PHIP No. 002-0324

Community Strengths and Themes Assessment Fiscal Year 2023 Annual Report

INTRODUCTION

The Community Strengths and Themes Assessment (CSTA) is part of a comprehensive suite of assessment tools for military communities to assess health risk factors and perceptions of health-related needs to improve overall readiness and resiliency. The CSTA identifies priorities for community coalitions to assist Command-level leadership in development of a responsive and holistic community support plan. This Public Health Information Paper documents findings from respondents across 21 military locations where the CSTA was executed during fiscal year 2023 (FY23).

BACKGROUND

Current Department of Defense Instructions (DODIs) direct completion of comprehensive assessments of military communities for health risk factors and needs. A comprehensive CSTA is supported by DODI 1010.10 (*Health Promotion and Disease Prevention)*, DODI 6400.11 (*DoD Integrated Primary Prevention Policy for Prevention Workforce and Leaders)*, the Total Force Fitness Framework, and service specific regulations (e.g., Army Regulation (AR) 600-63, AR 40-5, AR 608-1). Additionally, for locations seeking Public Health Accreditation, the CSTA helps eligible installation departments of public health meet the national public health accreditation standards for community health assessment as delineated by the Public Health Accreditation Board (PHAB).

The Defense Centers for Public Health–Aberdeen (DCPH-A) developed a standardized CSTA based on rigorous scientific requirements for assessment tools. The CSTA is designed to capture perceptions from military community members regarding quality of life and health among key physical, emotional, family, spiritual and social risk areas within the military environment.

The CSTA is available for all military locations to obtain perceptions of health and wellness in their local communities. Additionally, the CSTA helps to identify priorities for community coalitions and assists commands in the development of a responsive and holistic community support plan. Results are summarized for distribution to respective military community leaders and recommended for inclusion in Community Health Improvement Planning endeavors.

DISCLAIMER: The views expressed in this document are those of the author(s) and do not necessarily reflect the official policy of the Department of Defense, Defense Health Agency, or the U.S. Government.

The mention of any non-federal entity and/or its products if for informational purposes only, and is not to be construed or interpreted, in any manner, as federal endorsement of that non-federal entity or its products.

Approved for public release; distribution is unlimited.

Overview

Military locations complete the CSTA once every 2 years, and all military community members are invited to participate. Participation in the CSTA is voluntary and all electronic data remains private, confidential, and password protected. Individual level responses are not reported. The DCPH-A Public Health Review Board reviewed and approved the 2023 CSTA as public health practice (Project Plan #14-320).

METHODS

Population and Sample

Prior to participation, each military community provides an estimate of their population size to the DCPH-A for computation of target sample sizes, which promotes a representative sample based on a 95% Confidence Interval (Krejcie and Morgan, 1970). The CSTA remains open to the community for one quarter (3 months) of the fiscal year with extensions granted when responses are not adequately meeting the community's target. For communities that achieve their target sample sizes, installation level reports are provided at the end of the assessment period. Responses submitted outside the assessment window, those without an indicated installation location, and those with completely missing data were not included in the analysis phase. All participating communities are included in the Annual Report regardless of total response numbers.

Questionnaire Items and Format

The CSTA includes 40 multiple-choice items that are quantitative (numeric) in nature and organized by health domain (physical, behavioral/emotional, social/environmental, spiritual, and family) as well as one open-ended item that provided qualitative (textual) responses.

The CSTA is administered electronically via Verint©, a Department of Defense approved platform for collecting and storing assessment responses.

Data Analysis

Quantitative data were analyzed descriptively to report frequencies and percentages, while qualitative data were analyzed using inductive coding methodology with both primary and secondary consensus coding to ensure validity and reliability. Primary coders analyzed textual data to discern appropriate themes from the responses while secondary coders reviewed the themes and initiated consensus discussions as needed. Final themes from textual responses are included in the report.

FINDINGS

Respondent Characteristics

During FY23, a total of 6,996 respondents across 21 locations participated in the CSTA. Participation included 10 locations in the Continental United States (CONUS) and 11 locations outside the Continental United States (OCONUS).

CONUS participation included three locations in Virginia (Fort Belvoir, Fort Gregg-Adams, and Joint Base Myer-Henderson Hall), two locations in Kansas (Fort Leavenworth and Fort Riley), as well as Fort Irwin in California, Fort Jackson in South Carolina, Fort Johnson in Louisiana, Fort Leonard Wood in Missouri, and Rock Island Arsenal in Illinois. OCONUS participation included five United States Army Garrison (USAG) locations in Germany (USAG Ansbach, USAG Bavaria, USAG Rheinland-Pfalz, USAG Stuttgart, and USAG Wiesbaden), three locations in Korea (USAG Daegu, USAG Humphreys, and USAG Yongsan-Casey), as well as USAG Benelux in Belgium, USAG Poland, and USAG Italy.

Respondents were predominantly Army affiliates (94.7%) and about half of the respondents (50.9%) were Active Duty Service members. The majority of respondents were male (58%), between the ages of 26 and 54 years old (62%), White/Caucasian (54%), and married (62%). Table 1 provides full details regarding respondent characteristics.

Table 1. Respondent Characteristics (*N* = 5,834)

Service Affiliation	Percent (*n*)
Army	94.7% (5,525)
Air Force	3.0% (175)
Marine Corps	1.1% (66)
Navy	1.0% (58)
Coast Guard	0.2% (10)

Principal Role at Installation	Percent (*n*)
Active Duty Service Member	50.9% (2,967)
Federal Civilian	31.9% (1,859)
Family Member	9.5% (552)
Military Retiree	3.3% (192)
Reserve Duty Service Member	0.5% (30)
Active Guard Service Member	0.5% (29)
Military Student/Trainee	0.3% (17)
Other (incl. multiple categories)	3.2% (188)

Grade	Percent (*n*)
E1-E4	13.7% (802)
E5-E6	16.0% (936)
E7-E9	11.7% (685)
WO1-CW5	1.5% (89)
O1-O3	6.2% (361)
O4-O6	10.9% (633)
General Officer	0.2% (13)
GS1-GS5	0.8% (48)
GS6-GS8	2.8% (161)
GS9-GS11	8.7% (509)
GS12-GS15	17.2% (1,002)
Senior Executive	0.2% (10)
Other (NAF/Local National)	2.3% (135)

Sex	Percent (*n*)
Male	57.5% (3,354)
Female	34.8% (2,028)
Prefer not to Answer	7.7% (452)

Age	Percent (*n*)
18 years or under	0.4% (23)
19-25 Years	15.4% (897)
26-39 Years	32.6% (1,904)
40-54 Years	29.8% (1,739)
55 Years and Over	14.4% (838)
Prefer not to Answer	7.4% (433)

Race and Ethnicity	Percent (*n*)
White/Caucasian	53.7% (3,134)
Black/African American	11.9% (694)
Hispanic/Latino	10.1% (592)
Asian/Pacific Islander	6.0% (349)
Native American	1.1% (65)
Other (Biracial/Mixed)	1.6% (91)
Prefer not to Answer	15.6% (909)

Marital Status	Percent (*n*)
Married	62.4% (3,640)
Never Married/Single	18.8% (1,094)
Divorced	6.9% (402)
Separated	2.1% (120)
Widowed/Widower	0.7% (40)
Prefer not to Answer	9.2% (538)

Education Level	Percent (*n*)
Less than High School Graduate	0.3% (16)
High School Diploma/GED	12.0% (698)
Some College	16.4% (954)
Associate Degree	9.5% (554)
Bachelor's Degree	24.7% (1,442)
Master's Degree	25.3% (1476)
Doctoral Degree	3.6% (212)
Other (Certificate/Trade School)	0.2% (12)
Prefer not to Answer	8.1% (470)

Physical Health Domain

Respondents provided their perceptions about the extent to which people are healthy or unhealthy on the installation. Across all 21 locations, over half of the respondents (57%) reported that people are *somewhat healthy*, while 31% reported that people are *somewhat unhealthy* (see Figure 1).

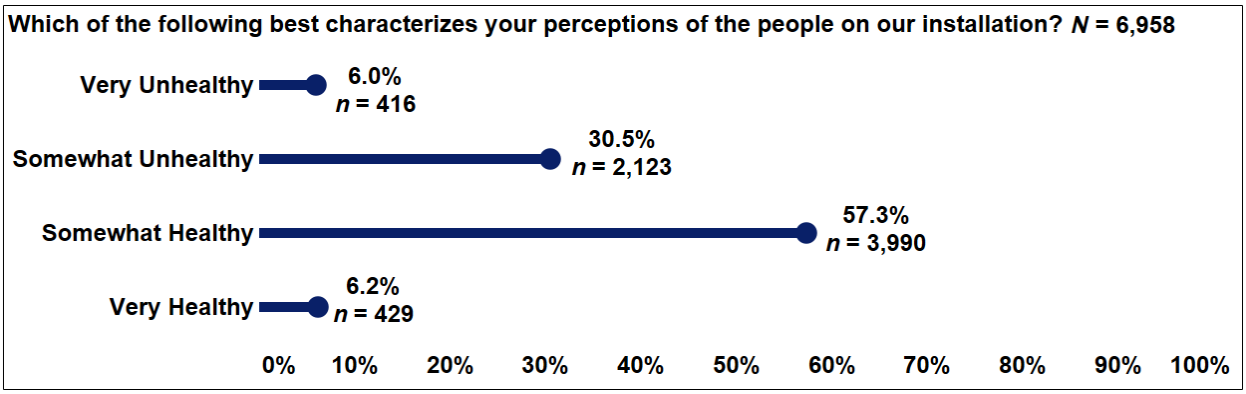

Figure 1. Perceptions of How Healthy People are on the Installation

Respondents were asked to indicate the top physical health-related concerns for their installation. The top five most commonly reported physical health concerns (by percentage) are indicated with brackets in Table 2, with lack of access to health care (34%), overweight/obesity (36%), poor diet (33%), tobacco use/vaping (26%), and lack of fitness (26%) as areas of concern by more than one-quarter of the respondents.

Table 2. Physical Health Concerns (*N* = 6,996)

Health Concern	Percent (*n*)
Lack of Access to Health Care	**33.8% (2,363)**
Overweight/Obesity	**36.0% (2,518)**
Poor Diet	**32.9% (2,303)**
Tobacco Use/Vaping	**26.4% (1,849)**
Lack of Fitness	**25.8% (1,802)**
Injuries	23.9% (1,672)
High Blood Pressure	19.9% (1,392)
Aging Problems	13.4% (937)
Work-related Hazards	11.7% (822)
Sexually Transmitted Infections	11.2% (781)
None	9.8% (686)
Dental Problems	9.4% (661)
Cardiovascular Conditions	8.4% (591)
Diabetes	8.2% (573)
Brain Health	7.6% (534)
Other*	7.3% (512)
Respiratory Disease	6.0% (421)
Cancers	5.5% (385)
Pandemics	4.1% (285)
Not Getting Immunizations	3.9% (272)
Infectious Diseases	1.9% (135)

Note: Percentages are not mutually exclusive; participants were allowed to select multiple responses. Percentages sum to > 100%.

*Other responses included:
Lack of healthy food options
Stress
Substance Use
Women's Health

Additionally, respondents were asked to indicate activities they feel their installation needs to address in support of community health. The top five most commonly reported activities (by percentage) are indicated with brackets in Table 3, with stress management (41%), physical activity opportunities (27%), weight loss programs (26%), healthy sleep strategies (24%), and nutrition classes (23%) selected by more than one-fifth of respondents.

Table 3. Health-Related Activities (*N* = 6,996)

Activities	Percent (*n*)
Stress Management Activities	**40.6% (2,840)**
Physical Activity Opportunities	**26.7% (1,868)**
Weight Loss Programs	**25.9% (1,810)**
Healthy Sleep Strategies	**23.9% (1,675)**
Nutrition Classes	**22.7% (1,585)**
Physical Activity Training/Classes	20.8% (1,452)
Alcohol/Drug Prevention	14.0% (982)
None: Plenty of Programs	12.3% (861)
Safe Housing	11.4% (797)
Tobacco Cessation	10.6% (744)
Other*	7.7% (538)
N/A Prefer Not to Answer	4.9% (345)

Note: Percentages are not mutually exclusive; participants were allowed to select multiple responses. Percentages sum to > 100%.

*Other responses included:
Recreational Activities
Wellness and fitness programs
Youth and family activities

4.3 Behavioral and Emotional Health Domain

Respondents were asked to indicate the top behavioral and emotional health-related concerns for their installation. At least half of respondents identified depression (57%) and stress (50%) as areas of concern, and at least one-third reported anxiety (40%), alcohol/drug abuse (38%), and toxic leadership (33%). Table 4 includes the list of behavioral health concerns with the top five (by percentage) indicated with brackets.

Table 4. Behavioral Health Concerns (*N* = 6,564)

Health Concern	Percent (*n*)
Depression	**57.3% (3,758)**
Stress	**50.1% (3,286)**
Anxiety	**40.4% (2,653)**
Alcohol/Drug Abuse	**38.1% (2,504)**
Toxic Leadership	**33.0% (2,168)**
Social Isolation	26.3% (1,727)
Sleep Issues	25.5% (1,675)
Family Conflict	24.4% (1,601)
Anger	20.9% (1,369)
Distracted/Reckless Driving	12.6% (826)
Suicide	12.3% (809)
Sexual Assault/Harassment	10.8% (712)
Post-Traumatic Stress Disorder (PTSD)	10.0% (655)
Hazing/Peer Pressure/Bullying	5.7% (374)
None	5.6% (368)
High Risk Sexual Behaviors	5.4% (352)
Other*	2.8% (183)
Not Using Seat Belts	0.9% (57)

Note: Percentages are not mutually exclusive; participants were allowed to select multiple responses. Percentages sum to > 100%.

*Other responses included:
High OPTEMPO
Leadership challenges
Limited access to health care

Respondents were asked about the likelihood of seeking support on the installation when either themselves or a family member experience a life challenge. A total of 30% indicated they were *somewhat likely* while 18% indicated they are *very likely* to seek support on the installation (see Figure 2).

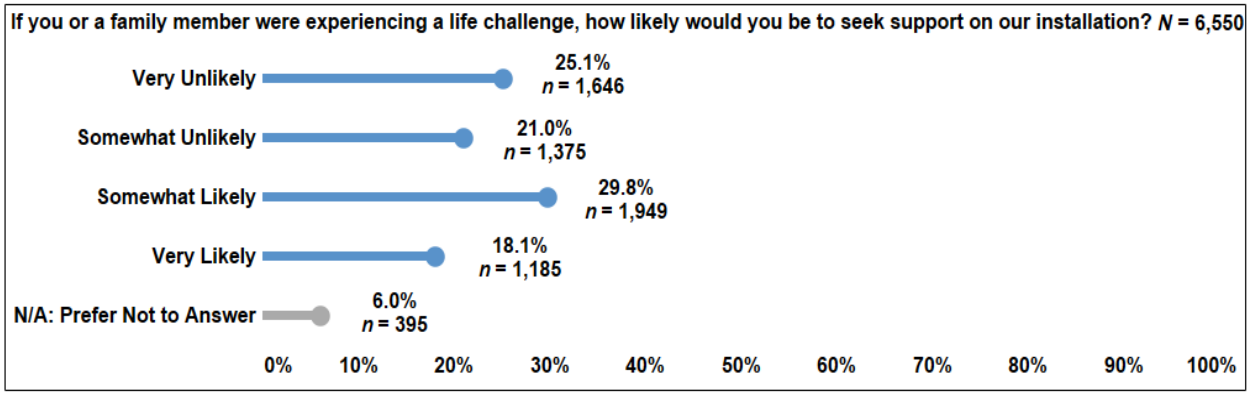

Figure 2. Likelihood of Seeking Support on Installation for Life Challenge

Respondents were also asked if seeking help for a behavioral or emotional concern would negatively impact their career. Just under one-fifth (19%) indicated that help-seeking behavior is *very likely* to impact their career while 27% indicated it was *somewhat likely* (see Figure 3).

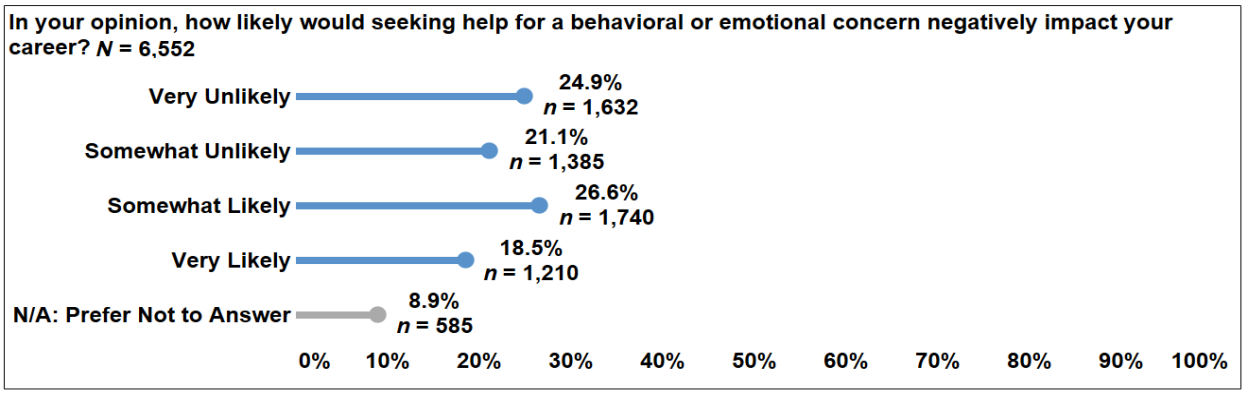

Figure 3. Likelihood of Career Impact from Seeking Help

Respondents were asked to provide their perceptions about the extent to which their community is behaviorally, psychologically, or emotionally healthy. The greatest percentage of respondents (44%) reported that their community is *somewhat healthy* while 30% reported their community as *somewhat unhealthy* (see Figure 4).

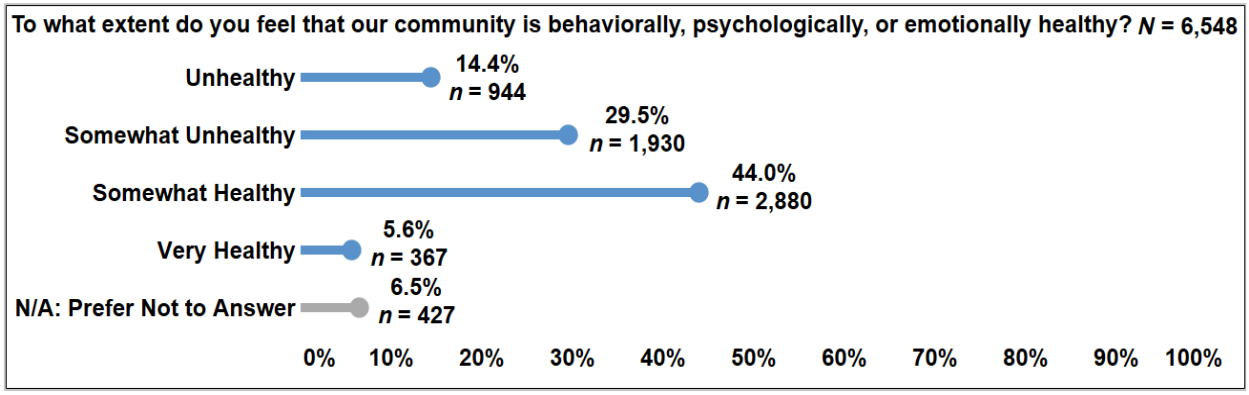

Figure 4. Perceptions of Behavioral, Psychological, and Emotional Health

Respondents were asked about the likelihood of couples experiencing relationship problems as well as the top precursors for relationship issues on the installation. Just under half of respondents (45%) felt couples are *somewhat likely* to have relationship problems while 24% felt couples are *very likely* to experience relationship problems (see Figure 5). Work-life balance was indicated as the most commonly reported precursor for relationship issues by 64% of respondents, while approximately half of respondents indicated communication problems (59%)

and finances (48%) as top reasons for relationship issues. Table 5 includes the list of reasons for relationship issues with the top five (by percentage) indicated with brackets.

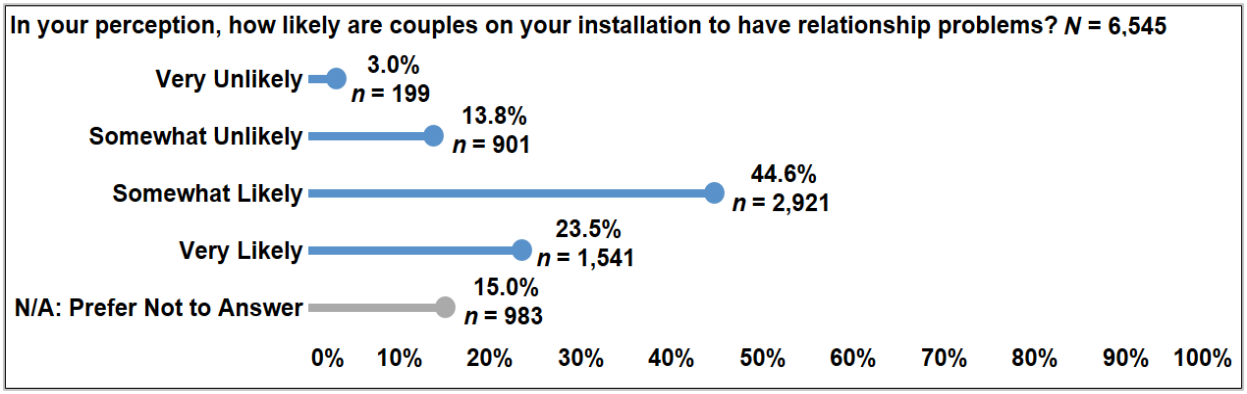

Figure 5. Likelihood for Relationship Problems on Installation

Table 5. Top Reasons for Relationship Issues (*N* = 6,564)

Top Reasons	Percent (*n*)
Work-Life Balance	**64.4% (4,227)**
Communication Problems	**58.5% (3,841)**
Finances	**47.7% (3,133)**
Alcohol/Drug Issues	**30.4% (1,996)**
Extramarital Affairs	**26.4% (1,732)**
Social Media	15.7% (1,028)
Other*	7.7% (508)
Open Relationships	5.8% (383)
Gaming	3.6% (236)

*Other responses included:
Adjusting to new environments
Childcare Challenges
Financial Hardships
High OPTEMPO
Lack of spousal employment
Social Isolation/Separation
Stress

Note: Percentages are not mutually exclusive; participants were allowed to select multiple responses. Percentages sum to > 100%.

Social and Environmental Health Domain

Respondents were asked to report the top social and environmental health-related concerns on their installation. The top five most commonly selected concerns were work-life imbalance (57%), financial issues (43%), career opportunities/unemployment (30%), military family housing (29%), and community connectedness (29%). Table 6 includes the list of social and environmental health concerns with the top five (by percentage) indicated with brackets.

Table 6. Social and Environmental Health Concerns (*N* = 6,291)

Health Concerns	Percent (*n*)
Work-Life Imbalance	**57.2% (3,596)**
Financial Issues	**43.4% (2,732)**
Career Opportunities/Unemployment	**29.6% (1,860)**
Military Family Housing	**28.9% (1,816)**
Community Connectedness	**28.5% (1,794)**
Transportation	18.5% (1,166)
Recreational Opportunities Lacking	17.3% (1,089)
Deployments	15.2% (955)
Unclean Environment	11.1% (699)
School Violence	9.6% (603)
None	9.5% (596)
Walkable/Bikeable Options Lacking	8.0% (506)
Youth Sports Lacking	7.0% (440)
Workplace Safety	6.8% (428)
Motor Vehicle Accidents	6.4% (404)
Other*	5.8% (365)
Base Security	5.7% (360)
Public Health Emergencies	4.4% (275)
Violence	3.7% (230)
Firearm Related Injuries	3.0% (191)
Neighborhood Safety	3.0% (188)
Homicide/Murder	1.7% (110)
Child Safety Seat Usage	0.7% (44)

Note: Percentages are not mutually exclusive; participants were allowed to select multiple responses. Percentages sum to > 100%.

*Other responses included:
Mold in Buildings
Poor Air Quality
Poor Housing Conditions
Poor Water Quality

Additionally, respondents were asked to indicate the top strengths of their installation. The top five most commonly selected strengths included a diverse community (29%), access to sports and recreational activities (25%), safe neighborhoods (22%), a clean environment (22%), and a good place to raise children (18%). Table 7 includes the list of installation strengths with the top five (by percentage) indicated with brackets.

Table 7. Top Strengths of Installations (*N* = 6,291)

Installation Strengths	Percent (*n*)
Diverse Community	**28.9% (1,816)**
Access to Sports and Rec Activities	**24.5% (1,541)**
Safe Neighborhoods	**22.1% (1,390)**
Clean Environment	**22.0% (1,386)**
Good Place to Raise Children	**17.5% (1,103)**
Good Schools/Academics	17.0% (1,069)
Better Opportunities for Single Soldiers	14.2% (892)
Supportive/Fair Leadership	13.9% (875)
Available Child/Youth Services	12.6% (794)
Good Neighbors/Communities	12.2% (766)
Arts and Cultural Events	11.9% (750)
Leadership I Can Trust	11.5% (724)
Engaged Senior Leaders	10.8% (679)
Low Death/Disease Rates	10.4% (657)
Emergency Responsiveness	10.4% (655)
None	10.2% (642)
Good Housing	10.1% (635)
Affordable Housing	9.9% (620)
Employment Opportunities	7.5% (473)
Strong Family Life	6.4% (402)
Good Social Network/Connectedness	6.0% (379)
Adherence to Army Values	5.8% (367)
"Esprit De Corps"	5.0% (313)
Healthy Nutritional Choices	4.2% (262)
Other*	2.2% (139)
Mental Health/Mental Hygiene	2.0% (128)

Note: Percentages are not mutually exclusive; participants were allowed to select multiple responses. Percentages sum to > 100%.

*Other responses included:
Community Offerings
Good Location
Good Travel Opportunities

Respondents were asked to report their perceptions of the environmental health conditions in buildings, housing, and facilities on their installation. The greatest percentage reported that environmental health conditions were *somewhat healthy* (42%) or *somewhat unhealthy* (28%) (see Figure 6).

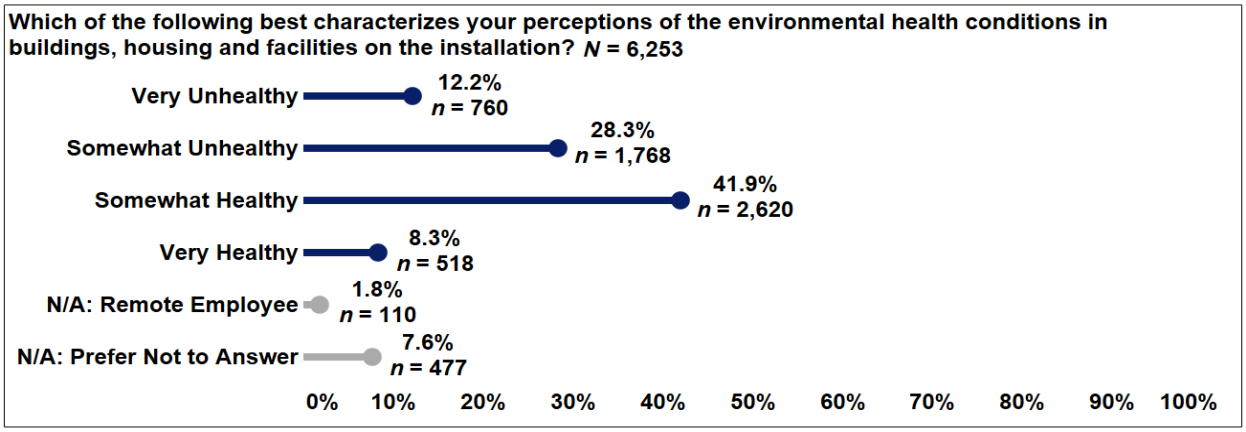

Figure 6. Perceptions of Environmental Health Conditions on Installation

Spiritual Heath Domain

Respondents were asked to report the top spiritual health concerns on their installation. Although 40% of respondents indicated no spiritual health concerns, approximately one-fifth indicated concerns regarding lack of morals (23%), lack of community cohesion (21%), lack of purpose (20%), and lack of ethics (18%). Table 8 includes the list of spiritual health concerns with the top five (by percentage) indicated with brackets.

Table 8. Spiritual Health Concerns (*N* = 6,111)

Health Concerns	Percent (*n*)
None	**40.4% (2,467)**
Lack of Morals	**22.7% (1,388)**
Lack of Community Cohesion	**21.3% (1,301)**
Lack of Purpose	**19.8% (1,213)**
Lack of Ethics	**18.1% (1,107)**
Lack of Adherence to Army Values	14.9% (911)
Lack of Spiritual Diversity	8.5% (520)
Lack of Spiritual Services	7.1% (436)
Lack of Chaplain Support	6.4% (391)
Other*	3.9% (237)

Note: Percentages are not mutually exclusive; participants were allowed to select multiple responses. Percentages sum to > 100%.

*Other responses included:
Cultural/Language Barrier
Lack of variety in offerings

Respondents were asked about the extent to which they were satisfied or dissatisfied that their spiritual needs are met on their installation. The greatest percentage of respondents reported that they were *somewhat satisfied* (23%) or *very satisfied* (15%). Similar to results reported in Table 8, 43% of respondents indicated they do not have any spiritual needs at this time (see Figure 7).

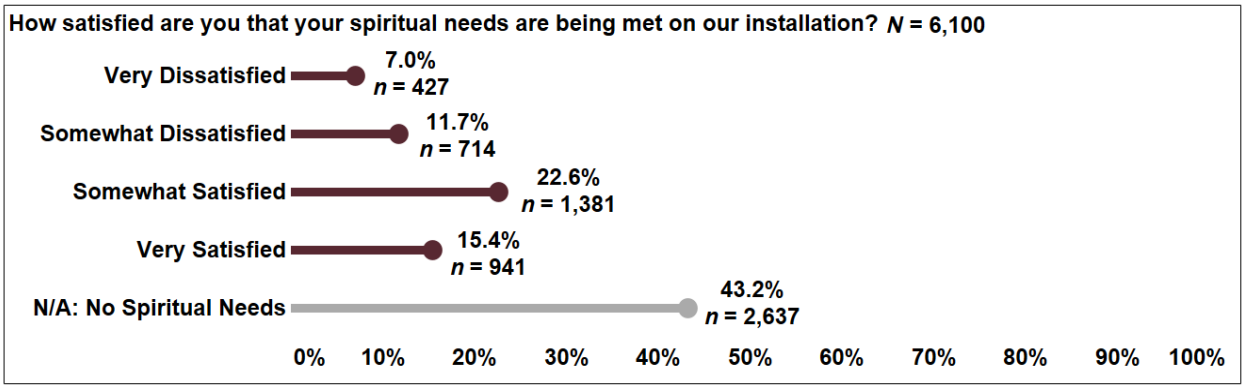

Figure 7. Satisfaction of Spiritual Needs Met on Installation

Respondents were asked to indicate areas within the domain of spiritual health that may need improvements within their communities. Although 40% of the respondents preferred not to answer this question, 23% indicated a preference for more time to participate in spiritual activities, 20% indicated a need for more alternative choices, 19% indicated a need for more spiritual activities, and 15% indicated a need for fewer ethical dilemmas in the workplace. Table 9 includes the list of improvements to community spiritual health with the top five (by percentage) indicated with brackets.

Table 9. Improvements to Spiritual Health (*N* = 6,111)

Health Improvements	Percent (*n*)
N/A: Prefer Not to Answer	**40.0% (2,445)**
More Time to Participate	**22.8% (1,395)**
More Alternative Choices	**20.3% (1,239)**
More Spiritual Activities	**19.1% (1,166)**
Fewer Ethical Dilemmas in Workplace	**14.8% (905)**
More Church Service Choices	14.5% (885)
More Chaplain Support	11.2% (686)
Other*	3.7% (226)

Note: Percentages are not mutually exclusive; participants were allowed to select multiple responses. Percentages sum to > 100%.

*Other responses included:
Improved Communication
Increased Chaplain Presence

Respondents were also asked about the extent to which they feel their community is resilient. More than half of respondents reported that their community is *somewhat resilient* (56%) and 19% reported their community as *very resilient* (see Figure 8).

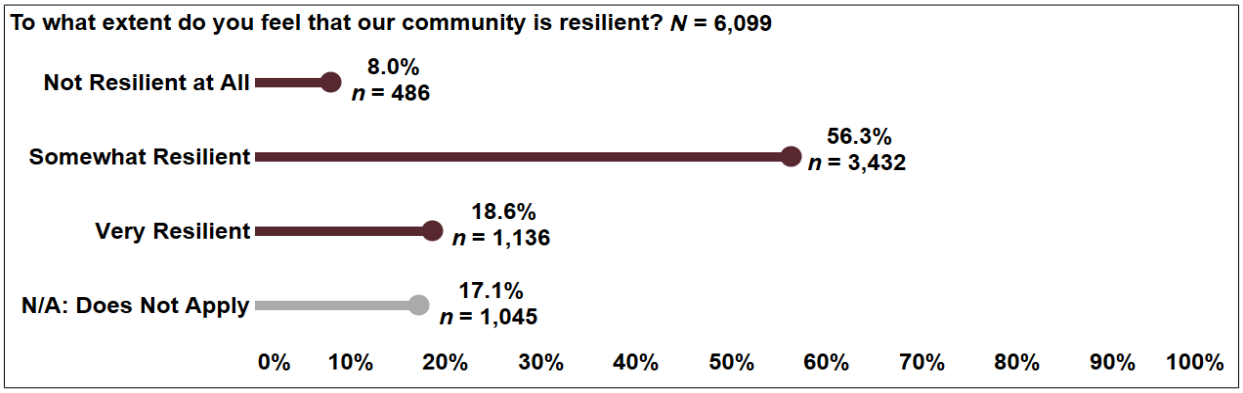

Figure 8. Perceptions of Community Resilience

Family Health Domain

Respondents were asked to indicate their top family health concerns on the installation. Work-life balance (39%), financial issues (34%), access to childcare (31%), family time (24%), and employment opportunities (22%) were indicated as the top five concerns. Table 10 includes the list of family health concerns with the top five (by percentage) indicated with brackets.

Table 10. Family Health Concerns (*N* = 6,002)

Health Concerns	Percent (*n*)
Work-Life Balance	**38.6% (2,315)**
Financial Issues	**34.1% (2,045)**
Access to Childcare	**30.9% (1,854)**
Family Time	**24.3% (1,458)**
Employment Opportunities	**22.2% (1,333)**
Deployments/Training Separations/TDY	20.6% (1,237)
Transitions/Moving/Retirement	19.4% (1,166)
Infidelity/Cheating	18.5% (1,109)
N/A: Prefer Not to Answer	15.4% (924)
Sponsorship/Integration	12.6% (758)
Domestic Violence	12.3% (741)
Lack of EFM Support	9.9% (596)
Youth Bullying/Peer Pressure	8.4% (506)
Neglectful Parenting	6.6% (396)
Educational Services	6.2% (373)
None	5.9% (354)
Child Abuse/Neglect	5.6% (338)
Neighborhood Safety	5.0% (302)
Other*	3.3% (200)
Dropping Out of School	1.4% (86)
Teenage Pregnancy	1.0% (61)

Note: Percentages are not mutually exclusive; participants were allowed to select multiple responses. Percentages sum to > 100%.

***Other responses included:**
Access to Health Care

Respondents were asked about the extent to which they were satisfied or dissatisfied with the support available in their community to assist with a financial setback. Although one-third reported no need for financial assistance (30%), one-fourth reported they were *somewhat satisfied* (25%) and 8.6% reported they were *very satisfied* (see Figure 9).

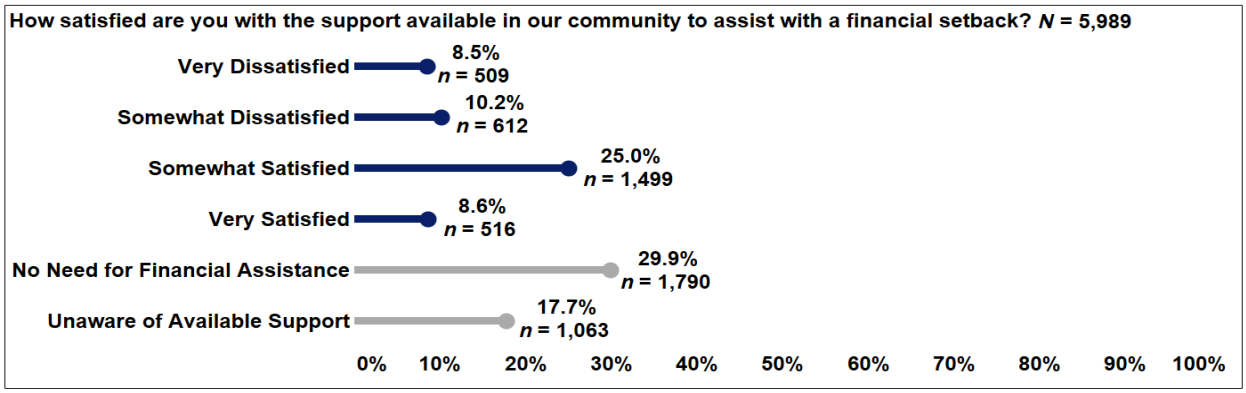

Figure 9. Satisfaction with Community Support for Financial Setbacks

Respondents were asked about their interests for financial training and education. The top five most commonly reported interests were retirement planning (47%), financial goals (44%), budgeting (41%), debt elimination (37%), and estate planning (29%). Table 11 includes the list of financial training and education interests with the top five (by percentage) indicated with brackets.

Table 11. Financial Training and Education Interests (*N* = 6,002)

Training and Education	Percent (*n*)
Retirement Planning	**47.2% (2.834)**
Financial Goals	**43.6% (2,617)**
Budgeting	**41.4% (2,484)**
Debt Elimination	**36.7% (2,203)**
Estate Planning	**29.4% (1,764)**
Spouse Employment	25.3% (1,519)
Transitioning Out of the Army	23.9% (1,435)
PCS Planning	20.6% (1,235)
Planning for College Education	15.5% (933)
Relocation Education	12.8% (770)
Deployment Planning	9.7% (581)
Other*	5.1% (304)

*Other responses included:
Basic Financial Training
Investments

Note: Percentages are not mutually exclusive; participants were allowed to select multiple responses.
Percentages sum to > 100%.

Programs and Services Utilization

Respondents were asked about the extent to which they were aware of installation programs and services. Most respondents indicated awareness of programs and services offered on their installation, with the greatest percentages responding as *somewhat aware* (36%), *aware* (29%), or *very aware* (18%) (see Figure 10).

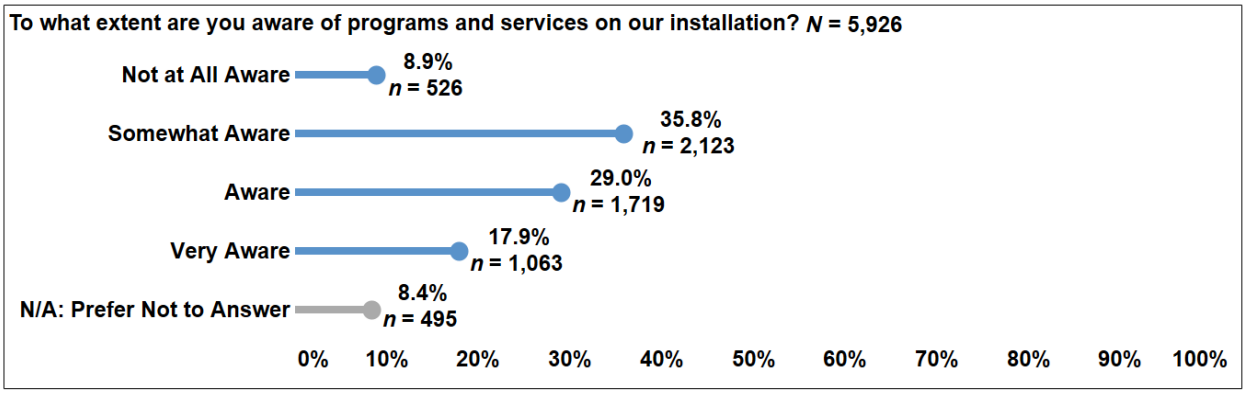

Figure 10. Awareness of Installation Programs and Services

Across all 21 locations, 27% indicated usage of the Community Resource Guide (CRG) while 39% indicated being unaware of the CRG (see Figure 11).

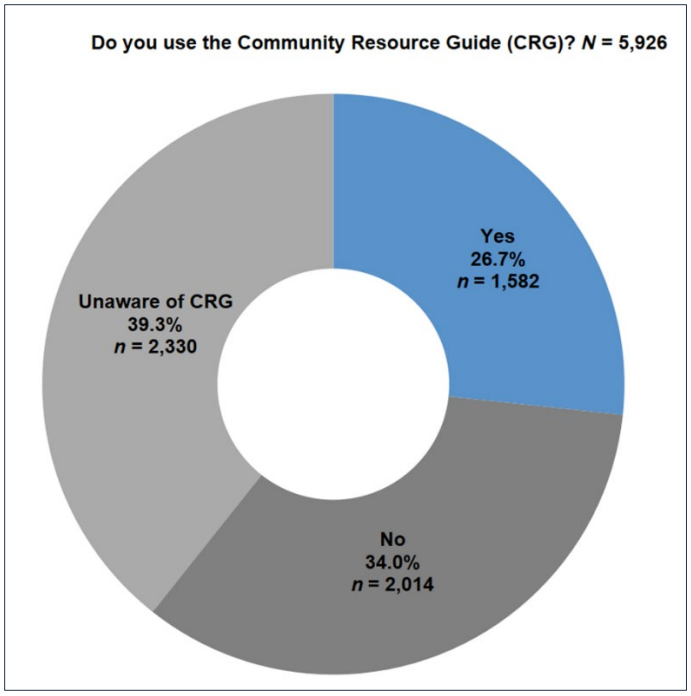

Figure 11. Reported Usage of Community Resource Guide

Respondents were asked to report reasons for lack of utilization in programs and services on their installation. Although 28% indicated no barriers to services, and 23% indicated being unaware of services at their installation, 22% indicated they do not utilize available services due to times the services are offered, 21% indicated their job interferes with usage of the services, and 14% indicated a lack of availability for services at their installation. Table 12 includes the list of reasons for lack of utilization with the top five (by percentage) indicated with brackets.

Table 12. Lack of Programs/Services Utilization (*N* = 5,935)

Lack of Utilization Reasons	Percent (*n*)
None; No Barriers to Services	**27.5% (1,634)**
Unaware of Services	**23.2% (1,378)**
Times Services are Offered	**21.5% (1,278)**
Job Interferes with Usage	**21.1% (1,252)**
Lack of Availability	**14.2% (843)**
Unsure What Meets My Needs	12.0% (711)
Lack of Accessibility	10.8% (641)
Confidentiality Concerns	9.5% (562)
Lack of Childcare	9.3% (553)
Low Quality/Value On-Post vs Off-Post	9.1% (541)
Cost of Service On-Post vs Off-Post	5.4% (318)
Other*	5.1% (301)
Bad Experience, Prior Location	4.1% (244)
Bad Experience, Current Location	3.5% (207)

*Other responses included:
Distance too far
No need for services
Not eligible for services
Transportation Challenges
Work-Life Balance/No Time

Note: Percentages are not mutually exclusive; participants were allowed to select multiple responses. Percentages sum to > 100%.

When asked if their health service needs were met in the past year, one-fifth reported they did not require services (21%), 16% of respondents indicated having their needs met *sometimes*, 19% of respondents indicated having their needs met *most of the time*, while 15% indicated *always* having their needs met (see Figure 12).

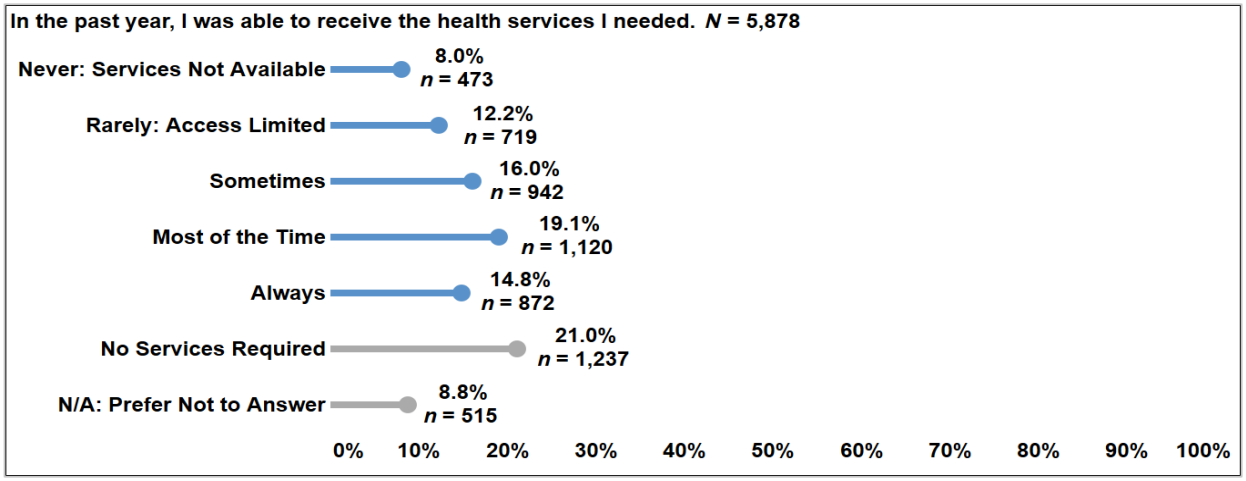

Figure 12. Receipt of Needed Health Services over Past Year

Additional Respondent Comments and Suggestions

The CSTA included one optional open-ended question at the conclusion of the assessment which asked, “Do you have any other suggestions for improving quality of life or readiness on our installations?” Inductive coding of the 1,528 responses received across all 21 locations produced the following themes, summary responses, and comments:

- Continue current programs and services for ongoing satisfaction and well-being.
- Provide more healthy food options on post to address nutrition and dietary concerns.
- Offer telework and options for flexible work hours.
- Improve childcare solutions by extending hours and increasing availability as well as accessibility.
- Improve environmental conditions by addressing air and water quality concerns.
- Improve on-post housing by addressing outdated barracks, overcrowding, and mold remediation.
- Improve healthcare access by reducing wait times and addressing staffing shortages.
- Expand operating hours for on-post services to improve overall quality of life and work-life balance.
- Provide transportation to decrease barriers to accessing both on and off post services.
- Raise awareness of available resources and activities on and off post through increased communication and messaging.
- Remove barriers for services and programs among the civilian workforce for increased participation and use.
- Increase employment opportunities for spouses, particularly in OCONUS locations.
- Provide more family-centered activities and opportunities for physical activity on post, including youth sports.
- Increase the sense of community and engagement with activities that increase social connections on post.
- Improve leadership communication, responsiveness, engagement, and accountability.
- Improve general morale and provide solutions that reduce social isolation as well as improve work-life balance.

CONCLUSIONS

Approximately half of respondents across all 21 locations considered the people on their installation as somewhat healthy from a physical health (57%), behavioral health (44%), and environmental health (42%) perspective. However, about one-third of respondents indicated concerns regarding lack of access to healthcare (34%), obesity (36%), and poor diet (33%). More than half of respondents (57%) indicated behavioral health concerns regarding depression, with 50% reporting stress as a top behavioral health concern. Anxiety as well as alcohol/drug abuse were identified as additional concerns from approximately 40% of respondents.

Work-life balance was indicated as a top concern for social and environmental health (57% of respondents) as well as family health (39% of respondents).

Just over one-third of respondents indicated financial issues as social and environmental concerns (43% of respondents) as well as family health concerns (34% of respondents). However, 25% indicated feeling somewhat satisfied with the support available in their community to assist with a financial setback; an additional 8.6% indicated feeling very satisfied with the same.

Across all 21 locations, respondents indicated diverse communities (29%), access to sports and recreational activities (25%), safe neighborhoods (22%), and the clean environment (22%) as top strengths of the installations.

Approximately one-quarter of respondents indicated concerns over access to childcare (31%), family time (24%), and employment opportunities (22%).

Just over one-quarter of respondents indicated awareness of programs and services on their installation (29%) and use of the CRG (27%). However, only 15% indicated an ability to receive the health services they needed over the past year.

Respondents also indicated a need for more healthy food options on post, extended hours for programs and services, improvements to environmental conditions including air and water quality, as well as solutions to reduce social isolation and improve work-life balance.

RECOMMENDATIONS AND RESOURCES

Leaders and stakeholders are encouraged to read and share the FY23 CSTA results widely with Department of Defense health, readiness, and prevention professionals.

Integration of CSTA findings into Community Health Improvement Planning efforts is strongly encouraged to support current and future programming efforts at the installation and Command levels.

Leaders and stakeholders can leverage the suite of health and readiness resources from the DCPH-A to action findings from the CSTA.

Public facing webpages created by the DCPH-A contain a variety of resources, references and reports that can be found at https://ph.health.mil/topics/Pages/default.aspx. Topics include:

- Injury prevention for Active Duty personnel (https://ph.health.mil/topics/discond/ptsaip/Pages/default.aspx)
- Child health, safety, and well-being (https://ph.health.mil/topics/healthyliving/chswb/Pages/default.aspx)
- Sexual health (https://ph.health.mil/topics/healthyliving/rsbwh/Pages/default.aspx)
- Women's health (https://ph.health.mil/topics/healthyliving/wh/Pages/default.aspx)

The CRG was developed by DCPH-A as a digital inventory of resources supporting community resource gaps and public health promotion processes. The CRG catalogs local resources, support services, and programs at the installation level. Categories include medical and behavioral health services, education and career development, as well as social services and recreational activities, among others. Installation CRGs can be located here: https://crg.health.mil/Pages/default.aspx

The *Health of the Force* report provides medical, environmental health, and Performance Triad metric data at the installation level, which can be used to provide a deeper understanding of population health. The *Health of the Force* report can be found online (https://ph.health.mil/topics/campaigns/hof/Pages/default.aspx) and can be used in conjunction with findings from the CSTA to support overall Community Health Improvement Planning efforts.

The *Health of the Army Family* report characterizes the health and well-being of Army Family members in the context of the unique military environment. This DCPH-A resource can be used in support of results from the CSTA to action specific findings for diverse audiences, including Service members and their Families, Army Leaders, Research and Evaluators, Policy Makers, and Program Proponents. The Health of the Army Family report can be found online (https://ph.health.mil/topics/campaigns/armyfamily/Pages/default.aspx).

REFERENCES

1. Department of Defense. Instruction 1010.10*, Health Promotion and Disease Prevention*, April 28, 2014.

2. Department of Defense. Instruction 6400.11, *DoD Integrated Primary Prevention Policy for Prevention Workforce and Leaders*, December 20, 2022.

3. Chairman of the Joint Chiefs of Staff. Instruction 3405.01, *Chairman's Total Force Fitness Framework*, September 1, 2011.

4. Department of Defense. Instruction 8510.01, *DoD Information Assurance Certification and Accreditation Process (DIACAP)*, November 28, 2007.

5. Department of the Army. 2015. Regulation 600-63, *Army Health Promotion*. https://armypubs.army.mil

6. Department of the Army. 2007. Regulation 40-5, *Preventive Medicine*. https://armypubs.army.mil

7. Department of the Army. 2017. Regulation 608-1, *Army Community Service.* https://armypubs.army.mil

8. Krejcie, R.V., and Morgan, D.W. 1970. "Determining sample size for research activities." *Educational and Psychological Measurement* 30(3), 607–610.