This report is part of the RAND Corporation research report series. RAND reports present research findings and objective analysis that address the challenges facing the public and private sectors. All RAND reports undergo rigorous peer review to ensure high standards for research quality and objectivity.

Appendix

RAND Survey of Behavioral Healthcare Providers

Overview of Measures

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Prepared for the United Health Foundation

Description of Survey Measures

The overall goal of the RAND Survey of Behavioral Health Providers was to understand the potential readiness of community-based providers to deliver high-quality behavioral health care to veterans and their families once they access such care. To assess provider readiness to deliver such care to veterans and their families, we employed a web-based survey of behavioral health providers. To assess readiness, we constructed a web-based, 25-minute survey that gathered information from current behavioral health professionals across several domains. Where possible, survey items come from or were adapted based upon prior surveys of behavioral health care professionals. RAND also developed new items in some domains. We reviewed several instruments from prior studies in topics related to our topics and population of interest. Table A.1 provides a summary of the other studies reviewed.

Table A.1 Description Studies Reviewed

Survey	Objective	Population	Date	Report / Citation
American Psychiatric Association (APA) Survey of Psychiatric Practice	To solicit representative national data on critical issues in psychiatry, including data on referrals, patient caseload, and practice characteristics	Psychiatrists participating in a research network designed to represent the discipline	1996 and 1998	Zarin, D. A., et al. (1998). Characterizing psychiatry with findings from the 1996 National Survey of Psychiatric Practice. *American Journal of Psychiatry, 155* 397–404. Suarez, A. P., Marcus, S. C., Tanielian, T. L., & Pincus, H. A. (2001, August). Trends in psychiatric practice 1988-1998 III: Professional activities and work settings. *Psychiatric Services, 52*(8). Tanielian T. L., Marcus, S. C., Suarez, A. P., & Pincus, H. A. (2001, July). Trends in psychiatric practice 1988-1998 II: Caseload and treatment characteristics. *Psychiatric Services, 52*(7). Marcus, S. C., Suarez, A. P., Tanielian, T. L., & Pincus, H. A. (2001, June). Trends in psychiatric practice 1988-1998 I: Demographic characteristics of practicing psychiatrists. *Psychiatric Services, 52*(6).
AAMC Survey	To assess the extent to which U.S. M.D.-granting medical schools are educating physicians in best practices for treating the unique needs of service members, veterans, and their families, including cultural competence and therapies for traumatic brain injury (TBI) and posttraumatic stress disorder (PTSD).	U.S. M.D.-granting medical schools	2012	Association of American Medical Colleges. (2012). *Serving Those Who Serve America Joining Forces: Results of an AAMC Survey*. Washington DC: Association of American Medical Colleges.
Air Force Mental Health Provider Survey	The survey examined Air Force mental health providers' perceptions of the Department of Defense (DoD) training on the use of evidence-based treatments for PTSD. The survey also assessed use and barriers to use of evidence-based treatment.	Air Force mental health providers	2013	Borah, E. V., et al. (2013). Implementation outcomes of military provider training in cognitive processing therapy and prolonged exposure therapy for post-traumatic stress disorder. *Military Medicine, 178*(9) 939.

Survey	Objective	Population	Date	Report / Citation
A State Needs Assessment of Civilian Behavioral Health Providers	To gather data on civilian behavioral health providers' knowledge, their practices for treating veterans and veterans' families, and their capacity to treat veterans and veterans' families	Civilian behavioral health providers licensed, Maryland	2012	Koblinsky, S. A., Leslie, L., & Cook, E. T. (2014). Treating behavioral health conditions of OEF/OIF veterans and their families: A state needs assessment of civilian providers. *Military Behavioral Health, 2*, 162–172.
Cultural Competence Self-Assessment Questionnaire	To assist organizations that serve families and children evaluate the extent to which the care they provide is culturally competent and inform the development of training activities and interventions to improve competence across cultures.	Direct-service providers and administrative staff from organizations that serve families and children	1995	Mason, J. L. (1995). *Cultural Competence Self-Assessment Questionnaire: A Manual for Users*. Portland, OR: Portland State University, Research and Training Center on Family Support and Children's Mental Health.
Patient Satisfaction Surveys to Assess Cultural Competence in Healthcare	To measure health care experiences among culturally and linguistically diverse populations and inform recommendations for improving standardized consumer surveys to better understand care experiences among ethnically and linguistically diverse populations	Key informants with expertise; patient experiences with health care systems and measuring diverse populations	2003	Morales, L. S., Puyol, J. A., & Hays, R. D. (2003, March). *Improving Patient Satisfaction Surveys to Assess Cultural Competence in Healthcare*. Oakland, CA: California Healthcare Foundation.
RAND Survey of Evidence-Based Practice Fidelity	To develop report measures for assessing clinicians' adherence to evidence-based practices for three types of psychotherapy for depression (cognitive behavioral therapy, interpersonal therapy, and psychodynamic therapy)	Clinicians (psychiatrists, psychologists, and master's-level therapists) who were connected to large managed behavioral health care organizations	2009	Hepner, K. A., Azocar, F., Greenwood, G. L., Miranda, J., & Burnam, M.A. (2010, February). Development of a clinical report measure to assess psychotherapy for depression in usual care settings. *Administration and Policy Mental Health, 37*, 221–229.
Educational Needs of Health Care Providers Working with Military Members, Veterans, and their Families	To assess mental health care professionals' capacity to provide treatment for service members, veterans, and their families. The survey specifically examined providers' practices, experiences with training, insurance acceptance, cultural competencies, and perceptions about quality of care and other issues.	Primary care and mental health professionals	2011	Kilpatrick, D. G., Best, C. L., Smith, D. W., Kudler, H., & Cornelison-Grant, V. (2011). *Serving Those Who Have Served: Educational Needs of Health Care Providers Working with Military Members, Veterans, and Their Families*. Charleston, SC: Medical University of South Carolina Department of Psychiatry, National Crime Victims Research & Treatment Center.

Survey	Objective	Population	Date	Report / Citation
Improving Treatment for Depression: Survey of Participating Psychiatrists	To collect data on the use of evidence-based practices to inform improved treatment for depression by psychiatrists in the State of New York	Psychiatrists in the State of New York	April 1996 and March 1998	New York State Psychiatric Association (1998, July). *Implementing Clinical Practice Guidelines for Major Depression" A Clinician- and Patient- Targeted Approach*. Garden City, NY: New York State Psychiatric Association.
Nurse Cultural Competence Scale	To describe the development of a Nurse Cultural Competence Scale using Mokken scaling	On-the-job nursing students in a college of technology in Taiwan	2010	Perng S. J., & Watson R. (2012, January 13). Construct validation of the Nurse Cultural Competence Scale: a hierarchy of abilities. *Journal of Clinical Nursing. 21*(11–12), 1678–1684.
Star Behavioral Health Providers Post-Training Survey: Tier 1	To assess the usefulness of Star Behavioral Health Tier 1 training	Behavioral health providers	2014	Star Behavioral Health Providers. (2014). *Star Behavioral Health Providers Post-Training Survey: Tier 1*. Center for Deployment Psychology and Military Family Research Institute.
Army Behavioral Health Practice and Treatment Study	To identify the extent to which evidence-based psychotherapy and psychopharmacologic treatments for PTSD are provided to U.S. service members in routine practice, and the degree to which they are consistent with evidence-based treatment guidelines	Army behavioral health providers	March 2010	Walter Reed Institute of Research. (2010, March). Army behavioral health practice and treatment study. *WRAIR, 1613*, Version 003.. Wilk, J. E., et al. (2013). Use of evidence-based treatment for posttraumatic disorder in Army behavioral healthcare. *Psychiatry 76*(4), 336–348.

Based on our review of these studies, we constructed a new instrument, adopting or adapting items where appropriate. The following section describes the measures used across the domains of interest.

Provider Characteristics

In addition to asking respondents to indicate their provider type (social worker, psychologist, etc.), we gathered information on provider gender, years since most recent degree, whether they ever served in the armed forces (modified from Kilpatrick et al., 2011), whether they had any close family members who have served in the military, and if they ever worked in a military setting or in the VHA, including training or fellowships (modified from Kilpatrick et al., 2011, to include military settings).

To assess how providers spend their time, we included questions about the hours they worked in the past week and the number of hours spent in direct patient care related to psychotherapy and assessments, direct patient care related to medication management, receiving supervision or consultation from others, providing supervision to others, or other professional or administrative responsibilities such as research or teaching (modified from Zarin et al., 1998, and WRAIR, 2010). One item also assessed whether they were working full time, part time, or were semi-retired, fully retired, or temporarily not in practice, with the latter two categories not included in the final sample (modified from APA, 1998).

Since different providers may approach patients using different therapeutic perspectives, we asked providers to indicate their primary therapeutic orientation with choices including acceptance and commitment/third wave, biological/psychopharmacologic, cognitive and/or behavioral, psychodynamic/relational, integrative or eclectic, or other.

In addition, we asked providers a series of questions about their involvement with provider networks that typically serve military and veteran populations, including TRICARE (the DoD insurance program for active-component service members and their families, retirees and their families, and some eligible Guard and Reserve Component personnel and their families), Military OneSource (an Employee Assistance Program-like program that employs some mental health providers), and the new VA Patient Centered Community Care Contract (established for specialty providers).

Practice and Clinical Caseload Characteristics

To understand the context in which these providers practice, we assessed a number of features of their practice setting and their clinical caseload. All questions in this section asked respondents to refer to patients seen and settings worked in during their last typical work week. All of the items in this section were adapted from previous surveys of behavioral healthcare

providers implemented by the American Psychiatric Association in 1996 and 1998 (some of which were also included in the 2010 WRAIR instrument).

We asked providers to report the size of their patient caseload (seen in the last typical work week), including patients seen in individual or family format, as well as those seen in group settings. We gathered information about the proportion of patients by the locus of care (inpatient, outpatient), by age group (under 18, 18–64, 65+), and current diagnosis using major DSM categories. We also asked respondents to estimate the proportion of their current caseload that rely upon informal caregiving assistance, were current members of the military, were former members of the military (veterans), or were family members of current or former members of the military.

In addition to understanding the demographic and clinical characteristics of their patients, we assessed the sources of payment used by the provider's patients (private insurance, Medicare, Medicaid, TRICARE, CHAMP-VA, self-pay, no charge/uncompensated, etc.). To understand the types of settings and facilities our respondents were working within (public, private, clinic, private practice, nursing home, etc.), we assessed the percentage of hours involving patient care that were spent in different physical locations. Using responses to the setting and insurance items, we were able to classify providers into one of three groups: DoD/VA providers (those providers spending any patient care time in a DoD or VA health care setting), non-DoD/VA providers who accept TRICARE, and all other providers (i.e., those that do not spend any time in a DoD or VA facility or accept TRICARE).

We also gathered the ZIP code of the facility in which the provider saw the greatest number of patients in the last typical work week. Using the ZIP code information for the provider's setting, we were able to calculate the distance between their setting and the nearest DoD or VA health care setting to create a proximity to DoD/VA variable. With this continuous variable, we also created a categorical variable for analyses—within ten miles or 11 or more miles away.

Assessment Behaviors

To understand the frequency of routine screening practices employed by behavioral health care professionals, we asked providers to report how often (using a five-point scale: never, seldom, occasionally, often, always) they screened patients to determine if they are current or former members of the Armed Forces or a family member of such a person; for history of any traumatic events, including those experienced during military service; and about stressors related to military life or being a veteran.

Military and Veteran Cultural Competence

To understand the degree to which providers were sensitive to military and veteran culture, we asked a series of questions designed to assess provider knowledge, attitudes, and understanding of military context, culture, and related assistance and care programs. While

knowledge and attitudes are important contextual issues, we also assessed routine behaviors and prior experience with respect to understanding and interacting with military and veteran populations.

To assess knowledge of military and veteran culture, eight items were adapted from a survey administered to participants in a military culture training program through the Center for Deployment Psychology and assessed provider familiarity with U.S. military culture and practices (service differences in subculture, slang, unique stressors, rank structures, reserve component differences, available health programs and adjustment services, and maladaptive behaviors learned in war) on a five-point Likert-type scale (completely unfamiliar, a little bit familiar, moderately familiar, very familiar, extremely familiar).

We gathered data on the level of comfort of providers (using a five-point Likert-type scale: very comfortable to not at all comfortable) with respect to three items: working with military service members and veterans, working with patients/clients with military and war-related stress, and working with family members of military service members or veterans. These items contributed to our assessment of attitudes relevant to cultural competence

Ten additional items examined self-reported proficiency in treating veterans and military service members in three different domains: cultural knowledge (three items), cultural sensitivity (one item), and cultural skill (six items). These items, modified from items on the Nurse Cultural Competence Scale, asked responding providers to read statements and agree or disagree on a five-point scale (strongly disagree, disagree, neither agree nor disagree, agree, strongly agree).

Finally, one yes/no item asked about prior formal training in military and veteran culture.

Using these items, we derived an overall score of cultural competence by scoring each of the item domains as follows and summing the items (range of 0–22):

- Military knowledge: If respondent answered "very familiar or extremely familiar" they were given a 1; if not, then 0 for each of the eight items (0–8 range).
- Comfort treating military and veterans: If respondent answered "most comfortable and extremely comfortable" they were assigned a 1 on each of the three items (0–3 range)
- Skills relevant to military/veteran culture:
    - Proficiency in military/veteran culture: If respondent answered "agree or strongly agree" they were coded 1; if not, then 0 for each of the ten items (0–10 range)
    - Prior training in military/veteran culture: If the respondent indicated they had received prior training in military/veteran culture they were assigned a 1.

After summing the items as indicated, a cut-score of 15 or above (out of the possible 22 points) was used to define high cultural competence.

Training in Evidence-Based Psychotherapies for PTSD and Depression

To assess provider capacity to deliver evidence-based psychotherapies for PTSD and depression, we assessed whether providers held formal certification or intensive/advanced training, and whether they had any supervised professional practice in each of five psychotherapies specified as first-line therapies for PTSD and depression in VA/DoD Clinical

Practice Guidelines (2009, 2010). Providers who had received training and supervision in at least one evidence-based psychotherapy were classified as "capable" of delivering evidence-based treatment for the given condition.

Evidence-Based Treatment Approaches

A continuous variable was used to summarize providers' reliance on evidence-based treatment modalities. Each provider estimated the percentage of patients that they treated in the last week with 16 different treatment approaches. Treatment approaches ranged from well-validated approaches to treating PTSD (e.g., Prolonged Exposure[PE]) to general therapeutic techniques without strong efficacy findings (e.g., supportive psychotherapy). Approaches included as evidence-based treatments included PTSD treatments (PE, Cognitive Processing Therapy [CPT] , Eye Movement Desensitization and Reprocessing [EMDR] , and Stress Inoculation Training [SIT]), depression treatments (Cognitive Behavioral Therapy [CBT] , Interpersonal Therapy [IPT] , and Acceptance and Commitment Therapy), and two additional treatments with support for use with patients with substance use disorders or borderline personality disorder (i.e., Motivational Interviewing, Dialectical Behavioral Therapy) (APA, 2004; Bisson & Andrew, 2007; VA/DoD, 2009, 2010; Glenberg et al., 2010; Jonas et al., 2013). Past-week evidence-based practice was summarized as the percentage of the providers' patients treated with one of the evidence-based psychotherapies listed above.

Practice Behaviors

Psychotherapy for PTSD

To assess providers' adherence to therapeutic techniques associated with three validated PTSD psychotherapies (PE, EMDR, CPT), we used a modified version of a session behavior scale developed by Wilk and colleagues (2013). The original 11-item scale was modified for this survey in three ways. First, the original scale instructions prompted providers to consider a specific, randomly selected patient with PTSD from their caseload. For ease of administration, these instructions were modified to ask providers about PTSD patients in general. Second, to reduce respondent burden, items were eliminated or modified to create a short, five-item scale. Finally, response options were modified from a dichotomous yes/no response to a Likert scale that assessed the frequency with which the provider would employ each therapeutic technique from "1" (never) to "5" (often).

Two items assessed treatment techniques representative of PE (e.g., "Ask the patient/client to recount the traumatic event(s) aloud repeatedly, including telling you the details of the event, their thoughts and feelings?"). Two items assessed techniques associated with CPT (e.g., "Ask the patient to write about the meaning of his or her traumatic event as well as beliefs about why this event happened? And then, read what they wrote out loud to you?"), and one item assessed a

technique unique to EMDR ("Have the patient focus on the traumatic image, negative thoughts, and body sensations while either (a) moving his/her eyes back and forth, laterally tracking your finger, or (b) tracking other auditory tones, tapping or other tactile stimulations?"). Psychometrics for the original scale are not available.

For this report, we summarize the proportion of providers who reported that they "often" or "always" use the therapeutic techniques associated with at least one evidence-based psychotherapy approach for PTSD. Note that providers who do not see patients with PTSD reported instead on their likelihood of using each technique if they "were to treat patients with PTSD."

Psychotherapy for Depression

We used a modified version of the Psychotherapy Practice Scale (Hepner et al., 2010) to assess providers' adherence to the therapeutic techniques associated with two evidence-based approaches to depression treatment (CBT and IPT).

The original scale prompted providers to consider a specific, randomly selected patient with depression from their caseload. For ease of administration, these instructions were modified to ask providers who treat patients with depression to estimate the frequency with which they use nine distinct therapeutic techniques. Providers who do not see depressed patients were asked to estimate the likelihood that they would use each technique if they were to treat a patient with depression. Three items assessed treatment techniques representative of CBT (e.g., "Assign 'homework' between sessions?"), three assessed techniques associated with IPT (e.g., "Help the patient to understand that addressing interpersonal situations may help improve their depression?"), and three assessed common, but less well supported, psychodynamic techniques (e.g., "Encourage the patient to talk about things in their childhood that made it difficult to discuss present-day issues?"). The nine items included for this study are a subset of the full, 16-item Psychotherapy Practice Scale (Hepner et al., 2010).

Reported psychometrics for the Psychotherapy Practice Scale are strong (Hepner et al., 2010). A factor analysis confirmed the predicted three-factor structure associated with the three treatment types; internal reliability was acceptable for all subcales (α=0.79-0.84), and subscale scores were significantly associated with self-reported adherence to the given therapeutic orientation (Hepner et al., 2010).

Given substantial scale revisions, we completed a confirmatory factor analysis with the revised items and failed to find the expected three-factor structure. A one-factor solution fit the data best (eigenvalue=3.88). Internal reliability, as measured by Cronbach's alpha, was good for each subscale (CBT=0.77; IPT=0.81; DT=0.81), but was stronger for the combined items (α=0.86). Given the failure of the revised subscales to substantially differentiate between the three therapeutic modalities, results from this scale are limited to a descriptive summary across items.

For this report, we summarize the proportion of providers who reported that they "often" or "always" use the therapeutic techniques associated with either CBT or IPT with depressed patients. Note that providers who do not see patients with depression reported instead on their likelihood of using each technique if they "were to treat patients with depression."

Medication Management for PTSD and Depression

To assess adherence to evidence-based guidelines for psychopharmacologic treatment of PTSD and major depressive disorder (APA, 2006; VA/DoD, 2009, 2010), prescribing providers listed the "two most common first-line psychopharmacologic treatments" they prescribe for patients with each condition. Providers were asked to select up to these two medications from among a list of 90 common psychoactive medications including antidepressants, anxiolytics, sedative-hypnotics, psychostimulants, and opioid analgesics. To meet our criteria for "evidence-based prescriptive practice," respondents had to select at least one antidepressant from the list for depression and at least one selective serotonin reuptake inhibitors or prazosin for PTSD.

Attitudes Toward Clinical Practice Guidelines

Clinical practice guidelines (CPGs) provide recommendations designed to improve patient care, and are developed after a systematic review of the evidence and consideration of the harm and benefit associated with a given approach (Institute of Medicine, 2011). Although the intent is to ease provider burden by succinctly recommending best practices for a given condition, some providers see CPGs as overly rigid, oversimplified, and a threat to their clinical independence. For this study, we included the 11-item CPG Attitudes Scale (New York State Psychiatric Association, 1998) as a proxy for provider attitudes toward evidence-based medicine and validated treatments for PTSD and MDD. Items are statements such as "Clinical Practice Guidelines are likely to improve the quality of care," and respondents indicate their agreement with each item on a scale from "1" (strongly disagree) to "5" (strongly agree).

Given that no psychometric information was available for the scale, we conducted an exploratory principal components analysis and confirmed a one-factor structure. The eigenvalue for the first factor was 4.60. Internal reliability among scale items was high (α=0.86). In the descriptive analyses below, scale scores are dichotomized into those who, on average, "agree" or "strongly agree" with CPG supportive statements (labeled "above threshold") and those who fall below this threshold. In regression analyses, attitude toward CPGs is entered as a continuous variable, that is, the mean of all 11 items.

The contingency tables described in the above paragraph were used to gauge the relationship between one of several outcomes of interest (e.g., competence of the provider with military and veteran culture, concordance of the provider with EBPs, provider readiness to meet mental health needs among military veterans and their families) and one of several potential "predictors" (e.g., provider type, years in practice, distance to a VA or DoD medical facility). Therefore, logistic

regression was used to assess the relationship between a binary outcome and several predictor variables simultaneously—these regressions identify which predictors (if any) are most influential with respect to a specific outcome variable.

RAND Survey of Mental Health Providers
March, 2014
- Questionnaire -

[SP]

S1. Are you trained and licensed as a professional provider of mental health services in your state?

Yes 1
No 0

[TERMINATE IF S1=0, DISPLAY A THANK YOU SCREEN]

[SP]

S2. Do you work directly with clients/patients as part of your regular professional activities?

Yes 1
No 0

[TERMINATE IF S2=0, DISPLAY A THANK YOU SCREEN]

[SP]

S3. Which best describes your provider type?

Master's-Level, licensed professional counselor (e.g., LPC or LMHC) 1
Licensed Clinical Social Worker (LCSW or MCSW) 2
Clinical Psychologist (PhD or PsyD) 3
Psychiatrist (MD or DO) 4
None of the above 5

[IF S3=5]
[SP]

S3_1. Please tell us which best describes your provider type.

Marital/Family Therapist 1
Psychiatric Nurse Practitioner 2
Physician Assistant 3
Other (please specify): **[TEXT BOX]** 4

[TERMINATE HERE IF S3=5]

[DISPLAY]
In the first few questions, we would like to learn a little about you and your prior training.

[SP]

P1. Are you:

Male.....1
Female 0

[NUMBER BOX, RANGE 1940–2014]

P2. In what year did you finish your professional training (please refer to the date you received your most recent degree)?

[NUMBER BOX] date

[SP]

P3. Have you ever served in the U.S. Armed Forces (this includes the Army, Navy, Air Force, Marine Corps, Coast Guard)?

Yes 1
No.....0

[IF P3=1]
[NUMBER BOX, RANGE 0–99]

P3a. Please indicate how long you served in the military?

[NUMBER BOX] years

[SP]

P4. Do you have any close family members who currently or formerly served in the US Armed Forces?

Yes 1
No.....0

[SP]

P5. Have you ever worked in either a military setting (such as a military treatment facility or clinic) or in the Veterans Health Administration (please include any time spent in a training fellowship, internship, or residency in a VA hospital, clinic, or vet center)?

Yes 1
No.....0

[IF P5=1]
[GRID]

P5a. How long did you spend working within a military or VA setting?

[NUMBER BOX, RANGE 0–99] years
[NUMBER BOX, RANGE 0–12] months

[GRID]
[MAKE SURE THAT THE SUM OF A-E IS NOT MORE THAN 168]

P6. In your last typical work WEEK, how many HOURS did you spend performing each of the following activities?

a. Direct patient care (individual or group psychotherapy, assessments/evaluations)	**[NUMBER BOX, RANGE 0–168]**
b. Direct patient care (medication management)	**[NUMBER BOX, RANGE 0–168]**
c. Receiving supervision or consulting with other providers related to patient care	**[NUMBER BOX, RANGE 0–168]**
d. Supervising others (trainees or residents)	**[NUMBER BOX, RANGE 0–168]**
e. Other professional and/or administrative activities not directly related to patient care (committees, CME, research, writing, training, forensic activities, etc.)	**[NUMBER BOX, RANGE 0–168]**
f. Total Number of Hours Worked LAST TYPICAL WORK WEEK	**[NUMBER BOX, AUTOMATICALLY CALCULATE TOTAL HOURS]**

[IF THE SUM OF P6_F=0 PROMPT ONCE WITH THE FOLLOWING: Earlier you told us that you worked with clients/patients as part of your mental health practice, please refer to the last typical work week that included patient care.**]**

[IF THE SUM OF P6_F=0 AFTER PROMPT THEN TERMINATE]

[IF P6_F<=20]
[SP]

P6a. Are you:

Working part-time 1
Semi-retired 2
Full-retired 3
Temporarily not in practice 4
Other (please specify): **[TEXT BOX]** 5

[IF P6A= 3 OR 4 TERMINATE]

[SP]

P7. How would you describe your primary therapeutic orientation? Please indicate your primary therapeutic orientation.

Acceptance and Commitment/Third Wave....1
Biological/Psychopharmacologic.....2
Cognitive and/or Behavioral 3
Interpersonal 4
Psychodynamic/Relational 5
Integrative or Eclectic 6
Other (please specify): **[TEXT BOX]** 7

[GRID, SP ACROSS]

P8. Have you been formally certified in or participated in intensive/advanced training in any of the following therapeutic approaches or techniques?

No	Yes
0	1

1. Prolonged Exposure
2. Cognitive Processing Therapy
3. Eye Movement Desensitization and Processing
4. Stress Inoculation Training
5. Cognitive Behavioral Therapy
6. Interpersonal Therapy (IPT)

[GRID, SP ACROSS]

P.9. When learning a new therapeutic approach or method, clinicians sometimes receive supervision (coaching or mentoring on the use of the techniques in the context of treating specific patients) when initially applying the approach. This is supervised professional experience, and is typically beyond the training received during a didactic workshop or class. Have you received supervision in any of the following therapeutic approaches or techniques (including internship or training experiences)?

No	Yes
0	1

1. Prolonged Exposure
2. Cognitive Processing Therapy
3. Eye Movement Desensitization and Processing
4. Stress Inoculation Training
5. Cognitive Behavioral Therapy
6. Interpersonal Therapy (IPT)

[DISPLAY]
In the next series of questions, we would like to learn more about your mental health care practice setting and the types of patients you serve.

[NUMBER BOX, RANGE 0–999]

PC1. In your last typical work WEEK, how many **patients** did you see in individual or family format (count multiple visits with the same patient as only one patient)?

[SHOW ON SAME SCREEN AS PC1]
[NUMBER BOX, RANGE 0–999]

PC1a. In your last typical work WEEK, how many **group sessions** did you run?

[IF THE SUM OF PC1 AND PC1A = 0 PROMPT WITH THE FOLLOWING: Earlier you told us that you worked with clients/patients as part of your mental health practice, please refer to the last typical work week that included patient care.**]**

[IF PC1A>0]
[NUMBER BOX, RANGE 0–999]

PC1b. In your last typical work WEEK, what is the average number of patients in your group sessions?

[NUMBER BOX] average number patients per group

[GRID]

PC2. In your last typical work WEEK, what percentage of your PATIENTS were seen in an:

1. Inpatient setting	**[NUMBER BOX, RANGE 0–100]** %
2. Outpatient setting	**[NUMBER BOX, RANGE 0–100]** %
3. Other setting (please specify): **[TEXT BOX]**	**[NUMBER BOX, RANGE 0–100]** %
4. TOTAL	**[NUMBER BOX, AUTOMATICALLY CALCULATE TOTAL PERCENTAGE, PROMPT IF TOTAL NE 100]** %

[GRID]

PC3. In your last typical work WEEK, what percentage of your PATIENTS were:

1. Under 18 years old	**[NUMBER BOX, RANGE 0–100]** %
2. 18 to 64 years old	**[NUMBER BOX, RANGE 0–100]** %
3. 65 years old or older	**[NUMBER BOX, RANGE 0–100]** %
4. TOTAL	**[NUMBER BOX, AUTOMATICALLY CALCULATE TOTAL PERCENTAGE, PROMPT IF TOTAL NE 100]** %

[GRID]

PC.4 In your last typical work WEEK, what percentage of your patients had a CURRENT diagnosis of (if a patient has more than one diagnosis, you can include them in more than one category):

a. Disorders usually diagnosed in infancy, childhood, or adolescence (e.g., conduct disorder, mental retardation)	**[NUMBER BOX, RANGE 0–100]** %
b. Alcohol use disorders	**[NUMBER BOX, RANGE 0–100]** %
c. Other substance use disorders	**[NUMBER BOX, RANGE 0–100]** %
d. Schizophrenia and other psychotic disorders	**[NUMBER BOX, RANGE 0–100]** %
e. Bipolar disorder or mania	**[NUMBER BOX, RANGE 0–100]** %
f. Depressive disorders (e.g., major depression, dysthymia)	**[NUMBER BOX, RANGE 0–100]** %
g. Posttraumatic stress disorder	**[NUMBER BOX, RANGE 0–100]** %
h. Other anxiety disorders (e.g., social phobia, generalized anxiety)	**[NUMBER BOX, RANGE 0–100]** %
i. Personality disorders	**[NUMBER BOX, RANGE 0–100]** %
j. Other mental disorders (e.g., adjustment disorders, delirium, dementia)	**[NUMBER BOX, RANGE 0–100]** %
k. Other (please specify): **[TEXT BOX]**	**[NUMBER BOX, RANGE 0–100]** %

[GRID]

PC6. In your last typical work WEEK, what percentage of your professional hours involving patient care was spent in the following physical locations?

a. Solo office practice (i.e., you are the only provider)	**[NUMBER BOX, RANGE 0–100] %**
b. Group office practice	**[NUMBER BOX, RANGE 0–100]** %
c. Private general hospital	**[NUMBER BOX, RANGE 0–100]** %
d. Public (non-DoD or VA) hospital	**[NUMBER BOX, RANGE 0–100]** %
e. VA facility (hospital or clinic)	**[NUMBER BOX, RANGE 0–100]** %
f. DoD hospital or clinic	**[NUMBER BOX, RANGE 0–100]** %
g. Private psychiatric hospital	**[NUMBER BOX, RANGE 0–100]** %
h. Staff or group model HMO clinic	**[NUMBER BOX, RANGE 0–100]** %
i. Private clinic/outpatient facility	**[NUMBER BOX, RANGE 0–100]** %
j. Public clinic/outpatient facility	**[NUMBER BOX, RANGE 0–100]** %
k. Nursing home	**[NUMBER BOX, RANGE 0–100]** %
l. Correctional facility	**[NUMBER BOX, RANGE 0–100]** %
m. Other (e.g., home visits), please specify: **[TEXT BOX]**	**[NUMBER BOX, RANGE 0–100]** %
TOTAL PROFESSIONAL HOURS	**[NUMBER BOX, AUTOMATICALLY CALCULATE TOTAL PERCENTAGE, PROMPT IF TOTAL NE 100]** %

[SP]

[IF MORE THAN ONE ITEMS FROM PC6 WHERE RESPONDENT ENTERED MORE THAN 0% AS THE ANSWER OPTIONS, LIST ITEMS]

[IF ONLY ONE ITEM FROM PC6 WHERE RESPONDENT ENTERED MORE THAN 0% AS THE ANSWER OPTIONS, AUTO PUNCH THE RESPONSE INTO PC7A, DO NOT SHOW PC7A]

PC7a. Of the settings you listed in the previous question, which one BEST describes the setting in which you saw the greatest number of patients in your last typical work WEEK?

[NUMBER BOX, RANGE 00000–99999]
[SHOW ON SAME SCREEN AS PC7A IF PC7A IS DISPLAYED]

PC7b. What is the ZIP code where **[IF PC7A IS DISPLAYED:**this setting**/IF ONLY ONE ITEMS FROM PC6 IS MORE THAN 0%: (IF A>0%:** the solo office practice (i.e., you are the only provider)**/IF B>0%:** the group office practice**/IF C>0%:** the private general hospital**/IF D>0%:** the public (non-DoD or VA) hospital**/IF E>0%:** the VA facility (hospital or clinic)**/IF F>0%:** the DoD hospital or clinic**/IF G>0%:** the private psychiatric hospital**/IF H>0%:** the staff or group model HMO clinic**/IF I>0%:** the private clinic/outpatient facility**/IF J>0%:** the public clinic/outpatient facility**/IF K>0%:** the nursing home**/IF L>0%:** the correctional facility**/IF M>0%:** the **[INSERT WHAT IS PUT IN THE TEXT BOX])]** is located?

[GRID]

PC8. Please estimate the percentage of your patients for which each of the following represents the MAIN source of payment for your services? (If patients have more than one source of payment, count the one that pays for the largest proportion of the costs for your services)

a. Private/commercial insurance (including all private insurance whether it is managed or not, but excluding categories below)	**[NUMBER BOX, RANGE 0–100] %**
b. Medicare	**[NUMBER BOX, RANGE 0–100]** %
c. Medicaid	**[NUMBER BOX, RANGE 0–100]** %
d. TRICARE (DoD health insurance)	**[NUMBER BOX, RANGE 0–100]** %
e. Veterans Affairs (CHAMP-VA)	**[NUMBER BOX, RANGE 0–100]** %
f. Other government/public	**[NUMBER BOX, RANGE 0–100]** %
g. No charge/uncompensated	**[NUMBER BOX, RANGE 0–100]** %
h. Self-pay (e.g., patient does not have insurance, patient chose NOT to use insurance; insurance doesn't cover services)	**[NUMBER BOX, RANGE 0–100]** %
i. Other (including worker's compensation)	**[NUMBER BOX, RANGE 0–100]** %
j. Don't know	**[NUMBER BOX, RANGE 0–100]** %
k. TOTAL	**[NUMBER BOX, AUTOMATICALLY CALCULATE TOTAL PERCENTAGE, PROMPT IF TOTAL NE 100]** %

[NUMBER BOX, RANGE 0–100]

PC9. What percentage of ALL patients in YOUR current caseload rely upon informal caregiving assistance for help in getting to/from appointments, for help with following your treatment recommendations (such as reminders to take medications), or for help in managing their health (this can include parents, spouses, or other informal caregivers for your patients)?

_____% **[NUMBER BOX, RANGE 0–100]**
[SP] Don't know

[GRID]

PC10. What percentage of ALL your PATIENTS in your current caseload are:

Current members of the military	**[NUMBER BOX, RANGE 0–100]** %

[SP] Don't Know

[GRID]

PC11. What percentage of ALL your PATIENTS in your current caseload are:

Veterans (former members of the military)	**[NUMBER BOX, RANGE 0–100]** %

[SP] Don't Know

[GRID]

PC12. What percentage of ALL your PATIENTS in your current caseload are:

Family members of current or former military members/veterans	**[NUMBER BOX, RANGE 0–100]** %

[SP] Don't Know

[GRID]

[COLUMN LABEL FOR THE % NUMBER BOX 'Percentage of Patient Care Time**']**

PB1. In your last typical work WEEK, what percentage of the **time** did you see patients in the following formats:

1. Individual session	**[NUMBER BOX, RANGE 0–100] %**
2. Group session	**[NUMBER BOX, RANGE 0–100]** %
3. Family session	**[NUMBER BOX, RANGE 0–100]** %
4. Couples/marital session	**[NUMBER BOX, RANGE 0–100]** %
5. TOTAL PATIENT CARE TIME	**[NUMBER BOX, AUTOMATICALLY CALCULATE TOTAL PERCENTAGE, PROMPT IF TOTAL NE 100]** %

[GRID]

[COLUMN LABEL FOR THE % NUMBER BOX 'Percentage of Patients**']**

PB2. In your last typical work WEEK, what percentage of your **patients** did you treat with each of the following (whether or not they were also being treated with medications):

(If a patient is being treated with multiple techniques or is receiving techniques in combination, count the patient only in the technique PREDOMINANTLY used with that patient)

1. Supportive Psychotherapy (including psychiatric management)	**[NUMBER BOX, RANGE 0–100]** %
2. Insight-Oriented/Psychodynamic Psychotherapy	**[NUMBER BOX, RANGE 0–100]** %
3. Motivational Interviewing	**[NUMBER BOX, RANGE 0–100]** %
4. Cognitive Behavioral Therapy (CBT)	**[NUMBER BOX, RANGE 0–100]** %
5. Prolonged Exposure (PE)	**[NUMBER BOX, RANGE 0–100]** %
6. Cognitive Processing Therapy (CPT)	**[NUMBER BOX, RANGE 0–100]** %
7. Eye Movement Desensitization and Processing (EMDR)	**[NUMBER BOX, RANGE 0–100]** %
8. Dialectic Behavior Therapy (DBT)	**[NUMBER BOX, RANGE 0–100]** %
9. Stress Inoculation Training (SIT)	**[NUMBER BOX, RANGE 0–100]** %
10. Family-Focused Therapy	**[NUMBER BOX, RANGE 0–100]** %
11. Interpersonal Therapy (IPT)	**[NUMBER BOX, RANGE 0–100]** %
12. Acceptance and Commitment Therapy	**[NUMBER BOX, RANGE 0–100]** %
13. Expressive or Creative Arts Therapy	**[NUMBER BOX, RANGE 0–100]** %
14. Child Play Therapy	**[NUMBER BOX, RANGE 0–100]** %
15. Other types of psychotherapy (please specify): **[TEXT BOX]**	**[NUMBER BOX, RANGE 0–100]** %
16. No psychotherapy (e.g., evaluation, and/or medication only)	**[NUMBER BOX, RANGE 0–100]** %
17. TOTAL PERCENTAGE OF PATIENTS	**[NUMBER BOX, AUTOMATICALLY CALCULATE TOTAL PERCENTAGE, PROMPT IF TOTAL NE 100]** %

[GRID, SP ACROSS; SHOW STATEMENTS ON 2 SEPARATE SCREENS]

PB3. How often do you or does your clinic/practice setting support staff implement the following approaches in your mental health care practice?

Never	Seldom	Occasionally	Often	Always
1	2	3	4	5

1. Screen patients to determine if they are current or former members of the Armed Forces or a family member of such a person
2. Screen patients for history of any traumatic events, including those experienced during military service
3. Screen patients about stressors related to military life or being a veteran
4. Screen patients for depression using a validated tool such as the Patient Health Questionnaire-8 or -9 item (PHQ-8 or PHQ-9)
5. Screen patients for posttraumatic stress disorder using a validated screening tool such as the posttraumatic stress disorder check list (PCL)
6. Screen patients for alcohol and/or drug use using a validated screening such as the CAGE or the AUDIT
7. Screen patients for suicidal ideation or risk
8. Screen patients for sleep-related problems (e.g., sleep duration, sleep quality)
9. Screen or assess patients for physical health–related problems (e.g., other chronic medical conditions or illnesses)
10. Screen or assess patients for pain-related concerns (e.g., migraines, low back pain)
11. Engage other clinicians (primary care providers or other behavioral health providers) for treatment planning, coordination, and/or implementation
12. Engage members of the patient's family in treatment planning, coordination, and/or implementation

[GRID, SP ACROSS]

KMV1. Using the scale below, please rate your current level of knowledge of the following topics?

As you consider your knowledge and awareness of our Armed Forces (U.S. Army, Navy, Air Force, Marine Corps, and Coast Guard), please rate your level of familiarity with the following:

Completely unfamiliar	A little bit familiar	Moderately familiar	Very familiar	Extremely familiar
1	2	3	4	5

1. Military rank structure
2. The subculture of military branches
3. Differences and similarities between active and reserve components of the military
4. General and deployment-related military slang and terms
5. General and deployment-related stressors for service members and veterans
6. General and deployment-related stressors for military families
7. Programs and services available to support healthy adjustment for military-affiliated clients
8. How behaviors learned in war can be maladaptive at home

[SP]

KMV2. Have you participated in any formal training regarding military and veteran culture?

Yes 1
No 0

[SP]

KMV3. Are you interested in receiving formal training regarding military and veteran culture?

Yes 1
No 0

[GRID, SP ACROSS]

KMV4a. Are you registered as part of one of the following networks of providers to receive referrals and/or provide services to service members, veterans, or their family members?

Yes	No	Don't know
1	2	3

1. TRICARE (through HealthNet Federal Services, Humana Military, or United Healthcare Military and Veterans)
2. Give An Hour
3. Military OneSource
4. STAR Behavioral Health Providers
5. IAVA's Rapid Response Referral Program
6. Veterans Patient Centered Community Care Contract (through HealthNet or TriWest)

[IF ANY OF KMV4A=2 OR 3]
[GRID, SP ACROSS]

KMV4b. Would you be interested in joining one of these networks in order to receive referrals to provide services to service members, veterans, or their family members?

Yes	No	Don't know
1	2	3

1. **[IF KMV4A_1=2 OR 3]** TRICARE (through HealthNet Federal Services, Humana Military, or United Healthcare Military and Veterans)
2. **[IF KMV4A_2=2 OR 3]** Give An Hour
3. **[IF KMV4A_3=2 OR 3]** Military OneSource
4. **[IF KMV4A_4=2 OR 3]** STAR Behavioral Health Providers
5. **[IF KMV4A_5=2 OR 3]** IAVA's Rapid Response Referral Program
6. **[IF KMV4A_6=2 OR 3]** Veterans Patient Centered Community Care Contract (through HealthNet or TriWest)

[GRID, SP ACROSS, SHOW QUESTIONS ON 2 SEPARATE SCREENS]

KMV5. Please indicate your level of agreement with each of the following statements.

Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
1	2	3	4	5

1. I can list methods or ways of collecting a military history and related mental health information (e.g., military and veteran benefits, options or eligibility for care)
2. I can explain how the perceptions of mental health beliefs are influenced by military and veteran culture
3. I usually actively strive to understand each military and veteran client's values and beliefs
4. I can teach and guide colleagues on the important features of military culture
5. I can teach and guide colleagues on planning mental health care for military and veteran clients
6. I can teach and guide colleagues on effective communication skills with military and veteran clients
7. Collecting information on a military or veteran client's mental health is easy for me
8. When implementing care, I can fulfill the mental health needs of military and veteran clients
9. I have the skills to communicate effectively with military and veteran clients
10. Diagnosing and treating military personnel and veterans with mental health problems is no different than diagnosing and treating civilians with mental health problems

[SP]

EBP_P. In the past three months, have you treated a patient with posttraumatic stress disorder (PTSD)?

Yes 1
No 0

[GRID, SP ACROSS]

STEM1. **[IF EBP_P=1]** In general, when treating patients with PTSD, how often do you…

STEM2. **[IF EBP_P=0]** If you were to treat patients with PTSD, how often would you …

Never	Seldom	Occasionally	Often	Always
1	2	3	4	5

EBP_PTSD1. Ask the patient/client to recount the traumatic event(s) aloud repeatedly, including telling you the details of the event, their thoughts and feelings?

EBP_PTSD2. Have the patient focus on the traumatic image, negative thoughts, and body sensations while either (a) moving his/her eyes back and forth, laterally tracking your finger, or (b) tracking other auditory tones, tapping or other tactile stimulations?

EBP_PTSD3. Ask the patient to write about the meaning of his or her traumatic event as well as beliefs about why this event happened? And then, read what they wrote out loud to you?

EBP_PTSD4. Either ask the patient to listen to recording of his or her recounting of the traumatic event, or work on in vivo exposure tasks in between sessions?

EBP_PTSD5. Ask the patient to complete self-monitoring homework through Antecedent Behavior Consequence (ABC) worksheets, identifying the connection between events, thoughts, and feelings?

[SP]

EBP_D1. In the past three months, have you treated a patient with depression?

Yes 1
No 0

[GRID, SP ACROSS; SHOW QUESTIONS ON 2 SEPARATE SCREENS]

STEM1. **[IF EBP_D1=1]** In general, when treating patients with depression, how often do you…

STEM2. **[IF EBP_D1=0]** If you were to treat patients with depression, how often would you…

Never	Seldom	Occasionally	Often	Always
1	2	3	4	5

EBP_MDD1. Help the patient to understand which thoughts are helpful and which thoughts are not (e.g. explain the cognitive triad, identify negative thinking)?

EBP_MDD2. Assign "homework" between sessions (e.g. asked patient to complete Mood Rating Scale or record of thoughts, feelings, or activities)?

EBP_MDD3. Ask the patient to monitor their activities or do things they enjoyed doing between sessions (e.g. behavioral activation, increasing pleasurable activities, recording pleasure ratings, developing an activity schedule)?

EBP_MDD4. Examine the emotional response the patient had during interpersonal interactions?

EBP_MDD5. Help the patient to understand that addressing interpersonal situations may help improve their depression?

EBP_MDD6. Assess the positive and negative aspects of how the patient got along with others in the past (i.e. a prior social role, dysfunctional patterns, depth of intimacy in previous relationships)?

EBP_MDD7. Discuss the patient's feelings toward you (e.g. transference)?

EBP_MDD8. Encourage the patient to talk about things in their childhood that made it difficult to discuss present day issues?

EBP_MDD9. Explore the deeper emotional meaning of the patient's concerns or behaviors (e.g. subconscious motives)?

[GRID, SP ACROSS; SHOW STATEMENTS ON 2 SEPARATE SCREENS]

CPG. The following questions refer to the clinical practice guidelines, defined as "systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances." Please consider the clinical practice guidelines developed by medical societies or by the government when answering the following questions.

Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly agree
1	2	3	4	5

1. Clinical Practice Guidelines are likely to reduce uncertainty in complicated cases
2. Clinical Practice Guidelines are unbiased syntheses of expert opinion
3. Clinical Practice Guidelines are oversimplified or "cookbook" medicine
4. Clinical Practice Guidelines are too rigid to apply to individual patients
5. Clinical Practice Guidelines are likely to improve quality of care
6. Clinical Practice Guidelines are likely to help communication with patients and families regarding treatment options and outcomes
7. Clinical Practice Guidelines are likely to interfere with the physician/patient relationship
8. Clinical Practice Guidelines are likely to decrease clinician satisfaction
9. Clinical Practice Guidelines are helpful in areas where my clinical skills are weakest
10. Clinical Practice Guidelines are helpful even when I know a lot about the guidelines topic
11. Clinical Practice Guidelines are of little use

[GRID, SP ACROSS]

CPG12_14. Please indicate your level of familiarity with the Department of Defense/Department of Veterans Affairs resources for providers:

Not at all familiar	Somewhat familiar	Very familiar
1	2	3

1. DoD/VA Practice Guideline for Treating Major Depression
2. DoD/VA Practice Guideline for Treating Posttraumatic Stress Disorder
3. Web-based resources for mental health providers through websites and webinars sponsored by the National Center for PTSD, Defense Centers of Excellence for PH and TBI, the National Intrepid Center of Excellence, etc.

[GRID, SP ACROSS]

C1. Please indicate your level of comfort, using a 5-point scale from not at all comfortable to extremely comfortable:
How comfortable are you in:

Not at all comfortable	A little comfortable	Moderately comfortable	Mostly comfortable	Extremely comfortable
1	2	3	4	5

1. Working with patients/clients who have depression?
2. Working with patients/clients who have PTSD?
3. Working with military service members and veterans?
4. Working with patients/clients with military and war-related stress?
5. Working with family members of military service members or veterans?

PP1. Do you currently have medication prescribing privileges?

Yes 1
No 0

[IF PP1=1]
[DISPLAY]

For the remaining questions, answer using the two-digit numbers from the alphabetized medication table on the next screen.

[IF PP1=1]
[GRID]

PP2. Please list the two most common first-line psychopharmacologic treatments you prescribe for **major depressive disorder** in patients.

[WHEN RESPONDENT CLICKS "HERE" IT SHOULD OPEN THE MEDICATION LIST IN A NEW WINDOW (MEDICATION LIST IS AT THE END OF THE QUESTIONNAIRE]

Click here for the medication list and enter the 2-digit medication ID in the answer boxes below.

Medication 1 **[NUMBER BOX, TWO DIGIT; RANGE 01 - 90]**
Medication 2 **[NUMBER BOX, TWO DIGIT; RANGE 01 - 90]**

[IF PP1=1]
[GRID]

PP3. Please list the two most common first-line psychopharmacologic treatments you prescribe for **posttraumatic stress disorder** in patients.

[WHEN RESPONDENT CLICKS "HERE" IT SHOULD OPEN THE MEDICATION LIST IN A NEW WINDOW (MEDICATION LIST IS AT THE END OF THE QUESTIONNAIRE]

Click here for the medication list and enter the 2-digit medication ID in the answer boxes below.

Medication 1 **[NUMBER BOX, TWO DIGIT; RANGE 01 - 90]**

Medication 2 **[NUMBER BOX, TWO DIGIT; RANGE 01 - 90]**

[DISPLAY]

Thank you very much for your participation in this survey.

Medication List: Use 2 digit codes to answer questions PP2 and PP3

ID	Common Name	Medical Name	ID	Common Name	Medical Name
01	Abilify	aripiprazole	46	Pristiq	Desvenlafaxine
02	Ambien	zolpidem	47	Prolixin	Fluphenazine
03	Ambien CR	zolpidem	48	Prozac	Fluoxetine
04	Anafranil	clomipramine	49	Remeron	Mirtazapine
05	Asendin	amoxapine	50	Restoril	Temazepam
06	Atarax	hydroxyzine	51	Risperdal	Risperidone
07	Ativan	lorazepam	52	Sarafem	Fluoxetine
08	Aventyl	nortriptyline	53	Serax	Oxazepam
09	Benadryl	diphenhydramine	54	Seroquel	Quetiapine
10	BuSpar	buspirone	55	Sinequan	Doxepin
11	Celexa	citalopram	56	Sonata	Zaleplon
12	Clozaril	clozapine	57	Stelazine	Trifluoperazine
13	Cymbalta	duloxetine	58	Surmontil	Trimipramine
14	Depakote	divalproex	59	Tegretol	Carbamazepine
15	Depakote	valproate	60	Thorazine	Chlorpromazine
16	Desyrel	trazodone	61	Tofranil	Imipramine
17	Effexor	venlafaxine	62	Tofranil-PM	Imipramine
18	Effexor XR	venlafaxine	63	Topamax	Topiramate
19	Elavil	amitriptyline	64	Tranxene	Clorazepate
20	Eskalith	lithium carbonate	65	Trilafon	Perphenazine
21	Fanapt	iloperidone	66	Trileptal	Oxcarbazepine
22	Geodon	ziprasidone NCL	67	Valium	Diazepam
23	Halcion	triazolam	68	Vasoflex	Prazosin
24	Haldol	haloperidol	69	Vivactil	Protriptyline
25	Invega	paliperidone	70	Vistaril	Hydroxyzine
26	Hypovase	prazosin	71	Wellbutrin	Bupropion
27	Klonopin	clonazepam	72	Wellbutrin SR	Bupropion
28	Lamictal	lamotrigine	73	Wellbutrin XL	Bupropion
29	Lexapro	escitalopram	74	Xanax	Alprazolam
30	Librium	chlordiazepoxide	75	Zoloft	Sertraline
31	Loxitane	loxapine	76	Zyban	Bupropion
32	Ludiomil	maprotiline	77	Zyprexa	Olanzapine
33	Lunesta	eszopicione	78	Mellaril	Thioridazine
34	Luvox	fluvoxamine	79	Orap	Pimozide
35	Moban	molindone	80	belladonna and opium	belladonna and opium
36	Minipress	prazosin	81	Codeine	Codeine
37	Navane	thiothixene	82	Dilaudid	Hydromorphone
38	Neurontin	gabapentin	83	Duragesic	Fentanyl
39	Norpramin	desipramine	84	Methadone	Methadone
40	Pamelor	nortriptyline	85	Morphine	Morphine
41	Paxil	paroxetine	86	Norco	hydrocodone and acetaminophen
42	Pexeva	paroxetine	87	Oxycontin	Oxycodone
43	Paxil CR	paroxetine	88	Percocet	oxycodone and acetaminophen
44	Pertofrane	desipramine	89	Tylenol 3	acetaminophen and codeine
45	Pressin	prazosin	90	Ultram	Tramadol

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