The Engaged Leader Paradigm

The Community Health Promotion Council as the Key to Family and Soldier Readiness

E. Margaret Phillips

ON 26 APRIL 2011, in his www.foreignpolicy.com blog, "The Best Defense," defense writer Tom Ricks posted, "A stunning post from an Army wife."[1] It opened with a quote from an Army spouse which appeared in her blog, "Misadventures of an Army Wife." The quote read, "If you are reading this, you should know that I am dead. At least I hope I'm dead. It would be awful to fail at your own suicide."[2] Ricks gave a brief synopsis of the online suicide note—no longer available—in which the spouse described her officer husband's altered manner and high-risk behaviors following redeployment. After suicidal ideations on the part of both partners, her husband expressed a desire to end the marriage.[3]

Ricks posted the quote, the chronicle of the spouse's suicide attempt, and an update on her well-being with no editorial commentary. The 37 ensuing reader comments made the post truly extraordinary on a blog focused primarily on strategy and policy. Soldiers wrote extensively of their concern for their spouses' well-being during past deployments, of negative family readiness group (FRG) experiences, and offered various solutions to the problem of family stress during deployments.[4] While not empirical evidence, those anecdotes are illustrative examples of a broader crisis of leadership, namely, who specifically is responsible for taking care of families. The responsibility for family readiness belongs to commanders, especially at the lowest unit levels.

The link between leadership and suicide prevention is almost a truism since former-Vice Chief of Staff of the Army General Peter Chiarelli released the *Army Health Promotion/Risk Reduction/Suicide Prevention Report 2010* (henceforth referred to here as the 2010 HP/RR/SP). That good order and

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PHOTO: Multiple welcome home ceremonies for approximately 1,160 101st Airborne Division (Air Assault) soldiers was held for the 3d Brigade Combat Team "Rakkasans," and the Combat Aviation Brigade, 101st Airborne Division (Air Assault), at Fort Campbell, KY, 19 May 2013. (U.S. Army, SPC Brian Smith-Dutton)

discipline are essential to reducing soldier high-risk behavior and suicides is now commonly accepted. It is also known that, in the Army, relationship problems are a common risk factor when it comes to suicide.[5] As the 2010 HP/RR/SP report notes, the contributing factors to a failed relationship can be complex and varied.[6] I submit that good leadership is important to family readiness, and although family readiness receives lip service, it is rarely seriously discussed in relation to soldier morale and readiness. The discussion that follows is woven from three strands. The first and largest strand that runs throughout is the oversight for family and soldier readiness by an installation-level Community Health Promotion Council (CHPC). The CHPC is a meeting of tactical, garrison, and medical assets intended to address the wellness needs of the military community. By providing a forum to identify needs and share best practices, it can ensure that clear areas of responsibility are established and observed so that Army leaders across the installation can take care of not only their soldiers, but also their soldiers' families. The second strand of this discussion is intended to establish the relationship between family satisfaction and unit readiness. The third strand outlines what, for our purposes, will be called the "engaged leader paradigm" and its positive impact on the family and soldier readiness relationship.

In its chapter entitled, "The Lost Art of Leadership in Garrison," the 2010 HP/RR/SP report identifies the leadership as "the garrison community (post, camps, and stations) comprised of commanders, staffs, and program/service providers; both military and civilian."[7] The report goes on to assert that "leadership must rely on the communication, collaboration, and experience of this full range of leaders to provide situational awareness and inform decisions regarding mitigation of environmental risk and individual high-risk behavior."[8] This exact interaction already takes place at Army installations via the CHPC discussed above, which is designed to provide a holistic approach to health promotion. The council is governed by Army Regulation (AR) 600-63, *Army Health Promotion*, which states that senior commanders "have overall responsibility for health promotion, risk reduction, and suicide prevention efforts."[9] Additionally, "all tenant organizations fall under the CHPC for health promotion policy and programs."[10] The regulation lays out a process by which leadership, installation agency representatives, and various other members of the community address holistic wellness issues, which are brought up through the health promotion council. Often, these issues are brought to the council after commanders have met with their units to discuss issues and best practices, often through a brigade-level health promotion council, referred to as brigade health promotion teams (BHPTs) here, although the name and structure can vary from unit to unit.[11] After the community council has discussed courses of action for the issues brought forward, the tasked agencies or units send out guidance and policies where appropriate based on the council's findings.

As it relates to family and soldier readiness, to make sure this top-down approach is effective, there needs to be a bottom-up effort on the part of units to make sure that trends, needs, best practices, and lessons learned are being identified and shared. As a brigade-level version of the community council, the BHPT allows leaders to provide the CHPC with the most relevant information. As will be shown, for a CHPC to truly address the holistic wellness of a military community, family readiness must be an integral part of holistic wellness discussions at the unit level. Even if it has not traditionally been thought of as a component of healthy living, family readiness matters to the overall health of the soldier and family.

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Before the role of the installation CHPC is examined, let us establish the relationship between soldier and family readiness. We begin with a look at the unit, which here refers loosely to the company, to see how commanders currently care for the well-being of their soldiers and their families at the most basic level. AR 600-20, *Army Command Policy*, states that, "If leaders show loyalty to their

soldiers, the Army, and the nation, they earn the loyalty of their soldiers. If leaders consider their soldiers' needs and care for their well-being, and if they demonstrate genuine concern, these leaders build a positive command climate."[12] Chapter 3 of *Army Command Policy* outlines the Army's concept of holistic well-being and the responsibility of commanders to ensure a positive standard of living for their soldiers and their families. The chapter makes it clear that the burden of improving and maintaining subordinates' quality of life is placed squarely on the shoulders of the commander.

Family Readiness Group

One tool at the commander's disposal is the family readiness group (FRG), a command program run by volunteers. *Army Command Policy* defines family readiness as "the mutual reinforcement provided to soldiers, civilian employees, retirees (regardless of marital status), and their family members-both immediate and extended. Examples include Family Readiness Groups (FRG), newsletters, telephone trees, and other volunteer programs and activities."[13] Unit commanders are required to "maintain, as appropriate to the needs of their units, a unit FRG to encourage self-sufficiency among its members by providing information, referral assistance, and mutual support."[14]

I'll say only one more thing on the matter of my wife. She, smartly, has said that FRGs shouldn't be run by family members. There's simply too much anxiety and too much pressure, and too much potential for rivalry…[15]

The quote above gets at the paradox at the heart of the FRG system—a required command program staffed by volunteers, one which requires family members undergoing the stress of military life to give of their time and energy for other families undergoing many of the exact same stressors. A look at the FRG system as it functions at the company level and above is crucial to understanding the way the Army has asked its commanders to take care of soldiers and families for the past decade, and what is necessary to move forward. Perhaps no other institution in the Army is so ubiquitous and yet so profoundly misunderstood. What are some perceptions of FRGs? The 2010 Survey of Army Families found that the majority of surveyed spouses said their readiness group was run well. Most rated them as good or fair in helping their family.[16] Tellingly,

(U.S. Army)

Family readiness group leaders from 1st Brigade Combat Team, 4th Infantry Division, attend an appreciation lunch and symposium, Fort Carson, CO, 4 March 2012.

of the four-fifths of spouses who said FRGs in their soldier spouse's unit was active, nine-tenths said they attending meetings, and one-fourth served as FRG leaders.[17] With a 28 percent response rate with 16,805 usable responses from spouses of Active Component soldiers, it is possible to conjecture that these findings are not necessarily indicative of the broader perceptions held of FRGs.[18] Surveys issued to spouses are never mandatory, and so one could hypothesize that those who voluntarily respond to a survey on Army family life might be the kind of spouses who are already more involved in their spouse's unit. Spouses who finds the Army lifestyle intimidating or not to their taste, or whose soldier spouse does not inform them about the Army or their unit, would probably be less likely to respond to a survey from the Army.

A survey of soldiers returning from deployment paints a smaller but contradictory picture of FRGs. The Reintegration Unit Risk Inventory is an 80-item questionnaire that screens for high-risk behaviors and attitudes related to combat and post-combat experiences that may compromise unit readiness. The inventory is required by Deployment Cycle Support (DCS) Directive, dated 26 March 2007, and is conducted 120 to 180 days after redeployment.[19] Fifty-one percent of redeploying soldiers indicated on the inventory that their spouse did not participate in a family readiness group.[20] When asked to rate their FRG, 13 percent said poor and 33 percent said the question did not apply to them.[21] While this data provides only a snapshot of one installation, it is worth noting that despite emphasis in *Army Command Policy* on the well-being of the total Army family (which includes the soldiers themselves), the soldier respondents either had a negative view of FRGs, were apparently unaware of them, or felt that family readiness did not include them. This is a marked contrast to the rosy findings in the 2010 Survey of Army Families.

There are many reasons a soldier might feel that questions on family readiness groups do not apply to him or her. Take the Survey of Army Families itself, which poses questions of family issues only to the spouses of Active Component soldiers. A soldier who feels questions about the FRG do not apply to him or her could likely be a soldier without a spouse, who believes family readiness groups are for married soldiers and their families. Assuming the Army means what it says in *Army Command Policy* about well-being including the soldiers, their families, veterans, and retirees, a true look at the effectiveness of the Army FRG and its related programs would presumably ask the soldiers themselves what they think of the utility of readiness groups. The very methodology of the survey would seem to indicate a perception of Army family care that is at odds with Army command and health promotion policy: in this view, spouses take care of spouses, families take care of families, and there is minimal command involvement. After over a decade of persistent conflict, Army leaders have grown accustomed to this paradigm. With so many tactical demands on the unit as it cycled through the Army Force Generation (ARFORGEN) process, leader responsibility for family readiness arguably shifted more to the volunteer-run FRGs. Like so many other proficiencies, tasks, and skills, family care was outsourced during Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF). This time, however, the responsibility fell not to contractors, but to the families themselves.

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Despite the negative views of FRGs indicated by the Reintegration Unit Risk Inventory results cited above, caring for soldiers and their families matters very much to the soldiers themselves. Results from a 2002 study of a 193-man sample from two infantry battalions at Joint Base Lewis-McChord (then Fort Lewis) showed that when asked to rate their identities as a soldier, 75 percent of respondents viewed their family identities as the most salient, and 93.8 percent viewed their family identity as one of their top three salient identities.[22] Additional data seems to support that

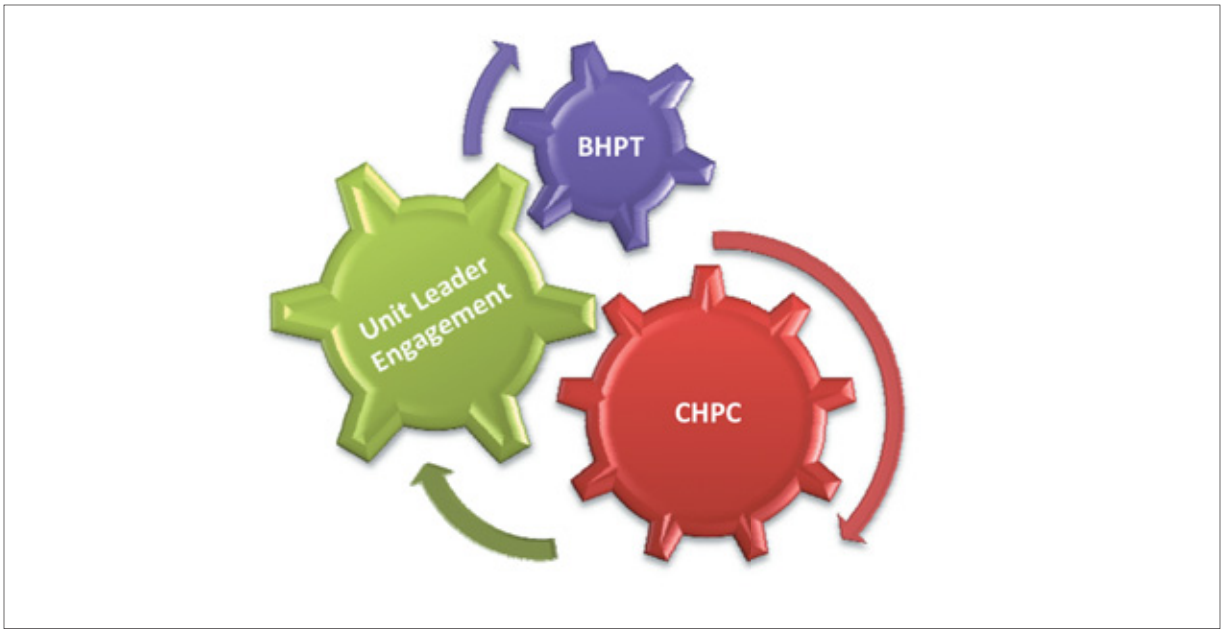
soldiers are very concerned about their families' well-being. In their January 2010 study, "The Effects of Multiple Deployments on Army Adolescents," Leonard Wong and Stephen Gerras found that even though 56 percent of Army adolescents responding to their survey said they coped well to very well with deployments, deployed "soldiers appear to be more pessimistic with estimates that a third of their children are coping poorly or very poorly with deployments."[23] While studies and data support that soldiers and their families need support from Army leadership, it is unclear that the family readiness group is necessarily the best way to provide that support. There are two key reasons for why the Army might have outgrown the FRG paradigm: a negative view of FRGs, and a need to overcome a misunderstanding of the commander's role vis-à-vis family care after 10 years of family-member run FRGs. The 4 August 2011 rapid action revision of *Army Command Policy* even appears to de-emphasize the role of the FRG. The acronym appears only three times in the regulation, not including its appearance in the glossary. Each time the FRG is mentioned in *Army Command Policy*, it is in conjunction with other tools for family readiness, and with an emphasis on self-sufficiency on the part of the soldier and his or her family.

Leader Paradigm

Suppose the Army were to shift to a family care paradigm without family readiness groups. That world would arguably be one in which soldiers and families could agree that they were receiving adequate support to meet the stressors of Army life. It would require the engaged leader paradigm mentioned earlier. In the engaged leader paradigm, Army commanders and leaders are not only engaged with their soldiers, but also understand and know the programs available to their soldiers and their families. Involved, knowledgeable leaders at the lowest level would likely result in a robust brigade health promotion team, which would in turn mean a robust and effective community health promotion council. Truly engaged leadership does not stop at barracks checks, regular counseling, and disciplinary action. A leader's concern must extend to the family if true soldier readiness is the goal. Additionally, a leader who is knowledgeable about the programs and resources which are relevant to family readiness supports the CHPC, which is tasked with "identify[ing] and eliminate[ing] redundancies and voids in programs and services by evaluating population needs, assessing existing programs, and coordinating targeted interventions."[24] Knowledgeable junior leader engagement will provide the brigade health promotion team with the ground truth about how these programs are being utilized by soldiers and their families, helping to ensure responsible resource management when the brigade commander takes these findings to the community council.

As Todd D. Woodruff and Thomas A. Kolditz argue in their paper "The Need to Develop Expert Knowledge of the Military Family," engaged leadership with knowledge of relevant resources is linked to family satisfaction, a vital component to retention and soldier readiness. Family readiness group operations typically take place at the company level, and were they to go away, company grade commanders and leaders would need to increase their knowledge of family programs and resources to fill that gap. Woodruff and Kolditz observe that "it is the frontline leaders who will have the greatest effect on the day-to-day lives of soldiers and families,"[25] and yet "not all Army leaders have developed adequate expert knowledge to care for families, and the retention picture for the Army overall has shown signs of possible problems."[26]

This is especially true at the company level, where junior leaders—officers, especially—are less likely to be familiar with the stresses of family life or the relevant resources, despite making the most decisions that directly impact soldiers and families.[27] This problem is easily remedied by incorporating family resource curriculum into Reserve Officer Training Corps and service academy training, the basic officer leader course, and the captains' career course. Serious discussions and thoughtfully developed programs of instruction on family topics taught by senior leaders will help abolish the perception that family issues are taken care of primarily by volunteers and other family members. With the link between family readiness and soldier readiness established, and the proposed engaged leader paradigm as a replace-



Optimal format for the CHPC, in which trends, best practices, and lessons learned are identified at the company level, brought up through the battalion, and shared with the BHPT, who in turn share their findings at the CHPC.

ment for the FRG system, let us examine how this paradigm would manifest at higher organizational levels in the Army.

As has been previously stated, the brigade health promotion team does not appear in the *Army Health Promotion*, but it appears in many installation health promotion policies in one form or another as a useful tool in the community health promotion council process. As a health promotion team at the brigade level, the BHPT shares the same emphasis on collaboration in the interest of holistic wellness. However, a BHPT will only be as effective as its battalions are engaged. If battalions model their steering committees, currently a regular meeting with commanders and FRG leaders, on the CHPC model, leaders and commanders would have a forum to address wellness trends and best practices within their units. The battalion commander then brings these findings to the BHPT, which the brigade commander then shares with the CHPC. This process ensures the best policies, collaboration, and best practices emanate from the CHPC back down into units, and the soldiers and families that comprise them.

It may be argued that the social support for spouses during deployments would go away if the FRG system were to be replaced with an engaged leadership model that simply enfolds family issues into its purview. These fears are misplaced for a few reasons, the first and foremost reason being tradition. The FRG is an artificial construct, and cohesive units and personal relationships between unit members and their families predate any formal family support network in the Army. Woodruff and Kolditz cite a poll conducted by the Kaiser Family Foundation, the *Washington Post,* and Harvard University in which the spouse respondents who coped best with the era of persistent conflict were those who developed meaningful relationships with other spouses.[28] There is no reason why, in an inclusive command climate, spouses would not know or see each other socially. Especially at the company level, a positive atmosphere is more likely to foster a sense of *esprit de corps* that would supplant any of the sense of obligatory participation that can accompany the FRG system.

Similarly, that pillar of unit involvement—volunteerism—predates FRGs. A unit in which leaders know their soldiers' families as well as their soldiers, and in which the families know each other, will likely experience little difficulty in getting participation when meals are needed after a pregnancy. In fact, *Army Command Policy* specifically states that soldiers should encourage

their spouses to support quality of life programs and activities, acknowledging that volunteers are essential to many such programs. Concerted effort on the part of junior leadership to care about their soldier's lives and families will hopefully foster organic relationships between leadership, members of the unit, and their families that will keep leaders informed of the needs and trends in their unit and benefit the soldiers and their families.

Displacing the FRG system with the engaged leader paradigm would greatly, although probably not entirely, eliminate the pressure family members, specifically spouses, sometimes feel to volunteer for unit activities. There are perhaps very few organizations in the civilian world that depend as heavily as the military on the unpaid, voluntary labor of the spouses of its employees to accomplish mission essential tasks. *Army Command Policy* provides a safeguard against pressure on family members to volunteer in Chapter 4, section 18: "Employment and volunteer work of spouse." This section of *Army Command Policy* supports a spouse's right to work or volunteer wherever he or she chooses, and prohibits a spouse's work or education decisions from influencing their soldier's career. In a unit under the engaged leader paradigm, the commander will know that and try to avoid the appearance of any official pressure on a spouse or family member to volunteer. It is not enough for commanders and junior leaders to know the relevant resources, they must know the regulations.

At the Fort Hood CHPC on 19 October 2010, Major General William Grimsley expressed concern that incoming company commanders to the installation seemed not to know the extent of their authority or those things for which they could be held accountable.[29] To fill this gap, Fort Hood provides recurring, local-level mandatory courses: a company commander and first sergeant course, an executive officer/operations officer course, and a battalion/brigade commander and command sergeant major course. These courses lay out the basic regulatory requirements for which leaders are responsible, as well as local policy, points of contact, and information unique to the installation. For the engaged leader paradigm to work, it is essential that unit leaders be acquainted with the relevant policies and regulations. Otherwise, unit leaders will either be limited by risk aversion or overstep their bounds and become overly intrusive. Army schoolhouses have a responsibility to review the existing programs of instruction on well-being and family care in their leadership courses to ensure that these crucial components of unit and soldier readiness are treated with the same seriousness as the tactical ones. Instructing students on the regulations and policies which govern well-being and family care is one important way to accomplish this. Once the leader leaves the schoolhouse, as Grimsley's comment at the CHPC demonstrates, the CHPC can serve as a helpful mechanism in identifying continuing gaps in leader knowledge and developing outcomes to fill them.

Not a Panacea

Before we conclude this discussion, a quote from an Army official raises a provocative insight. Speaking to the *New York Times* in response to the 16 March 2012 shooting of Afghan civilians by Staff Sergeant Robert Bales, who was then on his fourth deployment, the official said, "When it all comes out, it will be a combination of stress, alcohol, and domestic issues—he just snapped."[30] While these factors do not excuse the soldier's actions, they do illustrate that the impact of family readiness, mental health, and individual readiness of our soldiers can have broader strategic implications as well. The 24 hour news cycle and proliferation of social media mean that such actions by soldiers are interpreted and analyzed widely by the public who draw conclusions about how the Army cares for its soldiers and their families. Most lay people would be shocked to know that this soldier's wife had as her primary recourse a small cadre of volunteers—mostly spouses just like her—as she dealt with the stressors of four combat deployments.

After over a decade of persistent conflict, the FRG is something of a sacred cow, but it is not a panacea. Its volunteers are just that, volunteers. As such, the FRG apparatus can only react to crises, usually at the very lowest levels. Commanders relinquished their direct link to their soldiers' family lives when they made FRG volunteers their intermediaries responsible for providing command information to family members. Therefore, despite their legitimacy as leaders of a command program,

FRG leaders then have no real authority to follow up or to inquire as to whether a spouse is using the appropriate resources. However, the intent here is not to argue that FRGs are ineffective, but to make the case that BHPTs and the CHPC facilitated by the engaged leader paradigm are so much more effective. Rather than merely address the needs of a single family or company as an FRG does, the BHPT can spread best practices and raise awareness of trends across a brigade. When those results are brought before the CHPC, they have the potential to impact soldiers and families across the installation. As years of combat stress accumulate and the pressures of reintegration mount, the Army's focus is on prevention, and the FRG system does not and cannot support that goal. As the Army returns to more garrison-based operations, there is no reason why a leader's answer to a soldier's family stresses should ever be, "Let the FRG deal with it." Instead, an engaged leader knows the relevant resource, ensures that the soldier takes full advantage, and tries where appropriate to include the soldier's spouse. The engaged leader knows his soldiers and can determine whether this soldier's problem fits in with a broader trend within the unit, which the leader can then bring through the BHPT where the entire installation can benefit. The Army stops reacting and gets serious about prevention when leader involvement and knowledge at every level is engaged and brought before the CHPC to generate real solutions. ***MR***

NOTES

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