



UNDER SECRETARY OF DEFENSE

4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND
READINESS

JAN 20 2012

The Honorable Howard P. "Buck" McKeon
Chairman
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

The enclosed report responds to House Report 111-491, page 318, accompanying H.R. 5136, the Ike Skelton National Defense Authorization Act for Fiscal Year 2011, which requests the Secretary of Defense submit a report evaluating the barriers to treatment for post-traumatic stress disorder (PTSD) for Service members of both the Active and Reserve Components. This issue falls under my purview, and I have been asked to respond.

This report presents information on the barriers to treatment for PTSD and addresses the following: 1) an overview of current outreach, prevention, and treatment programs in place to identify and provide treatment for PTSD to Service members and their families; 2) an assessment of barriers to Service members receiving treatment for PTSD, including an assessment of the effects stigma, privacy, and career advancement concerns play in Service members not receiving treatment; 3) an assessment and identification of other factors that may deter Service members from seeking treatment for PTSD; and, 4) an assessment of the effectiveness of current programs and policies with recommendations for improvements to outreach, treatment, educational policies, and programs to improve identification and treatment for PTSD.

Thank you for your interest in the health and well-being of our Service members, veterans, and their families.

Sincerely,

A handwritten signature in black ink, appearing to read "Jo Ann Rooney".

Jo Ann Rooney
Acting

Enclosure:
As stated

cc:
The Honorable Adam Smith
Ranking Member



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JAN 20 2012

The Honorable Carl Levin
Chairman
Committee on Armed Services
United States Senate
Washington, DC 20510

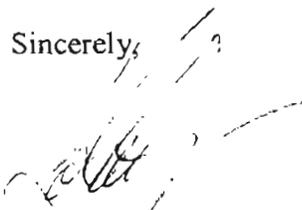
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The Honorable Jim Webb
Chairman
Subcommittee on Personnel
Committee on Armed Services
United States Senate
Washington, DC 20510

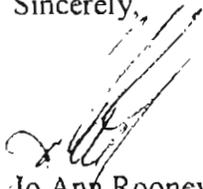
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The Honorable Lindsey Graham
Ranking Member



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The Honorable Joe Wilson
Chairman
Subcommittee on Military Personnel
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

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The Honorable Susan A. Davis
Ranking Member



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Oct 20 2012

The Honorable Daniel K. Inouye
Chairman
Committee on Appropriations
United States Senate
Washington, DC 20510

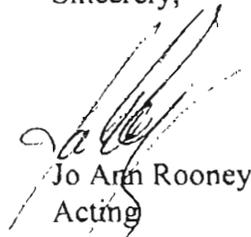
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The Honorable Thad Cochran
Vice Chairman



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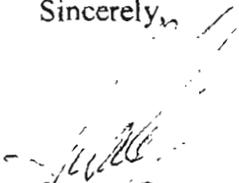
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The Honorable Norman D. Dicks
Ranking Member



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The Honorable C.W. Bill Young
Chairman
Subcommittee on Defense
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Washington, DC 20515

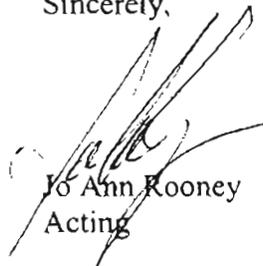
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Ranking Member

Report to Congress



Report to Congress

The Study of Treatment of the Active and Reserve Components
for Post-traumatic Stress Disorder

House Report 111-491 to accompany
H.R. 5136, the Ike Skelton National Defense Authorization Act

for

Fiscal Year 2011

Preparation of this study/report cost the
Department of Defense a total of
approximately \$ 8,360
in Fiscal Year 2011

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I. EXECUTIVE SUMMARY

This report is in response to language on page 318 of House Report 111-491 to accompany H.R. 5136, the Ike Skelton National Defense Authorization Act for Fiscal Year (FY) 2011, requesting the Department of Defense (DoD) provide an overview of the treatment and outreach programs for post-traumatic stress disorder (PTSD) that are currently available to Active duty, Guard and Reserve Service members, and their families. In addition, the report provides recommendations for ways to reduce the barriers to receiving treatment and describes ongoing efforts to measure the effectiveness of PTSD programs in order to identify areas for improvement.

The Department has created numerous programs to address PTSD and will ensure that these programs are high quality, effective, and reach the intended populations. There is a wide variety of effort across the DoD, the Department of Veterans Affairs (VA), and civilian communities to develop and provide outreach and treatment programs for PTSD, and to provide support to Active duty, Guard and Reserve Service members and their families. Healthcare providers, chaplains, family members, and Service leaders deliver these programs.

This report also assesses the effects of stigma, privacy, and concerns about career advancement as barriers to treatment. Recommendations for reducing these barriers to treatment include the following: expansion of the behavioral health provider in the primary care clinic model to reduce stigma, enhancement of the psychological health (PH) support system for leaders, and potential expansion of the types of licensed and credentialed providers that are able to provide care.

Additional recommendations include continuing to identify and catalogue all existing programs that provide treatment for PTSD across DoD, continuing to evaluate the effectiveness of existing programs, standardizing the process of access to mental health treatment in theater across all branches of Service, and continuing to train civilian and contract providers on military culture.

II. INTRODUCTION

PTSD is an anxiety disorder that can develop after exposure to a potentially traumatic event. A traumatic event is one in which grave physical harm has occurred, or a person has experienced a threat of serious harm and then feels intense fear or horror in response to the event. Symptoms of PTSD include flashbacks (reliving or re-experiencing the event), avoidance of event reminders, emotional numbing, and hyper-arousal (exaggerated startle response, increased vigilance to danger). The symptoms must persist for longer than a month and significantly impair social or occupational functioning. PTSD can seriously impact functioning in all areas of life. Early identification and intervention is likely to prevent PTSD from becoming chronic, severe, and incapacitating.

More than 2.2 million Service members have deployed in support of Operation Enduring Freedom (OEF)/Operation Iraqi Freedom (OIF)/Operation New Dawn (OND) since

2001. Approximately 2.4 percent of those deployed Service members have been clinically newly diagnosed with PTSD post-deployment (Medical Surveillance Monthly Report: 2010). DoD, VA, and civilian communities have many programs available geared toward outreach for PTSD and relief of PTSD symptoms in military members and their families, including the Guard and Reserve.

III. OVERVIEW OF CURRENT TREATMENT PROGRAMS

In researching the current programs in place to identify and provide treatment for Service members with PTSD, the DoD has created a list that provides summary descriptions of the major programs offered, Appendix 1. Appendix 1 lists many of the key programs in place for Service members with PTSD, but it should not be considered an exhaustive list of all available programs. Currently, the Department is in the process of developing a complete list of all PTSD and behavioral health treatment programs. Many of the programs in Appendix 1 apply only to Reserve Component members when they are designated as eligible beneficiaries.

The Services work closely with the Center for Deployment Psychology (CDP) to provide training about such evidence-based treatments as Prolonged Exposure (PE) and Cognitive Processing Therapy (CPT) to all psychology and social work residents in their military training site as part of a new PTSD training program. The training is consistent with the recommendations of the Clinical Practice Guidelines (CPGs) discussed below. The mission of CDP, a DoD psychology-training consortium that was established in 2006, is to train military and civilian psychologists, psychology interns/residents, and other behavioral health professionals to provide high-quality deployment-related behavioral health services to military personnel and their families. Their mobile training team travels to bases around the world to train seasoned providers (military, federal civilian and contractor providers) on evidence-based approaches, and has trained more than 300 mental health providers since 2010. After the CDP trains providers, it offers weekly supervision via teleconference to ensure the providers maintain proficiency. These CDP-trained providers are now providing evidence-based treatments, such as PE and CPT, in theater shortly after traumatic events occur. In addition, to date, more than 1,600 civilian non-federal and federal providers have completed CDP's 36-hour continuing education course, entitled *Addressing the Psychological Health of Warriors and Their Families*.

CDP also works to enhance existing mental health training programs. For example, they actively collaborate with the Center for Innovation and Research on Veterans and Military Families (CIR) at the University of Southern California, the Military Family Research Institute at Purdue University, and the psychology programs at Widener University and George Mason University. The Center for the Study of Traumatic Stress (CSTS) hosts trainings for civilian clinicians (federal and non-federal) at meetings that take science "from bench to bedside" (the annual Uniformed Services University's Amygdala conference). Additionally, the CSTS distributes "Courage to Care," a public health education campaign directed toward all community providers, and recently published the Clinical Manual for the Management of PTSD. Finally, the CSTS is

currently editing another clinical manual about managing family issues associated with post-combat reintegration.

DoD is committed to providing state-of-the-art care for PH conditions, such as PTSD, for Service members and their families. The Department has added more than 2,000 behavioral health providers to military hospitals and clinics, and 10,000 more to the networks since 2009. This pool of providers includes up to 215 Public Health Service mental health and traumatic brain injury (TBI) providers via a Memorandum of Agreement with the Department of Health and Human Services. DoD takes great effort to ensure that wounded warriors, especially those with PH conditions, consistently receive excellent care across the entire medical continuum. DoD uses a multidimensional approach to the continuum of care for PTSD, which includes evidence-based research and the dissemination of effective treatment, enhanced access to care, and early detection and treatment of PTSD.

The first part of this approach is to provide a number of evidence-based treatment options for Service members with PTSD. All of these methods are based on current scientific literature and can be found in the VA/DoD CPGs for PTSD, released in 2010. An expert multidisciplinary panel of DoD and VA providers develops the VA/DoD CPGs. CPG treatment recommendations may involve the use of psychotropic medications, psychological interventions, and other methods of treatment. An example of a treatment recommended by the CPG is Cognitive Behavioral Therapy (CBT). The DoD recently initiated a novel use of this treatment for military couples in which one member has PTSD (referred to as Conjoint CBT for PTSD). The Army teaches this type of treatment through its Army Medical Department Center and School (AMEDD C&S) and currently is undergoing a randomized control research trial to study the effectiveness of this type of treatment for PTSD, with a military subject population.

The VA/DoD PTSD CPG serves as one means of communicating the state-of-the-evidence to providers in the field. The PTSD CPG includes a comprehensive and rigorous review of the effectiveness of psychotherapy, medications and their side effects, adjunctive medications, as well as consensus-based strategies for the management of specific PTSD symptoms and co-occurring conditions. It also includes recommendations for psychological treatments (CPT, PE, etc.) and pharmacotherapy (Selective Serotonin Reuptake Inhibitors (SSRI) anti-depressants, etc.). Further, the CPG includes recommendations for adjunctive medications for the management of specific PTSD symptoms. Clinical Support Tools (CST), which are materials to help providers translate the CPG into practice, also have been developed by the Defense Centers of Excellence (DCoE) for PH and TBI and are widely disseminated among clinicians in the DoD.

In order for the Service member to be able to receive the best treatments identified, the Department has launched an extensive effort to improve access to care related to psychological stress. Two key examples of this effort include the use of behavioral health in primary care and telemental health. The Re-Engineering Healthcare In Primary Care Program (REHIP) enables DoD primary care providers to screen and treat health-seeking patients in primary care clinics for PTSD, suicidal ideation, and depression while

integrating behavioral health care providers into routine care. REHIP was based on the Re-Engineering Systems of Primary Care Treatment in the Military (RESPECT-Mil) program in the Army, and the Behavioral Health Optimization Project (BHOP) in the Air Force. The Reserve Component (RC) member is only eligible to access this type of care when receiving treatment in a military treatment facility (MTF), while activated or up to six months after deployment. The RC member often experiences significant difficulties obtaining appropriate treatment for PTSD when not in an eligible status. To address this gap, Public Law 111-163, Section 304 (May, 2010), expands the VA's authority to provide readjustment counseling and mental health services to Service members, veterans, and their families for three years beginning on the date of return from deployment. These additional services will provide maximum support to RC members and their families should the services be needed upon expiration of benefits through the Transitional Assistance Management Program (TAMP). Also, the DCoE for PH and TBI's National Center for Telehealth and Technology's (T2's) program develops and delivers web-based telemental health care that is likely to further extend the reach of services to underserved beneficiaries, particularly RC members and those in rural areas where the telehealth infrastructure is not always available. However, RC members must be in an eligible status when attempting to use telemental health services, otherwise they will be excluded from accessing these services. The use of telemental health will improve access to care for most Service members and families beyond the physical boundaries of military bases.

IV. OVERVIEW OF OUTREACH PROGRAMS FOR SERVICE MEMBERS

Education-focused outreach to Service members and their medical providers is vital. Outreach (the connection of information or ideas about services and programs for PTSD with the military members and their families) is an important part of DoD's multidimensional approach to PTSD treatment. Typically, PTSD outreach educational components are part of a larger resilience, anti-stigma, or reintegration outreach campaign, such as the Total Force Fitness Initiative and the Real Warriors Campaign. The Chairman of the Joint Chiefs of Staff's Total Force Fitness Initiative contains a psychological fitness component and provides guidance to military leaders on the importance of and tactics for promoting and measuring the resilience of the force and the broader military community. To combat stigma related to seeking mental health treatment in the military, DCoE launched *The Real Warriors Campaign*, a public education campaign that reinforces the notion that seeking help is a sign of strength.

In addition, DoD provides many outreach and early intervention programs to raise awareness among Service members, to train civilians treating Service members, and to increase leadership involvement in behavioral health efforts. DoD's approach includes raising public awareness and building resilience, as well as delivering early and effective interventions. DoD conducts efforts to prepare Service members for deployments, as each of the branches has developed Service-specific outreach programs to educate military members and their families on how to recognize the warning signs of PH

problems, and ways to get help. These programs include Army Resilience Training, Navy Operational Stress Control, Air Force Landing Gear, and Marine Corps Combat Operational Stress Control. As a result of these efforts, operational commanders are better able to respond to mental health concerns as they arise and assist in the early detection of PTSD symptoms.

An example of one such program is the Marine Corps Operational Stress Control and Resilience (OSCAR) initiative, which was operationalized for DoD in 2007, when the commanding generals of the three Marine Expeditionary Forces convened a working group of Marine leaders, chaplains, and medical and mental health professionals to address the issue of Combat/Operational Stress. The working group developed a new stress continuum model that was unit leader oriented, multidisciplinary, integrated throughout the organization without stigma, consistent with the warrior ethos, and focused on wellness, prevention, and resilience. The program's three core objectives are the early recognition by caregivers of distress in military members, breaking the code of silence related to occupational stress reactions and injuries, and engaging peers and all caregivers in seeking early help. Monitoring and managing stress using this model is primarily the responsibility of unit leaders, but individual Marines, Sailors, and their family members bear responsibility as well. For Marines and Sailors suffering from diagnosable mental disorders, such as PTSD, depression, or other anxiety disorders, support from unit leaders remains critical to the recovery and reintegration of Service members.

The DoD collaborates with the VA in many areas related to overall PH care, and for PTSD outreach. The DoD and VA formalized their collaboration in 2010 via the DoD/VA Integrated Mental Health Strategy, consisting of 28 structured work groups, each focused on an aspect of VA/DoD PH and/or TBI prevention, intervention and research. Many of these work groups focus on topics related to PTSD outreach and treatment. Another specific example of innovative outreach collaboration for the treatment of PTSD is the Deployment Anxiety Reduction Training (DART). Located at the Northern California Institute of Research and Education (NCIRE)/The Veterans Health Research Institute, researchers are exploring better ways via outreach to help Service members access effective PTSD treatment through DART. This new pilot program was developed by NCIRE researchers, along with officers from the David Grant Medical Center at Travis Air Force Base in collaboration with VA. The DART program was a major focus of this year's annual *Brain at War* symposium, hosted by NCIRE in San Francisco in June 2011. The goal of DART is to help Service members dampen the initial physiological stress reaction to combat trauma in an attempt to reduce the risk of developing PTSD. DART is being launched as a small pilot program in Afghanistan. As a part of this outreach program, medical personnel conduct trainings in battlefield settings to help Service members learn how to recognize expected stress responses, and how to monitor and control stress. The information and exercises are simple, and the short handbook is easy to read.

Finally, DoD also employs a more robust person-to-person mental health surveillance program to enhance the early detection and treatment of deployment-related

psychological health challenges such as PTSD. Four mental health assessments are completed before and after deployment (Pre-Deployment Health Assessment (Pre-DHA)/Post Deployment Health Assessment (PDHA)/Post Deployment Health Reassessment (PDHRA), including one- and two-years post-deployment as part of the Periodic Health Assessment (PHA)). These assessments are in addition to the Mental Health Assessment portion of the PHA that occurs annually for all Service members.

In addition to the programs and initiatives listed above, free resources, including written instructional materials, monthly webinars, and online trainings are available to the general public through DCoE, CDP, CSTS, VA, and the National Center for PTSD websites.

V. OVERVIEW OF OUTREACH PROGRAMS FOR FAMILY MEMBERS OF ACTIVE DUTY, RESERVE, AND GUARD

Outreach and prevention efforts are equally important to family members. DoD provides numerous diverse PTSD outreach and prevention programs, as well as educational materials geared to educate families on the signs of PTSD. A related RAND study from 2008, entitled *Educating Military Personnel and Their Families about Post-Deployment Stress*, noted 56 known PTSD family programs, many of which are web-based and/or use social networking services (Facebook, Twitter, YouTube, etc.). Due to the large number of available DoD programs that cover aspects of PTSD and outreach for families, as well as broader PH issues, only a limited number of key, comprehensive programs are described in this section.

Family Readiness Groups: Some of the most important outreach programs for families are such programs as the Army Family Readiness Groups (FRGs). The other Services have similar programs in place, including the Navy Ombudsman Program, the Marine Corps Key Volunteer Network, and the Air Force Key Spouse Program. The Services offer these programs at several levels of command structure, in all branches of Service, and they can be an official source of information for families of deployed Service members. The FRG informs spouses, friends, and family, pre-identified by the Service members, of official news regarding unit deployments, location, and ultimately, when the unit will return home. This program serves as both a formal clearinghouse of information and an informal support network for military families. For RC family members, the FRG is often the only point of contact with the military system. FRG representatives can participate in a PTSD/TBI train-the-trainer program and teach others how to disseminate information about PTSD to families of Service members.

Yellow Ribbon Reintegration Program: Another significant outreach and prevention DoD program is the Yellow Ribbon Reintegration Program (YRRP). The YRRP is a program that assists Guard and Reserve Service members and their families to connect with local resources before, during, and after deployments, especially during the reintegration phase that occurs in the months after Service members return home. Yellow Ribbon events (the Returning Warrior Workshops developed by the Navy Reserve) typically take place in non-military venues where Service members and families can

access information on health care, resiliency, suicide prevention, employment, education/training opportunities, and financial and legal benefits. PTSD experts and presentations on reintegration with an educational component often are available. The YRRP maintains a Center of Excellence, which collects and analyzes lessons learned and suggestions from State National Guard and Reserve organizations. The program also provides a cadre of speakers who present at YRRP events on issues related to military members and their families.

Military OneSource: Military OneSource is perhaps the best-known resource for both Service members and families. Military OneSource is a free service, funded and operated by DoD for Active duty, eligible Guard and Reserves, deployed government civilians, and their families. Any Veteran with an honorable discharge from the military also is eligible to utilize Military OneSource for up to 180 days post separation. Military OneSource provides a 24/7 toll-free hotline, which is staffed by trained consultants, and offers referrals to a wide range of services. In addition, they contract with licensed mental health providers who counsel and provide psycho-educational services to Service members and their families through in-person services, online chats, and phone calls. The 12-session short-term-solution based programs offered by Military OneSource are geared toward reducing stress and improving relationships, but they are not intended for the treatment of more serious mental disorders. For PTSD, military members must be treated by military mental health providers due to reasons of security, mission impact, and fitness for duty.

Families Over Coming Under Stress Program: The Navy's Families Over Coming Under Stress (FOCUS) is another example of an effective PTSD-related outreach and treatment program. FOCUS is a family-centered resiliency-training program based on evidence-based interventions that enhance both understanding of PH, and the developmental outcomes of highly stressed children and families. Notably, program participation has resulted in statistically significant increases in family and child positive coping behaviors and significant reductions in parent and child distress over time. To date more than 100,000 Service members, spouses, children, and community providers have received services from FOCUS.

Unit, Personal, and Family Readiness Program: The Marine Corps Unit, Personal, and Family Readiness Program (UPFRP) was established to assist Marines and their families throughout their careers in the Marine Corps. This program emphasizes the use of support networks by including the families of origin, spouses, and children. The UPFRP is the primary way that leadership communicates with families to tell them about deployment news (dates of redeployment, etc.). The program also incorporates YRRP to aid both the Marines and their families during their reintegration after deployment. Training about special issues that Marine families face, including the possibility that a Marine may come home with PTSD, is a core component of this program.

Center for Deployment Psychology Trainings: In addition to training military and civilian behavioral health professionals, the DoD's CDP runs an interactive online training that focuses on resiliency building and maintenance in families. Specifically, the

purpose is to teach families how they can increase resiliency while navigating the challenges of deployment.

Deployment Health and Family Resource Library: The Deployment Health and Family Readiness Library is another DoD-operated online resource for military members and their families, providing Service members, families, leaders, health care providers, and veterans with a library for deployment health and family readiness information. The library contains fact sheets, web links, guides, and other products published by the Services and other DoD organizations on a wide variety of topics, including PTSD.

The Support and Family Educational Program: The Support and Family Education program (SAFE) is a psychoeducational family intervention program that was initiated in 1999 and updated in 2003. SAFE is administered at VA Medical Centers by trained mental health professionals and is designed for caretakers of Veterans living with PTSD and other mental illnesses. The program consists of 18, 90-minute classroom sessions about mental illness, stigma, and problem-solving skills, and also provides an opportunity for participants to ask questions directly to a psychologist or psychiatrist.

Talk, Listen, Connect Program: For outreach and prevention programs that are specific to the needs of military children, DCoE has partnered with the Sesame Workshop to create the “Talk, Listen, Connect” program. This multiphase, bilingual, multimedia resource guides families through the changes that are often intrinsic to military life. The resource incorporates characters from the popular children’s television show *Sesame Street*. Initiated in 2006, the program addresses issues related to multiple deployments, explores the family changes that occur when a parent is physically or psychologically injured and helps families cope with the loss of a parent. The Sesame Workshop series uses recognizable characters to explain, in a manner understandable to young children, the situations faced by military families, including PTSD.

The Department also has partially funded a community collaboration with the Public Broadcasting Service and Vulcan Productions to create a handbook for friends and families of deployed Service members. The handbook explains typical Service member reactions to deployment, provides hints on how to handle the deployment process, and includes education about PTSD. In addition, DCoE operates a 24/7 Call Center staffed by mental health professionals who are available to educate families about PTSD and other mental health issues through phone calls, emails, and live chat.

VI. ASSESSMENT OF BARRIERS TO IDENTIFICATION AND TREATMENT

There are many barriers to the identification and treatment of PTSD. This report focuses on the many significant obstacles that include stigma, privacy and career issues, peer influence, leadership, Guard/Reserve status, gender, and minority status (based on a review of the DoD Task Force on Mental Health report (2007), the DoD Task Force on Mental Health Report to Congress (*DoD Plan to Achieve the Vision of the DoD Task Force on Mental Health*, 2007), and the Joint Mental Health Advisory Team 7 (J-MHAT-

7) 2010/2011 reports). These barriers, which appear to reduce treatment-seeking behavior for PTSD, are described in more detail below. Additional barriers identified not listed above are discussed below. For reference, a list highlighting the various types of barriers to treatment, their primary impacts on Service members, and their relevance to the 2007 Task Force on Mental Health key objectives is located in Appendix 2.

Stigma: Stigma can be defined as a mark or token of infamy, disgrace, or reproach, and is a significant factor that deters Service members from seeking treatment. Stigma can be something assigned to oneself, or assigned by a social group or an institution. Service members have stated that they were fearful the negative impact of seeking treatment for psychological problems would end their careers, harm promotion and job selection opportunities, or their problems would prevent deployment or delay their long-awaited return home. Many Service members perceived emotional wounds to be less severe than physical wounds, thus reducing their motivation to seek care.

The recently promulgated Department of Defense Instruction (DoDI) 6490.08, *Revising Command Notification Requirements to Dispel Stigma in Providing Mental Health Care to Military Personnel*, seeks to limit the perception of negative career impact by limiting information reported to commanders when a Service member in their unit seeks mental health treatment. This DoDI also addresses the stigma associated with the mission requirements related to communications about the Service member's diagnosis, treatment, and other protected health information to command. Recently, it appears that stigma about mental health treatment for the Service member may be gradually lessening (J-MHAT-7), perhaps associated with increased outreach and awareness efforts by the DoD, such as the Real Warriors Campaign.

Privacy and Career: The 2008 RAND study, entitled the *Invisible Wounds of War: Summary and Recommendations for Addressing Psychological and Cognitive Injuries*, found that concern over medication side effects was the most cited reason that inhibited Service members from seeking mental health treatment (45 percent). Approximately 42 percent of respondents believed that mental health treatment would hurt either their career, their chances of getting a security clearance, or their opportunity for a desirable job in the private sector. Service members also cited privacy concerns as a barrier to seeking care or treatment. Limitations on privacy in military mental health clinics exist because mental health disorders, by definition, result in impairment or distress, which may have implications for security clearances, reliability for nuclear missions, and retention. Service members also expressed concern that having sought mental health services would impede their ability to compete for future law enforcement and emergency services positions, as many exiting Service members seek employment in this line of work.

Social Support/Peer Influence: Service members have reported that team loyalty, and the desire not to let the team down, could easily serve as a barrier to seeking and accepting treatment. In addition, the fear that other Service members would perceive them as weak if they sought treatment may cause peer pressure to avoid seeking treatment, and thus creates a barrier. Service members also reported they hesitate to seek

care for PTSD to avoid harassment, humiliation, or unfair treatment by leaders and/or peers.

Leadership: In general, there are barriers resulting from the perceptions of some Service members viewing leadership as not understanding or supporting of them when PH problems occur. Service members reported that unsupportive leadership was a significant barrier to seeking PTSD treatment. They are concerned about trusting more senior-ranking individuals with their PH problems, and they have difficulty gaining permission to take time away from work to attend treatment. Service members expressed concern that if diagnosed with PTSD, their value to leaders would be reduced. Also, some military leaders may not fully understand how to hold their unit members with PTSD accountable for misconduct (related or unrelated to PTSD), or may not be aware of the degrees of variation of the symptoms of PTSD. Some leaders also may feel isolated by nature of command, and may hesitate to seek treatment for their own mental health symptoms due to the barrier of responsibilities as a commander and leader. Impaired leaders are ineffective leaders.

Guard/Reserve Status: Some of the barriers reported by Guard and Reserve Service members included an expectation by others that they will immediately get back to business as usual. They also reported the perception by non-military colleagues that “they took time off” from work to serve, making returning Guard and Reserve members hesitant to take time off from work for mental health care. Additionally, Guard and Reserve members often receive treatment from civilian providers who are not skilled in military PH issues, which may lead them not to seek care in order to avoid feeling misunderstood, or to drop out of care prematurely for the same reasons.

Additional barriers to care differ for the Guard and Reserve members, as they may not have access or eligibility to MTFs or VA centers. While there are TRICARE programs available to OEF/OIF Guard and Reserve members after de-activation (such as TRICARE Reserve Select), Guard and Reserve members reported encountering numerous physical and logistical barriers to obtaining timely treatment upon return. These barriers occur in part because they may be geographically dispersed from mental health resources. Although they might be able to access care (entitlement to benefits) using civilian employment insurance for a private provider, those benefits vary greatly. Also, since PH issues often occur outside windows of eligibility, the Reserve member may be eligible only to receive federal health care from the VA. This challenge also leads to problems with continuity of care. In rural or remote areas, there are unique challenges in finding providers who understand military culture. Other reported barriers included the limited pool of authorized treatment providers and laws and related policies for accessing care. Finally, Guard and Reserve members reported that they were likely to experience fragmentation of their social networks, which are protective to PH.

Individual Augmentee: As the Services continue to increase joint cooperation, a Service member often may be embedded with another Service branch. This practice has become more common in recent years due to the Joint Service deployment policies of the OEF/OIF/OND. Because each military culture is unique and the process of accessing PH

services while facing the stressors of war varies across Services, lack of familiarity with and difficulty adjusting to a different Service's process may deter an individual from seeking care and lead to a feeling of isolation. Additionally, as Individual Augmentees from all Service branches return to diverse locations, their fragmentation from a centralized system of care results in problems with the identification of PTSD, as well as tracking of treatment progress once diagnosed.

Policy Barriers: Policy barriers include those related to retention, special duty clearance, mental health diagnoses, and medical separations due to mental illness, as they create the general and pervasive perception that being diagnosed with PTSD will lead invariably to discharge from service. Additional policy barriers include those related to the use of medication and its impact on both retention and deployment status, as some military members are fearful of taking psychiatric medication due to the potential impact on their promotion and selection opportunities.

Operations Tempo: Service members reported that the operations tempo at times made it difficult to get permission to take time off from work. Each Service has Combat Operational Stress Control personnel and chaplains in theater, but being stationed in forward deployed locations created significant challenges in accessing PH support.

Confidence in Mental Health Providers: Approximately 40 percent of respondents in the 2010 Behavioral Health Needs Survey (BHNAS-5) believed that professional mental health treatment was less effective than discussing their problem(s) with a friend.

Continuity of Care: Frequent duty rotation of both providers and Service members was reported as a barrier to seeking treatment because a stable enduring therapeutic relationship is one of the keys to success when treating PTSD, and frequent moves by providers and Service members disrupt that relationship.

Lack of Civilian Provider Familiarity with Military Culture: There was recently a large hiring action to expand the pool of mental health providers to increase the availability of treatment for Service members. Most of the new providers are civilians, creating an unexpected barrier to care, as the military experience of uniformed mental health providers cannot easily be replaced by the experience of non-military civilian providers. Military providers understand the military culture and can communicate more effectively with command leaders and Service members. Perhaps most importantly, both Service members and commanders perceive uniformed providers as being more credible, and that perception creates a barrier that may be difficult for civilian providers to eliminate. This is a significant barrier to RC members as most live outside a military treatment facility catchment area.

PTSD Symptoms of Withdrawal, Emotional Numbing and Avoidance: The symptoms of PTSD itself (withdrawal from activities and people, avoidance of triggers of traumatic memories, and emotional numbing) appear to be barriers to treatment. There was a marked resistance noted among all J-MHAT 7 Focus Groups related to seeking

help for stress symptoms. Resistance was most noticeable among those who reported they had avoidant/numbing symptoms.

Gender: In RAND's *Invisible Wounds of War* report, released in 2008, military females were identified as one group that was at higher risk for depression, PTSD, and suicide. Also, female Veterans report significantly higher rates of Military Sexual Trauma (MST) (defined as sexual assault and/or sexual harassment) than males, and MST victims appear to have a greater risk of developing PTSD. Males appear less likely than females to seek treatment for PTSD. Seeking care for MST-related PTSD may be impacted by gender-specific factors in response to stigma, marital status of the Service member with PTSD, and support from the non-military spouse for the Service member's treatment-seeking behavior.

There is an ongoing DoD/VA collaborative project to address potential gender-specific needs, identify gaps, and develop methods to address these issues. The working group will use existing data to explore gender differences in the delivery and effectiveness of mental health services, develop strategies to overcome health care disparities and barriers to care, and identify the need for further research.

Minority Status: Military members who belong to a minority group may face cultural barriers that impact their decision to seek treatment. DoD has invested in researching the needs of minority population, but there are no known programs designed for minority military members with PTSD. With recent changes to DoD policy for the service of homosexual military members, there will be new challenges regarding the mental health needs of individuals impacted by this change in policy.

Additional Assessment of Barriers: Information provided to the Service member is inconsistent from one location to the next about the career consequences of seeking treatment for PTSD. Negative consequences for treatment seeking effectively maintain and reinforce stigma against PH interventions because military members may mistrust and avoid treatment services. Outstanding quality of care is not enough to overcome the stigma of negative career consequences for obtaining PH services.

Lastly, programs that deliver services directly to the intact small unit structure may be an efficient way to reduce barriers to seek help for PTSD.

VII. ASSESSMENT OF EFFECTIVENESS OF PROGRAMS AND POLICIES

OVERVIEW OF PROGRAM EFFECTIVENESS

The DoD has made significant efforts to evaluate evidence-based treatments for PTSD, including the robust Army Medical Research and Materiel Command (MRMC) PTSD research program. It represents more than a \$300 million effort and is broad-based, spanning areas of epidemiology, basic science, prevention and education, early screening and interventions, assessment, treatment, and recovery/return to duty. The overall

research effort began in earnest in 2007, and since that time, the Military Operational Medicine Research Program (MOMRP) has incorporated additional research projects. There are now more than 300 studies funded and in progress, with a few close to completion. The overall research strategy is multi-pronged, with significant portions of the funding (approximately 66 percent) focused primarily in three areas. The first area involves understanding the mechanisms that contribute to the development of PTSD. The second area is focused on identifying early indicators of PTSD. The third area of research is focused exclusively upon the development and best-practice use of evidence-based interventions that target PTSD symptoms and their associated co-morbidities. Interventions in this area include psychotherapy, the use of medications, and development of the best treatment modalities (individual, group) for delivery of treatment.

Specifically, within the treatment domain, the PTSD research portfolio includes a broad variety of intervention research. Most of the interventions under investigation are considered evidence-based and include primarily those therapies that are considered cognitive-behavioral in nature. Significant treatment efforts also focus upon both the development and validation of medications for use in alleviating the symptoms of PTSD and returning the Service member to a higher level of functioning. In addition to specific treatments, the treatment portfolio includes research evaluating the various modalities of treatment themselves, and where or how they are most effectively delivered. Some recent research initiatives include the development of an integrated treatment program to include psychotherapy, virtual reality therapy, and medication. The goal of this research is to develop a treatment regimen that is intensive and effective within a two-to-three week delivery period. The care-protocol for PTSD is rapidly and frequently changing as a result of ongoing innovative evidence-based research in the DoD. The dissemination of treatment information, which includes changing provider behavior to adopt new treatment recommendations, also requires implementation research be conducted to evaluate efficacy and outcomes. As a result, implementation research also is included in this portion of the MRMC PTSD research treatment portfolio.

DoD has initiated a process for comprehensive evaluation of PH programs in order to ensure continuation of high quality, effective mental health programs for Service members. One part of the process of program evaluation under construction involves developing a standardized PH program evaluation process. DoD has commissioned studies to assist with the development of parts of the process. For instance, the RAND Corporation, through its National Defense Research Institute (funded by the Office of the Secretary of Defense), is conducting a study that has not only created a framework for assessing the effectiveness of current programs, but is also conducting independent evaluations for a subset of these programs. The study is ongoing and expected to be complete in FY12. From this study, RAND recently published the first of several reports, *Programs Addressing Psychological Health and Traumatic Brain Injury Among U.S. Military Service members and Their Families*.

The DCoE developed the Program Effectiveness Toolkit (PET) and the Program Evaluation Guide (PEG) to assist PH and TBI program and project managers implement

and evaluate new programs for Service members and their families. The PET provides new programs with a standardized and practical approach to follow to initiate a treatment or outreach program utilizing appropriate measures of effectiveness. The ultimate aim of the PET is to assist the Services in establishing, from inception, programs with the capacity to demonstrate (both statistically and clinically) significant outcomes for their target populations.

OVERVIEW OF POLICY EFFECTIVENESS

There are multiple policies in DoD, as well as specific to each Service, that impact the prevention, identification, treatment and appropriate disposition of the military member with PTSD. These policies address the effect of mental health on a range of issues, including security clearance, special duty, entry into service, continuing service, and occupational policies. In addition, there are policies on mental health and confidentiality, medical record management, and management of medically compromised military members with PTSD. One common challenge of existing policy appears to be maintaining a balance of the individual's mental health treatment needs while meeting the military mission's operational needs.

Efforts are being made to evaluate existing policy related to PTSD. There is no current process in place to systematically assess the overall effectiveness of existing policy on PTSD in the DoD. However, a policy related to PTSD that will be evaluated for effectiveness is the pre- and post-deployment mental health assessment process mentioned in Section IV above (Directive-Type Memorandum (DTM) 11-011, Mental Health Assessments for Members of the Military Services Deployed in Connection with Contingency Operation, August 2011). DoD will conduct an evidence-based assessment of the effectiveness of this policy, in addition to quality assurance. Once completed, the results of the assessment will shape ongoing recommendations for quality improvement to this DoD policy and process.

VIII. DISCUSSION AND RECOMMENDATIONS

In order to reduce barriers for Service members and their families in accessing care for PTSD, the committee report requested the following: recommendations related to outreach and education policies and programs, family outreach and educational policies and programs, and recommendations for improvements or new programs to expand or improve identification and treatment for PTSD. DoD evaluation of existing programs is ongoing and forthcoming results will inform future recommendations for improvement to existing programs.

RECOMMENDATIONS FOR IMPROVEMENTS TO SERVICE MEMBER OUTREACH AND EDUCATION POLICIES AND PROGRAMS

Privacy and Career

- **Increase awareness, via targeted outreach, about the impact of mental health diagnoses on career.** Barriers to seeking treatment may be reduced by educating Service members that a mental health diagnosis does not always equate to medical retirement or separation from the military.

Leadership

- **Create a leader support system.** Leaders are often hesitant to seek mental health treatment for many reasons involving the nature of their command. Their role places them in a position of isolation, thus reducing the protective factor that social support typically provides for PH. Strong leadership is a protective factor for the PH of Service members.
- **Expand existing efforts to enhance commanders' knowledge about how PTSD impacts Service members and their performance at work,** as well as how commanders can monitor Service members for signs of emerging or worsening PTSD symptoms.

Operations Tempo

- **Focus on timely access** to ensure that military members who have experienced psychological trauma are permitted to seek treatment, regardless of the operations tempo, through outreach and policy.

Confidence in Mental Health Providers

- **Embed mental health providers into line units alongside leaders** to increase the perception that mental health providers understand the work that the line does, while also facilitating communication between line leaders and PH resources.

Provider Familiarity with Military Culture

- **Ensure that civilian/contract providers attend trainings about the military system and culture** to become more credible resources for commanders and improve their rapport with Service members seeking care.
- **Increase access to regional trainings** to allow all military mental health providers regardless of civilian, military, or contractor status to use regional trainings through government agencies (AMEDD C&S, CDP, etc.). For example, contractors provide significant portions of PH care at MTFs, but may have limited access to CDP trainings due to contractual or fiscal limitations, which vary from contract to contract.

This limitation could be resolved by changing contract Statements of Work to permit attendance by the contractor at these training activities.

RECOMMENDATIONS FOR IMPROVEMENTS TO FAMILY OUTREACH AND EDUCATION POLICIES AND PROGRAMS

Families

- **Analyze if family programs should be made more proactive** and actively reach out to families, rather than relying on passive web-based programs that family members must seek out. The focus of programs should not be limited to PTSD, but should highlight overall resilience and health.

PTSD Symptoms of Withdrawal, Emotional Numbing, and Avoidance

- **Enhance outreach and education about the potential for PTSD symptoms to be a barrier to seeking treatment** by using outreach programs for both the military member and families. This will further strengthen family and Service member skills to encourage the Service member with PTSD to seek care despite these discouraging symptoms.

RECOMMENDATION FOR NEW PROGRAMS TO IMPROVE OR EXPAND IDENTIFICATION OR TREATMENT

Stigma

- **Continue exploring and expanding the incorporation of mental health providers into routine care delivery** by integrating behavioral health care providers into Primary Care Clinics. Doing so would increase Service members' familiarity with discussing PH with a mental health professional as part of their ongoing medical care regardless of deployment status, afford an opportunity for prevention, and consequently help to reduce stigma. Expanding this effort to the Guard and Reserve Component Service members would be especially beneficial.

Social Support/Peer Influence

- **Examine the efficacy and benefits of creating a DoD sponsored peer-to-peer network** of military recovering PTSD patients (mentor/buddy program). If effective, DoD could expand this program for all diagnostic categories, not just PTSD.

Guard/Reserve Status

- **Continue to streamline the Military Health System treatment process** in order to improve Guard and Reserve access to mental health treatment services, especially post-deployment.

Individual Augmentees

- **Standardize PH access to care and evaluations across the continuum of care**, regardless of Service branch. Increased standardization of the delivery of evaluation and treatment services available for PTSD, as well as the process of accessing the entry points for care across the continuum of care, would benefit distressed Service members who are deployed and embedded within a different military subculture.

Policy Barriers

- **Revise access to care policies** to reduce logistical barriers for Guard and Reserve members.
- **Develop a structure and process to evaluate PH policy effectiveness.**

Gender

- **Conduct more research** to understand gender specific issues related to PTSD.
- **Encourage evidence-based treatment programs for victims of MST** (both genders) as the victims of sexual assault and sexual harassment are more likely to develop PTSD than their counterparts without a history of MST.

Minority Status

- **Address why Service members with minority status** (ethnic, cultural, religious, race, sexual orientation differences, etc.), appear to be at higher risk to develop PTSD. There are very few research studies or treatment programs available to address the needs of minorities with PTSD in the military.

Program Evaluation

- **Accompany new PTSD programs with a prospective evaluation component** to demonstrate the effectiveness of these programs. The use of a standardized set of outcome measures would maximize the value of the evaluation component, as it would allow for comparison across various programs. Effectiveness of existing programs should be examined to improve efficiency and knowledge sharing prior to allocation of additional resources toward new treatment programs.
- **Evaluate the effectiveness of existing PTSD outreach and educational programs**, prior to the allocation of additional resources toward new outreach and educational programs for either Service members or families. Program owners should not assume that outreach or educational programs are effective without this evaluation.

- **Use RAND program evaluation study findings and DCoE Toolkits to improve the process of all DoD PH program evaluation** and enhance efforts to determine if evidence based programs for PTSD are effective.

Staffing Shortages

- **Continue to use the DoD Psychological Health Risk-Adjusted Model for Staffing (PHRAMS)** to analyze the availability and access to PH care that is needed. Based on these findings, consider expanding the types of licensed and credentialed providers acceptable to provide care under TRICARE and as Active duty providers. For example, including nationally credentialed and/or certified or licensed Master's prepared clinicians (Psychological Associates) would expand the types of professionals available to provide mental health treatment.

IX. SUMMARY

As evidenced by the efforts of the DoD, VA, and civilian communities noted in this report, the Department is committed to improving the outreach, identification, and treatment of PTSD for its Service members and families. The report highlights the work DoD has accomplished to address the existing barriers to care (stigma, privacy and career, leadership, etc.). Future efforts will include the implementation of the corresponding recommendations (minimize stigma attached to mental health visits, improve Service member perception of seeking care from military mental health providers, etc.). In addition, the report emphasizes the importance of a DoD/VA collaborative standardized system of program evaluation for effectiveness and recommends increased focus toward outcomes when developing new programs. Moving forward, the challenge for policy makers will be to manage the delicate balance of the mental health treatment needs of the individual with the operational needs of the military mission.

APPENDIX 1 – OVERVIEW OF OUTREACH/TREATMENT PROGRAMS

Title and Description of Current Program	Components of Program							Target Audience
	Identification	Access to Care	Treatment	Outreach to Educate/Inform	Active Duty Service Members	Reserves	Families	Children
AFTER DEPLOYMENT (T2 and DCoE) www.afterdeployment.org After Deployment delivers web-based applications to the military community targeting Psychological Health (PH) and Traumatic Brain injury (TBI). The website's focus is directed at Post-traumatic Stress Disorder (PTSD) and other mental health conditions commonly experienced by Service members and their families following a deployment. The intent is to provide content via an array of multimedia-based approaches. The website includes information and self-guided solutions for dealing with multiple problems including PTSD and war memories, conflict at work, depression, anger, sleep problems, relationship problems, children and deployment, and living with physical injuries.	●	●		●	●	●	●	●
CITIZEN SOLDIER SUPPORT PROGRAM (University of North Carolina and Reserves) http://www.citizensoldiersupport.org The mission of the Citizen Soldier Support Program (CSSP), hosted by the Odum Institute for Research in Social Science at the University of North Carolina at Chapel Hill through a federally funded grant, is to engage and connect military and community service systems to increase the readiness and resiliency of Reserve Component (RC) Service members and their families. Through a variety of methods including evidence-based, best practice training, a robust searchable provider database and other innovative solutions, CSSP is working with numerous partners throughout the country and with the Department of Defense to develop effective and sustainable military/community partnerships. The goal is to build and reinforce the military-civilian conduit between behavioral health professionals, agencies, systems and resources, and to penetrate into geographically isolated, rural and underserved regions to more effectively serve the Reserve Component members and their families.	●	●				●	●	
COMBAT OPERATIONAL STRESS CONTROL (Marine Corps) https://www.manpower.usmc.mil/portal/page/portal/M_RA_HOME/MR_OLD/COSC%20Home Combat Operational Stress Control (COSC) encompasses all policies and programs within the Marine Corps to prevent, identify, and holistically treat mental injuries caused by combat or other operations. COSC is one of the priorities of the Commandant of the Marine Corps, to ensure that all Marines and family members who bear the invisible wounds caused by stress receive the best help possible and that they are afforded the same respect given to the physically injured. The two goals of COSC are to maintain a ready fighting force, and to protect and restore the health of Marines and their family members.	●	●		●	●		●	
COMPREHENSIVE COMBAT AND COMPLEX CASUALTY CARE (Navy) http://www.med.navy.mil/sites/nmcsc/Patients/Pages/c5_mentalhealth-top.aspx Comprehensive Combat and Complex Casualty Care (C5) mental health providers deliver outpatient mental health services for eligible C5 patients. The providers employ evidence-based treatment and adhere to the VA/DoD CPG's for the management of PTSD. In addition, clinical practice also is guided by standards set by the Joint Commission. Services include but are not limited to crisis intervention, diagnostic evaluations, therapeutic treatment modalities, psychological fit-for-duty assessments, family education sessions and inpatient follow-up sessions. In addition, an 8-week intensive outpatient program targeting PTSD recovery falls under the C5 department.	●	●	●		●			
COPING WITH DEPLOYMENTS: PSYCHOLOGICAL FIRST AID FOR MILITARY FAMILIES (Red Cross) http://www.redcross.org/portal/site/en/menuitem.d8a9ecf214c576bf971e4cfe43181aa0/?vqnextoid=0742cd7a973e3210VqnVCM10000089f0870aRCRD&vqnextfnt=d Coping with Deployments: Psychological First Aid for Military Families is a Red Cross initiative serving military families. The course (designed specifically for the spouses, parents, siblings and significant others of Service members), provides useful information on how military family members can strengthen their ability to successfully respond to the challenges they may encounter throughout the deployment cycle. It also explains how to provide psychological first aid to others experiencing stressful feelings or events.				●		●		

<p>DEPLOYMENT HEALTH CLINICAL CENTER (DCoE) (http://www.pdhealth.mil/)</p> <p>The DoD Deployment Health Clinical Center (DHCC), a component center of DCoE, provides hands-on care for returning Service members with post-deployment health concerns while simultaneously serving as a resource center for the continuous improvement of military health care. The Center supports military health care innovation by offering complementary and alternative (CAM) treatments for PTSD and combat stress, by researching the effectiveness of innovative health service delivery models for PTSD and behavioral health care, and by implementing RESPECT-Mil (Re-Engineering Systems of Primary Care Treatment in the Military – see separate entry, below) at Army medical treatment facilities world-wide. DHCC offers a strategy of direct health service delivery, provider education and outreach, and clinical and services research.</p>	●	●	●	●	●			
<p>SPECIALIZED CARE PROGRAM (Army, DHCC, and DCoE) http://www.pdhealth.mil/clinicians/scp_program.asp</p> <p>A three-week milieu-based program where Service members support one another in a group, while each individual receives treatment from a multidisciplinary team of deployment health specialists. One of three clinical “tracks” is exclusively for Service members with persistent PTSD, trauma spectrum symptoms, or difficulties re-adjusting to life following recent deployments.</p>			●		●			
<p>DEPLOYMENT TRANSITION CENTER (Air Force) http://www.ramstein.af.mil/deploymenttransitioncenter.asp</p> <p>The U.S. Air Force Deployment Transition Center at Ramstein Air Base, Germany, provides critical reintegration and decompression time to meet the needs of Airmen at high risk to traumatic exposure. The DTC is not considered Mental Health (MH) treatment and is not designed to decrease the frequency of PTSD. One focus, however, is increasing the awareness of potential MH problems and their functional impact on life. Information on resources, the Wingman concept, and how and when a person should seek additional care will be reinforced. The DTC will provide strategies and recommendations to Service members on common reactions to combat and operational stress as well as build awareness of evidence-based treatments.</p>	●	●		●	●			
<p>DELIVERY OF SELF-TRAINING AND EDUCATION FOR STRESS SYMPTOMS – PRIMARY CARE (DoD) http://fhp.osd.mil/deployed/projectDetail.jsp?projectId=1055&region=0&researchTopic=9&majorDeployment=0&researchSubTopic=21</p> <p>This Institutional Review Board (IRB)-approved research study seeks to enroll 160 eligible participants and compare six weeks of Delivery of Self-Training & Education for Stress Symptoms—Primary Care (DESTRESS-PC) plus optimized usual primary care PTSD management to optimized usual care alone, with follow-up at 6 and 12 weeks post-randomization. Entry criteria include psychological trauma related to combat in Iraq and/or Afghanistan, primary care referral to a study nurse manager for PTSD, PTSD diagnosis on the Clinician Assessment for PTSD Scale, and absence of unstable medical or psychiatric illness. Study sites are at Walter Reed National Military Medical Center (WRNMMC) in Bethesda, Maryland; Womack Army Medical Center (WAMC) at Fort Bragg, North Carolina; Savannah VA Clinic in Charleston, South Carolina; and Boston VA Clinic in Boston, Massachusetts. During the first year of the study, the PI reports that approval from the four sites IRBs plus the USAMRMC IRB were granted. In addition, two nurses, one each at the WAMC and Savannah sites, were hired. Recruitment at the Savannah VA center has begun with one subject enrolled.</p>	Clinical Research Study		●	●		●	●	
<p>D-STRESS (Marine Corps) http://www.dstressline.com/</p> <p>Marine Corps Pilot Program: self-assessment and online training/coaching program providing six weeks of stress management skills post-deployment for Marines experiencing symptoms of combat stress and PTSD. This program aims to reduce stigma via anonymous/private online-access, and is also currently available to Marine veterans and families.</p>		●			●	●	●	●
<p>FOCUS (DoD and Navy) http://www.focusproject.org/</p> <p>The FOCUS Project addresses concerns related to parental combat operational stress injuries and combat-related physical injuries by providing evidence-based family resiliency services to military children and families. FOCUS was initially integrated into designated Navy and Marine Corps sites by the Navy Bureau of Medicine and Surgery (BUMED). In 2009, FOCUS Family Resiliency Services have been made available to Army and Air Force families at designated installations through support from the Defense Department’s Office of Family Policy.</p>	●			●	●		●	●
<p>inTRANSITION (DCoE) http://www.health.mil/InTransition/default.aspx</p> <p><i>in Transition</i> is a voluntary program to support Service members receiving mental health care as they move between health care systems or providers. The program provides a personal coach, along with resources and tools, to help Service members successfully and seamlessly make the transition either from one base to another, one level of care to another, or from Active duty to separation or retirement and care through VA.</p>		●		●	●	●	●	●

<p>PTSD COACH MOBILE APPLICATION (T2, DCoE, and VA) http://t2health.org/apps/ptsd-coach</p> <p>T2 collaborated with the VA's National Center for PTSD to develop this mobile app to assist Veterans and Active duty personnel who are experiencing symptoms of PTSD. It is intended to be used as an adjunct to psychological treatment but can also serve as a stand-alone education tool. Key features of the app include: "Self-Assessment," "Manage Symptoms," "Find Support," "Learn About PTSD."</p>	●	●	●	●	●			
<p>NATIONAL GUARD PSYCHOLOGICAL HEALTH PROGRAM (National Guard and DoD) http://www.jointerservicesupport.org/PHP/Default.aspx</p> <p>The National Guard Psychological Health Program was launched in 2007 at the direction of the Assistant Secretary of Defense for Health Affairs. The Program is led by a Director of Psychological Health in every State who assists with connecting National Guard members to mental health and substance abuse services in their own communities. The program website provides Guard members and their families information and contacts to help build resiliency, including education to support wellness, support for family members and friends, and immediate access to help for callers who are experiencing troubling symptoms, including PTSD.</p>	●		●		●	●		
<p>NAVAL CENTER FOR COMBAT AND OPERATIONAL STRESS CONTROL (Navy and Marine Corps) http://www.med.navy.mil/sites/nmcsc/nccosc/Pages/welcome.aspx?slider2=1</p> <p>The Naval Center for Combat and Operational Stress Control (NCCOSC) is dedicated to the mental health and well-being of Navy and Marine Corps Service members and their families. The major focus of the Center is to promote resilience and to investigate/implement the best practices in the diagnoses/treatment of PTSD and TBI. The center is a program of the U.S. Navy Bureau of Medicine & Surgery (BUMED).</p>			●	●		●	●	
<p>NAVAL SPECIAL WARFARE RESILIENCE ENTERPRISE (Navy) http://www.defense.gov/news/newsarticle.aspx?id=51554</p> <p>A four-day post-deployment retreat for Naval Special Warfare Service members and their families, designed to identify and treat symptoms of combat stress early to prevent them from becoming bigger problems. The Family Resiliency Enterprise seeks to accomplish this through three steps: assessing individual sailors' and family members' needs; providing educational programs and services tailored to those needs; and helping newly reunited families reintegrate after deployments.</p>	●	●	●	●		●		
<p>NAVY RESERVE PSYCHOLOGICAL HEALTH OUTREACH PROGRAM (Reserves and Navy) http://www.navyreserve.navy.mil/Pages/PHOP.aspx</p> <p>The Navy Reserve (USNR) Psychological Health Outreach Program (PHOP) was established in September 2008, and is co-located with Regional Care Coordinator staff in six regions: Mid-Atlantic, Southeast, Southwest, Northwest and Midwest. The USNR PHOP is a Resource Management service, and does not provide direct treatment or counseling. Teams of clinical licensed professionals conduct behavioral health screenings to assess an individual's current level of psychological, physical, social, and family well-being functioning, then link the caller with appropriate providers within the military or community health systems. PHOP Resource Specialists follow up on referrals to ensure that the recommended provider is a "good fit" for the Service member. PHOP Resource Specialists also provide Outreach calls to recently demobilized Service Members and assist with non-behavioral health service referrals, which can include, but are not limited to housing, food and employment assistance. PHOP staff partner as needed with other military service providers including local Chaplains, and MFLC, to ensure coordination of support services to Service Members and their families.</p>	●	●	●		●			
<p>NAVY SAFE HARBOR (Navy and Coast Guard) http://www.public.navy.mil/bupers-npc/support/safe_harbor/Pages/default.aspx</p> <p>Navy Safe Harbor is the Navy's lead organization for coordinating the non-medical care of wounded, ill, and injured Sailors, Coast Guardsmen, and their families, providing a lifetime of individually tailored assistance designed to optimize recovery, rehabilitation, and reintegration. Services include: TBI/PTSD support services, child and youth programs, and personal and family counseling.</p>		●		●		●	●	●
<p>NAVY CAREGIVER OCCUPATIONAL STRESS CONTROL PROGRAM (Navy and Marine Corps)</p> <p>The Navy/Marine Corps Caregiver Occupational Stress Control (CgOSC) program supports early identification of stress injuries using the stress continuum model, which provides a non-threatening, color-coded (green, yellow, orange, red) language to identify and mitigate stress, enabling open communication about risk factors before symptoms become clinically significant. CgOSC's emphasis on leadership and accountability is congruent with the Navy and Marine Corps culture and improves the capacity of units to identify and address the welfare of Service members, while also alleviating some of the burden from overworked and overstressed clinicians. Local CgOSC team members and champions promote individual resilience by using an "all hands" approach that offers and facilitates peer-to-peer ("buddy care") consultations to encourage discussion of stressors (relationship, anger, burnout, etc.), coping skills and resources. CgOSC Champions involve and empower commanders by conducting environment assessments to identify avoidable stressors (fatigue and burnout due to frequently rotating night shifts). CgOSC teams also provide feedback and offer consultation to commands to support unit resiliency and take corrective action, if necessary.</p>	●	●			●	●		

<p>NAVY AND MARINE CORPS COMBAT AND OPERATIONAL FIRST AID (Navy and Marine Corps) Combat and Operational Stress First Aid (COSFA) is a flexible multi-step process for the timely assessment and preclinical care of psychological injuries in individuals or units with the goals to preserve life, prevent further harm, and promote recovery. Unlike other acute stress management procedures, COSFA was designed specifically to augment the physical, psychological, social, and spiritual support structures that exist in the military, and to help restore these support structures over time. It is consistent with the Navy and Marine Corps Combat and Operational Stress Continuum model, which is fundamental to the Navy Operational Stress Control (OSC) and Marine Corps Combat and Operational Stress Control (COSC) programs described in MCRP 6-11C/NTTP 1-15M.</p>	●			●	●	●	●	●
<p>OPERATION BUILDING RESILIENCE AND VALUING EMPOWERED FAMILIES (Army) www1.cyfarnet.org/FRConf2011/ws/2011-Chun-Brave.ppt Operation Building Resilience and Valuing Empowered (BRAVE) Families is a program designed at WRNMMC to care for the needs of family members and children of Service members who were wounded in combat. The objective of the program is to mitigate against family and child stress, maladjustment, and PTSD that can result from reuniting with a severely combat-injured (physically and emotionally) returning warrior by helping to relieve family distress, sustain parental functioning, and foster effective injury related parent-child communication.</p>	●	●	●	●			●	●
<p>OPERATIONAL STRESS CONTROL AND READINESS (Marine Corps) http://www.marines.mil/news/messages/Pages/MARADMIN0667-09.aspx The current Operational Stress Control and Readiness (OSCAR) program augments the COSC program in Marine Divisions by embedding full-time mental health professionals as part of the Division table of organization down to the infantry regimental level. OSCAR personnel are organic to the Division and infantry regiment. They deploy with their units in theater and stay with them when they return to garrison. They help commanders build unit strength, resilience, and readiness, as well as help keep Marines and sailors in the fight through prevention, early identification and intervention with stress-related problems. Full manning of OSCAR teams is in progress with completion projected for FY11. Until then, the Navy Bureau of Medicine and Surgery (BUMED) plans to fill OSCAR teams for deploying units with available mental health personnel on an ad-hoc basis.</p>	●	●	●	●	●			
<p>PSYCHOLOGICAL HEALTH ADVOCACY PROGRAM (Air Force Reserves) http://www.pittsburgh.afrc.af.mil/news/story.asp?id=123240248 Psychological Health Advocacy Program (PHAP) refers Air Force Reserve members to needed psychological health services, including PTSD, and follows up with them to ensure they get the appropriate results. Resources are available to everyone in the Air Force Reserve, whether deployed or not, as well as their spouses and dependents.</p>				●	●			
<p>PSYCHOLOGICAL HEALTH PATHWAYS PROGRAM (Navy) http://www.navy.mil/search/display.asp?story_id=53602 The Psychological Health Pathways Program (PHP) program was implemented in August 2009 and streamlines, standardizes and manages the treatment of Service members, returning from combat zones, who require mental health services, including PTSD. The program provides a wide-range of services to Service members including assessing mental health symptoms and needs, recommending appropriate comprehensive evidenced based treatments and tracking patient progress in treatment through case management meetings and via a trauma registry to ensure Active duty and discharged veterans have follow-up care at new commands.</p>	●		●	●	●			
<p>PTSD PROVIDER TRAINING PROGRAM (DoD, CDP, DCoE) http://www.dcoe.health.mil/Content/navigation/documents/signed%20guidance%20for%20mh%20training%20for%20ptsd%20and%20asd.pdf The Office of the Assistant Secretary of Defense for Health Affairs issued a Memorandum to the Services on December 13, 2010, providing guidance on recommended training requirements for DoD and civilian mental health providers who treat Service members with PTSD and acute stress disorder.</p>				●				
<p>REAL WARRIORS CAMPAIGN (DCoE) http://www.realwarriors.net The Real Warriors Campaign is an initiative launched by DCoE to promote the processes of building resilience, facilitating recovery and supporting reintegration of returning Service members, veterans and their families. The Real Warriors Campaign promotes help-seeking behavior among Service members and veterans with invisible wounds and encourages Service members to increase their awareness and use of these resources. To reach the broadest audience possible, the campaign features a variety of strategies including outreach and partnerships, print materials, media outreach, an interactive website and social media. The campaign features stories of real Service members who have sought treatment for mental illness including PTSD, and are continuing to maintain successful military or civilian careers. In addition, DCoE established the DCoE Outreach Center, a 24/7 call center staffed by health resource consultants to provide confidential answers, tools, tips and resources about psychological health and traumatic brain injury.</p>				●	●	●	●	
<p>R&R CENTER/WARRIOR COMBAT STRESS RESET PROGRAM (Army) http://www.crdamc.amedd.army.mil/default.asp?page=randreset The Warrior Combat Stress Reset Program provides education and time-limited intensive counseling to soldiers with moderate to severe PTSD. The 11-week program includes a three-week intensive outpatient phase which incorporates alternative treatment approaches to help soldiers develop new and effective coping and self-regulation skills to manage their physical and emotional symptoms and reactions to war experiences.</p>			●	●				

Clinical Research Study	<p>SOUTH TEXAS RESEARCH ORGANIZATIONAL NETWORK GUIDING STUDIES ON TRAUMA AND RESILIENCE (University of Texas and DoD) (https://delta.utscsa.edu/strongstar/)</p> <p>The South Texas Research Organizational Network Guiding Studies on Trauma and Resilience (STRONG STAR) is a multidisciplinary and multi-institutional research consortium funded by DoD to develop and evaluate the most effective early interventions possible for the detection, prevention, and treatment of combat-related posttraumatic stress disorder (PTSD) in Active duty military personnel and recently discharged veterans. Under the leadership of the University of Texas Health Science Center at San Antonio, Department of Psychiatry, the consortium will examine a broad array of clinical, exploratory, and preclinical trials and utilizing specialized research cores to assess novel delivery methods of evidence-based PTSD treatments, specially adapted to meet the unique needs of the military population.</p>	●	●	●	●				
	<p>TRAUMATIC STRESS RESPONSE TEAM (Air Force) (http://journalrecord.com/tinkertakeoff/2010/06/01/traumatic-stress-response-team-ready-to-help-when-disaster-strikes/)</p> <p>The Traumatic Stress Response (TSR) team is an Air Force crisis response program that responds to traumatic events such as natural disasters, man-made disasters, suicides, airplane crashes and fatal accidents. TSR team members include mental health providers, chaplains, and counselors from the Airman and Family Readiness Center. The team's primary objective is to foster resiliency in those exposed to traumatic events that can potentially lead to a post-traumatic stress response. The team also provides Pre-Exposure Preparation (PEP). PEP is education and training for units and first responders, such as security forces, ambulance crews and firefighters that will likely be exposed to distressing situations outside the realm of "normal" human experience. It teaches coping skills for managing distressing situations and emphasizes resiliency and the normalcy of feeling stress under these circumstances. Because not all events require the same level of response, the preparatory education can be tailored to specific unit requirements.</p>	●	●	●	●	●	●	●	●
Demonstration Project	<p>TRICARE ASSISTANCE PROGRAM (DoD, T2, and DCoE) (http://www.tricare.mil/mybenefit/ProfileFilter.do;jsessionid=N2LPGBxdLsHxGVsTG2RJGGTLK23T8TbxGSBMcMh1RkRWGJIY(kjK!1260790818?pur=%2Fhome%2Foverview%2FSpecialPrograms%2FTRICAREAssistanceProgram)</p> <p>The web-based TRICARE Assistance Program (TRIAP) Demonstration began on August 1, 2009 and is available from any location in the United States. The purpose of this demonstration is to test the use of web-based technologies to:</p> <ul style="list-style-type: none"> • Deliver information and counseling services to our beneficiaries • Determine if web-based technologies increases efficiency of identifying beneficiaries who need behavioral health care • Identify behavioral health needs of beneficiaries earlier • Refer and get beneficiaries access to the appropriate level of behavioral health care more effectively. <p>The TRIAP Demonstration expands access to existing behavioral health services by using audiovisual telecommunications systems such as video chat and instant messaging to access existing behavioral health centers in your region. It also expands access to behavioral health call centers and counseling services for eligible beneficiaries. TRIAP services are available to: Active duty Service members, Active duty family members (<i>Children must be age 18 or older.</i>), Beneficiaries using TRICARE Reserve Select, Beneficiaries covered under the Transition Assistance Management Program (TAMP).</p>	●	●	●	●	●	●	●	●
Clinical Research	<p>VIRTUAL IRAQ/AFGHANISTAN (Army, Navy, T2, DCoE, and For-Profit) (http://ict.usc.edu/projects/ptsd/)</p> <p>Virtual Iraq/Afghanistan is an Exposure Therapy (ET) approach developed by the Institute for Creative Technology (ICT), funded by the Office of Naval Research and the Telemedicine and Advanced Technology Research Center, and is currently in use at approximately 50 sites, including VA hospitals, military bases and university centers. Thus far, in controlled clinical research studies, the approach has been shown to produce a meaningful reduction in PTSD symptoms. Additional randomized controlled studies are ongoing. Organizations using the system to treat wounded warriors and/or train clinicians include the USC School of Social Work, WRNMMC, the San Diego Naval Medical Center and Wright Patterson Air Force Base. ICT researchers are also adapting the system as a tool for stress resilience training and PTSD assessment. Future work will also involve advanced brain imaging and psychophysiological assessment.</p>			●	●	●			

APPENDIX 2 – BARRIERS TO PTSD TREATMENT

BARRIERS TO TREATMENT - TYPES OF BARRIERS	PRIMARY IMPACT ON SERVICE MEMBERS			RELEVANT 2007 DoD TASK FORCE KEY OBJECTIVES
	Biopsychosocial	Occupational	Systemic	
Biopsychosocial (BPS); Occupational (O); Systemic (S)				Leadership, Culture, Advocacy (LCA); Access to care (AC); Quality of care (QC); Resilience building and stigma reduction (R/S); Screening, Surveillance, Research, Evaluation (SSRE); Care transition and coordination (CTC); Uniform Code of Military Justice (UCMJ).

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1. Stigma - BPS, O, S	●	●	●	LCA, R/S
2. Lack of psychological health training for medical personnel - O, S			●	LCA, QC, CTC
3. Lack of primary prevention activities - O, S			●	LCA, AC
4. Lack of uniformed providers - O, S			●	LCA, QC, SSRE
5. Lack of access to TRICARE providers in community - S			●	LCA, AC, SSRE, CTC
6. Lack of services specifically for women - BPS, S			●	LCA, AC, SSRE

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7. High troop dispersion - O, S			●	LCA, AC, SSRE
8. Increased time outside of forward operating base - O, S			●	LCA, AC, SSRE
9. Embarrassment - BPS	●			LCA, R/S, CTC
10. Fear that problem will harm career - BPS, O	●	●		LCA
11. Fear that those in unit will lose confidence in service member - BPS, O	●	●		LCA, R/S
12. Fear that leadership will treat differently - BPS, O	●	●		LCA, R/S
13. Fear that leaders would blame service member for problem - BPS, O	●	●		LCA, R/S
14. Fear of being seen as weak - BPS	●			LCA, R/S
15. Mental Health services not available - O, S	●		●	LCA, AC, SSRE, CTC
16. Not sure where to get help - S	●			LCA, AC, CTC
17. Difficulty getting an appointment - BPS, O, S	●		●	LCA, AC, SSRE
18. Trouble getting time off from work - BPS, O	●	●	●	LCA
19. Problem getting to Mental Health specialist - BPS, O, S	●	●	●	LCA
20. Leaders discourage use of Mental Health services - BPS, O	●	●	●	LCA, AC
21. Providers do not like to do/are not trained for/fail to see the value in outreach services - O, S	●	●	●	LCA, QC, SSRE, CTC
22. Travel to supported units is too dangerous - BPS, O, S	●	●	●	LCA, AC
23. Lack of communication between supported units and Behavioral Health - O, S	●	●	●	LCA, AC, CTC

Additional Barriers Identified by Panel of Psychological Health Experts

24. Fear of disclosure/intimacy - BPS	●			LCA, R/S
25. Fear of loss of control - BPS	●			R/S
26. Fear of letting others down - BPS	●			LCA, R/S

27. Fear of vulnerability - BPS	●			LCA, R/S
28. Fear of being institutionalized - BPS	●			LCA, QC, R/S
29. Fear of losing partner/family - BPS	●			QC, R/S
30. Fear of UCMJ action for behavior in theater - BPS, O, S	●			LCA, QC
31. Beliefs about mental illness - BPS, O, S	●	●	●	R/S
32. Thought that others should change and accommodate to meet his/her needs - BPS	●			LCA, R/S
33. Idea that problem will go away on its own - BPS	●			LCA, R/S
34. Expectation of 'quick fix' - BPS, S	●			QC, R/S
35. Impaired problem solving - BPS	●	●		LCA, QC, R/S
36. Providers are not available after duty hours - O, S	●	●		LCA, AC
37. Mistrust of/lack of confidence in providers - BPS, O, S	●		●	QC
38. Learned helplessness - BPS, O	●			R/S
39. Avoidance - BPS	●			R/S, LCA
40. Procrastination - BPS	●			R/S, LCA
41. Denial - BPS	●			LCA, R/S
42. Cultural/gender/ethnic/family/racial background - BPS	●			LCA, R/S
43. Peer pressure - BPS, O	●			LCA, R/S
44. Previous negative experiences with Behavioral Health - BPS, S	●		●	QC, SSRE, CTC
45. Shame - BPS	●			LCA, R/S
46. Lack of knowledge/education about PTSD - BPS, S	●			LCA, R/S
47. Sense of isolation/lack of unit cohesion - BPS, O	●	●	●	LCA, R/S
48. Guilt - BPS	●			LCA, R/S
49. Difficulty putting discomfort into words - BPS, S	●			R/S, QC
50. Behavioral health co-morbidities - BPS	●			QC, R/S
51. Medical co-morbidities - BPS	●			QC, R/S
52. Fear of losing security clearance - BPS, O, S	●			LCA
53. Avoidance of medication that might interfere with readiness and ability to perform duty - BPS, O	●	●		LCA, R/S
54. Symptoms of PTSD itself (withdrawal, avoidance) - BPS	●			AC, R/S, SSRE