health flight commander at one of the bases reported that the first 50 appointments were supervised for each LCSW before they were released to practice unsupervised and that oversight of TFTN providers had created 1,100 hours of additional work at the clinic. While this was a high burden for the clinic, it was still perceived as insufficient training by some clinicians and leaders. A senior leader at a different installation stated that to bring new civilian LCSWs up to Air Force standards of practice would normally take one year, but that the PM and MHC had streamlined the process to six weeks of full-time training with ongoing supervision. This senior leader questioned whether this streamlined training was sufficient.

The EMHTs also have to work with the MHC to receive proper credentialing to support the airmen. However, the requirements for retaining credentials are unclear to both PMs and LCSWs and not always supported. LCSWs reported an obligation to engage in a certain number of continuing education credits per year to maintain their state licensing, but there was no financial support or time allowed by the contracting company for this activity. The MHC requires LCSWs to conduct a certain amount of one-on-one counseling per year to continue credentialing their practice on base, but it is unclear to the PMs and LCSWs how many hours this is and whether limited scope counseling in units is included or only appointments conducted in the clinic facility.

LCSWs also noted that they needed to have their notes from limited scope counseling sessions reviewed. The training load has led to an increase in the MHC's workload. Since then, both groups have been dissatisfied with the quality and the length of the training. Furthermore, some EMHT members felt as though the conflicts caused from training negatively affected the MHC staff's perception of the EMHTs. One EMHT provider stated:

We were not trained sufficiently. The clinic treated us like interns, and it became an us-versus-them situation. . . . They do not want us. We have gone to the medical personnel for assistance and were treated like a bother and so now we do not go. . . . Additionally, a couple months into it, the peer reviewers told us that our notes sucked, even though at the beginning the clinicians said they were good.

MHC staff also questioned the qualifications of the EMHTs and discussed how they required more training than expected. One MHC staff member remarked, "I've spent hours a day helping someone with spelling, turning on a computer. When it's consistent, it makes me wonder about the caliber of the people sent. How is it affecting the people they're supposed to be helping?" The difficulty presented by the training demands is exacerbated by low levels of staffing at the clinic.

Continued Challenges

In addition to increased attrition and negative interactions between the EMHTs and MHCs, other issues existed through both phases. Moreover, the high levels of attrition resulted in these problems continuing unabated because new employees need to be taught the same lessons as the EMHT providers they are replacing.

One of these issues is the EMHT members' lack of Air Force knowledge. Leaders are still largely dissatisfied with the providers' lack of military experience, as conveyed by this sample comment by one leader: "The providers should also understand some stuff about the military. There was a large learning curve in learning about the military." Some EMHT providers who remained in their positions were growing more familiar with the Air Force, but with such high turnover, these EMHT providers will be needed to teach new personnel.

Along with the EMHT providers' lack of Air Force knowledge, security clearance issues continued to be a problem for EMHTs at Minot, Beale, and Whiteman. As one leader described:

With security requirements and how the contract was done, we have to have the [Entry Authorization List]. We have to escort them around to the field. That's a challenge. We're the boss and the "bad guys." No one is going to talk to the clinician with the big, bad commander there. We can't get the discussion going. That's been a problem I've tried to figure out. I've tried to send the clinician to the field with an airman from the support staff, but while I'm doing that, the airman isn't doing the other work needed. It's been a challenge to get past our own security.

In the second phase of visits, there had been no progress made in terms of the timeline required for EMHT providers to obtain the necessary clearances to embed with units that work in secure areas. With high attrition, new personnel also needed to begin the process of acquiring the appropriate security clearances. The lack of access to airmen in secure areas was still described as a point of contention for the EMHT initiative and was seen as a major hindrance to EMHT provider effectiveness.

Leaders and EMHT providers also continued to express frustration at the providers' inability to have limited scope counseling sessions with non-active-duty spouses and family members. One EMHT member remarked, "Can't have couples counseling, can't talk to spouses; all this is a long list of restrictions. What's the point? [We're] not going to achieve the desired end state." EMHT providers did not believe that they would effectively work with airmen through familial issues if they were not able to meet with their families. Several leaders also mentioned that some airmen preferred to meet with RST providers instead of EMHT providers because they wanted to have meetings with their spouses or families.

Conclusion

The continuing challenges of the EMHT initiative point to several larger issues that need to be addressed. As stated, attrition appears to be the most important of these challenges, and it seems to affect nearly every other issue described by the leaders and providers. Without sufficient numbers of providers, the initiative will not be operational. In addition, even when vacant positions have been filled by new contractors, they must complete the same time-consuming training. Furthermore, the providers' inability to interact with family or to access secure areas while awaiting security clearance continues to be a major source of frustration for

the EMHT providers and the airmen. Attrition is itself a symptom of other problems with the program, however, and these challenges must be addressed before meaningful attempts to slow or prevent attrition can be made. For example, reasons for leaving the job given by LCSWs include a mismatch between what they were told and what they found when they arrived at the installation; a lack of a clear chain of command so that providers did not know to whom to address complaints or where to seek help; and discomfort with the ethical challenge of being asked to serve on a separation board for an airman whom they had treated as a client in counseling, a dual role that would not exist in a civilian practice. The challenges faced by the initiative must be addressed to prevent further attrition.

Despite these challenges, the initiative has been respected and appreciated when properly staffed. The EMHT initiative is already considered an important aid to the airmen, and with several modifications, the initiative will be more likely to operate at its full potential. Chapter 9 goes into more detail about recommendations that may improve the EMHT initiative's ability to help airmen and their families and ways in which TFTN can better support its contracted personnel.

7. Operational Support Teams

The OST is a base-level asset, closely modeled after the POTFF program, designed to provide a full range of medical, sports medicine, psychological, nutritional, and general resilience support to Air Force special operations forces and their families. The OSTs are intended to provide support to units with the highest risk for psychological and physical stressors. The intent of this support is to optimize mission performance by developing interventions and tools to enhance psychological and physical resilience in the squadrons. The OST is made up of six mental health and musculoskeletal health and resilience experts who are either contracted civilians hired through the contracting company responsible for filling the contracted positions across the TFTN initiatives or Air Force professionals. These six team members include a clinical psychologist, LCSW (or mental health NCO), physical therapist, exercise physiologist (or athletic trainer), human performance integrator (to connect with other helping agencies), and human performance information manager (for gathering and analyzing performance data).

To meet its goal of providing targeted, evidence-based interventions to units and thus enhancing mission-specific duty performance, the OST spends a predetermined period, usually approximately three months, in a unit identified as high risk to (1) observe, evaluate and analyze performance, and assess needs; (2) develop and implement interventions and long-term plans that the unit can use to address stressors, improve resilience, and prevent future issues; and (3) evaluate the use of these interventions so the unit can continue to utilize them effectively at the end of the OST's rotation, and the OST can continue to develop interventions to be implemented in future rotations. The intent is for this "cycle" to take about 90 days total—30 days for each of the three phases listed above—at the end of which the OST prepares to move on to the next unit it will be supporting while maintaining contact with previous units as needed. However, in some instances, the team may spend more time in a unit before moving on to the next one, for example, in the event of a death or suicide in the unit after which the leader and OST agree additional support would be beneficial for the airmen.

During the first phase, for example, an OST might learn from the commanding officer that the unit is not meeting expectations with respect to physical fitness tests and observe that poor nutritional choices and work-related injuries are reducing overall performance. During the second phase, the team would implement specific interventions developed to address these challenges, which might include leading PT and providing coaching to PT leaders within the unit; recommending changes to available snacks and educating airmen about nutrition; and teaching proper form for work tasks, as well as teaching remedial exercises for existing injuries. During the third phase, the team would observe and document how well these interventions are

performing, while supporting the unit in sustaining these new practices after the OST rotates to a new unit.

As a base asset, the OST reports to the MDG, with oversight from the MDG chief of aerospace medicine, as a component of the base-level Aerospace Medicine Enterprise. During the OST members' time in a unit, they report to the squadron commander, mainly providing consultation and updates on unit needs and recommended interventions. Throughout this cycle, the OST should be cultivating relationships with base organizations, so the OST members can provide their interventions in coordination with these existing resources. OST members should also be coordinating closely with the 711th HPW to gather and analyze performance data and other metrics and to develop appropriate evidence-based interventions for their units. The 711th HPW is intended to evaluate the impact of the OST after the 90-day cycle has completed using metrics reflecting the unit's mission readiness and performance, unit health, and base OST activities. However, these evaluations did not occur.

The OSTs were in place at both Whiteman and JBER and gradually made improvements in airmen health and fitness over the course of the two sets of base visits, as reported by OST members and unit leaders. Members of both teams became more comfortable with their roles and with the bases as well as with the structure of the initiative. This initiative is highly sought after by units and bases without it. Many unit leaders across the four bases were aware of the OST initiative and were very eager to have the team as a part of their unit. However, challenges remain, as unit leaders expressed concerns about the 90-day rotations even though OST members grew more confident in their ability to make sustainable changes in that time frame. The overall status of the OSTs at Whiteman and JBER is presented in Table 7.1.

Table 7.1. Operational Support Team Status Overview

	Whiteman	JBER
Phase 1		
Phase 2		

NOTE: Yellow indicates a mostly operational initiative with the exception of some challenges that could be addressed going forward.

Phase 1

The first discussions with OST providers and leaders from the units they served revealed that the initiative was perceived as gradually improving the performance of their units while overcoming challenges surrounding the initiative's rollout. Leaders expressed appreciation for the OST members and praised them for improving the health of airmen in their units. The OST

members themselves also reported improvements in airmen well-being, with anecdotes about preventing airmen injuries as well as reports of airmen making healthy choices and habits. However, both leaders and OST providers described multiple problems with the structure of the initiative and perceived lack of support from their bases.

Successes

Health Education

One of the roles of an OST is to provide nutritional and physical education to improve the health of the airmen. According to OST members at both Whiteman AFB and JBER, these educational initiatives have been well received by airmen and have led to praise from leaders. As one unit leader stated, “The OST has helped us understand how to run our own PT more effectively. The nutrition component has been challenging because there is not an abundance of healthy options on the base, but they did help us revamp our snack bar.”

Along with support from leadership, the OST members generally believed that they were able to properly connect with airmen in their units, to provide education and information one-on-one. Members from OSTs at both bases discussed how airmen were receptive to the initiative and felt comfortable with the OST members. As one OST member shared:

Airmen see me in the gym and talk with me about their issues sometimes, and I have been able to suggest embedded mental health services on occasion with them when relevant. Airmen . . . are comfortable coming to us with small, nagging injuries without concern about repercussions from that. Airmen were receptive to feeling like someone cared about them and were concerned about their problems.

Challenges

90-Day Rotations

The most commonly cited complaint about the OST initiative was the 90-day limit the OST members have in each unit before they switch to another unit on the base. Focus groups with both OST members and unit leaders with exposure to the initiative brought up the time limit as a major barrier to effectiveness. Even when praising the OST members’ efforts, leaders lamented that there might not be sustained change once the team left. As one leader stated:

Towards the end, we saw awesome potential for an enormous effect, but 90 days is not nearly enough time for success, but they were great. By 90 days, you could see a little more involvement, improvement in those who were consistent, and people were really getting ready to spark, and then overnight they were gone.

Leaders often enjoyed their time with the OST members but felt that the unit leaders were not given enough tools, information, or resources to continue the changes made by the OST. The changes made by the OST members, while positive, were seen as only temporary, and both leaders and providers were concerned that any progress made would dissipate over time. In

reality, some of the classes and programs put in place would have no way to continue without the OST being in place in the unit. Others discussed how 90 days would not be enough time to get buy-in from airmen in the first place or give OST members enough time to learn about the duties and culture of the unit. OST providers also expressed concerns with the emotional toll of leaving the units after a short period. One OST member stated:

I am very concerned about the risk for burnout and compassion fatigue for OST providers, particularly for the mental health care providers, but not to exclude any of the other members. It requires significant time and mental/emotional energy to genuinely build rapport with so many individuals in a squadron. To put this effort forward and finally see a relationship form, only to then walk away from [the] squadron, knowing any changes you have worked hard to build have minimal chance of actually helping them, and then be required to start the process again, in a new unit, every three to four months . . . It is not sustainable.

This concern was reflected among the leaders, who were also concerned with airmen becoming dependent on helpful individuals who would leave after a few months. Several leaders believed that any positive impact made by the OSTs would be temporary.

Facilities

OST members at both bases listed space as an issue for their initiative. Similar to the EMHT members, OST professionals sometimes require privacy for speaking with airmen. However, the OST members described multiple situations where they either did not have space, their offices were moved, or the facilities lacked appropriate furniture. One OST member recalled, “All of us have had our offices moved several times, and airmen need to know where to find us.” Another stated, “My computer access seemed to go smoothly, but no office space, and I was sifting through the trash room to find furniture.” Further complicating facilities issues is the 90-day rotation. With OST members moving around the base, some may need to repeat the process of finding space whenever they switch units. The OST mental health providers have space in the MHC that they use, but this is not available or viable for other OST members who may need to have a space closer to the unit.

Lack of Unit-Level Data to Measure Improvements

The OST initiative is designed to create improvements to the unit’s overall resilience and fitness based on the overall fitness of the unit rather than individual airmen. However, the OST members do not have any method to measure these potential improvements. OST members at both bases noted that they are not equipped to evaluate the changes and can only report case studies or anecdotal success stories from airmen. At both bases, the OST members have attempted to conduct their own data collection, but they did not feel confident about the quality of the data or whether it would accurately capture unit-level information. OST members at both bases attributed this issue to a lack of guidance and training. In one focus group, an OST member stated, “I have not been told at all what type of data to collect or where to put it; now we wing it and see what sticks.”

When asked if they have had a chance to assess unit performance and cohesion as outlined in the CONOPS, one OST member replied, “We have not performed or designed assessments of unit performance and cohesion. Learning formal and objective tools to conduct these assessments would be necessary to making this happen.” Without the proper preparation or knowledge about how to collect unit-level data, the OST members relied more on helping airmen on a case-by-case basis. As a result, OST members felt as though they were underserving the unit as a whole and could not give the unit leaders effective suggestions for systematically improving the health of the unit.

Phase 2

At the time of the second set of visits, the OST members at Whiteman and JBER each had the opportunity to support two more units and had applied lessons learned from their first units. Both teams indicated that they had successes with their services and improved the health of multiple airmen. However, the initiative still faced challenges surrounding hiring, communication, and resources.

Successes

Operational Support Teams Are Truly Embedded

Despite not being a permanently embedded asset within their units, as are the EMHTs and RSTs, discussions with unit leaders and OST members revealed that the OST providers were able to truly embed within their units. This was likely due to the concentrated time in the unit during their rotation. Unit leaders consistently described situations where the embedded OST members would make recommendations, have regular meetings with leadership, and have positive one-on-one interactions with airmen. As an example, one unit leader stated:

They’ve provided us with initial recommendations . . . from their out-and-about engagements. I addressed one last week regarding training day schedule changes that filtered up from the OST teams. I could see that they recognized that it is being discussed at the higher level. I could tell they were happy it came up and was being discussed. We meet with them Thursday for the biweekly luncheon to go over the recommendations and go over the feedback from the OST members in regard to other feedback or concerns.

OST interactions with their units have led to various positive outcomes related to nutrition, physical fitness, and improvements in personal training. In some cases, good outcomes are reflected in the feedback and impressions of airmen and leaders. In others, higher pass rates and scores on physical fitness tests were observed in units that had an embedded OST. The majority of unit leaders expressed gratitude when discussing the OST’s services. One unit leader believed the OST members were “invaluable” and described how OST exercise physiologists would help airmen by facilitating stretches, giving massages, and observing PT in the unit. They also praised the team for its ability to quickly schedule appointments.

Challenges

90-Day Rotation

In the first set of visits, the 90-day rotation was identified as a major complaint regarding the OST initiative. OST members did not feel as though it was enough time to spend in a unit, and unit leaders were concerned that airmen would become accustomed to their support, only for it to be taken away after a few months. In Phase 2, however, the OSTs were more comfortable with the rotation and made some changes to render the process more efficient. As a result, OST members at Whiteman and JBER felt more confident. When asked about the 90-day rotation, one OST member replied:

Our team has it down to a science. [We] had to write our own policies, which have subsequently been pushed out to other OSTs. [We] saw what worked and didn't work . . . [and] improved over time. Now we have: month one is data collection, month two is implementation, and month three is observation.

Another OST member described:

A good example would be that we were originally to go into a squadron and observe, not engage much but observe, and go to different shifts and flights and just observe, not interact. And then in the second month, we devise recommendations, and the third month we give the [commander] recommendations on what to do. Today, I can tell you that what happens is that we're interacting from the get-go. We meet with the commanders usually every two weeks, and then we make recommendations at that time and then follow up. It's an ongoing process. So that's changed significantly since the onset of OST.

While the OST members were more confident about the 90-day rotation, unit leaders were still concerned that airmen would not adjust well to having the OST members leave the unit. One leader stated:

My biggest concern with OST is that when you rotate them through, it should be institutionalized, has to be persistent over time. When the members see the value of the program, the resources that were given, they respond. When you pull them away so quickly—the unit rotates so fast that people quickly forget what OST even is.

Similar to responses in the first visit, unit leaders were still concerned that the benefits created by the OST members would only be temporary, and any recommendations would not be sustainable.

Insufficient Support

OST members work with the MDG and multiple units over the course of their initiative. OST members must ensure that their work is compliant with the standards set by the base, as well as units to which they are assigned. However, OST members and unit leaders remarked that they did not believe that OST members had enough support to reach their full potential. One issue has been the lack of training that OST members have received, and this training is key—OST members

work with the MDG and need to learn proper documentation as well as how the clinics support their units. One OST member commented:

We discussed the fact that some of us received no initial training. We received little to no ongoing training either. When the new data program was finally released (a year after initial plans), we did receive training, which was very welcome, but nothing else has been addressed to such a level.

The lack of training and orientation has led to confusion among OST professionals as well as the MDG in terms of roles, policies, and procedures. During discussions with OST members and MDG staff, participants described situations where OST members were unprepared or unaware of certain procedures that could have been clarified in a training course or orientation. One OST member described:

There are some struggles between what the civilians are being asked to do [and] what the clinic wants them to do, partly due to vague CONOPS and local memos. Mixed signals on this. [There are] some militaryisms that a civilian might not be familiar with. Need to work out some of the ambiguities here and set expectations on all sides.

Similarly, another provider discussed poor communication between OST members and others who could help the initiative:

Overall, communication has been horrible. Communication from the 711th, from [the contracting company], from our leadership here on base, et cetera . . . Many of our issues as employees could have been addressed much easier, or wouldn't have even become issues, if the communication had been better from the beginning.

Given the challenges inherent in the work of a multidisciplinary team rotating frequently between units, responsive leadership would seem to be a foundational need. While OST members prepare data and plans that they share with HPW, a team member pointed out that little of this information is disseminated to other teams or used as the basis for feedback. More active direction from AF/A1Z and the 711th HPW, according to this member, would clarify OST expectations and standards, which could help the team get established in its units more quickly. In particular, because the OST members are meant to be treating units and responding to unit needs rather than individuals, they require data about the units. An OST member described how requested unit data that would be used to identify weaknesses OST could target through interventions were never received. The team also tried to acquire statistical software to do their own quantitative analysis, which should be provided to the teams by HPW, in accordance with the CONOPS.

Roles and Team Staffing

More clarity around the roles of OST members and expectations for their rotations could improve the program. OST members reported conflicting information about what they could do outside the medical clinic. Leaders sometimes did not appreciate that the purpose of the OST

initiative was to develop and implement interventions at the unit level rather than treating individual problems. OST members also expressed that they could benefit from ongoing professional development, which was not always factored in to their schedule or supported by the contracting company. Additionally, hiring was a consistent issue for the OSTs: Whiteman did not have an LCSW, JBER did not have a clinical psychologist, and neither team received any word from the contracting company responsible for filling the contracted positions across TFTN on the status of filling those positions. Since each of the six roles on the team had specific responsibilities and often required specific training and credentialing, this hampered the team's ability to work as intended. Whereas a team of EMHTs that was lacking one LCSW might have a higher workload for the other LCSWs, in the case of the OST, a missing team member meant a missing capability, not simply a heavier burden.

Conclusion

OSTs at both Whiteman and JBER matured significantly between Phase 1 and Phase 2. The OST members appeared overwhelmed in their first rotations as they dealt with large units and adjustment to their bases. With more experience, OSTs have become more confident in their abilities and have improved their support for airmen. However, there are still challenges for OSTs, including getting more support from the contracting company, MDG entities, and the 711th HPW. Overall, the initiative has been a positive addition to units and can continue to improve with some modifications discussed in Chapter 9.

8. Overarching Findings

Up to this point, the successes and concerns identified by interview and focus group participants have been discussed by initiative. However, three findings cut across multiple initiatives or concern multiple features of TFTN. This chapter will cover these administrative and structural findings of TFTN that may influence the progress and potential effectiveness as it is expanded to more installations.

Issues with the Contracting Company

One of the most serious concerns regarding the TFTN program is the conduct and performance of the contracting agency responsible for hiring providers for EMHTs and OSTs. Providers have heavily criticized the contracting company for its poor vetting procedures, lack of support, and for giving contractors misleading information about their positions. Senior leaders and leaders at the bases are also dissatisfied with the contracting company's hiring process and their inability to fill vacant positions. Across both phases of interviews, the contracting company was one of the most commonly discussed topics and is regarded as a major hindrance to TFTN.

It is important to note that, while the participants' perceptions about the contracting company were verified by AF/A1Z, RAND did not independently verify reported information directly with the contracting company. It is possible that some of the shortcomings associated with the contracting company can be justified by factors external to their control (such as lack of availability of mental health professionals in the remote areas where the bases are located resulting in the difficulty backfilling empty positions). However, the poor administrative processes and inconsistent human resources policy, as outlined here and in Chapter 6, remain a point of great concern that must be addressed.

In every discussion with both EMHT and OST members, the contracting company was identified as a challenge for TFTN. The major complaints revolved around EMHT and OST providers not being properly informed about their future roles and the expectations of their positions. Some mentioned that they felt as though the contract did not accurately outline the details of the CONOPS. This led to conflicts when providers arrived at their base and were unaware of certain tasks and responsibilities.

As one EMHT provider noted, "In the beginning they didn't inform us correctly on what we're supposed to be expecting because they themselves didn't know. The job description that I was provided was opposite from what I was informed the first day I got here." This was a major concern for providers, who reported that several of their colleagues had left their positions because of the incongruence between their expectations and the reality of their work in the units. Furthermore, some contractors described situations wherein the contracting company did not

provide proper financial support for moving contractors to their positions. In one description, an EMHT provider recalled:

[The contracting company recruiter] sent me a link to the [TFTN] program, all three programs. [Their] description of EMHP was “there would be mental health services to the squadron.” No mentions of clinic. By then I had moved and sold my home. There was no financial support for that. They didn’t keep their promises, and what I was told wasn’t accurate.

OST and EMHT providers often remarked that the contracting company was simply giving inaccurate information in order to fill vacant positions quickly. One provider stated, “[The contracting company’s] problem was that they rushed us up here, said what they needed to say to get us here. They need to have a better understanding of what this job is.”

Providers were also seriously concerned about the contracting company’s lack of vetting. Multiple providers revealed that they were not interviewed or evaluated in any way aside from giving the contracting company their credentials. One provider recalled:

I submitted [my] résumé, one week later [I was] hired, [but] no one knew I was coming. . . . I heard someone who was here was not a good fit, so I’m surprised they brought someone in without digging more. Interestingly, I was brought on without speaking to anyone, [so I] could have been the same person for all they know.

The presence of inaccurate information given to the providers along with the lack of vetting led to confusion and a lack of trust in the contracting company. Providers often felt that they were deceived into filling their roles. As one provider summarized, “It’s unfortunate when you have trouble staffing and you’re not vetting people appropriately, so people get here without knowing what they’re supposed to be doing.”

Even despite the shortcuts of poor applicant vetting and position misinformation, the contracting company has been unable to fill positions in areas where there are a large number of vacancies, such as the EMHT providers at Beale. This has led to a strain on the TFTN providers affected by these personnel shortages, including RST members who do increased counseling when no LCSW is available in a unit, and severely hampers the effectiveness of all TFTN initiatives, not just the EMHTs. As one unit leader described:

Most all of [the EMHT members] have departed; we’ve got two remaining. The company that was contracted [redacted] made no effort to backfill any of the vacancies—that’s obvious. They’re not even trying, nor were they paying their employees consistently.

As noted in this quotation, the criticisms of the contracting company extend beyond hiring and into serious human resources issues. EMHTs and OSTs both described their irritation with the contracting company’s lack of communication, guidance, and conflicting information. This has contributed to turnover for multiple EMHT members who were not comfortable with the

contracting company's lack of support. One unit leader described their EMHT members' interactions with the contracting company before their eventual departure:

They don't give them answers [or] resolve questions in time, like [paid time off], benefits not being given to them in a timely manner, no chances of pay increase, no [cost-of-living adjustment] for California, no travel reimbursement, even paychecks. . . . I had a contractor say [they] hadn't been paid and might not be able to drive into work because [they didn't] have gas. They say they're looking into it.

In another case, one EMHT member did not receive adequate notice about their contract extension and left the initiative as a result. The leader of their embedded unit recalled:

The big complaint I had from my primary provider was that the decision to extend or renew the contract took too long for [my LCSW] to ensure [they] had a living. [My LCSW] was not getting word back from the Air Force or the contract owner on if [their] contract was going to be renewed. [My LCSW] had to take matters into [their] own hands. That terminated what was going to be a full 12-month period. I only had [them] seven to eight months. It took six to get comfortable. It was about two to three months where we really had that embedded feature in the unit. We need to look at contract length and the timeliness of renewing their contract.

Situations such as those described have led to a general distrust in the contracting company's ability to handle the providers' contracts. EMHT and OST members also began to question the contracting company's ethics as they continued to receive misinformation about the terms of their contracts. The most referenced issue involved the paid time off (PTO) policy for the providers. The concern was described by one OST provider:

[The contracting company] has struck a few of the TFTN members as not very ethical, and as the majority of the TFTN is social workers, ethics are very important. They offered us our time off when we were hired (most of us two weeks) and said nothing about time limits or anything. As the anniversary dates of staff started to roll around, we were realizing that the balance of our accrued PTO had been reset to zero. After much complaining and threatening (by some), PTO was reinstated, but the employee had a limited time to use it. This created a need for staff to take time off immediately, which often displaced appointments/duties here at work.

Across both phases of base visits, providers, unit leaders, and senior leaders all discussed major complaints about how the contracting company was limiting the effectiveness of the program. TFTN relies heavily on its providers, and if the contracting company does not adequately supply bases with an appropriate number of positions, the initiative will not be functional.

According to interviewees and focus group members across all participant types, the contracting company has been damaging to both the EMHT and OST initiatives, but the EMHT's success has been particularly impaired by the contracting company. The EMHT initiative is much larger than the OST initiative in terms of number of providers as well as

their presence at more bases. Also, attrition among EMHTs has been much worse than OSTs due to a greater number of conflicts with the MHCs, credentialing, and inability to connect with airmen. As a result, the contracting company's inability to fill EMHT positions has been a severe challenge. However, OST providers still have had major concerns with the contracting company's human resource policies and misinformation. Members from both OSTs were very vocal about their dissatisfaction with the contracting company and echoed many of the same complaints as the EMHT providers.

Provider Fit

It is important that the providers have the expertise and experience to be qualified for their position, but they must also be able to properly connect with their unit. Without this, they will not be able to effectively administer the services provided by their initiative.

When discussing provider fit, multiple leaders described how their provider needed to match the personality of the units, which is often tied to the demographics and duties of the unit. For example, multiple leaders noted that their airmen would be able to better connect to providers who were closer in age or had an interest in the type of work the airmen did. The issue of fit was particularly problematic for the EMHT providers. In at least one unit at every base, one leader did not believe their EMHT provider was a good fit for their airmen. On the other hand, most unit leaders believed that their RST providers were successful because they fit in well with their unit, and only one unit had leaders that expressed frustration with the fit of their chaplain. Overall, leaders felt that fit was still a key predictor of the providers' success. To that end, several leaders indicated that they wished their units could play a role in the selection process. As one leader stated,

I want to be able to access all counselors, so I can find someone my guys need, and ideally, we'd get to have a say in who we get, not just sent someone for TFTN, but to find someone who fits with us . . . the chance to say we don't want that guy. It would be awesome if we could have a say in who's embedded in our unit.

While most discussions of fit were focused on EMHT providers and chaplains, fit could also play a role for OST providers and the Welcome Center. The success of Whiteman's Welcome Center was partially attributed to the enthusiasm of the representatives from the relevant offices and functions, as well as their knowledge of the base and ability to connect with the airmen. Although Welcome Center representatives are not embedded, their personalities matched the base well.

Some unit and senior leaders surmised that EMHT attrition was due to not being a good fit for TFTN and expressed a desire to be able to vet the EMHTs. In Phase 2, a lack of provider fit was tied to attrition levels, as providers who did not fit the program or their unit were more likely

to leave or be removed. This perceived lack of fit was compounded by leaders learning that the contracting company did not thoroughly evaluate contractors. One senior leader recalled:

We didn't vet the contractors; [they] took the first ten bodies with a pulse and brought them in. Right off the bat, I dismissed one because they were not going to work. If I had the chance to read their résumé, call and check references, phone interview, I wouldn't have let that person on the base. I actually worked on and created a plan to vet people before they sign a contract and get out here, make sure background checks are clear, then have them go to each squadron that has a vacancy, then see who's a good fit.

With more in-depth evaluations, base and unit leadership might be able to better tell if a potential contractor will be able to match the demands of TFTN. Leaders and providers also noted that units with multiple embedded providers allowed airmen to find one that matched their personalities.

Several participants noted that airmen in groups with multiple EMHTs and RSTs were able to connect with multiple providers until they found one that fit. As one RST stated:

If an issue happens, we try to connect them with another provider. If they can't relate to someone or that person can't understand them, if they're uncomfortable or can't relate—we'll ask another to relate to them. We want them to be comfortable with the provider to give them that care. We transition to work with what the airman needs.

This ability to “shop around” for a provider cannot occur with high attrition. With limited personnel, airmen who are unable to connect to their assigned RST or EMHT provider might disconnect from the initiative as a whole.

Participation in Task Force True North Initiatives

Another critical consideration when determining the impact that TFTN has on the units receiving its services is the number of airmen participating in the initiatives' services. TFTN providers track participation in their services in a variety of ways. Welcome Centers track those who in-process there, as well as the number of appointments scheduled for other base entities. NORTH STAR tracked data on percentage of survey participants and their demographic characteristics. RSTs track the number of airmen that attend their events, the hours of engagements with airmen and leaders, and the number of counseling sessions they hold. EMHTs track their counseling sessions and time in the units and in the clinic and maintain detailed notes of counseling sessions to meet typical counseling standards, but these notes are kept private with limited access. Because of OST's focus on the unit, they focus less on individual participation.

In general, participation metrics tend to show upward trending in interactions between these initiatives and airmen and a clear increase in comparison to similar entities prior to the stand up of TFTN. Many factors, however, can impact participation, and it is helpful to identify those influences.

Across both phases of data collection, it became clear that interviewees and focus group participants perceived a number of things affecting participation in the initiatives, including the following:

- initiative manning (i.e., initiatives that are properly staffed see increased participation)
- the size of the squadron, which can have a varying relationship with participation (e.g., large squadrons might have more participation due to greater numbers of airmen or less participation due to limited resources)
- the functional area of responsibility of the squadron (e.g., maintenance squadrons might be easier to access in one location, while security forces squadrons are likely to be spread out across the base)
- the proportion of active-duty versus civilian personnel, with squadrons with a high number of civilians recording lower participation percentages because TFTN is available exclusively to active-duty members
- initiative resourcing (e.g., RST being TFTN funded while EMHT is not)
- airmen perception of stigma related to help-seeking behaviors, where greater stigma would result in less participation
- airmen awareness of the availability of services, where lack of awareness would result in less participation.

Leaders and providers believe airmen are aware of the initiatives and are utilizing them, though the perceived percentage doing so varied based on the unit, activity type, and whether it was a leader or provider answering, mainly due to “guesstimates” provided by focus group participants when accurate numbers were not readily available. Still, leaders, providers, and even airmen perceived increased participation across the initiatives, comparing how participation might typically look for chaplains and mental health resources before TFTN with participation at the time of the RAND team’s first visit and the time of the RAND team’s second visit. In particular, informal interactions appear to be increasing, likely due to the increased familiarity of the providers and their length of time in the unit, which supports the decision to embed.

However, as previously discussed, a number of units lost some of their EMHT members, and only some of the units have received replacements. This attrition was one of the main hindrances to airmen participation in the counseling aspects of TFTN. Lack of visibility within the unit of some TFTN providers, the mismatch between airmen and provider availability across the airmen’s various work shifts, and the mismatch between airmen’s needs and the TFTN services provided were also cited as factors with an adverse impact on participation in TFTN initiatives. Conversely, visibility of providers in the unit and during social events, as well as the ability of providers to adapt their services to the needs of each squadron, were associated with increased airmen participation in TFTN initiatives.

One element of TFTN that has had continued high participation is the events held by RSTs, particularly those that get the airmen out of their units during the workweek or those that provide free and fun activities at any time. RSTs shared that these events were continuously full of airmen, though workshops and educational events often had fewer participants than activities

such as free movies and white-water rafting. The primary obstacle keeping airmen from attending these events was difficulty getting permission to take time off from work to do these things, and that was particularly true for airmen working jobs that are not fully staffed and/or have a high operational tempo. Airmen need to be encouraged by leadership to attend, which means, when possible, airmen need to be given time off, perhaps even when their workplace is undermanned, if the TFTN initiatives are to realize their potential.

Another element of promoting airmen access to TFTN initiatives is transparency. During focus groups, EMHTs mentioned their efforts to communicate to airmen that seeing an LCSW would not have negative career consequences. While EMHTs may believe this to be true, particularly if they are generalizing from prior experience in the civilian sector, it is in fact not entirely accurate. As with all medical professionals (and unlike RSTs), EMHTs are obligated to break confidentiality in certain circumstances. EMHTs are also required to document their encounters with airmen in files that are subject to review by military personnel. For some situations, this could influence arming status, ability to retain a clearance, or medical separation from the military. Misrepresenting or understating the EMHTs' status regarding confidentiality may increase engagement in the short term but could reduce trust in EMHTs when it becomes clear that disclosing some issues can indeed have career consequences. Some EMHTs pointed this out, and one with a prior service background suggested that a better approach is to tell airmen that while seeing an EMHT may have career consequences, if a problem of that magnitude exists, the best way to minimize consequences is to seek help as early as possible. For ethical reasons as well as to maintain the trust of airmen in the EMHTs and TFTN initiatives more broadly, honesty with airmen about the benefits and risks of seeking counseling with an LCSW is important.

Conclusion

These three overarching findings—issues with the contracting company, provider fit, and participation in TFTN initiatives—will be critical factors to consider as the initiatives continue their services and as TFTN is expanded to more installations. If the issues that exist with the contracting company are not addressed, high turnover rates, misinformed contractors, and inability to fill open positions will continue. These contracting issues will likely also affect provider fit, which can be a crucial factor in determining the providers' success in connecting with their units and providing their services. Provider fit, in turn, can affect airmen's willingness to participate in the initiatives, as can their understanding of the consequences of participating. The next chapter lays out several recommendations to address these three findings and the initiative-specific findings discussed in previous chapters.

9. Recommendations and Conclusions

AF/A1Z sought a qualitative analysis of TFTN to determine whether the individual initiatives and the program as a whole were meeting the objectives of improving airmen and family resilience and well-being through efforts to engage airmen and their families early, normalizing help-seeking behavior, and decentralizing helping services to locations where airmen are. The RAND team was able to gather insight into the implementation and management of the initiatives and perceptions of important stakeholders on the effects of the initiatives. However, without longitudinal data over several years and a full program evaluation including both qualitative and quantitative measures of outcomes resulting from the initiatives, the RAND team cannot speak directly to the effectiveness of the program. There are several limitations to the use of qualitative data that should be considered when reviewing the preceding findings and the following recommendations, which are described in both Chapter 1 and Appendix A.

It is also important to recognize, however, that it is not always possible to have complete data when having to make important policy and operational decisions, and indeed, having to make such decisions without optimal data is more the rule than the exception. Such is the case with TFTN: the Air Force has reason for urgency, and leadership is responsibly taking steps to address negative outcomes and continuing issues with suicides.

RAND has therefore created a set of recommendations derived from the data that have been collected and compiled. Overall, RAND is recommending that AF/A1Z continue with TFTN at its current locations and undertake a phased expansion of the initiatives to other bases. This top-line recommendation comes with supporting recommendations that must be addressed to secure the necessary talent and changes to processes needed to continue the initiatives and ensure their success.

The RAND team has developed ten recommendations to address the key issues and concerns expressed by senior leaders, leaders, airmen, providers, and other stakeholders. The first four of these recommendations are policy-driven changes, the next five are programmatic changes to improve the probability of future success of the initiatives, and the final recommendation proposes an implementation plan for the institutionalization of TFTN. As TFTN prepares to expand its reach, it will be imperative to address these issues, ascertain the correct solutions, and execute the remediations. If resolutions can be achieved, the Air Force will be well positioned to expand the rollout of this important set of initiatives, in what would be a win for airmen, their families, and the Air Force's readiness and resilience.

Policy Recommendations

1. **Conduct a more thorough evaluation of TFTN using qualitative and quantitative data collected across multiple points in time to determine the effectiveness of the initiatives. Complete frequent evaluations to seek continuous improvement in the initiatives.**

Data beyond the perceptions of key stakeholders are vital to determining the effectiveness of the initiatives and of TFTN as a whole in meeting its goals of improving resilience and well-being among airmen and their families. Ideally, longitudinal quantitative data would be collected on each of the “risk indicators” initially assessed by 711th HPW (as described in Chapter 1), as well as from physical and mental health records. Qualitative data on stakeholder perceptions collected through interviews, focus groups, and written feedback (potentially via an online comment portal) should also be included in this longitudinal analysis. Using a multimethod approach that incorporates both quantitative and qualitative data, especially if longitudinal, would allow a deeper understanding of effects. These data could be collected quarterly or annually and leveraged for opportunities for improvement as they arise.

In addition to programmatic improvements, these data can help inform the expansion of TFTN to new bases by providing answers to lingering questions, such as the following:

- How broadly should the initiatives be expanded? Would certain bases or units benefit from these resources more than others? Would particular populations—military, civilians, families, high-risk units, and/or units with 24/7 missions?
- Which initiatives should be implemented for each base? Should this vary by unit?
- How many providers will be necessary to successfully implement and maintain the initiatives?
- What level of resourcing is needed for the initiatives to be effective?
- Is there full support from leadership at all levels?

2. **Pursue authorizations and funding for civil service providers to fill EMHT and OST member roles.**

RAND strongly recommends that the EMHT and OST roles currently being filled by contracted professionals be transitioned to civil service roles. Although each personnel category has advantages and disadvantages, the beta test of TFTN unveiled a broad set of disadvantages with a contracted workforce that are unlikely to be completely resolved by a change in contracting company. Obtaining authorizations and funding for a civil service workforce would be difficult and time-consuming but would likely result in important advantages in stability, access to airmen, and the opportunity for leadership input into the selection process. Stability would be enhanced as civil servants would be a permanent party workforce. Access would be enhanced because clearances would be possible, thus allowing providers greater access into secure areas. Leaders, as part of the hiring process, would have a voice in the selection of providers, possibly identifying fit issues before offers are made.

3. If a civil service workforce is not possible, a number of improvements in choice of contractor and contract administration would be required for the initiatives to realize their potential.

If the numerous existing challenges that have emerged with contracted EMHT and OST members are not addressed, these challenges will likely undermine the effectiveness of the initiatives when promised services either do not materialize or are unreliably available. First, AF/A1Z will require a contracting company with broad contacts and resources in the provider community, particularly due to the challenges of recruiting providers for bases that are outside of major metropolitan areas as many AFBs are. Because the limited labor market in many rural areas will be a major hindrance to filling these positions, the contracting company should have demonstrated experience recruiting for such locations.

In addition, the contract for EMHT and OST providers must be carefully drafted to address as many of the issues faced by these initiatives as possible. Given the inability to provide input into hiring choices of the contracting company, AF/A1Z must carefully consider the characteristics of providers that will be required to meet the needs of airmen and build those attributes into the contract requirements. Additional critical requirements for the contract include the following:

- Include a maximum time frame in which EMHT positions can be vacant without contractual penalties.
- Set contractual expectations for transparent and frequent communication among the contracting company, contracted professionals, TFTN PMs, and Air Force leadership as necessary.
- Require an identified contracting company representative be available and responsive to TFTN management.
- Ensure the contract includes clear and stable human resources policies for contracted professionals with policies and practices that may promote contractor retention, including
 - timely paychecks
 - straightforward filing for reimbursements and expenses and timely payment of them
 - well-thought-through relocation policies and assistance, recognizing that some locations (e.g., JBER, Minot) will require incentives commensurate with location
 - paid time off
 - cost-of-living adjustments in high-cost areas
 - written policy with clear descriptions of all human resource policies, benefits, and compensation issues.

4. Determine the scalability of TFTN and its individual initiatives for Air Force-wide expansion.

A critical consideration in the expansion of multifaceted, resource-heavy programs such as TFTN is the determination of what modifications are necessary for the programs to succeed on a larger scale and across locations. TFTN initiatives are heavily resourced, and projected costs will need to include not only the number of providers for targeted bases and units but also the costs incurred for dedicated office space, as well as such equipment and supplies as computers and educational materials.

One modification we recommend is having services offered by TFTN initiatives available to families of airmen and to civilians in the units with embedded assets. Although family members can currently interact with RST members, the inability of EMHTs to counsel civilian spouses, particularly when airmen are dealing with relationship and domestic problems, creates frustration among airmen and among their leaders as well. Spouses, for example, often see early signs of airmen distress that may be overlooked in the workplace. The EMHT initiative may prove more effective if marital counseling and family issues can be included within the program. Additionally, a majority of the units with embedded TFTN assets have both uniformed airmen and civilians working together, but civilian employees cannot access EMHT's services even when dealing with the same stressors and demands as the airmen they work alongside. A potentially have-and-have-not situation, this distinction in eligibility should perhaps be considered and addressed vis-à-vis the potential for mitigating existing high risks of negative behavioral outcomes.

Additional considerations are discussed in Recommendation 9.

Programmatic Recommendations

- 5. Ensure the MDG and TFTN parties are aligned in understanding that the top priority of embedded mental health professionals is support to the squadrons in which they are embedded and that the squadrons should be their primary work location. Responsibilities that EMHTs have to the MHCs should be in line with TFTN's foundational mission.**

After contractor challenges, the second most serious issue that emerged in RAND's study was the lack of alignment and agreement on participation of EMHT and OST resources in the MHC. MDG does not appear to be aligned with the TFTN contractors and program management. Agreement must be worked out and policy drafted to address concerns on each side, but the overarching consideration must be that the primary role and responsibility of the TFTN mental health professionals is to their embedded units. The preponderance of EMHT time and TFTN resources must be directed to the squadron and other embedded units.

The alignment issues also include the need for resolution on the appropriate amount of training that is required of new TFTN mental health providers, including necessary privileging and credentialing to carry out TFTN mission requirements, training on required data systems, additional certifications deemed necessary by the Air Force, and the credentials for which the EMHT and OST providers were hired.

A liaison position may be needed to assist in maintaining a productive partnership between the parties; however, the underlying disagreements likely need resolution of policy that would go beyond the scope of this role.¹

¹ At the time this recommendation was written (November 2019), the RAND team was made aware that TFTN is already pursuing and beginning to implement a liaison role—the "clinical support coordinator."

6. Work with chaplain career field management to ensure the new RST roles are incorporated in mainstream chaplain career development.

The widely perceived success of the embedded chaplains and religious affairs airmen suggests the initiative should be continued. To ensure RST assignments are normalized as part of the formal chaplain career path and that the role is not career limiting, AF/A1Z may wish to collaborate with the Chaplain Development Team to institutionalize the role. At some later time, comparisons of personnel data following RST assignments and more traditional assignments should be undertaken to ensure RST assignments are not career limiting. If they are perceived to be so, RST roles may not be sought out by high performers, and given the strong connections RST chaplains have developed in these high-risk units,² it will be advantageous to be able to recruit the “best and brightest.” Importantly, it will also be necessary to educate commanding officers on the nomination of RST members for chaplain-specific awards and other institutional recognition since RST members will continue to be outside the standard chaplain chain of command.

7. Develop standardized training for EMHTs and OSTs, and maintain and update curricula as TFTN initiatives evolve. Important changes within the Air Force would also need to be included in updates.

Whether the TFTN initiatives continue with civil service or contracted providers, it will be important that standardized training be developed to onboard and acculturate the incoming civilians, most of whom have no military experience. Aside from the training that will be required for mental health providers addressed in Recommendation 5, training for all EMHT and OST providers would ideally include the following:

- basic knowledge of the Air Force, with such topics as protocol, culture, acronyms, and general expectations
- role-specific information, such as typical duties, chain of command, and systems and databases
- base-specific information, such as mission sets, layout, and considerations for living in the area
- unit-specific information, such as mission, culture, and structure, which should include introductory conversations with unit leaders.

The most cost-effective and efficient solution for Air Force knowledge and role-specific training may be centralized training via computer-based training or video chat training sessions, prior to arrival on the providers’ base, supplemented by acculturation to the location and specific unit and mission. Appropriate training prior to arrival and onboarding at the location and in the

² As a reminder, the units for the TFTN beta test were selected based on 711th HPW’s analysis of the eight risk indicators, indicating that these units were at high risk for negative behavioral outcomes.

unit will accelerate learning and enhance the providers' abilities to become more acculturated, credible, and efficient.

8. Determine and plan for all preparations and qualifications needed for providers to be able to begin work upon arrival or as quickly as possible.

Major frustrations of both leaders and providers were voiced regarding the months of delay that resulted from EMHTs needing additional training and certification to work as an Air Force mental health provider. Further frustration resulted from office space not being ready and available and computers not being preordered. Several changes should take place to ensure the EMHT providers can “hit the ground running” and begin immediately providing the services for which they were hired. These actions include the following:

- Military- and Air Force–specific training and certification that is required after a hire should be resolved via policy that will cover all TFTN locations and not leave interpretation to the base level.
- Prior arrangements should also be made for physical space that is required for mental health professionals to do their jobs, including necessary office, furniture, and supplies. For EMHT members, this space should be move-in ready and out of the line of sight of unit leadership and supervisors. A networked computer must be supplied on arrival to meet requirements for proper notes and documentation.

9. As the beta test concludes and TFTN initiatives are expanded, clarify lines of authority and responsibilities. Update the CONOPS, and disseminate broadly among stakeholders.

When preparing for beta tests, not all questions or circumstances can be anticipated, and that reality is why beta tests are so advantageous. Several areas of uncertainty within TFTN initiatives were brought forward by participants in the focus groups and interviews, and the RAND team would recommend these be resolved and that the resolutions be subsequently institutionalized in the CONOPS or other appropriate policy. Resolution will not only assure the vision of TFTN initiatives are implemented uniformly, but policy will also assist providers and PMs if they are tasked with activities or responsibilities that are not part of the TFTN charter. Clear policies also assist leaders in communicating accurate information to airmen.

Some areas of confusion that could be clarified, according to RST, EMHT, and OST members, and Air Force leadership include

- *“Ownership” of the teams.* Stakeholders pointed out that RSTs are a group asset and should not be tasked by the base chapel; EMHTs are a squadron asset and should not be tasked by the MHC; and OSTs are a squadron asset and should not be tasked by the MDG.
- *RST funding.* RST funds were intended to be spent in line with base chapel spending guidance. However, group guidelines at times have been imposed, which is a misinterpretation of the original intent for the funds. As discussed in Chapter 5, uncertainty and conflicting interpretation of guidance have damaged RST events and activities on several occasions.

- *Chaplain career paths and RST members.* Career paths and evaluation processes for RSTs are not thoroughly understood by several TFTN chaplains and religious affairs airmen. As noted earlier, the integration of RST roles into the formal chaplain career path will be required.
- *Multiple EMHT policy clarifications.* EMHTs have the largest number of uncertainties and unclear, misinterpreted, or missing policy. As addressed in earlier recommendations, Air Force–level policy is needed to clarify the EMHT member role, if any, with local MHCs; what training, if any, is needed by the local MHCs; and what, if any, certification is required beyond the credentials for which they are hired.

In addition, it will be critical that those responsible for the success of the initiatives have the proper authority to make decisions and get buy-in as needed. TFTN PMs would benefit greatly from having a direct reporting relationship on base, to the base or wing commander. Such a reporting relationship may be necessary for the PMs to be able to resolve local issues and issues related to the execution of policy at the base and unit levels.

Implementation Plan

10. Develop a clear plan for scaling up and institutionalizing TFTN across the Air Force. Use findings from the beta test to inform modifications that will optimize the TFTN initiatives.

The proposed plan below offers a road map that incorporates the recommendations outlined above, puts forward a means to scale the initiative across the Air Force, and expands on identified implementation challenges:

- Baseline the Air Force.** Given the substantial resource commitment to implement the TFTN initiatives across the Air Force, a baseline of data and information on unit risk indicators should be established that will inform priorities for fielding TFTN capabilities. The data will also serve as a starting point for the assessment of change that results from the initiatives. AF/A1Z may want to advocate for a common database across the multiple functional entities that will assist in prioritization as well as measurement of progress.
- Sizing of the TFTN workforce.** The Air Force will need a full manpower study to determine the appropriate size for the TFTN workforce and the total manpower costs for competing in the program objective memorandum phase of the program, planning, budget, and execution process. It should also seek recommendations on the organizational placement of activities and major command oversight responsibilities to ensure clear lines of authority and responsibility without day-to-day management from Air Force headquarters. The assessment should address impact on the total force (including both military and civilians) and expansion of select services to family members. A “one-size-fits-all” approach is not likely to be effective for the expansion of these initiatives. Specific sizing criteria will assist in decisions, and the following questions are a few notional examples regarding criteria:
 - Should the Welcome Centers be expanded to every Air Force installation?
 - Should criteria on unit stress determine which groups receive an RST?

- iii. Should all squadrons have access to an EMHT, or does it make sense for units with lower risk for negative behavioral outcomes to utilize MDG support?
 - iv. Should OSTs be assigned only to those units with the highest risk for negative behavioral outcomes?
- c. **Baseline funding.** Funding identified by workforce requirements and other initiative costs will need to be detailed at the budget level, ensuring “fenced” funding, or monies set aside specifically for the TFTN initiatives. Clear guidance should be given to the major commands regarding how to use the funds in line with the TFTN goals and whether any flexibilities apply in this spending. Bases should maintain details on how funds are used. The TFTN PM could be responsible for working with the local budgeting office on prioritizing and distributing the funds to the various activities.
- d. **Commander and senior enlisted training.** Leaders will need to demonstrate full buy-in and support for TFTN initiatives, and leaders will need to be trained on TFTN prior to assuming command. Successful Air Force-wide implementation of TFTN will not be possible without a full and clear understanding of each initiative, what can and cannot be offered by each initiative, and what is involved in the management of each initiative.
- e. **Increasing or reallocating civilian end strength.** If AF/A1Z recommends a civil service workforce, civilian end strength growth will need to be strongly justified. AF/A1Z will need to make a compelling case based on the importance and potential for impact of the TFTN initiatives. If the case cannot be made to increase civilian end strength, a plan should be put into place to offset the costs of TFTN by reallocating funds from lower priority programs.

Conclusions

The four current TFTN initiatives have excellent potential to improve the resilience and well-being of airmen and their families. The Welcome Centers, once up and running, eliminate a major stressor in the PCS process of having to go to multiple offices for in-processing across a new and unfamiliar base, and the Air Force benefits by having airmen integrated into the workplace more quickly. RSTs, EMHTs, and OSTs all address unmet needs for care that is near the workplace, readily available, and takes place in a low-threat environment. Making these resources more accessible, particularly in high-risk units, is without doubt a major step forward for the Air Force. These initiatives have the potential to provide support that may limit negative behavioral outcomes, such as substance abuse, suicidality, and domestic abuse, that hurt airmen and their families and decrease mission readiness and performance.

Vice Chief of Staff of the Air Force Gen Stephen W. Wilson has strongly encouraged the expansion of TFTN, and verbal support for TFTN extends down and throughout most wing, group, and squadron commanders who have been involved with the program. Commanders clearly want what is best for airmen and their families, and the beta test confirmed that airmen are interested in what is being offered. The continued investment in these initiatives and support of senior leaders for them have the potential to result in a set of optimal solutions that can truly serve airmen best.

Appendix A. Methodology

Due to the personal nature of the problems, behaviors, and negative outcomes that the TFTN initiatives were designed to address, as well as the challenges with the quantitative data of the NORTH STAR survey (discussed in Chapter 4), AF/A1Z recognized the need for a qualitative means by which to evaluate progress. Leadership required a clearer understanding of the progress of the initiatives, and the perceptions of the TFTN stakeholders—including leaders, providers, and airmen—were essential in this regard. This study therefore utilized a qualitative approach, as it is particularly appropriate for collecting detailed information related to participants’ perceptions.¹

To assess the perceptions of those involved in the TFTN initiatives, the RAND team conducted two visits to each of the four beta test locations: Whiteman AFB, Minot AFB, JBER, and Beale AFB. The first set of visits (Phase 1) occurred in February 2019, and the second set of visits (Phase 2) occurred during July and August 2019. These visits were purposefully spaced roughly six months apart to assist in establishing whether there had been any changes over time in the perceptions of TFTN stakeholders regarding the initiative. The RAND team conducted focus groups and interviews with senior leaders, leaders, providers, and airmen from units receiving services of the TFTN initiatives. Specifically, the RAND team spoke with those in units with an embedded RST, EMHT, and/or OST, as opposed to those exposed to only the basewide TFTN initiatives (i.e., the Welcome Center and NORTH STAR).

Generally, focus groups consisted of four to eight participants, with a RAND facilitator and note taker. The facilitator led the discussion of the TFTN initiatives, using a protocol discussed later in this chapter. The note taker took near-verbatim notes to allow for the thorough analysis of responses. Focus groups were scheduled for roughly two hours, although the actual length varied based on the number of participants and their responses. The focus groups were conducted similar to group interviews, where the question was posed to the entire group, and any participant could respond, but participants could also respond to others’ comments. Interviews were typically one-on-one conversations, with one participant, the RAND facilitator, and the RAND note taker. These were scheduled for roughly one hour, but, again, the actual length varied based on the responsiveness of the interviewee, their familiarity with TFTN, and their availability.

The remainder of this appendix provides details about participants in the interviews and focus groups, the protocols used, and how the team analyzed the responses.

¹ Michael Berkwits and Thomas S. Inui, “Making Use of Qualitative Research Techniques,” *Journal of General Internal Medicine*, Vol. 13, No. 3, March 1998; J. Hammarberg, M. Kirkman, and S. de Lacey, “Qualitative Research Methods: When to Use Them and How to Judge Them,” *Human Reproduction*, Vol. 31, No. 3, January 2016.

Participants

The four participant types invited to formal data collection interviews and focus groups were senior leaders, leaders, providers, and airmen. A description of each participant type and numbers of participants in both the first and second sets of base visits can be found below in Tables A.1 and A.2.

Table A.1. Summary of Phase 1 Participants

Participant Type	Whiteman	Minot	JBER	Beale	Total
Senior leaders (base, wing, group commanders)	11	6	7	3	27
Leaders (squadron commanders, chiefs, senior NCOs, supervisors, first sergeants)	26	26	32	19	103
Providers (RSTs, EMHTs, OSTs)	18	14	29	11	72
Airmen	0	0	0	0	0
Total	55	46	68	33	202

Table A.2. Summary of Phase 2 Participants

Participant Type	Whiteman	Minot	JBER	Beale	Total
Senior leaders (base, wing, group commanders)	8	6	8	3	25
Leaders (squadron commanders, chiefs, senior NCOs, supervisors, first sergeants)	22	15	22	18	77
Providers (RSTs, EMHTs, OSTs)	16	14	20	8	58
Airmen	4	9	6	16	35
Total	50	44	56	45	195

Senior leaders included base, wing, and group commanders of units receiving the embedded TFTN initiatives. For the most part, the RAND team gathered input from senior leaders via one-on-one interviews, with the exception of a few leaders who opted to bring their deputies to the interview. During the first set of base visits, the team held 18 interviews with 27 senior leaders across the four bases, which included all relevant wing and group commanders. The second set of base visits involved 19 interviews with 25 senior leaders.

Leaders consisted of squadron commanders, as well as those who were in supervisory positions over units receiving the embedded aspects of the TFTN initiatives, which included both officers and senior NCOs. A total of 103 leaders participated in 19 focus groups in Phase 1 and 77 leaders participated in 20 focus groups in Phase 2.

Providers were defined as the team members of RSTs, EMHTs, and OSTs. Most often, the focus groups were with one type of provider at a time (i.e., groups of just RSTs, just EMHTs,

and just OSTs). Mixing providers occurred at times due to scheduling constraints, and mixed groups consisted of RSTs and EMHTs only, as those providers often collaborated with one another in their units. The RAND team spoke with a total of 72 providers across 13 focus groups in Phase 1 and 58 providers across 10 focus groups in Phase 2.

Finally, *airmen* refers to the airmen in units that were receiving the embedded TFTN initiatives. Unfortunately, the team was unable to speak with this population during Phase 1 due to a lengthy approval process regarding the protection of human subjects. To address privacy concerns, we modified our original approach for Phase 2 to include in our focus groups any airmen in the relevant units as opposed to just those who personally participated in TFTN initiatives. Additionally, as we discuss later in the protocol section, the RAND team asked the airmen about their observations of the TFTN initiatives in their units and whether they had observed any outcomes from the presence of the initiatives rather than asking airmen about their own experiences. In Phase 2, we conducted eight focus groups with 35 airmen.

During both sets of visits, we also had informal conversations with subject-matter experts that informed our results. For example, the RAND team spoke with the TFTN PMs at each base regarding progress of the initiatives, although these conversations were often guided by what the PMs felt was most important to discuss. Additional informal conversations took place with Welcome Center staff and with the MDG or MHC leadership and staff. Information collected in these additional interactions are included in Chapters 3 through 8 of the report.

Protocols

The team developed distinct protocols for each of the four participant categories, which can each be found in Appendix B. In general, facilitators followed the protocols closely, deviating only when responses indicated that additional detail was needed or a set of questions did not apply to the participant(s). All focus groups and interviews began with introductory questions about the participants' length of time on the base and in their unit, as well as how long TFTN had been operational at their location, to their knowledge. All participants were also asked for their titles or roles and the extent of their involvement with TFTN initiatives. The exception was airmen, who were not asked for their title or roles, as they were being asked about participation in the initiatives, and thus privacy concerns were primary.

All protocols included questions to solicit participants' perceptions of the management, implementation, and effectiveness of each of the initiatives as well as the overall effectiveness of TFTN. All participant categories were asked about the level of participation in the initiatives to the extent they could estimate it and whether there seemed to be consistent participation (i.e., whether airmen were using the initiatives' services repeatedly). Whereas facilitators asked senior leaders, leaders, and airmen these questions in relation to TFTN as a whole (i.e., across all initiatives they received), they asked providers to respond to participation questions in relation to their specific initiative.

Additional specific questions varied across each of the protocols for the four participant categories, and some minor changes were made for Phase 2 interviews and focus groups based on responses received during Phase 1. For example, during Phase 2, senior leaders, leaders, and providers were asked to discuss any changes that had taken place since Phase 1 related to either initiative management or outcomes they had noticed.

Senior leaders, who typically discussed high-level perceptions of the initiatives in their units, tended to focus on the management and implementation of the initiatives. This included resources, if any, they or their squadron commanders used to encourage participation and any challenges faced by the initiatives during stand up, as well as how those challenges were addressed. Senior leaders were also asked for their perceptions on the value of TFTN for airmen and their families and any evidence they may have had that there had been behavioral and attitudinal changes among airmen since the inception of TFTN. The team concluded each interview with questions about the possible expansion of the TFTN initiatives across the Air Force, including whether the senior leader would recommend expansion overall, which initiatives would be most successful if they were to be expanded, and what changes would be necessary for successful expansion.

Leaders, in contrast with senior leaders, typically discussed more granular aspects of the daily management and implementation of the initiatives, as well as their perspectives of the initiatives' impact on airmen in their units. In addition to the topics discussed by senior leaders, leaders were asked specific questions about each of the initiatives, such as how the EMHTs were meeting the TFTN goals, as well as their perceptions of their assigned EMHT and RST members. Leaders were also asked to explain which of the initiatives and the specific services they found most and least valuable for airmen and what kind of outcomes they had seen or heard about among airmen in their units.

Provider focus groups tended to focus on the management and effectiveness of their respective initiatives, as well as outcomes the participants have seen as a result of their presence in the unit. The topics addressed were similar to those addressed with senior leaders and leaders, although there was greater focus on the specific services provided by each initiative. Additional provider-specific topics included the resources they received to provide their services, their interactions with other entities on base, experiences with onboarding, and their perceptions of leader and senior leader involvement in TFTN. Importantly, providers were asked about changes that should be made to their initiatives going forward to improve effectiveness.

Finally, airmen were asked to discuss what they had noticed among other airmen in their unit (without identifying them by name or otherwise) in terms of participation in the initiatives and outcomes of that participation. Airmen participation questions also asked for their perceptions of obstacles that limit airmen's ability to participate in the initiatives. While questions asked of airmen were similar to those asked of leaders, though framed for their unique perspective, topics that were unique to airmen included their own awareness of the initiatives and any feedback they may have received from other airmen in their units regarding the initiatives. In addition, NORTH STAR was only addressed with airmen as a reminder that the initiative had been terminated, and further feedback was not requested.

Qualitative Data Analysis

Thematic analysis is a commonly used method of analyzing qualitative data involving the identification of themes or patterns in data, particularly in transcripts of interviews or discussions.² The RAND team used this approach to identify conclusions regarding what has and has not been going well and recommendations for improvement in the TFTN initiatives.

The RAND team used Dedoose, a qualitative analysis software, to code the interview and focus group notes. In addition to coding general themes, we coded the valence of responses (positive [success] or negative [challenges]). Successes were positive themes or strengths that participants mentioned about the initiatives and TFTN with respect to implementation, management, and effectiveness. Challenges were negative comments or recommended improvements in the initiatives and TFTN as a whole. A team of three coders divided responses—which often covered several topics or themes—into segments that focused on specific topics. The coders worked together to develop the codes used to analyze the transcripts of the discussions and practiced coding the same passages to establish interrater reliability.

This process resulted in a large number of themes—such as attrition, trust, resourcing, and provider fit—and the occurrence of these themes across discussion type were counted by Dedoose. These themes were analyzed by each of the four beta test locations to determine similarities and differences across each base that was receiving an aspect of TFTN. The themes were also analyzed by each specific initiative, which helped the team determine the effectiveness of each initiative across the bases.

² Virginia Braun and Victoria Clarke, “Using Thematic Analysis in Psychology,” *Qualitative Research in Psychology*, Vol. 3, No. 2, 2006.

Appendix B. Protocols

This appendix contains each of the protocols used during Phase 2 of our data collection efforts described in Appendix A. There are four protocols, one for each of the participant types: senior leaders, leaders, providers, and airmen.

Senior Leader Interview Protocol

Introduction

1. How long has True North been operational at your base?
2. Were you in your current position when True North became operational [in your wing/in your group/at your base]?¹
 - a. If not, how long have you been involved in Task Force True North?
3. Our information tells us that [group identifiers]² are receiving services from the [TFTN initiatives].³ Is that your understanding?
 - a. Do you have a sense of how this differs at the squadron level?
4. How involved are you in the True North initiatives [in your wing/in your group/at your base], and what does this involvement typically look like?

Participation

5. Have you been given any resources to implement the True North initiatives or to encourage participation? If so, what were the resources and how useful are they?
 - a. What have you heard from group or squadron leaders about the resources they've been given to implement the initiatives and encourage participation?
6. What are your observations about airmen participation in True North initiatives? Do airmen seem to be aware of the initiatives and understand them?
 - a. To your knowledge, are there a lot of airmen participating, some airmen participating, or only a few airmen participating?
7. Have there been any changes in TFTN initiatives since our last visit in February? These can be changes to how the initiatives are managed, what services are offered by the initiatives, or personnel involved in the initiatives.

Effectiveness

8. Do you get reports or other metrics on either participation or effectiveness of the initiatives? How useful are these reports? Is there additional information you would like to receive?

¹ The appropriate level of leadership was selected from the bracketed options.

² The interviewee's groups, squadrons, or units receiving TFTN initiatives were listed here.

³ The TFTN initiatives present in the interviewee's units were listed here.

9. Overall, what value would you say the initiatives have provided for airmen and their families?
10. Do you have a sense of what needs airmen typically express and how these are addressed by TFTN initiatives?
11. Have you noticed or heard about a change in mission effectiveness as a result of the True North initiatives?
12. Have you noticed or heard about changes in well-being or resilience among airmen and/or their families as a result of the initiatives?
13. Would you say more airmen or families are seeking help as a result of the True North initiatives?
14. Have your unit leaders given you any feedback about how well the initiatives are working?
 - a. Which initiatives tend to get the most positive feedback?
 - b. Which initiatives tend to get the most negative feedback?
15. What changes would you like to see in any of the initiatives we've discussed?

Conclusion

16. If you were making the decision, would you recommend that True North initiatives be expanded Air Force-wide?
 - a. Are there some initiatives that would be more successful than others, if expanded Air Force-wide?
 - b. Are there any additional changes that would need to be made if the initiatives were expanded Air Force-wide?
17. Is there anything else we should know or anything you would like to add?

Leader Focus Group Protocol

Introduction Questions

1. How long have you been at this base, and how long have you been within your unit?
2. What is your current title, and how long have you been in this role?
3. How long has True North been operational at your base?
4. How long have you been involved in Task Force True North?
5. Which initiatives have been implemented in your unit?
6. How many people are in your unit? What is the breakdown for airmen and civilians?

Participation

7. Are you aware of airmen in your unit participating in these initiatives?
 - a. To your knowledge, are there a lot of airmen participating, some airmen participating, or only a few airmen participating?
 - b. Do you have a sense of whether there is consistent participation in these initiatives among airmen in your unit (i.e., are the same airmen returning to the same initiatives consistently)?
8. Have you recommended services to any individual airmen? If so, how have they responded? If not, why?
9. What resources have you been given or do you use to encourage participation in these initiatives? How effective are these materials and activities?

10. What obstacles exist that interfere with airmen's ability to participate in the initiatives?
11. Have there been any changes in TFTN initiatives since our last visit in February? These can be changes to how the initiatives are managed, what services are offered by the initiatives, or personnel involved in the initiatives.

Effectiveness

Religious Support Teams

12. Would you consider your Religious Support Team to be truly embedded within your unit?
13. What RST activities are you aware of?
14. Which RST activities have been most effective? How can you tell?
15. How would you describe the nature of your interactions with your Religious Support Team?

Operational Support Teams

16. Is your unit currently receiving services from the Operational Support Team? If not, has it in the past, or do you know if and when it will in the future?
17. Would you consider your Operational Support Team to be truly embedded within your unit?
18. What outcomes or effects have you noticed as a result of the Operational Support Team in your unit?
19. Which of the OST services have been most effective? How can you tell?

Embedded Mental Health Providers

20. Would you consider your embedded mental health provider to be truly embedded within your unit?
21. How well do you think the embedded mental health provider initiative has reached the following goals: promote resilient behavior, reduce negative outcomes, decrease stigma, encourage help-seeking behavior, intervene early and enhance mission effectiveness?
22. Do the EMHTs hold events or classes for airmen in your unit?
 - a. Are these events or classes well attended?
 - b. As far as you can tell, do these seem to be relevant to your unit?
 - c. Do you have a sense of whether these events or classes are effective?

NORTH STAR

23. Have you been satisfied with the way data have been presented to you via the NORTH STAR dashboard? Are the data useful? How so?⁴
24. Have you received adequate support for creating and implementing prevention action plans?
25. Have you received any feedback on the evidence-based interventions that were selected for your airmen? If so, what has been the feedback?

⁴ Please note: facilitators skipped NORTH STAR-specific questions as the initiative was ended before our second set of base visits. The NORTH STAR questions listed here reflect those asked in Phase 1 of data collection.

Welcome Center

26. Are you aware of the Welcome Center on the base?
27. Has the Welcome Center helped new airmen in your unit? If so, how?

General Effectiveness

28. In considering the initiatives we discussed, which activities seem to be the most valuable? Which are the least valuable? Why?
29. What kinds of responses to or comments about the True North initiatives have you heard from airmen within your unit?
30. Do you have a sense of what needs airmen typically express and how these are addressed by TFTN initiatives?
31. Have you noticed any changes among the airmen in your unit? If so, what were they?
 - a. Have you noticed a change in well-being and resilience among airmen in your unit? Do you attribute these changes to Task Force True North initiatives or to another factor?
 - b. Have you noticed a change in mission effectiveness in your unit? Do you attribute these changes to Task Force True North initiatives or to another factor?
 - c. Have you noticed a change in help-seeking behaviors? Do you attribute these changes to Task Force True North initiatives or to another factor?
32. Have there been any challenges for any of the initiatives, such as issues with implementation or lack of participation?
33. How could these initiatives be improved?

Conclusion

34. Do you think True North initiatives should be expanded Air Force-wide?
 - a. Are there some initiatives that would be more successful than others, if expanded Air Force-wide?
 - b. Are there any additional changes that need to happen if the initiatives were expanded Air Force-wide?
35. Is there anything else we should know or anything else you would like to add?

Provider Focus Group Protocol

Introduction Questions

1. How would you describe your title/position?
2. How long have you been at this base? In your current role?
3. How long has your initiative or initiatives been operational?
4. Do you interact with any other Task Force True North initiatives?

Initiative Management

5. What services does your initiative provide?
6. What resources have you been given? How useful are these resources?
7. Has your initiative encountered any ongoing challenges, such as lack of awareness of the services, overdemand for services/activities, staffing, or availability of other resources?
8. What was your experience with the hiring/onboarding process like?

9. Do you collect any type of data about your services? If so, what?
 - a. Do you have any requirements for data collection or documentation? Do you need to report the data to anyone? If so, who?
 - b. How do you collect and store these data?
 - c. Do these data inform your service delivery or other aspects of your initiative?
10. Have there been any changes in your initiative since our last visit in February? These can be changes to how the initiative is managed, what services are offered by the initiative, or personnel involved in the initiative.
 - a. Why did these changes occur?
 - b. What were the effects of the changes?
11. Are you expecting any major changes to your initiative going forward?
12. What does unit and wing/base leadership involvement look like for your initiative? What kind of support do they and TFTN managers provide in carrying out the TFTN mission?

For Religious Support Teams

13. From what we can tell, Religious Support Teams provide community and religious events, pastoral/spiritual counseling, informed referrals, advice to leadership, and religious support. In general, does that describe your efforts, or did we leave something out?
 - a. What are some examples of each of these types of activities?
 - b. Of these categories, which seem to be most valued by airmen?
 - c. Which have had the best outcomes? How can you tell?
 - d. Which require the most effort and/or resources to coordinate?
14. To what extent do you interact or collaborate with the wing chaplains?
15. In general, what spiritual or supportive needs do airmen typically have?
16. Are these needs typically met through the religious support activities?

For Operational Support Teams

17. What specific services do you provide to the units?
18. Have you had the chance to conduct assessments on the outcomes of your services? If so, how do you conduct them?
19. In general, what needs do airmen typically express, and which of those are met through your services?
20. What outcomes or effects have you noticed as a result of your services?
21. How do you know which services are working well and which need improvement?
22. Has the 90-day rotation process gone according to plan? Have you encountered any problems?
23. To what extent do you interact or collaborate with the Med Clinic?

For Embedded Mental Health Providers

24. Once you have connected with an airman, how do you assess his/her needs? Do you use standardized measures, a structured interview, an unstructured conversation, the *DSM*?
25. In general, what mental health needs do airmen typically express, and which of those are met through your services?
26. In your experience, what are good outcomes for airmen who seek your services, that is, outcomes you hope they will achieve?
 - a. In your experience, how often do airmen have positive outcomes like that?

27. To what extent do you interact or collaborate with the mental health clinic?
28. What type of events, activities, or classes do you hold for airmen?
 - a. Are they well attended?

Initiative Effectiveness

29. Can you think of a few examples of how your initiative has met the goals of Task Force True North?
30. Are there any other changes or outcomes that have resulted from your initiative you would like to share?

Participation Questions

31. Have you experienced strong participation in your services? In other words, would you say there has been many airmen participating, some airmen participating, or only a few airmen participating?
 - a. Has the number of participants changed over time?
 - b. Has the participation been consistent? In other words, have the same airmen been participating consistently?
32. Have you noticed changes over time in participants' willingness to seek help and/or show that they trust providers? If so, how long does it take for trust to develop, or does it vary by airman?
33. How often do service members seek you out? Do you at times identify them and approach them?
 - a. What strategies do you use to identify service members or families who may benefit from your services?
34. How has base leadership encouraged participation?
 - a. Do participants typically attend voluntarily or have they been "voluntold" to attend?
35. Once someone expresses interest in participating, about how long does it take for them to receive services?
36. Have you had to turn away any airmen or families because you lacked sufficient resources?
37. Have any participants mentioned they sought out your program because someone they know had a positive experience with it?

Concluding Questions

38. Are there any changes you would like to see within your initiative?
39. Are there any other outcomes you may have seen but we haven't had a chance to discuss?
40. Is there anything else we should know or anything else you would like to add?

Airmen Focus Group Protocol

Introduction Questions

1. How long have you been at this base, and how long have you been within your current unit?
2. How long has True North been operational in your unit?

Participation

3. Are you aware of airmen in your unit participating in these initiatives?
 - a. To your knowledge, are there a lot of airmen participating, some airmen participating, or only a few airmen participating?
 - b. Do you have a sense of whether there is consistent participation in these initiatives among airmen in your unit (i.e., are the same airmen returning to the same initiatives consistently)?
4. How have these initiatives been advertised to you? Do your unit leaders encourage your unit to utilize them?
5. What obstacles exist that interfere with airmen's ability to participate in the initiatives?

Effectiveness

Religious Support Teams

6. What RST activities are you aware of?
7. Which RST activities have been most effective? How can you tell?

Operational Support Teams

8. Are you aware of the OST's presence in your unit?
9. Which of the OST services have been most effective? How can you tell?

Embedded Mental Health Providers

10. How well do you think the embedded mental health provider initiative has reached the following goals: promote resilient behavior, reduce negative outcomes, decrease stigma, encourage help-seeking behavior, intervene early and enhance mission effectiveness?
11. Do the EMHTs hold events or classes for your unit?
 - a. As far as you can tell, do these seem to be relevant to your unit?
 - b. Do you have a sense of whether these events or classes are effective?

Welcome Center

12. Did you utilize the Welcome Center upon your arrival to this base? If not, are you aware of the Welcome Center and its services?
13. Which of the Welcome Center services appear to be the most effective? How can you tell?

General Effectiveness

14. In considering the initiatives we discussed, which activities seem to be the most valuable? Which are the least valuable? Why?
15. What kinds of responses to or comments about the True North initiatives have you heard from airmen within your unit?
16. What needs do airmen typically have, and how are these addressed by TFTN initiatives?
17. Have you noticed any changes among the airmen in your unit? If so, what were they?
 - a. Have you noticed a change in help-seeking behaviors? Do you attribute these changes to Task Force True North initiatives or to another factor?
 - b. Have you noticed a change in stigma related to help-seeking behaviors? Do you attribute these changes to Task Force True North initiatives or to another factor?

- c. Have you noticed a change in well-being and resilience among airmen in your unit? Do you attribute these changes to Task Force True North initiatives or to another factor?
- d. Have you noticed a change in mission effectiveness in your unit? Do you attribute these changes to Task Force True North initiatives or to another factor?
- 18. Are you aware of any challenges for any of the initiatives, such as issues with implementation or lack of participation?
- 19. How could these initiatives be improved?

Conclusion

- 20. Do you think True North initiatives should be expanded Air Force-wide?
 - a. Are there some initiatives that would be more successful than others, if expanded Air Force-wide?
 - b. Are there any additional changes that need to happen if the initiatives were expanded Air Force-wide?
- 21. Is there anything else we should know or anything else you would like to add?

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Task Force True North (TFTN) is a collection of five initiatives chartered by the U.S. Air Force to improve resilience and well-being in airmen and their families. These initiatives have been undergoing beta testing at four locations: Whiteman Air Force Base (AFB), Minot AFB, Joint Base Elmendorf-Richardson, and Beale AFB. The authors undertook a qualitative analysis of the perceptions of key stakeholders across all TFTN initiatives to identify what is or is not working well with the goal of expanding TFTN to a broader section of the Air Force.

The authors conducted interviews and focus groups with leadership, providers, and airmen during two sets of base visits to each of the four beta test locations. Thematic analysis of the data collected from the base visits allowed the authors to identify key findings related to each of the initiatives and to TFTN as a whole, as well as changes in perceptions in the six months between the first and second set of base visits.

The authors provide background information on TFTN and its initiatives—Welcome Centers, NORTH STAR, Religious Support Teams (RSTs), Embedded Mental Health Teams (EMHTs), and Operational Support Teams (OSTs)—and describe perspectives gathered from the interviews and focus groups. The authors conclude with recommendations designed to help each of the initiatives reach its full potential to improve airmen resilience and well-being

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